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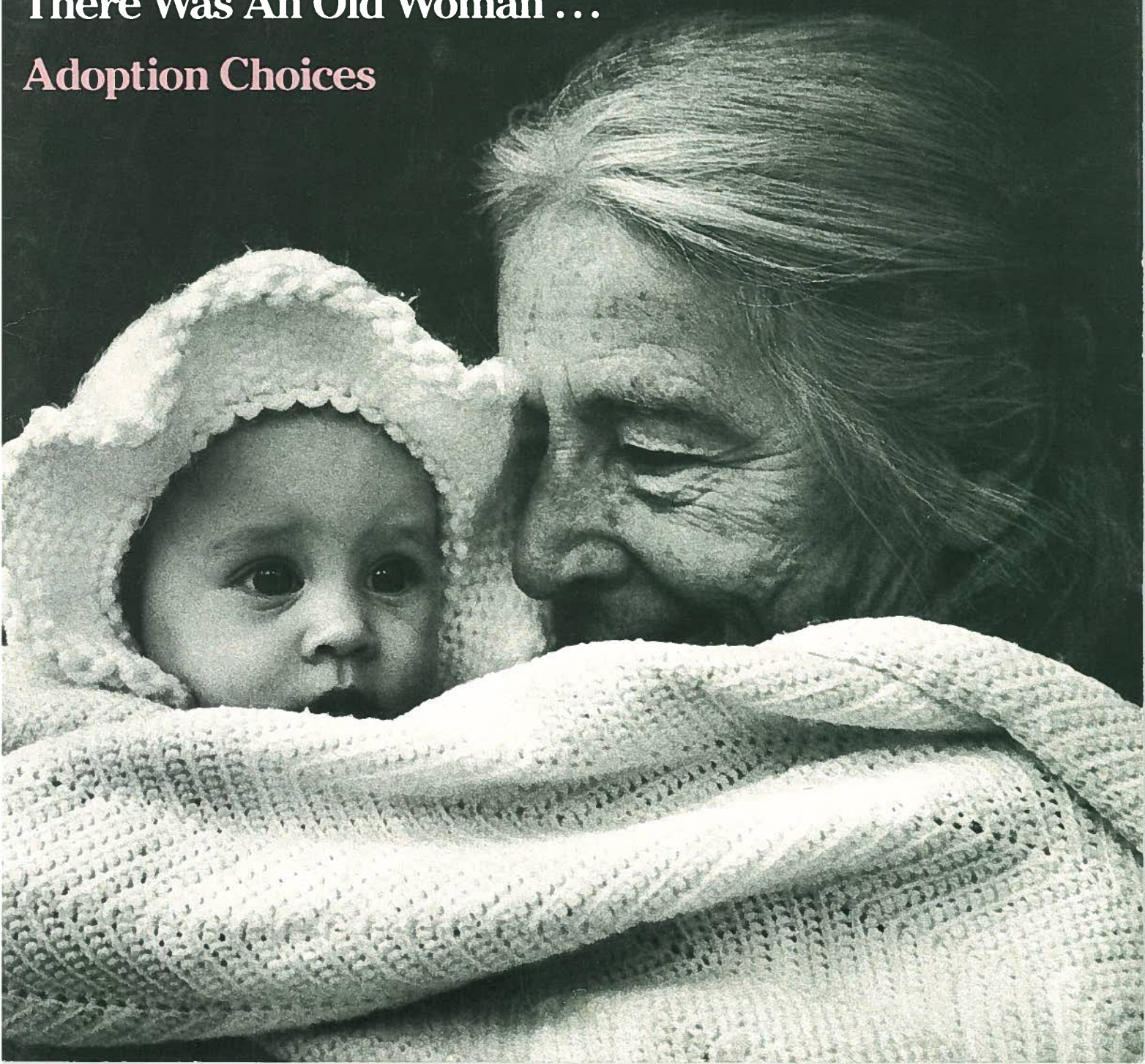
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Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

There Was An Old Woman ...

Adoption Choices



INSIDE

Healthsharing

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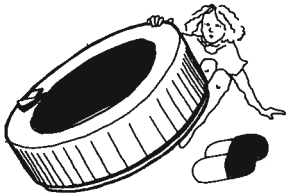
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COLLECTIVE NOTES

Emergency Consultation '86

Over the past century, women in Canada have claimed equal rights with men... Long and difficult struggles resulted in modest progress in terms of new legislation. Often, efforts to obtain implementation of the new laws were as arduous as had been the efforts to win their adoption in the first place.

Madeleine Parent

— written for use at the emergency consultation with Secretary of State, June, 1986

By the time this editorial is in your hands we hope that women's volunteer organizations across Canada will have received long awaited payments from the Secretary of State Women's Program. A government freeze this spring placed many organizations in jeopardy and caused upheaval and uncertainty in others. (Some examples are reported in our Update column.)

Concern about the freeze and persistent rumours of a government plan to dismantle the program entirely heightened anxiety during the spring and early summer. In response, Joan Brown Hicks, then president of the Canadian Congress for Learning Opportunities for Women (CLOW), convened a meeting of women to plan an emergency consultation with the Secretary of State. *Healthsharing* was among the organizations whose representatives made up this planning committee. On May 23 a decision was made to meet with the minister on an emergency basis.

Less than one month later, one representative from each of 55 women's organizations from across Canada met in Ottawa to begin the three-day consultation. Every province and territory was represented, as well as native and Inuit women, women of colour, disabled, and immigrant women. It was a formidable delegation.

Three very full days later, after

meetings with the Women's Program staff, the then Secretary of State, Benoit Bouchard and an informal reception open to all MPs, the event was declared a success.

We had called on the government to guarantee the existence of the Women's Program with its mandate to fund women's volunteer organizations working to improve the status of women. We wanted assurance that funding to the Women's Program would not be cut; on the contrary, we wanted it increased. And we wanted a promise that money expected on April 1 would be forthcoming as soon as possible. Our questions to the minister were designed to elicit a *government* commitment on all of these issues.

In response, M. Bouchard stated that the existence of the Women's Program was not in question. He announced that its budget had at last been established — \$12.5 million for this fiscal year. He said that all groups under his ministry had suffered a five per cent cut with the exception of organizations representing the disabled. M. Bouchard agreed with the delegation that private sector funding was not the answer for these women's groups and therefore, he said, that the government wanted to increase its support. However, he said, the situation was "complex."

Our co-chair, Joan Brown Hicks, responded that women find this budget cut unacceptable. While we recognize that the government's objective is to reduce the deficit, until women have reached equality in society we are not prepared to contribute to this reduction. We feel strongly that subsidies to groups working to improve the status of women should be increased by 13 per cent to return to the 1984 level.

The delegation was confident and assertive through all the meetings. Inspired by the statement of purpose

by NAC delegate, Madeleine Parent, we took a strong position with the minister. Parent urged women not to go to the government begging for things they had already won. She reminded everyone of the Canadian government's repeated commitment to the achievement of the equality of women, beginning with its endorsement of the United Nations Universal Declaration of Human Rights of 1948. Since then there have been a Royal Commission on the Status of Women, 1967-1970; the funding of the Women's Program, Secretary of State, in 1973; and the institution of a Minister Responsible for the Status of Women in 1976. Many other policy statements endorsing improvements in the status of women have been made by the government over the years.

During the entire planning process there were rumours of a cabinet shuffle. The committee did not want to delay the consultation which we considered urgent and so we were careful to ask M. Bouchard to commit not just himself but the government. Two days after our meeting with Benoit Bouchard, it was announced that he had been re-assigned and that a new Secretary of State, David Crombie had been appointed. We are now planning to meet with the new minister at the earliest opportunity.

To reinforce the achievements of the women's delegation, we urge our readers to telephone, write and meet with members of parliament in the ridings. Inform them of the important work groups funded by the Women's Program. Urge MPs to communicate with The Hon. David Crombie, Secretary of State and Minister for Multiculturalism about their support for the program. In six months he will be negotiating with the Treasury Board for next year's budget. He needs to understand the importance of the work being done by women's volunteer groups and the crucial role of the Women's Program in that work. He will need the support of other cabinet members and MPs.

Women's Program funding must be secured and increased.

Elizabeth Amer, Amyra Braha, Connie Clement, Susan Elliott, Deborah Feinstadt, Connie Guberman, Diana Majury, Lisa McCaskell, Heather Ramsay

UPDATE

Psychiatric definitions defeated

Intense lobbying efforts by feminist psychiatrists, psychologists, therapists and women's groups throughout Canada and the U.S. have convinced the American Psychiatric Association (APA) to reject three new definitions of psychiatric illness.

The APA renamed premenstrual tension as *periluteal phase dysphoric disorder*. A woman who suffers from low self-esteem and negative self-image is labelled as having a *self-defeating personality disorder*. Men who rape are said to have *paraphilic coercive disorder*. All of these definitions are distinctly anti-female and dangerous.

After months of controversy, the APA board of governors voted 10 — 4 not to include the new definitions in its Diagnostic and Statistical Manual of Mental Disorders (DSM 3). The opposition led by individuals and groups such as the American Psychological Association, NAC and the National Organization of Women succeeded in removing paraphilic coercive disorder from the manual completely. If it had been listed as a psychiatric disorder, this would "legitimize sexual abuse," said Toronto psychologist Paula Caplan, who spearheaded the Canadian movement to reject the diagnostic categories.

The other two definitions

will be listed in the appendix of the manual. "There is still a real concern," says Caplan "that these definitions could very well be listed in the DSM 4 in the 1990s. The admission of premenstrual tension as a category of mental illness gives credibility to the idea that "women still go insane once a month," says Caplan. Self-defeating personality disorder is particularly insidious and dangerous. It ultimately means that the expected and traditional behaviour of women can be labelled sick.

The claim that these definitions are based primarily on science and grounded in scientific research is vehemently denied by Dr. Caplan and others. In September, the board of the APA will review these diagnoses. "We won a victory but still need to be very concerned," said Caplan to Healthsharing.

Letters of support and contributions would be most welcome and should be sent to Dr. Paula Caplan, OISE, 252 Bloor St. West, Toronto, Ont. M5S 1V6.

DEBORAH FEINSTADT

Depo Provera hearings

The federal government is holding closed meetings on the controversial contraceptive, Depo Provera this fall. Although the Canadian Coalition on Depo Provera had urged Minister of Health Jake Epp to establish a *public inquiry* to assess the safety of the drug, the meetings are by invitation only. Fifteen to 20 groups in each of six cities are presenting briefs between September 4 and 22.

The coalition is very concerned about the composition of the panel hearing the briefs. In a letter to Epp, the coalition asked that the panel "reflect a range of disciplines and viewpoints" and specifically requested there be equal consumer and medical representation.

According to a story by Ann Pappert in the *Globe and Mail*, panel members will include three doctors and no representatives from the community. Although panel members are

supposed to be neutral, one of the doctors, Norman Barwin has already said he believes Depo Provera is useful as a contraceptive.

The role of the panel remains undefined. Although the government states that the panel is to hear briefs and present a summary, some panel members assume that they will be making recommendations for the future use of the drug.

The safety of Depo Provera has been debated for years in both the United States and Canada. The use of Depo as a contraceptive was denied in the U.S. in 1984 after lengthy hearings and public debate. In Canada, it is approved for use in palliative treatment of some cancers and for endometriosis. Its use as a contraceptive has been approved in more than 80 other countries despite the fact that Depo has been linked to cancer, blindness and other side effects over long term use.

Right to life rout

There was good news this summer for residents of the Markham-Stouffville area near Toronto. None of the recently elected board members for the Markham-Stouffville Hospital, scheduled to open in 1988, were candidates backed by the York South Right To Life organization. Last year the Right To Life group, along with several churches, urged their followers to become voting hospital members. The strategy worked. Anti-choice candidates were voted on, and several long standing devoted trustees were voted off the 27 member board. The community was shocked and disappointed. This year many pro-choice supporters, determined not to let this happen again, became voting

members as well. The question of whether or not the Markham-Stouffville Hospital will have a Therapeutic Abortion Committee fuelled the annual meeting, resulting in hundreds arriving to cast their votes for the 9 positions open each year. Over 2,000 members in all showed up, the largest turnout yet. Each one had to dodge through a dozen anti-choice leafleters passing out names of candidates sympathetic to their cause. However, the victory which ensued was proof that the community would never again stand back and watch a special interest group take control of the hospital board.

KATHRYN GREENWOOD

Health north and south

A recent conference in Montreal entitled "Health: a Social Phenomenon?" was the first public appearance of AMARC — l'Association Médicale pour l'Amerique Latine et les Caraïbes. AMARC is a Montreal based group, formed one year ago to forge links and promote exchange between health care workers in Quebec and Latin America. Activities to date have included monthly educational sessions (such as a recent one on the health effects of torture) and the establishment of an ongoing committee structure. Last year AMARC sent a group of doctors to Nicaragua and this year doctors and nurses will travel to Nicaragua for a November health conference

after which they will do two weeks of volunteer work.

AMARC's conference marked their readiness to expand into new areas as well as to attract new members. Speakers such as Vincente Navarro (a well-known writer and theoretician on the politics of health care), Asa Christine Laurell (a Swedish teacher of social medicine) and Giles Bibeau (a third world activist and teacher of community health at Université de Montréal) highlighted the importance of the social and political dimensions of health care. The conference helped the participants learn more about the particular health care challenges in Latin American countries — for

instance, how 'aid' money sent to many countries ends up working against health care goals by being spent on more arms. Appreciation for many of our common concerns was brought out in a forum on urban community health co-chaired by a Nicaraguan MD and a Quebec community doctor. Plans are under way for a one day conference on the use of the media for health education in Latin and North America. Individuals interested in AMARC (you don't need to be a health care worker to join) can call (514)842-4345.

DEBORAH VAN WYCK (with thanks to CLARA VALVERDE)

Breast still best

La Leche League Canada, an organization that provides information and encouragement to women who wish to breastfeed their babies, celebrates 25 years in Canada this year. LLLC has over 400 groups and 1000 leaders across the country who provide information and support through meetings, telephone information lines and group libraries. La Leche League has for many years advocated that women take control of nourishing their children through informed and free choice. The organization began in Canada in 1961 at a time when the word "breast" could scarcely be mentioned in the media and those who did breastfeed were in the minority. LLLC has changed attitudes. Now over 60% of Canadian mothers leaving hospital breastfeed. The advantages of breastfeeding are widely acknowledged, from the emotional bonding of the mother and infant to the extensive health benefits to both.

La Leche League maintains an extensive publishing program for both the public and health professionals. Available reference materials include "Breastfeeding and Drugs in Human Milk" which lists drugs by chemical and brand name, quotes the latest findings on their effect on nursing babies and supplies bibliographic information on the original studies. LLLC celebrated its quarter century in Canada with "LLLC — A Resource for Canadian Families" — a national conference in Ottawa this past July.

JANICE HANDFORD

Nova Scotia consumer support network

HALIFAX — The Consumer Support Network (CSN) is entering its third year of enabling Nova Scotian women to participate in planning a new maternity hospital. The CSN was formed in 1984 when the Salvation Army announced its intention to appoint one consumer representative to each of six committees which would plan the proposed new Grace Maternity Hospital in Halifax. CSN works in two ways — it provides the consumer reps with political, organizational and some financial support and it gives the women and families of the province a means to get their ideas before the planning committees.

During the first year of operation, CSN worked mainly through its newsletter CSN UPDATE, concentrating on establishing the network (the mailing list has grown from 13 to over 300 groups and individuals), publicizing the existence and function of the

consumer representatives, and gathering feedback from women on such planning issues as in-hospital childcare, access to medical records and research data, and alternative maternity care such as midwifery and out-of-hospital services. Over the past year CSN has made an effort to reach less accessible groups of mothers and has focused on arranging for groups like

parents of twins, disabled women, single mothers, birth parents, Forces wives, and wives of foreign students to meet with the consumer reps and talk about their special needs and viewpoints.

For more information write: Consumer Support Network, c/o PCANS, PO Box 5052 Armdale, Halifax, N.S. B3L 4M6.

JAN CATANO

Vaginitis linked to TSS

Women with a recent history of vaginitis could run up to twice the risk of acquiring toxic shock syndrome (TSS), according to a study conducted by doctors in Massachusetts. The study also found that women whose tubes were tied were more likely to acquire TSS than women without tubal ligations.

The study, published in the

American Journal of Obstetrics and Gynecology found that the use of oral contraceptives seems to lessen the risk of TSS.

While results are not conclusive, the study's findings do suggest that factors other than only menstruation and tampon use may lead to TSS.

ANNA KOHN

Funding — a national women's issue

The problems and struggles faced by Canadian women's groups are diverse, differing north to south, east to west. Yet one common factor shared by all of our organizations is the money problem. Chronically short of money and never certain that funding will continue from year to year, nevertheless, we accomplish incredible amounts of work.

This spring, as we at *Healthsharing* tried to cope with a funding freeze at Secretary of State, our primary source of operational funding (see *Collective Notes*), we began hearing stories from women's groups across the country. Some had received no funding, some had received interim funding and other groups were not even eligible for federal government funding.

Whether different organizations receive federal, provincial or regional funding, the stories are the same. How is it possible to do long term planning on a short term budget? How can groups maintain credibility in their community when financially, they are insecure and cannot always complete the projects? How can we hire staff and keep them when we cannot offer financial security? How can we give enough energy to our work when so much time and effort go into fundraising, proposal writing and reporting? These are a few of the questions that arose again and again. The following is a short survey of a few groups across the country and the problems they face. Not all of them receive Secretary of State funding.

St. John's funding problems

The St. John's Status of Women Council was founded in 1972. Since that time, the council has been involved in many issues of concern to women, most notably, the Matrimonial Property Act, non-sexist school texts, health, violence, education, constitutional rights, peace and poverty. We have received grants from Labour Canada, Health and Welfare Canada, CEIC, Provincial government and Secretary of State.

While our organization has only two staff, delayed funding puts these positions in jeopardy. If money is not received we have difficulties in achieving our mandate and yearly goals.

The uncertainty of long term

funding makes it difficult to set long term goals. The council now plans from year to year with short term funds. To plan for a longer time span seems wasteful of much needed energy as we are not at all certain funding will be maintained. Without long term funding and April 1 cheque issue, we run into problems keeping staff, and lose volunteers when projects they have been working on fall through because of lack of funds. Services expected by the community are also reduced or dropped when funding is not forthcoming.

BETH LACEY
ST. JOHN'S STATUS OF
WOMEN COUNCIL

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Vancouver women's health collective may have to close!

After fourteen years of providing a unique service for women, we face a crisis in funding. Since the Provincial government cut off all our funding in 1983, we have relied on short term federal grants and donations from our supporters to keep us going. Now, as federal grants get scarcer, we need your help.

The Health Collective was founded on the principle of self help and thus promotes women's active participation in, and control of, our health care. Our resources give women both an understanding of the ways in which the conditions of our lives create ill health, and comprehensive information on prevention and treatment options. With this information, we are better able to make informed decisions about our health care. Our information centre gives women access to clear understandable information on hundreds of health-related topics. Women across Canada use our resources by requesting information on specific topics and by purchas-

ing our publications through our mail order service. Some of our publications are "A Feminist Approach to Pap Tests," "Premenstrual Syndrome: A Self Help Approach" and "Breast Health."

As well as direct services such as informational, supportive and referral counselling, the Health Collective organizes and supports actions around specific issues such as abortion, DES, Depo Provera, the Dalkon Shield and the Copper 7 IUD.

Over the years, women have built the Health Collective into an organization with a national reputation for consistent and excellent work.

Help us stay open! Your donation will help keep this essential service going. All donations over \$10 will receive a tax receipt.

VANCOUVER WOMEN'S
HEALTH COLLECTIVE
888 BURRARD STREET
VANCOUVER, B.C. V6T 1X9
(604) 682-1633

Patient assertiveness training budget cut

In 1985, Regina Healthsharing completed a project, funded by Secretary of State, to assess the need for assertiveness training workshops for women to help them improve their relationships with health practitioners. The findings were overwhelmingly in favour of workshops and other assistance for women.

Regina Healthsharing submitted a follow-up grant proposal in June 1986 to start the workshops and to create an assertiveness training workbook. The grant proposal

got caught up in a cabinet shuffle and, although it had been submitted in June, the money was not received until November. The original proposal for the follow-up project was around \$30,000 but only \$12,000 was received by the group. The government gave no explanation for the cut or what the \$12,000 was to cover. Consequently, the scope of the project had to be drastically altered.

CAROL GORDON
REGINA HEALTHSHARING

Transition House funding refused

The Vancouver Transition House for battered women and their children will not receive funding through the British Columbia Ministry of Human Resources according to a recent government decision.

Since a 1983 Social Credit decision to privatize many social services, Transition House has been in a precarious financial position. It was sold to the YWCA in 1984 who ran it for almost one year. Giving only six weeks notice, the "Y" threatened to close the house.

Faced with closure, Transition House was occupied on June 28, 1985 by concerned Vancouver women and kept open for eight months. Over 100 women did shifts at the house and on the crisis line and over \$10,000 was raised to keep the house supplied.

"We ended an eight-month occupation of the house when Vancouver City Council agreed to seek funds to open a new house. City Hall has followed through on its commitment and has sent a proposal to the

Ministry of Human Resources," (MHR) said Francis Wasserlein, spokeswoman for the Women's House Saving Action (WWSA).

But this July the MHR turned down the proposal and the problem has now come back to Vancouver City Council. Funding problems have been complicated by the Social Credit leadership race and upcoming elections. All budgets have been frozen. "It appears that the Social Credit party is too busy with its leadership race to pay attention to the needs of

women in this city," said Wasserlein.

"Vancouver has the lowest number of transition house beds per capita of any major city in Canada. This means that some women will stay in dangerous situations longer, and it also means that if a woman can find safe shelter she will have to stay longer because of the crisis in low cost housing created by Expo. In recent weeks, some nights there has been no available space for battered women and their children. The current situation is critical," said Wasserlein.

Calgary women's health collective

The Calgary Women's Health Collective feels that there is a need in Calgary for education and self-help for women. Our philosophy is to enable women to take control of and responsibility for their own health and well-being.

All of our grant applications to the Secretary of state have resulted in our receiving some funds. However, we have never received as much money as we requested and both the funds and the confirmation have always been late in arriving.

This has meant that we didn't know until the last moment whether or not we would be continuing with the project. In the spring of 1986 we cancelled a health conference for just these reasons.

On the positive side, our project officer at Secretary of state is very supportive of us, and so is the community in which we function. In mid-June we held a fundraising garage sale. The community supported us by donating goods for us to sell and by purchasing almost \$1,000 of those goods.

SAC funds cut

The Saskatchewan Action Committee on the Status of Women (SAC) finally received notice four months into their fiscal year that Secretary of State would be granting them most of the money they had requested. The funding package to SAC shows approximately a five per cent cut on the amount applied for.

Like many other women's groups, SAC had received "interim" funding in May from Secretary of State. But, also

like many other groups they had no idea if or when they would get more funding, or what amount they would receive.

During the long interim period, SAC was placed in a tight financial spot. The organization had to apply for a bank overdraft, no long term plans could be made and ongoing work suffered as staff and volunteers had to turn their energies to fundraising problems.

CAROL GORDON

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Yukon women

The Yukon Status of Women Council (YSWC) is one of two multi-issue lobbying groups on issues concerning women in the Yukon, the other being the Yukon Indian Women's Association. Our lobbying efforts help to improve the status of women in the Yukon, and thus their quality of life. We also do public education and maintain up-to-date resource materials so that women are kept aware of issues and how they may be affected by territorial, national and international events.

For 12 years, the YSWC has published *The OptiMSI*, a quarterly Yukon women's newspaper. This paper has a circulation of about 800 and provides information to women on Yukon and national women's issues, as well as providing a forum for women to express themselves, to publish their art, poetry and prose.

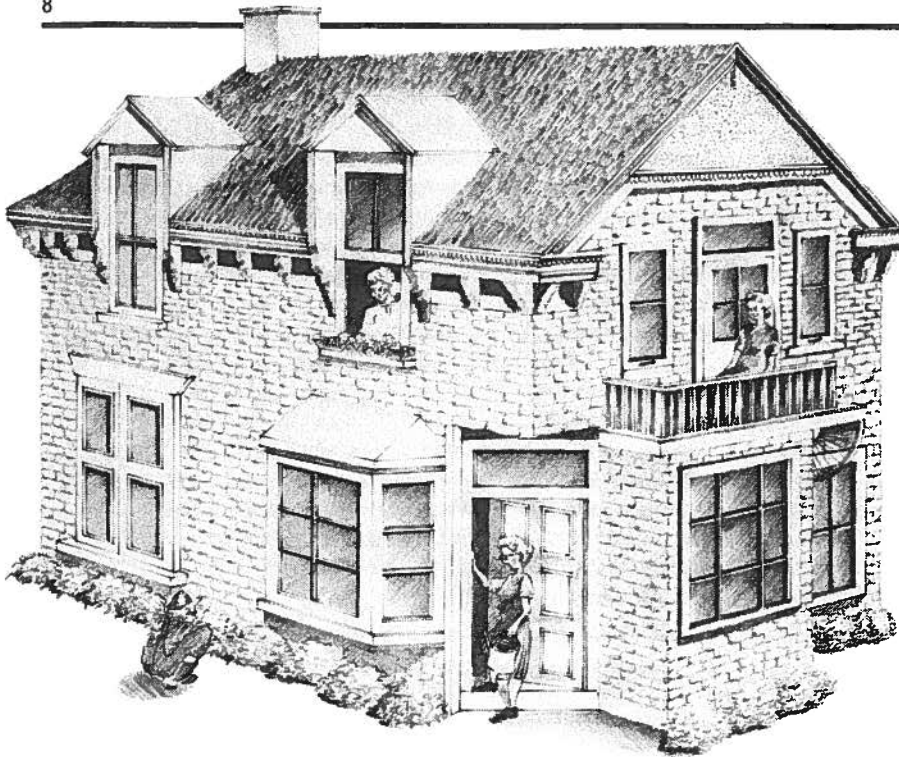
Funding uncertainty results in our inability to do any sort of budget or to plan for and commit ourselves to future events. This has additional repercussions when we want to

do something with another organization — they can not depend on us to come through in the end. For example, the YSWC is unable to adequately commit itself to the co-sponsorship of the 8th annual Yukon Women's Conference.

Lobbying for continued government funding consumes valuable volunteer energy. And because of the short notice of potential funding cutbacks and the withholding of our funds, we have not had enough time to find alternate sources of funding. The realities of the North dictate that the population base is too small to expect the community to contribute substantial amounts to any one organization.

Further delays in funding, or cutbacks, would likely result in the necessity of closing down our office, which means laying off staff and an end to services in the community and territory.

JENNIFER ELLIS
YUKON STATUS OF WOMEN
COUNCIL



L. Emily Elliott

Since Ethel Richardson moved into an Ontario government demonstration Granny Flat in her hometown of Vars last November, she has been visited by a steady stream of journalists, photographers and “even TV, with their big lights on me.”

One of the first Granny Flat occupants in Ontario, Mrs. Richardson says, “If I was 40 instead of 78, I wouldn’t mind so much.” But continuous media attention from fast-talking media people “takes a lot out of me.”

Now that she has spent a winter in her one-bedroom, free-standing apartment, Ethel reports satisfaction. “The house is fine,” she says. She was warm and cozy during the cold Ottawa Valley winter. Maybe too cozy.

“I think a little bigger (flat) for a single would be better,” she confides. Average living space in a Granny Flat is 50 sq. metres (600 sq. ft.). For someone like Mrs. Richardson who lived for 52 years in a two storey house with three children and a husband, the new flat is cramped.

The term Granny Flat, although sexist in tone, reflects the fact that women outnumber men in the plus-65 age group. In Ontario, for every 100 males over age 65, there are 140 females. And as people reach 80 or 90 years of age, the gap between absolute numbers of men and women grows. By 2006, the number of women aged 65 and over in Ontario will be almost

600,000. Currently about 400,000 Ontario women have reached society’s retirement age. About half of them are widows.

Women *are* the elderly in Canada. But by living longer than men, we inherit a dubious legacy. Today, a woman’s best chance of being a homeowner comes when she’s over 65 and is willed a house by her late husband. A woman’s best chance of being poor in Canada also comes when she’s an elderly widow.

For women whose health allows them to, living in the home where they’ve lived most of their adult lives is usually what’s desired. If her health deteriorates, however, an older woman living alone may be forced by nagging, worried children to abandon home for a “home.” Between autonomous living and the chronic care ward of a nursing home there are palatable housing options. Developing new options is a challenge for women themselves, for health care professionals and for housing policy managers.

The Granny Flat idea comes from Australia. For the last decade, senior citizens there have been settling into portable houses located on their adult children’s property. Last fall, the Ontario government launched a three-year demonstration project for the flats in Ottawa, Sudbury and Waterloo — municipalities which have shown a commitment to providing a range of

Debra Pilon

There Was An Old Woman ...

housing options to older people. Twelve flats — owned by the government of Ontario — are being rented to independent seniors and couples for between \$300 and \$600 a month. By 1988, Ministry of Housing officials will have evaluated the success of the flats, and will decide whether to provide them to a larger segment of the elderly population as a permanent project.

Tied to offering appropriate housing to elderly women is a growing belief among health care professionals that living with dignity as one ages is crucial. For Ethel Richardson, whose Granny Flat sits right beside her daughter Carroll’s house on the main street of Vars, living with dignity means *not* living in a backyard.

Granny Flats are *supposed* to be installed in a backyard — and in every case but hers they have been. “I’m not going to sit in the backyard,” she says. “I never did live in a backyard.”

For many reasons, Granny Flats are “not a big solution to the housing needs of seniors,” says Cassie Doyle, co-author with Janet McLain of *Women and Housing: Changing Needs and the Failure of Policy*. “For one thing, it’s only an option available to fairly upper middle-class households that have a lot which can accommodate a second building,” she explains. “The other thing is there’s an assumption here that seniors have to resort to being dependent on their families. A lot of older women don’t have family connections or can’t rely on children to look after them in their older years. And I’m a little bit opposed to the assumption that somehow we should be

developing housing options that assume a family connection."

Another thing about Granny Flats is that construction and transportation costs for the units are high. In Australia, where Doyle says the program was very successful, "under very different conditions," the cost of building each flat was about \$24,000. With Canada's harsh winters, insulation and a heat pump have raised the cost per single unit to \$33,000 and per double unit to \$37,000. In Nepean, Ontario where a Granny Flat had to be lifted over the "host" house into a suburban backyard, the \$800 cost to hire a crane had to be added to "normal" installation costs of \$7,000 (for transportation, water and sewer hook-ups and landscaping).

On the positive side, "the thing about a Granny Flat is you have no land costs involved," says Doyle. In rural areas, "where there aren't real resources to place an older person into her own living situation," Granny Flats could be potentially useful and popular. "The question is whether government should really be involved in it," Doyle concludes. "Because if it's really targeted to a group of families with fairly high incomes, then is that really where government intervention should be and where limited dollars should be allocated?"

Granny Flats have the psychological appeal of encouraging independence within the ambit of close family ties. But financial constraints or a need for like-minded or same-age companionship outside the family might prompt an older woman living alone to consider other options. For some, sharing the family home with a younger, caring person is the solution.

Sharon Peebles, co-ordinator of Match and Share, a project funded jointly by the Regional Municipality of Ottawa-Carleton and the Ontario Ministry of Housing, believes home sharing is "part of the spectrum" of housing options which should be available to older women. "As people get older, they shouldn't have any less choice in housing," she says.

Working as a professional match-maker to bring together elderly homeowners with prospective tenants, Peebles has helped 68 matches become reality. More than 700 people have inquired about the program since it began about 15 months ago. "Almost

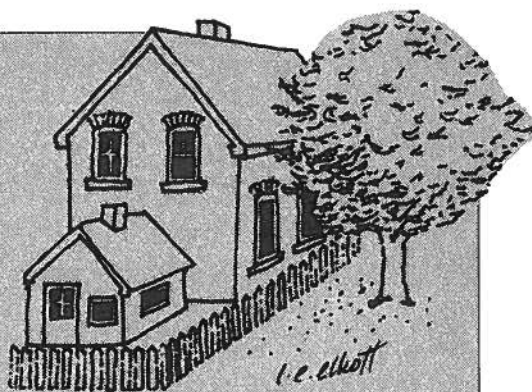
Too Old Yet Too Young

Although elderly women — defined as those over age 65 — are increasingly the subject of research and analysis, unattached women, ages 55 to 64, often live with worse financial constraints and have fewer housing options than their older sisters. "Too old yet too young" succinctly describes the situation of many older but not yet elderly women in Canada. If a woman is unmarried, divorced, separated or widowed between the ages of 55 and 64, chances are her life is not easy.

"Many of these women are just waiting until they turn 65 so that their incomes will be secure," says a report entitled *Too Old Yet Too Young: An Account of Women in Limbo* by the Council on Aging of Ottawa-Carleton. When they turn 65, the report adds, "these women will be able to do things: ride the bus, go to the movies, take courses, buy things on seniors' discounts. Some of them have nine years to wait, hoping that things do not get worse."

Of 14 women interviewed for the study, five lived in government subsidized housing, four lived in their own houses, four lived in apartments and one was a boarder. Nine of the women said they would like to move; all of the women in public housing wanted to move. The reasons included fear for their safety, cramped quarters and distance from shopping centres, friends or family.

Any Canadian spending more than 58.5 per cent of her income on



basic necessities such as housing, food and clothing is considered to be living in hardship. Ten out of 14 women interviewed had incomes below the poverty line. One woman's rent was 74 per cent of her income, two others paid rent or housing expenses which totalled 58 per cent of their superannuation pensions. Women in public housing paid rent calculated at 25 per cent of income, allowing them, in their own words, to "keep my head above water."

Between the ages of 55 and 64, women said they suffered discrimination (ageism) in the workplace, were uncertain of support payments from ex-husbands and were ineligible for the secure pensions available to women in the 65 plus age group.

"The most striking features of the world of a preretirement-age woman," the report concludes, "are the uncertainty she must live with and the lack of support to help her manage on her own."

Summaries of the report (free of charge) and copies (\$10 each) are available from the Council on Aging of Ottawa-Carleton, 256 King Edward Avenue, Ottawa, Ont. K1N 7M1.

half of them (participants) are seniors together and most of the homeowners are women who own their own homes," she says. "Financial considerations, loneliness, the need for companionship and security at night" are reasons elderly women call Match and Share.

"A lot of older women have always been able to look after their days but they need someone around at night," says Peebles. For such women, a

young working woman or student might be an ideal housemate. "They've told me they don't want another senior rattling around the house all day." But with frail women aged 70 to 75, the preferred match, according to Peebles, is a woman about 55.

Match and Share promotes intergenerational house sharing. "It's the kind of situation where one can barter," she adds. "You can get someone



Elaine Deschenes

Theresa Walton, 69, on left, Helen Beddingfield, 68, in Helen's apartment which they share.

to help with shovelling snow or cutting grass."

This bartering introduces what Casie Doyle calls "a service component" into the Match and Share program. "So, we're talking about more than a shared living arrangement; we're talking about built-in support, which is good." But what price does an older woman pay for this seemingly altruistic arrangement that usually means reduced rent for her boarder?

"What I don't feel very comfortable about in the Match and Share program," says Doyle, "is that I think people have a right to privacy and to security of tenure in their housing, particularly seniors." With Match and Share, privacy is reduced as kitchens, living rooms and dining areas become communal space. And, unfortunately, the "match" part of the sharing arrangement may mean a short tenure for one of the women.

Doyle paints a realistic picture of the worst case scenario. "So let's say she (a woman needing housing) gets all settled in and let's say eight months down the line they (she and the older woman who owns the home) can't see eye to eye or can't seem to adapt their lives to each other. Then who's going to leave? The senior who has moved in."

On a societal level, Doyle wonders about the policy and planning goals on which Match and Share is based. "I'm a

little concerned that everybody is jumping on the bandwagon with Match and Share, because it's cheaper than building a separate unit for seniors. It uses the existing (housing) stock better," she says, "... so there seems to be, from certain sectors, a real enthusiasm around this which I don't completely share."

With a masters degree in social policy and six year's experience with City Living, the City of Ottawa's non-profit seniors' housing department, Doyle doesn't see Match and Share as an alternate way of providing needed housing for senior citizens. "It's okay as an option," she says. "But what concerns me is that there isn't going to be as much of a choice as there should be."

What kinds of choices should there be? What housing alternatives give seniors the range that Doyle feels is so important? "I would see a progressive model as one where, in a building, women could live independently while still having the support of other people living in the building," she explains. "Another component is that it should be a staggered or a phased kind of care."

Such housing arrangements — Doyle says her aunt in Vancouver lives in a "wonderful" place which offers fully self-contained apartments, bachelor units with light cooking facilities

and, finally, nursing care units — help to prevent two things. "One of them is when you all of a sudden get sick, you don't have to leave where you're living. There's a light level of nursing care, meals are provided and more importantly, somebody's keeping an eye on you. The other thing is, sometimes when a woman is living alone, she takes a fall or has a bad spell or a bad flu she just can't shake. Then everybody freaks out and they say 'Well, we'd better put her in a home.' But six or eight months later — I've seen it many times — she's fine."

In a word, continuity is provided in such a housing complex. Doyle's aunt, for example, lived first in a full apartment. Now, she has moved into a bachelor unit in the same building. She takes some of her meals in the cafeteria but is able to cook breakfast or make tea in her own place, as well as entertain visitors privately. Maintaining a sense of independence is important to elderly women.

In a recently submitted master's thesis about the risks experienced by elderly widows who live alone in their own houses, Nancy Gnaedinger describes the 20 women she interviewed as teetering between dependence and independence.

"In order to stay there (in their own homes), every one was dependent on home support services of some kind, neighbourhood support, help from children, especially daughters and grandchildren, hiring help and saving money very, very carefully, for perhaps a couple of years, to hire help to do things. By living in houses, they were incredibly dependent on other people who were providing these services. So, I figured the balance between dependence and independence was pretty precarious."

One woman living alone told Gnaedinger about having to wait 2½ weeks to get a lightbulb replaced because her son, who had to climb a ladder to change it, didn't have time to stop by to do it. Yet such a woman would consider herself independent.

If wishing can make it so, then wishing to be independent may be what creates a sense of independence in older women.

"Health, of course, is everything; it's physical and spiritual and emotional and psychological well-being and being in a state where you can cope

well with living and crisis; it's a huge concept," explains Gnaedinger. "Well, if one of the aspects of your life that can be considered unhealthy is being at risk of losing or having a chunk taken out of any of those parts ... then I think the psychological health of the women I interviewed was pretty good. And living there (in their homes) was very good ... for making them able to cope because the patterns they had developed were easier to carry on with than developing new ones. But their physical well-being was the thing that was at risk. So, there's this opposition going on all the time."

In an ideal society, housing for elderly people would — according to Cassie Doyle — not be built in isolation. Instead, housing would incorporate grocery stores, shopping malls, recreation facilities. "I think there needs to be more work done on what seniors really want in terms of their housing. It would be important to ask seniors themselves and to build research together."

Doyle doesn't believe that housing designed specifically for seniors is ghetto housing. "I think the jury is out on whether older people really want to live with other generations," she

says. "In our senior citizens' housing, we've been introducing people between the ages of 50 and 60. We've had quite a reaction. They (the people over 65) don't want them there."

Living with dignity doesn't become any easier as one ages. But when older women's views are sought and their needs are integrated into housing policies at all levels of government, no one will be able to prevent a full blooming of perennial self-esteem.

Debra Pilon is an Ottawa writer.

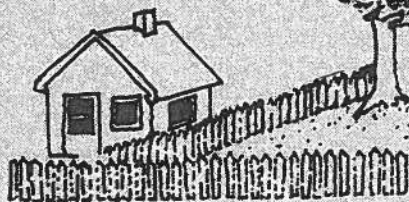
Ottawa social scientist and feminist Nancy Gnaedinger sparkles when she talks about last year. She spent most of 1985 working on an exceptional master's thesis in women's studies at Carleton University. During the year, she journeyed from the negativism of academic theory about older women into a small world of 20 elderly widows whose life affirming energy has provided personal inspiration. The title of her thesis is *Elderly Widows Who Live Alone in Their Own Houses: Assessments of Risk*.

"I spent so long reading about all the horrors of aging. Most of the news is bad news when you read the gerontological literature, isn't it? You get frail, you get poor, you get bereaved, you get this and that. And then I went out and met these positive, spunky women, many of whom were just so gracious and so happy to tell their experiences and so delightful to be with. I fell in love over and over again with these wonderful people."

The thesis, as its title suggests, is an examination of the risks associated with deciding, when one is an elderly widow, to live alone, usually in what was formerly a "family" house. The hypothesis, borne out by interviews conducted with 20 women living in an older residential neighbourhood in Ottawa, is that symbolic rather than practical considerations account for the women's choice to live alone.

By researching this subject and

Older Women in Their Own Homes



using the methodology she used, Nancy Gnaedinger hopes she is adding to the body of "qualitative" research on the elderly. "A lot of research on elderly people tends to be of the survey variety. Not much is face-to-face and not very much of it asks older people themselves what they think about and how they assess things."

Qualitative research is useful for policy makers, health care workers and gerontologists who want more than dry data when discussing elderly women's housing needs. Gnaedinger decided to investigate and write about elderly widows living alone in their own houses for three, mostly personal, reasons.

"One, I had worked with elderly people directly for six years in long term care institutions at various levels and so I had this feeling for and experience with older people, women in particular, since most older people are women.

"Another reason is that I have a real passion for design and I absolutely detest bad design. I'm really

concerned about people's relationship with the built environment — more particularly elderly women with environments they tend to live in.

"And the third one is that I'm very concerned myself with being an older woman alone, which most women are when they're older, and I think we should all be aware of it and very practical in our thinking about it."

Why do elderly widows stay in their homes? What risks are associated with that decision? How do they balance these risks against the benefits?

The group Gnaedinger studied was unique yet generally representative of the elderly female population in Canada. They share with other women of their generation a longer life span than men, a likelihood of living below the poverty line as they age and a 50 per cent chance of being widowed beyond age 65.

"The risk of being older and widowed includes the risks of loneliness and bereavement," says Gnaedinger. "It almost always includes the risk of being poor ... and added to that, older houses tend to be less safe than modern ones. They're darker, they have narrower stairways and heavier windows. They've got all these features that are hard enough to cope with if you're younger and stronger and you have good eyesight and agility."

After she had assessed the risks associated with the women's coura-

geous decision to live alone, Gnaedinger found herself wondering: "How do these women cope? The next step for me was to find out how *they* assess their risks, not just the risks of staying in their homes but those associated with the alternatives. Because I figured if they're still staying there, maybe they figure the alternatives are worse than the actual, real physical risks of staying."

It turned out that the women stayed on in their homes for definite reasons related to psychological and emotional well-being. "The strongest two impressions (I got from my research) were, first, that not just older women but all older people and maybe all people from a certain age onward, want continuity: continuity in identity, continuity in relationship to their environments, continuity in habits, in associations, in daily patterns. It makes people feel good. Continuity is comforting. Secondly, for the sample of women she interviewed, "the status of being a homeowner was really important, besides all the emotional attachment to the house."

This emotional attachment is something younger women do not feel as strongly as "somebody who is 75 and has raised six children in a house," she says. "One woman said to me, 'Every room in this house is saturated with memories for me.'"

Most of the women spent their younger years caring for husbands and children in traditional marriages. Aging has brought with it an invigorating opportunity to live as a single, independent woman. "Not one of them wanted to live with her children and not one of them wanted to share her home with a housemate," says Gnaedinger. "The reasons were that they didn't want to live by anybody else's schedule anymore. Certainly, nobody wanted to do cooking for anybody."

This is not to say the women did not love their children. Nor does it mean they were estranged from them. "Children seemed to be far more significant others in their (the women's lives) than their late husbands. That could be because the

kids are still alive. A husband may have been dead 20 years and they had incorporated that loss into their lives."

Although they didn't want to "mother" anymore, some of the women were very tied to the mother role. "One woman would bake her 66-year-old son's favourite cookies every week so when he came by on the weekend he could have some!"

Describing the group she interviewed as a biased sample — since they were all elderly widows living alone in their houses — Gnaedinger is quick to point out they were not unduly privileged women. Like all women in their age bracket (from 70 to 91, with a median age of 77), who live on fixed incomes, their finances were often tight. "Some of them were spending a tremendous portion of their income — I didn't ask but they inferred — just to stay in their homes. And they would budget all year to pay the oil bill in order to heat their houses."

Long years of self-discipline allowed them to live this way, Gnaedinger believes. "They also, and I think this is characteristic of their generation, didn't have terribly high expectations ... they've gone through two world wars and a Depression. Most of them mentioned that they never bought anything until they'd saved up money for it."

An unwillingness to go out at night was a common feature of all the women's lives. "Most of them said, 'Oh, I never go out at night.' Simple as that. Statement of fact. Their socializing with friends took place during the daytime, either at the church or a restaurant or shopping or whatever."

"So what they would end up doing is spending most of their evenings alone. In that way you could say they were socially isolated. But their telephones were absolutely crucial. The telephone was how they made up for a lack of social interaction face to face."

The knowledge that they might be targets for criminals frightened everyone. "Their main precaution was not going out at night," says

Nancy Gnaedinger. On the practical side, women who could afford to, installed double locks on doors or bars on basement windows. "And after that," Gnaedinger adds, "it was a case of: 'I don't worry about it. If I sat here worrying about it, I'd be miserable all the time!'"

For all women with an interest in the lives of elderly women, this thesis is excellent reading.

For the author herself, 38-years-old and aging beautifully, the opportunity to share two or three hours with these elderly widows was uplifting. "I was impressed by their lack of whining," she says, adding quickly that she does not think it's acceptable for elderly women to have to live on meagre, fixed incomes. "You and I will probably have much higher expectations in terms of the furniture expected, holidays, wardrobe, all of that."

Her impressions of the women are varied. They come tumbling out as the warm memories return.

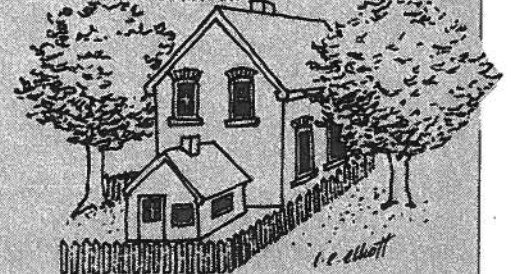
"They were so creative about the way they coped ... keeping things in unexpected places because then you wouldn't have to climb up on a stool to get it ..."

"The only woman who cried was a woman who was crying about her daughter having died of cancer. It was really, really sad for her."

"I had a very good feeling with a number of them and lots of good laughs. I tell you, if you were to listen to any of my tapes ... they're just punctuated with howls of laughter."

"One woman, the oldest one I interviewed, who was 91, living alone, in the most spotless house I've ever seen — she did all her own housework — made me look like a pigpen. When I left, I said, 'You know, you really make me look forward to being 92.'"

"And I meant it!"



Side Effects

A Dramatic Prescription

First we were all just people... The earth turned a couple of times... A woman got a headache... Her friend said she knew of a flower that worked for headaches. The earth turned again... A little boy hurt his finger... His uncle said: "Let's see now. If we just pull here, maybe that'll fix it." The earth turned a few thousand times... One morning we woke up... Everything had changed... Oh, we were still just people. But... Most of us were patients...

excerpt from the play *Side Effects*

Gisele is a housewife with six kids and an abusive husband. Margaret is alone at home, trying to get used to her "empty nest." Terri is a young woman whose mother had taken DES to prevent miscarriage. Mary Ann is a young nurse dealing with the stress of combining a part-time job and taking care of her family. Fatima, a community worker in Bangladesh, is concerned about the "side effects" women in her village are experiencing from birth control pills.

These women exist only on stage, but they are as real as the women who sat in darkened community auditoriums, high school gyms, church halls and theatres to watch their lives as "patients" unfold before them in the community theatre production *Side Effects*. Seen by nearly 10,000 women across Canada, from Cornerbrook, Nfld. to Terrace, B.C. in the spring and fall of 1985, *Side Effects* is a play about women's experiences in the health "care" system.



Developing Side Effects

Every drug prescription is a two way street. It's a doctor handing you a prescription and you taking it. When you accept a drug you have the right to ask about the side effects.

audience comment

When Inter Pares, a Canadian non-profit agency that supports community development in Canada and the Third World, sponsored a Canadian tour of two Bangladeshi women community development workers, they

never expected that the discussions between the Bangladeshi women and Canadian women would unearth so many shared health concerns. The interest and energy generated by this tour resulted in a follow-up workshop on women and pharmaceuticals. Here women talked of living with the effects of drugs and how to make changes. One suggestion of a way to promote change was to develop a vehicle that would further information-sharing and solidarity, and empower women to work for change.

The vehicle had to meet certain

"Side Effects" Speaks for Itself

Pharmaceutical Company Executive: There's our target ... She's wormed her way into the work force, and she's hanging on by a slim thread. She knows she can't show weakness or feminine ... odor. She's stressed, has headaches. She's single. She has PMS. ... She can't afford to miss work, so she's taking antibiotics at the first sneeze. Her natural resistance is down: chronic yeast. ... We've got pills for all that — all she has to do is swallow.

Mary Ann: Pills helped me to handle the loneliness, the heat, the stress, the noise, the ... anger. ...

Giselle: You want to know something? No doctor ever mentioned to me that my pills could be what was wrong with me. ... The doctor who gave me the first sleeping pill ... I kept asking him if it was going to do me any harm, and he kept saying, "No!" He was always laughing it off. I've got to go back and tell him, cause he doesn't know. I don't think doctors are so much knowledgeable. I question doctors all the time. I'm sure he said they were not addictive. There's no saying they're not addictive.

Doctor: Her chicks have flown. ... her mate is still vital. ... he may be away from the roost more frequently. ... her feathers are ruffled and she doesn't know what to do with herself. ... I'd give her Valium, 5 mg, she'll feel happier, and so will her husband and daughters.

Granny: Getting off drugs. Don't try it "cold turkey." Withdrawing from Valium can be tougher than withdrawing from heroin. It's hell — vomiting, diarrhea, can't sleep, can't sit still, hallucinations, convulsions. It's like pouring kerosene all over you, and setting yourself on fire. Did anybody tell you that the last time you were offered something to "take the edge off"?

Mary Ann: At 26, I'm told that my headaches are migraines. A neurologist puts me on a lovely pill called Fiorinal, with half a grain of codeine. For two years, I use it appropriately. I go for 2 or 3 weeks never taking any, but then a headache comes. I get a lovely buzz from codeine. ... so, 2 years of appropriate use, then I start to abuse it. ... I take it in case I get a headache. ... I take 2 instead of 1, one doesn't give me the same effect ...

Granny: You know what tickles me? ... according to the warnings, in one country, the birth control pill can cause strokes. ... in another country, the pill causes headaches and nausea, and in some countries, the pill causes no adverse side effects of any kind! Ain't science great?

Third World Woman: First my husband decides whether or not I should have children. Now the government decides. ... I have never decided. ... The family planning worker comes to our village. Before she receives her monthly salary, she must fill her quota. ... Two women must go on the pill, one must have her tubes tied, one must go for the contraceptive injection, Depo Provera, and one must get an IUD. Lots of us have had problems with the pill. The family planning worker still has to fill her quota. ... So we take the packets ... and throw the pills away! ... When you can guarantee that our children will live past the age of five, then we will have only two.

criteria. It must reach the greatest number of women in areas of greatest need. It had to be affordable, accessible, articulate and factual. At the same time, it had to be gripping, not only intellectually but also emotionally and socially — an inspiration for change, a focus for community groups, a catalyst for further activity. This tool for informing and connecting women could not be imposed but had to be offered within the framework of each community's own activities, resources, needs and development. Because this was to be a shared healing, participation on a local and individual level was essential. The women at the workshop formed Women's Health Interaction (WHI) and turned to the task of filling the prescription.

A few members of WHI who had previous experience working with Ottawa's Great Canadian Theatre Company (GCTC) in the area of popular theatre shared their vision of using a play to bring women together around the issues raised in the workshops. The response was enthusiastic. Thus, *Side Effects* was conceived within a womb of enormous energy, excitement and commitment.

Throughout its work over the next two years, WHI, in its structure and process, embodied the tone and intent of the entire project. The group worked collectively, within itself and with GCTC. Each woman in the group contributed in an essential way from her own experience and her own resources and retained a sense of ownership in the project through her involvement and participation. The project was empowering for each of the women who saw the play to completion and, in doing so, felt the sweet pride of accomplishment. These women were activists, nurses, development workers, mothers; they were women drawn to the issues from their own experiences and wanting to "do something about it."

The script was developed collectively using improvisation. The actors combined written materials with their own personal experiences. Drugs had touched everyone's lives. This universality of personal experience is the primary source of the play's emotional power. The principal writer, Janet Irwin, and the editor, Barbara Lysnes, finalized the script and developed the play into a cohesive whole.

A Woman's Product

That is the key to what we're trying to do here tonight. The doctor is not a place to go for support — It's among ourselves — That's what we should look for.

comment from a *Side Effects* sponsor

In the workshops, final rehearsal and production period, and on tour, the cast and crew were all women. The politics of the project demanded such an affirmation of the competence of women working in theatre and of the need to provide women with the opportunity to take control of their own cultural statement.

Even in its research and development stages, the play proved to be a valuable networking tool for women's groups and health groups. Women from various organizations were linked up and key regional contacts were identified. Many diverse groups and organizations began to work together for the first time around a strong concrete focus — the play.

There were health collectives, women's groups, government agencies, development organizations, educational institutions, church organizations, mental health associations, public interest research groups, medical reform groups, popular theatre educators and individuals working together to bring *Side Effects* to their town or city.

WHI wanted to ensure the play did not exist as a one time event. We hoped that the increased awareness and organizing skills developed through sponsoring the play would further the work of local groups and help to develop a national network.

Further community response to the issues was a critical goal of the play. We were most gratified to hear of meetings or other community actions which took place as follow up to the *Side Effects* production. It was even more rewarding for us when we were able to participate in the follow up. In The Pas, Manitoba the tour/network co-ordinator was able to participate in such a workshop. Health needs in the community were examined with particular reference to the drug and alcohol abuse prevalent in the area. One participant quipped: "In The Pas, doctors treat alcoholism as a Valium deficiency." A rudimentary plan of action



Heather Esdon and Mary Burns in "Side Effects."

was developed at the workshop which included plans to involve social service agencies and community groups in an audit of doctor's use of tranquilizers, starting with patients discharged from hospital.

Filling the Prescription

The last thing we need to be told is to take pills to calm us down, it's happening here and it's happening now. So I feel really blessed that you're here with this play and I feel really blessed that we're organizing because it's absolutely crucial.

audience comment

Side Effects toured Canada for 12 weeks, playing 45 shows to 8,180 women in 37 communities in eight provinces. Many thousands more heard about, read about, or saw excerpts of the play through the extensive media coverage which included a clip on CBC's *The Journal* and a *Marketplace* episode on women and pharmaceuticals (based on *Side Effects*). The play was performed in nurses' residences, school auditoriums, civic centres, community halls, church basements, well-equipped theatres, and Native Friendship centres. The professionalism of the show, while

reducing its adaptability to non-theatre locales, did increase the play's credibility and gained respect and a raised profile for many sponsoring groups in their own communities.

Short discussions led by the tour/network co-ordinator and local sponsors after each performance were an integral part of the project. This provided WHI and GCTC with verbal feedback on the play and allowed women in the audience an opportunity to respond to *Side Effects* in a public forum. However, there were drawbacks. Taking the stage after the show was intimidating for some of the sponsors and the acoustics of a performance hall are not always good for informal discussion. Members of the audience were still reacting to the performance and were not always able to process and articulate their responses immediately.

Had the tour been longer, we might have been able to play more consecutive nights in some of the centres which would have increased the opportunities for networking. And there would have been more travel-free days for the cast and crew to participate in follow-up workshops. The tour would not have been quite so exhausting and audiences could have been built by word of mouth. We frequently

heard: "I wish you were doing another show, I've got a friend (sister, mother . . .) who should see this." Playing consecutive nights would also have decreased the sponsors' feelings of a whirlwind hitting town. Sponsoring groups had often been working for over a year to get *Side Effects* to their community and in some spots the cast and crew stayed less than 24 hours. Some sponsors experienced a real sense of anti-climax — after all that lead up work, the big event was over before they could catch their breath.

Effectiveness

It's not an individual pain. It's not something wrong with just me. The pain is something I share with others.
audience comment

The play succeeded in reaching out and touching women across Canada. Audiences were entertained. They hooted with laughter at Granny's antics and they were moved to tears by the plight of the DES daughter. They responded with standing ovations and they stayed to discuss the play afterwards. The women in the audience identified strongly with the women in the play. More than once we were told,

"You've put my life on stage." We heard hundreds of personal stories of addiction, overprescription and experiences with insensitive doctors. It was rewarding to see how relevant the play was to so many women. At the same time, it was overwhelming to realize the extent of the problem by meeting so many women who had been victimized and drugged by a social and medical system that did not meet their needs.

Portraying the everyday lives of women on stage validated the experiences of women. "I always knew there was something wrong but I always thought it was me." It was important to give a context to these experiences, to build an understanding of the economic, political and cultural factors that operate universally to promote the misuse of drugs. To do this, *Side Effects* documented the impact of the drug industry on women world-wide.

Women in smaller communities identified most closely with the Canadian women in the play. The information provided through the Third World and drug company scenes was new to many of them. Audiences in the north found similarities between the treatment of native women in Canada and the treatment of women in the Third

World. In larger centres, where *Side Effects* played to audiences who already had some exposure to the issues, the satire in the drug company scenes brought humour and laughter to an issue which is otherwise sometimes overwhelming in its magnitude and impact. The play re-energized health activists in their commitment to work on these issues.

The most common response to the play was anger. Some members of the audience directed their anger towards the play itself. They reacted against the portrayal of women as victims, and urged each other to be strong and take control of their own health. Others spoke of the lack of real alternatives. Health care providers and social workers agreed there is a scarcity of alternatives and resources, especially in the smaller communities where women are more isolated. One woman in a discussion could barely sit still long enough to tell the other women there about a self-help group she was attending to help her cope with withdrawal from psychotropic drugs. Those who saw the play wanted to reach out further into their communities, to get a video of the play, to reach other women by showing it on TV in the soap opera time slot. Some women directed their anger toward the doctors who prescribe the drugs and the companies who make and market them. Others defended the doctors, speaking of the demands patients place on them for quick, easy solutions to their problems.

The discussion showed the need for women to organize around health issues on many different levels. In urban areas, the comments and discussions focused on the need for more public education on the issues, greater access to alternatives, increased regulation of multi-national corporations, and change of the entire health care system. In rural communities, the discussions focused on the importance of bringing the issues out into the open and providing support for each other in taking control of our own health. These women felt the issues personally and looked for concrete, immediate solutions. In the urban areas there was a tendency to intellectualize the issues and discuss analytically how to proceed.

The majority of audience members filled out the personal evaluation



The Side Effects Prescription

Rx

Patient's Name: Everywoman.

Diagnosis: Inappropriate consumption of dangerous pharmaceuticals whose side effects have not been adequately tested.

Symptoms: Ill health and even death, addiction, loss of self-esteem, powerlessness, loss of job, breakdown of relationships, sterility, and loss of control over body and spirit can result from prolonged consumption of particular drugs.

Patient Susceptibility: Social stereotypes and conditioning mean that women are much more likely than men to be overprescribed or inappropriately prescribed drugs. The following are some of the factors which render women more susceptible: contraception is usually perceived as a woman's responsibility; women are often solely responsible for the health of their families; woman's role and status in society are in a state of flux and expectations are confused, creating stress and excessive demands; women's lives are valued less and so less care is taken in prescribing drugs to them; doctors respond to women's cries for help by prescribing drugs for what are, in fact, social not individual problems; and finally, women have been taught not to question the "expert."

Treatment: Inform women across Canada about the hazards of pharmaceuticals; place this information in a context that helps the individual woman to understand the factors leading to the overprescription of drugs to women, empowers her to take control over her own body and health, and encourages her to work with other women to effect change in the health care system as a whole, both in Canada and overseas.

forms they were handed with the program. The over 6,000 forms that flooded the Inter Pares office in the months following the tour in addition to those completed and collected on performance nights, testified to the degree of the play's impact on women's lives.

The most important role that *Side Effects* played was to bring women together to hear about and talk about their health. When 71-year-old Jane Murphy of Kitchener, Ontario first heard of *Side Effects*, it never occurred to her that prescription drugs might be causing her deep depression and mental confusion. "I was lethargic. I was unhappy and antagonistic. I tried several different avenues to pull myself out of it. I thought it was all in my head and I should be able to get over it," Jane describes this grey period in her life. When she changed doctors, her high blood pressure medication was also changed, and so did Jane.

At the Kitchener performance of *Side Effects* Jane wanted to know about the health needs of other women. A series of six weekly health seminars for women came out of their common needs. Covering topics such as over-the-counter drugs, mood-altering drugs and tranquilizers, birth control, menopause and hormone therapy, holistic health, alternatives to drug therapy and mental health, these seminars are providing reliable and accessible health information to women in the Kitchener-Waterloo area.

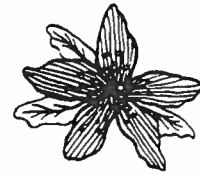
The Northern Women's Centre in Thunder Bay, Ontario started a buddy system for any woman wanting company going to the doctor. And in Manitoba, as follow-up to the *Side Effects* tour through six communities, a provincial women's health network was formed to look at consumer action on drugs, theatre as a tool in health education, self-help groups and improving health services for women. Regina Healthsharing is developing a health access workbook for women. The Learner Centre in Medicine Hat, Alberta, is hoping to get a women's health group going. The Terrace Women's Centre in British Columbia co-sponsored a workshop in March with the Oxfam Third World Health project focusing on global health, including women's health concerns. A franco-phone theatre group (Le Theatre des

Filles du Roy) has translated the script and a free tour of *Maux Caches* is in the works for Quebec. These are just a few concrete examples of some of the work either initiated or furthered by *Side Effects* and the networking it has sparked.

For the women who were touched by *Side Effects* and who made it possible through sharing stories, working tirelessly to host the play, and who continue to work in their own communities, *Side Effects* was, and is, an inspiring contribution to women's health based on a feminist and grass roots approach to change.

Major portions of this article are based on the Side Effects Final Report, written and compiled by Barbara Lysnes of The Great Canadian Theatre Company, and on quotes from personal feedback from audiences and direct quotes from the Side Effects script. The final report and other resources developed by WHI are available, at cost, from: Women's Health Interaction, c/o Inter Pares, 58 Arthur St., Ottawa, Ont. K1R 7B9.

Article contributors: Irene Boucher, Mary Ann Howard, Yolande Mennie and Karen Seabrooke for Women's Health Interaction.



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Unsafe By Any Name

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The pharmaceutical industry wields almost uncontrollable power in most developing countries. The marketing of a dangerous group of hormonal preparations, high dose estrogen-progesterone combination drugs, to women in many of these countries provides a striking example of this power and of the priorities of the pharmaceutical industry. Estrogen-progesterone combination drugs (EP drugs) were withdrawn from the market by Western countries in the mid-70's, but continue to be sold today in the Philippines, India, Africa and other developing nations.

International pharmaceutical companies are under little pressure to take any action which might limit their profits. Their power is boosted by weak drug regulations, doctors' dependency on them for information and peoples' almost magical belief in Western medicine. This seems especially true when the drug involved is taken exclusively by women. In a patriarchal society, important decisions are made largely by men, and women have little control over their lives and bodies.

Mercy, a Filipino woman, found her period was delayed. Because she was not sure whether she was pregnant, she went to see her doctor. He gave her an injection of Gynaecosid, an EP drug, without asking her whether she would want to terminate her pregnancy if she found out that she was pregnant. He also said nothing about the side effects or possible risks. Three months later her period still had not started. Mercy went back to her doctor three times, and every time he gave her the same injection, without any examination and again without telling her about possible side effects and risks. After the third visit, the doctor confirmed Mercy's pregnancy. Months later she gave birth to a boy with a club foot.

According to Mercy, the use of EP drugs is very common in the Philippines. Women know of the existence of these drugs and will buy them (if they have the money) every time their periods are late. Doctors ignorant of the fact that EP drugs are no longer indicated for pregnancy testing still prescribe them for this purpose. Mercy was shocked and angry to hear that these drugs are ineffective and have long been taken off the market in most European countries because of the risk of birth defects.

EP Drugs: The Facts

High dose estrogen-progesterone combination drugs (EP drugs) are pills or injections containing the same female sex hormones as the contraceptive pill but in a much higher dosage. EP drugs have been around for a long

time and have been sold under many different brand names. In the 1950s EP drugs were brought onto the market as a treatment for missed periods (secondary amenorrhea). They were thought to induce menstruation in women whose periods were delayed and who were not pregnant.

A woman whose period did not start after taking EP drugs was presumed to be pregnant, and so EP drugs also began to be seen as simple pregnancy tests. But because of the drug's apparent ability to bring on menstruation, women all over the world have taken and continue to take EP drugs to induce abortion. The belief in the power of Western medicine is so strong that it is not surprising that women hopefully conclude that a drug that starts menstruation in nonpregnant women might also do so in pregnant women, which EP drugs do *not* do. No pharmaceutical company has ever claimed that these drugs would induce an abortion. But doctors in many countries nevertheless prescribe them for this purpose, and many women are able to buy them over the counter.

Other hormonal drugs brought onto the market for use by women, for example synthetic estrogen or the birth control pill, have a similar history of initial use without sufficient research, and a later change in indication and/or dosage. Around 20 years after EP drugs came on the market, research uncovered evidence that these drugs were unreliable as pregnancy tests and ineffective as treatment for missed periods. Of even greater concern was the suggestion they might cause birth defects in ba-

bies whose mothers took EP drugs early in pregnancy. Since the most common use for EP drugs at that time (the 1970s) was hormonal pregnancy testing, women who took the drug for this purpose and who later turned out to be pregnant, unknowingly exposed their unborn babies to the possibility of birth defects. Women who take EP drugs now to induce abortion run the same risk, of course, since we know they are ineffective as abortifacients.

The *British Medical Journal* reports, in a 1974 editorial, that synthetic sex hormones such as EP drugs may damage the fetus, and says that associations have been reported between the taking of such hormones during pregnancy and congenital birth defects, including defects of the heart, circulatory system, central nervous system, and limb reduction deformities.

In a 1981 report, the World Health Organization (WHO) recommended that hormonal pregnancy tests no longer be done. On the use of EP drugs as a treatment for missed periods, the report says: "women who are not pregnant will have their menses further delayed if hormones are administered."

In the mid-70s respected medical journals like *Lancet* and the *British Medical Journal* carried editorials advising doctors not to use EP drugs in hormonal pregnancy testing. In the face of controversy, a number of Western countries decided to withdraw these drugs from the market, among them Australia in 1975, the United States in 1975, the United Kingdom in 1977, Belgium and Austria in 1978, and Germany in 1980. Other western countries included warnings on the use of EP drugs in pregnancy on package inserts and did not allow the drugs to be used for pregnancy testing.

Marketing in Developing Countries

Although the growing body of evidence about the hazards of EP drugs was sufficient to bring about a market change in Australia, the United States, and most European countries, it had hardly any effect at all on women in developing countries. When Australia withdrew EP drugs from the market for pregnancy testing in 1975, WHO informed all other governments of this

change and of the reasons for it. But due to the overwhelming problems that developing countries face in trying to meet the medical needs of their people, they were unable to withdraw EP drugs from sale in their countries, or to adopt measures that would have ensured they were safely administered.

The poor in most developing countries, and particularly women, suffer from the lack of a health care infrastructure that meets their medical needs. A 1979 WHO report estimates that in many developing countries up to 70 per cent of the people have no access to organized health care.

Though drugs are not necessarily the best solution in an environment where poverty, hunger, lack of clean water and safe housing are the real causes of ill health, they can sometimes be life-saving. But where there is no infrastructure to deliver basic health services, a safe and effective distribution of these lifesaving drugs is almost impossible to achieve. While essential drugs like penicillin are often out of stock in developing countries, vast numbers of nonessential and sometimes harmful drugs are freely available over the counter at drugstores and markets, even in the smallest towns. Drug regulatory agencies in various countries are supposed to balance the risks against the possible benefits of a drug before allowing it to be sold, but when these agencies are badly underfunded, as in the case in developing countries, they cannot carry out even the most basic inspections and controls. So they are forced to rely totally on the pharmaceutical companies for their information on drugs.

Pharmaceutical companies are only too eager to take advantage of this situation. Like any other industry, the pharmaceutical industry is in business to make profits. If a company can ensure the sale of a certain drug in developing countries by providing agencies with biased information on the drug, it makes good sense for them to do so. Biased information includes playing down side effects, giving more indications for use of the drug than in the company's "home" country (usually a developed country with more stringent safety regulations), or omitting contra-indications for the use of the drug. The consequences of this

situation are that nonessential and potentially harmful drugs can more readily find their way onto the market in developing countries, and drugs withdrawn from sale in developed countries can continue to be sold in developing countries. Furthermore, many essential, lifesaving drugs are often out of stock because they are less profitable for the pharmaceutical companies.

In her 1982 book *Bitter Pills*, British writer Dianna Melrose clearly documents all the complex factors involved in drug marketing and regulation in the developing world. She shows, for example, how the poor in the Third World have an array of questionable products such as vitamin tonics, cough and cold remedies, and antidiarrheals to spend their money on. Strongly influenced by the intensive drug advertising campaigns, they are made to believe that these products are cures, that is more rational to spend money on drugs than on food. When one child in a family is sick, the mother often decides to buy an expensive drug because she believes that this will cure her child faster. The result may well be that the whole family goes without food for a day or two.

The Campaign in India

These shameful practices continue, and EP drugs are prominent among those nonessential and harmful drugs still on the shelves of drugstores in developing countries. In India, many women's and consumers' organizations have been actively campaigning against EP drugs for several years. They succeeded in getting the government to impose a ban on EP drugs in 1982, only to have the ban overturned a few months later after the drug companies mounted their own pressure campaign. Since then, the groups, spearheaded by the Voluntary Health Association of India (VHAI), have been working to get the ban reinstated, so far to no avail. Yet the campaign has had a definite impact in India.

Though EP drugs are still sold, there is much greater awareness about their hazardous nature. VHAI has tried to popularize the use of the "Nancy Kit" (based on the immune assay of human chorionic gonadotrophin in the urine) among women's groups for safe pregnancy testing. One of the reasons

women buy EP drugs over the counter is that they do not want to visit doctors because this involves travel, waiting and added expenses in consultation fees. They find the self-administration of EP drugs from a neighbouring chemist shop cheaper and easier.

One problem is the availability of abortions and birth control. In India over 600,000 women die each year due to induced abortions which are being conducted unsafely and clandestinely, even though abortion is legal in India and family planning is the major health activity of the government health services. Also, a tubal ligation and the IUD are often the only contraceptive options available to women. And in India, as elsewhere, the responsibility for avoiding unwanted pregnancy is still considered to be the woman's problem — a matter not to be discussed, nor shared with the husband.

Traditional attitudes towards menstruation also enter into the EP issue in India. Delay or absence of periods is considered unhealthy, as it is associated with retention of bad blood in the body. Many diseases are supposedly associated with this condition. In certain communities a menstruating woman is considered unclean and is not allowed to enter the kitchen. Among more educated middle-class

women lack of periods may cause concern, giving rise to a feeling of lack of femininity and womanliness.

Women in traditional Indian society depended on signs and symptoms to confirm pregnancy. If the child was desired, they could afford to wait for another month to confirm it. Trained "dais" and birth attendants could diagnose pregnancy in 8 to 12 weeks. But just as increased medicalization of birth control has taken place, so has unnecessary tampering with women's and unborn children's bodies with EP drugs and other hormones. When safer urine tests exist to confirm pregnancy, the continued availability of such hazardous drugs becomes yet another form of women's exploitation.

At present, the government is in the process of formulating a new Drug Policy for India, and activists in the EP campaign have had to focus their attention on other drug-related issues — shortages of essential and life-saving drugs, continued sale of hazardous drugs, and the need for a rational overall drug policy, as well as other problems such as the plight of women gas victims in Bhopal. In developing countries where survival is the major issue, where calamities such as droughts, cyclones and political violence demand urgent attention, and where hazardous drugs and pesticides

are sold by the dozens, it is very difficult to focus undivided attention on one product like EP drugs only. Furthermore, poor drug controls, the unavailability of unbiased drug information and safer alternatives make fighting such a campaign a very demanding and difficult proposition in a developing country.

In 1985 Health Action International (HAI), an international network of consumers', health and women's organizations lobbying for rational use of pharmaceuticals worldwide, launched an international survey on the availability and use of EP drugs. With the results of this survey HAI hopes to mount a campaign for an international ban on the production, marketing and sale of all EP drugs, and to start a worldwide educational campaign among women on the ineffectiveness and possible dangers of EP drugs.

Despite the fact that there is no rationale for the continued sale of EP drugs, the fight to get them off the market in developing countries promises to be an ongoing, uphill battle.

Dr. Mira Shiva is the coordinator of Low-Cost Drugs and Rational Therapeutics of the Voluntary Health Association of India (VHAI), an organization composed of some 1,400 community health clinics across the country. She is also the co-ordinator of the All India Drug Action Network (AIDAN), which spearheaded the campaigns on EP drugs and injectable contraceptives in India.

Carla Marcelis has been involved for a number of years in women's health and pharmaceutical issues in the Netherlands, both with WEMOS, a Third World solidarity group, and Health Action International (HAI). She recently moved to Canada, where she is active in Women's Health Interaction, a network concerned with women's health and development issues.

This article is an edited version of one which will appear in the forthcoming anthology Adverse Effects: Women and the Pharmaceutical Industry, edited by Kathleen McDonnell. The book will be published by the International Organization of Consumer Unions (IOCU) in Penang, Malaysia, and in Canada by Women's Press, Toronto.



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MY STORY, OUR STORY

Choices for Adoption

Pamela Russell

She sat contentedly on the floor of the crowded children's theatre, somber, sun-tanned and self-assured. Not a family member in sight, this 1-1/2 year-old was enjoying her solitude. I knelt down beside her and we quietly studied each other. A woman sitting on the steps nearby was eager to identify this little person; "That's Shelley's daughter, you know." I smiled and kept silent. That's funny, I thought, she's my daughter too.

I love to share this story because it is full of joy and learning and powerful choices. Three years ago when I found out I was pregnant, I had three options: to have an abortion, to give birth to and parent this child or to end my responsibility to the child with its birth. I made the third choice.

At the time, my plans, and those of my partner's, did not include raising a child. I was not willing to commit such a large part of my energy to mothering, and Chris and I weren't interested in sharing each other's company in such a complete way just yet. I also decided against abortion, recognizing that I not only wanted to complete this pregnancy but was in a position to do so.

What I didn't realize right away was that I could set up an adoption just the way I wanted, and that there was something terribly wrong with a system which made it so hard for me to do so.

We found it difficult and scary to talk with other people about our pregnancy and our plan for this child. My favourite response was, "Congratulations!" The most horrifying, "Shouldn't you do the responsible thing and keep the child?" What we were doing was truly extraordinary but certainly possible. We saw this as an opportunity to share rather than as an event to regret or feel shame about. And yet I often felt like I was walking some fine line of acceptability, constantly wondering

how I was being judged. When I got scared, I sometimes resented having to continue to make decisions. However, with each choice we often felt strengthened, and reassured that our plan made sense.

I was 24 and working on my degree, and I was planning to move to Toronto in the fall to take a college program. Chris was in the last year of his degree. Neither one of us changed our plans; this child of ours was not going to get resented.

Once in Toronto, I lived with my brother and sister-in-law and their daughter, Jennie. She was three months old when I moved in. I found out exactly what caring for an infant was like — the devotion, the sacrifices, the fears, and of course the wonder of it all! That year, I fell in love with my niece and her mother. She was a wonderful model of nurturing and I understand more clearly why I will eventually choose to be a full-time mother. During this time her support was a constant and as I encountered social workers, doctors, and prenatal teachers, she listened as I thought each decision through.

Occasionally, I was keenly aware of my relationship with this fetus — I had chosen, both knowingly and unconsciously, the extent to which I was going to feel our connection. It was not a given that just because my fertility had been confirmed that the maternal



T. Robertson

instinct followed automatically or that bonding was inevitable. My caring for this life was only temporary and so I was not preoccupied with fantasizing about what she would be like and what we would "do" together. My thoughts, when they were focused on some sort of grown-up version of what was in my belly, were full of questions. Would she understand? Would she resent me? Would I be able to explain to her what it had been like for me? Consistently my answers were simple ones: she is alive; she is with people who are committed to parenting.

We began to explore the adoption system and were given information about both Children's Aid and private adoptions. The main difference is the degree of involvement one has in choosing the adoptive parents. We were told by advocates of social agencies that private agencies were a business whose clients were anxious for a child and willing to pay for the service. We would be able to pick the parents and to meet them. This was the choice that was the scariest. It seemed so risky and subjective. Better to leave that to people whom I was sure had my best intentions at heart, and who had lots of experiences in making such decisions. The underlying fear for us was, What if we chose the "wrong" parents? Although I didn't consciously think it, it seemed easier to blame someone else than to live with the knowledge that a "bad" choice had been our fault.

And so we began the process with Children's Aid. The system is set up so that birth parents can voice certain preferences about who the parents will be, for example, rural or urban dwellers, already parents. Adoptive parents remain anonymous to birth parents and vice versa. The final decision on the adoptive parents is made by a group consisting of the birth parents' social worker, adoption workers representing prospective couples, a supervisor and the birth parents — if they wish to attend.

This group meeting, in which the birth parents have one vote, takes place at least seven days following the child's birth. This is the minimum amount of time which must elapse before the birth parents sign any papers, and the most important part of the process takes place — choosing the parents and getting the child to them.

My social worker was full of information and support which I continually tapped. I learned about the politics, that the people who make the decisions about crucial questions such as whether files will be open or closed to birth parents, adoptive parents and people who have been adopted, are often very far removed from the actual process. Some people working within the system were sympathetic to easier access to information. However, everyone was expected to follow the existing rules and assumed that those making use of the system would do likewise.

Other parts of my pregnancy included choices around doctors and prenatal classes. It was challenging to find a doctor I was comfortable with; I didn't succeed. The relationship with my physician began well enough. However, from visit to visit, as I read more and learned more in our prenatal class, I saw more clearly how traditional her approach was. I would ask her about perineal massage or the birthing chair and her responses lacked the information and the enthusiasm I craved. Of course, if not for these feelings of disappointment, dissatisfaction and doubt, I would not have looked at our other options.

What an adventure to seek out a prenatal class for a couple who weren't interested in raising their child. We considered classes for unwed mothers and private classes. We chose finally to join a "regular" class of first-time parents, wondering whether we would fit in.

What a privilege to be a part of a group of people who shared their ignorance, their fears, and their hopes so openly. We were not quite as honest but given another chance I would have trusted them. What was I afraid of? That they would feel threatened by such a powerful decision, if in fact any of them had resigned themselves to, rather than welcomed, this life they were carrying? Or was I afraid that they would be able to change my mind?

During a discussion with friends about birthing options, I discovered how strongly I felt about a woman's sense of control during such a pivotal experience. I remember defending a woman's right to decide how and where to give birth. In one sense, I was saying power to women; yet I distanced myself from exercising this power completely. Because some of my birthing options seemed outside of the realm of possibility, I didn't consider them. I thought home birth was out of the question, since we didn't have our own physical space.

Knowing of our intention not to raise our child, Deidre, our prenatal teacher, told us she had an adopted son, the parents of whom she never knew. With us, she saw an opportunity to actively express her gratitude to them by not only offering us her home as a place to have our child, but also offering to care for this child until she would be placed in an adoptive home.

It was then that we realized that this was something we *could* give our child — the kind of birth we would most

likely choose if we were beginning our family. I can remember our excitement as we talked about and then decided upon a home birth.

However, reactions like "Don't you think you're just making it harder for yourself?" became common, though the logic would usually elude us. Why, we reasoned, should our resolve about our part in this child's future waver, simply because we were planning to welcome her into this world in the best way we could think of?

We learned all about this particular way of doing things; from our midwives, from literature and from other people who questioned and advised us. I relished the activeness of the role we were playing in this pregnancy and would be playing in the birth. This was *it*. This was the only part to which I was prepared to contribute and I felt wonderfully alive and clear about what we were doing and why.

As I became more in touch with my strength and trusted my choices, I was no longer satisfied with two Children's Aid procedures. The first was that this child's parents would not be chosen until after I gave birth; the second was that they would not be with her until at least nine days after she was born.

I did not want to worry during my labour, that the child's parents had not been chosen. I did not need seven days to mill over my decision. I had thought it through carefully months before. But Children's Aid found this too risky; birth mothers often reconsidered and decided to keep their babies after they gave birth. It was time-consuming to have these meetings before the papers had been signed, only to have the mother change her mind. Ironically, my social worker said that it was more likely we would decide to keep our child since we had supported each other through the pregnancy.

My desire to have this process make sense for us and for our child overcame my very real fear of taking an active role in the choice of her parents. If at all possible, the first nine days of a person's life should not be spent in a hospital nursery without knowing who his or her parents are. And so we took a deep breath and recalled the offers we'd received over the last few months: "If you change your mind and decide to do this yourselves, I know a wonderful couple ..." Switching tacks within two weeks of my due date was

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certainly challenging.

The two offers which we considered came to us through our midwife and our prenatal teacher. Fortunately we were able to keep it simple, making our choice between two very vibrant, loving and capable pairs.

It felt at times as if events were moving too quickly. Yet it began to seem natural that we were the ones making this choice. Who could think more lovingly and carefully about the sort of home in which this child would begin her life? We had no illusions that this choice of ours was any sort of guarantee about the quality of her life. The people we would decide upon would change and perhaps grow apart; what we trusted was that they wanted a child and were eager to take care of her.

And so we made a choice. Meeting Eric and Shelley was scary for two reasons, both of which depended on our ability to go after what we wanted for our child. First, what if we didn't like them right away? And second, what if we made a very strong connection and wanted to maintain the contact?

Once we got past these fears, it made sense to find out for ourselves what Eric and Shelley were all about and to give them an opportunity to do the same. This was not simply an exchange of goods; here was a way for us to add dimensions, features and voices to the picture we had of each other. If that was all the contact we or they wanted, then it was an opportunity to reassess our plan for our child.

Our meeting was wonderfully human. There was lots of laughter and honesty and awkwardness. Some of the questions were tentative, others wonderfully direct. Their eight-year-old son Christopher, adopted from birth, appeared from time to time, continually eyeing my stomach and us. Meeting him was incredibly reassuring; he knew he was adopted and why, and where his mother was, and he was encouraged to share what all that meant for him. This was a strong family unit and Eric asked us why we didn't want that for ourselves, and if we thought giving birth would change our mind. We explained why we wished to remain childless for now and shared our thoughts on the birth process.

I knew that giving birth would affect

me in an extremely significant way. It was like a mysterious secret which left me feeling nervous, at times terrified, and mostly curious. This was the part that no one could tell me about. What would the experience of childbirth and of welcoming this brand new person be like for me? Even so, I explained, it was hard to understand how my basic commitment to what we were doing might be completely shaken to the point of crumbling.

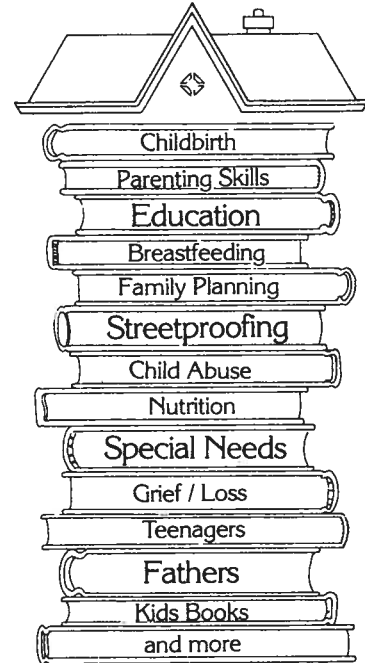
That first meeting began a hopeful, trusting relationship. We didn't have a chance to explore completely whether Shelley and Eric would attend the birth because I went into labour a few days after that first meeting. Our plans for a home birth were unsuccessful and Lauren was born in the hospital on a crisp, clear winter morning. She and Chris and I spent some wonderful time together before she went to the nursery. A day later, we left the hospital and Chris placed her in Shelley's arms. Later that afternoon, Shelley and Lauren crawled into bed together and their love affair began.

We had considered dozens of names. Eric and Shelley not only admired our choice but decided to use it. This felt like a very special sort of present, the best kind, in fact, since it was completely unexpected and full of thought and caring. This sort of sharing typifies so much of the interaction we have had with Eric and Shelley and Christopher.

There is no rigid plan for how we maintain contact and see each other. Occasionally this happens . . . and we continue to thoroughly enjoy our time together.

Who invented the gruesome phrase "Giving it up for adoption"? This sounds painful, guilt-ridden and, most of all, helpless. Each of us feels a tremendous satisfaction with the choices thus far and a strong sense of gratitude and joy characterizes our relationship. We recognize that this is rare, but we know it doesn't have to be.

Pamela Russel lives in Toronto and works with a group of small Canadian publishers. She welcomes letters from those who have questions or comments about this experience she has shared.



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REVIEWS

The Next Step

National Film Board of Canada, Studio D, Directed by Tina Horne, assisted by Barbara Doran, 1986.

Reviewed by Ida Wellwood

One in six Canadian women is battered by her partner. Battering crosses all socio-economic lines and affects all age groups. The three films which comprise *The Next Step* series were made to demonstrate the desperate needs of battered women and their children in every part of the country and to encourage communities to provide coordinated services to help meet those needs.

The films examine what happens to battered women once they decide to leave their violent partners. Each illustrates that a different geography requires a different approach.

Sylvie's Story is the true account of one battered woman's transition from fear and anxiety to growing hope and self-worth. When Sylvie's husband leaves for work that last morning, she knew she could not take another beating — she has to get out to save her life. Sylvie dresses her three-year old son, walks to a phone booth and calls the police. She is taken to the Auberge Transition, a shelter for battered women and their children in downtown Montreal. Staff members give Sylvie the support and advice she needs to make her own decisions. And she and the other women in the house gain confidence by sharing experiences and encouragement.

Sylvie's Story is the least personal of the three films. It is sometimes scattered and confused.

The second film, *A Safe Distance*, looks at various services and programs for women on isolated farms, in northern industrial towns, in rural communities and on reserves. It introduces the women who worked, often

with very little resources, to establish these services in communities with rigid, traditional attitudes toward a woman's place in the family.

When rural women decide to leave their violent partners, they often face a lack of services or services that are too far away to be readily accessible. Escaping to a safe place may depend on having bus or taxi fare — something many battered women in these areas do not have — to get to the nearest town offering the safety of a shelter.

A group of women in Portage La Prairie, Manitoba set up a project, Safe House, because they feel the need for a confidential approach to providing shelters for battered women and their children. The women of West Bay Reserve in Ontario show the power of their support system by constructing a large shelter to stand as a safe place and as a visible reminder that women will no longer tolerate violence.

A Safe Distance shows a more personal attitude in examining these and other innovative approaches to the needs of battered women in isolated areas.

Moving On is the final film in the series and examines the highly successful and integrated approach to provide services for battered women in London, Ontario. The quality of the film reflects this cooperation.

What makes this city unique is that it acknowledges wife battering as a community problem and has done something about it. The Co-ordinating Committee on Family Violence was established, comprising representatives from the police, social service agencies, hospitals, transition houses, the legal profession, and from support programs for men who batter.

In London, police are willing to lay charges, the court is ready to convict men who batter, and the community has pulled together to provide services

to battered women and their children. The London Battered Women's Advocacy Clinic and Changing Ways, a therapy program for men who batter, are two important elements of the city's innovative attempt to break the cycle of violence.

London is one of only a few communities in Canada that have adopted a co-ordinated approach to battering, but its success in dealing with the problem makes it a model for the rest of the country.

All three films in *The Next Step* series illustrate that battering does not respect class, income, race or religion. They demonstrate that myths, misconceptions and traditional attitudes can be overcome and that society is responsible for and capable of solving this problem.

Although each film could be viewed individually, the three films together are an inspiring educational tool. They demonstrate that when women share a need, they can create valuable support networks. The series will provide ideas, truth, hope and encouragement to community groups, women's groups, law enforcement agencies and legal professionals, social service, health care and mental health professionals, students of social work, medicine, psychiatry and criminology, shelters for battered women, school boards, town councils, and the general public.

The Next Step series and support material is available through the offices of the National Film Board of Canada. A series of three corresponding, but not identical, french-language films entitled *Se débattre* is also available.

Ida Wellwood is a Healthsharing volunteer who lives in Toronto.



Sex, Power and Pleasure

Mariana Valverde, *The Women's Press*, Toronto, 1985, \$9.95, paper, 212 pp.

Reviewed by Abbe Edelson

Reading *Sex, Power and Pleasure* is a lot like being taken on a whirl through feminist theory and history — a journey punctuated with personal anecdotes and written in a popular conversational style. This is a book that I wish I had read when I was 15. By stating that, I don't intend to diminish the book's present significance but rather to compliment the incredible overview of ideas about sexuality, and insight into the power dynamics of relationships it offers.

Sex, Power and Pleasure enables the reader to find a new and different place to start when trying to approach discussions about sex and sexuality. And it has the potential to reach a large number of people who previously would not have been exposed to ideas that, until now, have remained within feminist circles. While this is extremely valuable in itself, it is problematic as well. Aimed at so many sectors of the population, the book tries to be (at times) too many things to too many people. However, given the task which Valverde sets out to accomplish, clearly she comes through in the end.

She offers insights, information and clarity on issues such as eroticism, power, pornography, censorship and heterosexual and gay relationships. The reader is given a chance to pick and choose, accompanied by a sense of permission and freedom. The book is rich enough in historical references on feminist history and theory to keep one reading and researching through a long, cold winter. Valverde's expertise as an historian enables us to feel a sense of common struggle. Our sexuality and its practice are not only personal conflicts and joys, but come out of a history of people living and struggling.

Valverde undoubtedly has done her research, and has moved ahead developing new ideas. But there's so much in the book it becomes somewhat overwhelming. The anecdotes are interesting but often distract the reader from the flow of the argument.



Terri Robertson

Personal stories should illuminate the material and move the argument along but unfortunately this is not always the case in *Sex, Power and Pleasure*. What seems to be lacking is not the writer's commitment or material, but a strict and meticulous editor.

What's most exciting about *Sex, Power and Pleasure* is its major premise that deals with the dialectic of desire/eroticism. Too often, sexuality is talked about in a highly personal, categorical or scientific mode placing the activity of human relationships outside the realm of social relationships and their environment. Valverde places the conversation about sex and sexuality back into the world.

What goes on between two people is examined from an informed political consciousness that includes an analysis of gender, race and class oppression. It is more than just a meeting of Marxism with a "Masters & Johnson's" approach to sexuality, but is, rather, one which synthesizes that interaction between individuals and the real world.

While many feminists have grappled with the politics of relationships and the struggle to achieve "equality" within relationships, our ideas have

often fallen short when we are faced with our own human needs and conditioning. Valverde sheds new light on the politics of sexuality by acknowledging that "where there is strong eroticism there is power . . . In my view, it is not power itself which is inherently bad, but rather the way in which power gets used by one gender against another, and by one individual against another . . . We have to collectivize and equalize power. Then we will be free to really play, to really explore the possibilities of the dialectic of desire."

Valverde has put "sex and/or eroticism" back in the conversation about sex in the feminist critique. She examines the interplay of opposites that are a part of eroticism, rather than just the struggle for equality within relationships. The dialectic of desire is not only the interplay of opposites, nor individuals playing out different roles, but the awareness as Valverde writes "of that which is contained in each other." Sexuality and the dynamics of power in relationships then becomes something which is fluid, evolving and part of a process that includes our social development, influences and experiences. Valverde believes we need "social change rather than just an improvement in attitudes" in order to reach the ideal place where relationships operate differently.

There's much, much more in *Sex, Power and Pleasure*. The book is easy to read and not esoteric. Now I want to read another book by Valverde which covers in more depth many of the questions and issues raised here.

Abbe Edelson is a freelance radio reporter and writer living in Toronto.

♀ CHOICE

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LETTERS

ECT useful

I am writing in regard to an update in the Spring 1986 issue of *Healthsharing*. The item was *Electro-Shock Findings* Rejected by Deborah Feinstadt.

There are dangers associated with ECT. I studied them before my decision to accept "shock" therapy for a severe, refractory, clinical depression, some four years ago. And while the horrors of early, unmodified ECT are acknowledged, the current practice is more positive.

I think it is necessary to note that patients now receive a muscle relaxant and a general anesthetic prior to the inducement of seizure.

Treatment is quick and painless. I was able to receive treatment on an out-patient basis.

While ECT can have an adverse effect on short-term memory, the risks of continued depression must be compared with the treatments. (This is particularly true when the sufferer is suicidal.) And depression itself, seems to affect memory. The benefits of "shock" can be tremendous.

I would also like to comment on sex-bias. Of course twice as many women as men receive shock therapy. Twice as many women suffer clinical depression.

Finally, I wish to encourage

your readers to view ECT as a medical issue rather than a feminist one.

Mary A. Hickmore
Edmonton, Alta.

Psychiatric Patient Advocate Program

Cathy Smith's poignant description of her experiences as a psychiatric patient in "My Story, Our Story," *Healthsharing*, Summer, 1986, moved me to respond. I also wish to tell Cathy and others who might be in her position about the Psychiatric Patient Advocate Program — a service that is currently available to the in-patients of Ontario's ten provincial psychiatric hospitals [fifty seven percent (57%) of people admitted to psychiatric facilities]. Had this service been available to Cathy, she could have had information and support to deal with her struggles with the hospital and the system.

The Psychiatric Advocate Program was established by the Ministry of Health in 1982. There are Advocates assigned

to each of the provincial hospitals and I am one of those Advocates. We report to the Ministry of Health, so that we can work from "inside" the system. We are, however, independent from the hospitals where we work. It is our mandate to inform patients, their families, hospital staff, and the community about patients' human and legal rights and to assist patients with their complaints according to the patients' instructions.

The Psychiatric Advocate Program is being evaluated. The extent of our mandate, our philosophy, our reporting structure, etc., will be considered. If you have opinions on these or other matters send a letter to your MPP or the Ministry of Health.

I want to thank Cathy for sharing her story. I hope it helps to raise awareness and to change the systems that are insensitive to human needs, rights and dignity.

Karen Walker
Patient Advocate, Whitby,
Ontario

Dalkon Shield Appeal

Winnipeg's Women's Health Clinic and the Vancouver Health Collective will jointly appeal the ruling by a U.S. judge in Virginia against them in the Dalkon Shield case.

In mid-June, District Court Judge Merbige denied the attempt by the groups to extend the April 30 deadline for filing new claims against the A.H. Robins Company. The National Women's Health Network in the U.S., UBINIG of Bangladesh and the Council for the Status of Women in Ireland had also sought to extend the deadline.

The claims revolve around damage attributed to Robin's Dalkon Shield. The Shield, an

interuterine birth control device, has been criticized for design flaws leading to severe health problems among women who used it. (See *Healthsharing*, Spring 1986, and Winter 1985.)

The women's health organizations also sought a substantially increased publicity and notification campaign in Canada of the Dalkon Shield problem and what action injured women can take.

Judge Merbige ruled that there would be no extension of the claim deadline for Canadian women. He also ruled against a request to have an advertising campaign on the Dalkon Shield lawsuit.

However, it was established that Canadian women (and all non-U.S. women) did not receive adequate notification. Because of a principle in U.S. bankruptcy called "excusable neglect," a woman who can swear that she did not know about the deadline can still become a claimant.

To become a claimant now, a woman must see a lawyer. The lawyer needs to prepare a formal affidavit which includes the woman's name, address, and the following statement: I wish to make a claim against A.H. Robins because of damages occurred by my use of the Dalkon Shield. My injuries are _____ Before

April 30, 1986 I was unaware of my right to file claim in the bankruptcy proceedings. I first learned of my right to file claim _____

If I had learned of my right to file before April 30, 1986, I would have done so.

This should be notarized and sent to the bankruptcy court at Dalkon Shield, Box 444, Richmond, Virginia 23203.

There are American lawyers willing to assist Canadian women, either to argue their cases or to find other lawyers. Contact Bob Manchester or Jerry O'Neil, Manchester and O'Neil, 95 St. Paul St., Burlington, Vermont, 15402. (802) 658-7444.



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RESOURCES & EVENTS

Women and Home: Women as Health Guardians

A new study from the Canadian Advisory Council on the Status of Women by Anita Fochs Heller reports on the primary role of women in caring for the health of their children, their husbands, their parents and other family members while all too often neglecting their own. It is filled with direct quotes from interviews with over 150 women across Canada and these provide fascinating glimpses into the lives and responsibilities of women across the country. It is available to individuals at a cost of \$4.95 from the Canadian Council on Social Development, 55 Parkdale Avenue, Ottawa K1Y 1E5 (613) 728-1865.

Women's Campground

Zone Three is a non-profit women's compound near 100 Mile House in the Cariboo region of B.C. Facilities are basic and include campsites, cold water, firepit and outhouse. Children are welcome but dogs must be leashed.

For more information contact Zone Three, C-44 Imp. Ranch, R.R. #1, 100 Mile House, B.C. V0K 2E0 or phone (604) 395-4721.

Changing Hospital Birth

Childbirth... The Changing Sounds was produced for the Canadian Institute of Child Health and deals with

family-centered maternity and newborn care. The film demonstrates how many of the attitudes and practices surrounding childbirth in hospital can be changed to the benefit of mother and child. High risk situations such as caesarean and premature birth, and the delivery of twins are also examined.

The 28 minute film is available on loan in 16 mm and video format, free of charge, from all National Film Board offices.

Menopause Manual

The Time of Our Lives is a booklet about menopause available from the Voluntary Resource Centre. The publication considers many aspects of menopause, including an explanation of physical symptoms, a discussion of nutrition and exercise and an examination of the psychological impact of the menopausal years.

For a copy contact the Voluntary Resource Centre, 81 Prince St., Charlottetown, P.E.I. C1A 4R3.

Housing Conference

The Nova Scotia Association of Social Workers is seeking support for a regional conference on women and housing. The proposed conference would bring together individuals and organizations to develop strategies and increase public awareness of the issues of women and housing. The organizing committee hopes to hold pre-conferences in each province to lay

groundwork for the conference which is scheduled for November 6-9, 1986 at the Memramcook Institute in Moncton.

For more information contact the organizing committee, Atlantic Women and Housing Conference, 1094 Tower Rd., Halifax, N.S. B3H 2Y5.

Farm Women's Rights

To Have and To Hold: A Guide to Property and Credit Law for Farm Families in Ontario is a new publication from Concerned Farm Women. It covers business structures, ownership of assets, credit agreements, bankruptcy, wills, estate planning and other legal issues of particular concern to farm women.

The book is available at the cost of \$4 per copy from Concerned Farm Women, Box 457, Chesley, Ont. N0G 1L0.

Feminist Cartoonists!

In order to establish a talent bank of feminist cartoonists across Canada, women who would like to be included are invited to submit their names, addresses and a sample of their work to Susan De Rosa c/o Communiqu'Elles, 3585 St. Urbain Street, Montreal, QC H2X 2N6. The bank will be accessible to feminist magazines and associations across Canada.

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