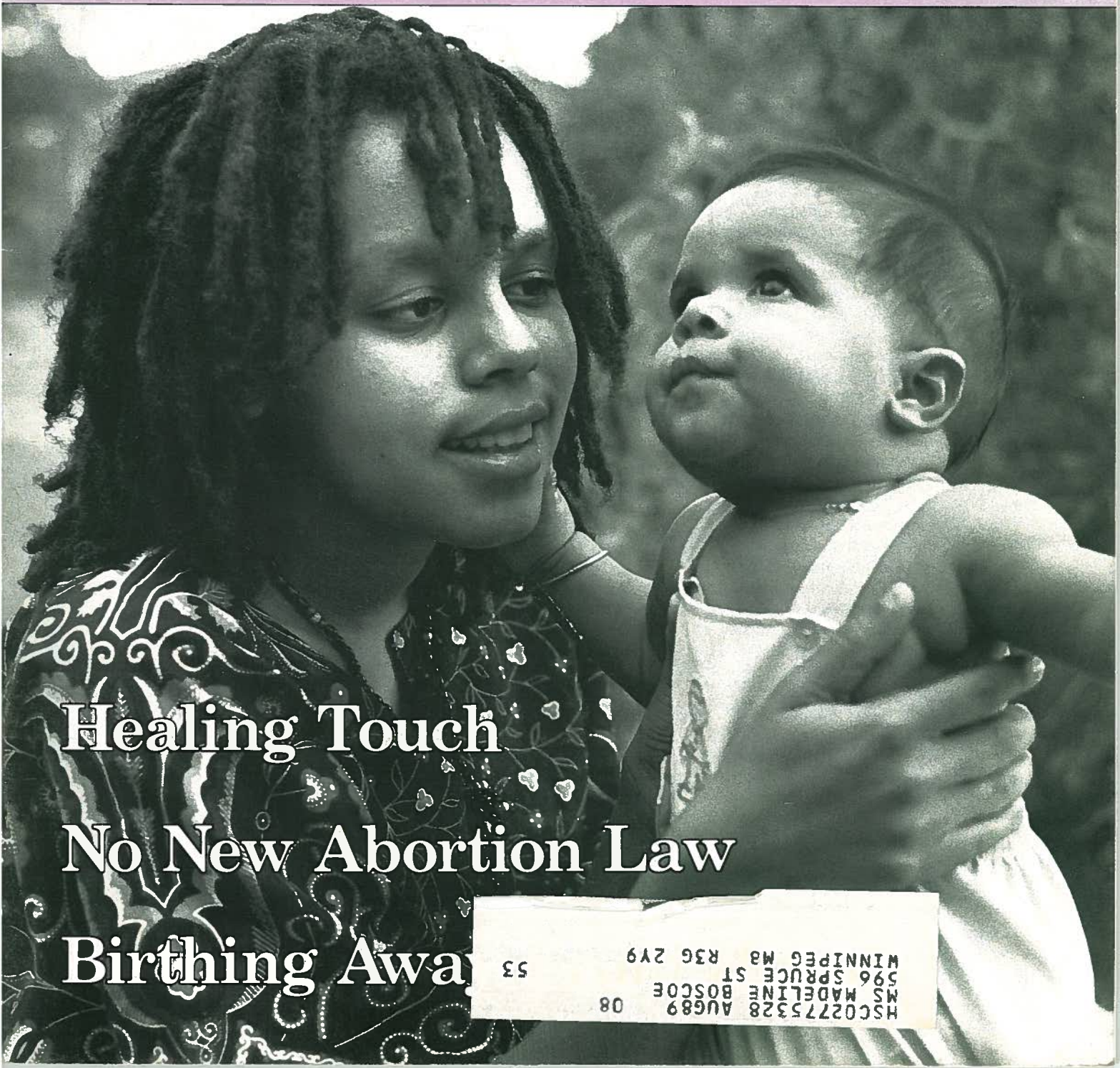


Winter, 1988
\$3.00

Healthsharing

10th Anniversary!

A CANADIAN WOMEN'S HEALTH QUARTERLY



Healing Touch

No New Abortion Law

Birthing Awa

HSC02775328 AUG89 08
MS MADELINE BOSCOE
596 SPRUCE ST
WINNIPEG MB R3G 2Y9 53

INSIDE

Vol 10:1 December, 1988

Collective Members

Susan Elliott, Deirdre Gallagher,
Amy Gottlieb, Alice Grange,
Ruth Kidane, Diana Majury,
Lisa McCaskell, Katie Pellizzari

Administration

Amy Gottlieb, Marie Huggard, Sharon Klein,
Jo-Ann Minden, Katie Pellizzari, Lisa Phipps

Advertising

Bernadine Arsenault, Susan Elliott

Circulation/Promotion

Amy Gottlieb

Copy Editing/Proofing

Amyra Braha, Lisa McCaskell

Design/Production

Susan Elliott (coordinator), Pam Bristol,
Jill Cameron, Mary Margaret Crapper,
Amy Gottlieb, Alice Grange, Marie Huggard,
Ruth Kidane, Sharon Klein, Lisa McCaskell,
Jo-Ann Minden, Katie Pellizzari,
Rhonda Sussman

Editorial

Amy Gottlieb (coordinator), collective
members, Sharon Klein, Heather Ramsay,
Linda Rosenbaum, Theresa Wright

Typesetting

Lynne Fernie/Type A

Printing

Delta Web Graphics

Cover Photo

Stephanie Martin

Editorial & Advertising Offices

14 Skey Lane, Toronto, Ont. M6J 3C4
(416) 532-0812

Subscription Offices

511 King St. W., Toronto, Ont. M5V 2Z4
(416) 591-1381

Published quarterly by Women Healthsharing, Inc. Anyone wishing to make a tax-deductible donation (\$10 or more) please send a cheque payable to Women Healthsharing Inc.

Women Healthsharing endeavours to print material with which we agree; however not every article or column reflects the opinion of all collective members or of our funders.

Authors and artists retain copyright, 1988. No part of this magazine may be reprinted without prior permission. Unsolicited manuscripts or artwork should include a stamped self-addressed envelope. A writing guideline is available upon request.

ISSN: 0226-1510. Second Class Mail
Registration: 5327.

Women Healthsharing receives partial financial support from Women's Program, Secretary of State, Employment & Immigration and other sources.

Advertising rates are available upon request.

Indexed in the Alternative Press Index; available on microfilm and microfiche from Micromedia (158 Pearl St., Toronto).

Subscription rates are \$12/year, individuals; \$24/year, organizations and groups. USA add \$2 Cdn or US funds; other add \$3. International Money Orders only.

FEATURES

10 Through Women's Eyes

A feminist looks at medical research
Patricia Kaufert

16 Long Distance Delivery

Birthing away from home
Holly Rupert and Dianne Lai

21 Healing Touch

The profound effect of touching
Cheryl Grossman, Leigh Hamilton, Wendy Simmons

27 No New Law!

Reactions to Supreme Court decision on
abortion
Norah Hutchinson



Joanne Dyck

ALWAYS IN HEALTHSHARING

3 Collective Notes

Our 10 th Year!

4 Letters

6 Update

14 Healthwise

More bad news about caffeine
Jeane Van Breuckelin

25 My Story, Our Story

Moving Forward
Teresa Gibson

31 Reviews

*Handi-Travel: A Resource Book for Disabled
and Elderly Travellers*
Doing It Ourselves

34 Resources and Events



COLLECTIVE NOTES

Our 10th Year!

This issue of *Healthsharing* (Vol. 10, No. 1) celebrates our 10th anniversary. Although the membership of the collective has changed over the years as new members arrived and older members moved on to new challenges, we still firmly adhere to the philosophy of the first collective notes:

"Healthsharing — the concept of sharing health is, for us, a feminist approach to health and healing. It denotes the caring and sense of community which are the essence of both feminism and healing."

Looking back over the past 10 years there are many health concerns that resurface repeatedly in *Healthsharing* — abortion, midwifery and occupational health hazards. Ten years ago DES was known only to a few and suspicions about the safety of the Dalkon Shield I.U.D. and its link to pelvic inflammatory disease were only just surfacing. Menopause was something that was euphemistically called "the change of life" — dreaded by most and never talked about. Childbirth improvements and options were being demanded by women and their midwives and self-help groups were flourishing.

It is also possible when we look back to trace within *Healthsharing* some of the ebbs and flows of the Canadian women's movement. *Healthsharing* arose in a period of intense activism, propelled by women, some new to the women's movement, some old hands, who had turned their attention to an issue vital to all of us — health. From the beginning our writers and the collective have tried to do more than just inform and initiate discussion; at times we have joined coalitions, organized conferences and attempted to formally establish a Canadian women's health network.

Within the collective there has been an ongoing discussion and tension over the definition of our role. Are we an activist organization or one whose work should be confined to the production of a magazine? At different times the balance has tipped one way or the other. This in part has been a reflection of who is in the collective and their energy as well as events in the world around us.

Our first years were our most active ones. The Canadian women's health movement was young and collective members and others associated with the magazine were enthusiastic. In recent years our perspective has been less activist. Over time, the magazine became more established, although commitment to our original goals remained. Some gains were made, priorities changed and women became active around other issues. Some of our personal lives changed also; demands of families, aging parents, children increased.

But we have continued to produce a magazine which addresses crucial issues of our times. Issues such as AIDS, New Reproductive Technologies and the impact of economics on health have been examined. *Healthsharing* has looked at illiteracy, aging in a youth oriented society, health problems of immigrant women, and the impact of Free Trade on health care. New discoveries in science and medicine have presented challenges to our writers and to you our readers.

It is now time to broaden our work again. *Healthsharing* has recently begun a long, perhaps difficult discussion on issues of racism (see Collective Notes, Vol. 9;4). This discussion is taking place throughout the women's movement and it is overdue in *Healthsharing*. We are looking not only at who the collec-

tive is, how we work and at the content and design of the magazine, but at what we can do to make the organization and magazine more representative of all Canadian women.

We are at the same time facing a financial crisis which is impelling us to work even harder. Our ongoing problem is one faced by most small magazines in Canada — distribution and production costs are increasing, promotional funds are limited and our potential market across Canada is limited.

We are embarking on a fundraising campaign to make our future as Canada's only national women's health magazine secure. In the months to come we will be appealing to readers for their support. We also ask that you support our new subscription price. We have raised it to more accurately reflect our production costs.

Healthsharing has always recognized the power of the individual and the collective in changing and determining our own health. We will continue to empower women by presenting alternatives to the Canadian medical system with its unhealthy dependence upon hospitals and doctors, drugs and drug companies. As we move into our second decade together thoughts from the original *Healthsharing* collective are still timely and relevant:

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

*Susan Elliott, Deidre Gallagher,
Amy Gottlieb, Alice Grange,
Ruth Kidane, Diana Majury,
Lisa McCaskell, Katie
Pellizzari.*

LETTERS

We encourage readers to write. Your debate is just as vital as the original articles and columns published in the magazine. Please take the time to share your opinions with other readers.

Healthsharing reserves the option to print and edit letters for length, unless they are marked 'not for publication.'

Dismayed by "Saying No to Amnio"

Were others as dismayed as I was to read Kathleen McDonnell's "Saying No to Amnio"? (September 1988). This kind of argument is not new to those of us in the abortion rights movement. The anti-choice lobby has always viewed amniocentesis as a threat because it allowed women to have information that might lead them to choose abortion. Now we have Kathleen McDonnell, seemingly well motivated by concern for the disabled, attacking amniocentesis with false arguments.

McDonnell's piece is replete with religious imagery and fatalistic thinking. Her final paragraph reveals an ambivalence about women

having control of their reproductive lives. While decrying medical control of childbearing, she seems unwilling and almost afraid to place that control in the hands of women. Rather she would leave things to chance. She asks us to believe that it is better *not* to exert control and to accept what life sends us. She tells us that by so doing unexpected gifts may come to us. Is this not what we have been hearing from orthodox religions for centuries?

Isn't this what women have been struggling to overcome? And hasn't *Healthsharing* been part of that struggle?

McDonnell concedes that some women might decide they cannot or don't want to cope with the demands of raising a child with physical or mental disabilities but goes on to say that deciding this has implications for society as a whole. She says, "Collectively, however, these choices add up to something much more chilling: a wholesale societal rejection of disabled people, a kind of reproductive quality control." Not only is this false logic but it can only make women feel guilty and

somehow responsible for diminishing our collective humanity.

McDonnell says that by aborting disabled fetuses we demean the disabled. This is patent nonsense. It is just as illogical as the anti-choice claim that societal acceptance of abortion is the cause of the rise in the incidence of child abuse or that access to abortion inevitably leads to euthanizing the elderly and putting Jews in gas ovens.

It in no way follows that if one avoids becoming disabled or having a disabled child one is therefore incapable of recognizing that society should be organized to ensure that the lives of disabled people are as full and meaningful as possible and that the disabled make valuable contributions to society. If one were to extend the "logic" of Kathleen McDonnell's argument we should not put our children in seatbelts, wear hard hats on construction sites or attempt to prevent disability in any way because by so doing we demean the disabled too.

Let us all defend the rights of the disabled. Let us all defend the right of women to make use of or reject technology. Let us be wary of arguments against a woman's right to control her reproductive life disguised as concern for the disabled. Neither women nor the disabled are well served. *Ruth Miller
Toronto, Ont.*

Kathleen McDonnell responds:

Although Ruth Miller makes some valid points in this letter, she undermines her own arguments by engaging in unnecessary innuendo. In her use of such phrases as "seemingly well motivated" and "disguised as concern for the disabled" she suggests that I have some kind of hidden agenda, and implies that I am

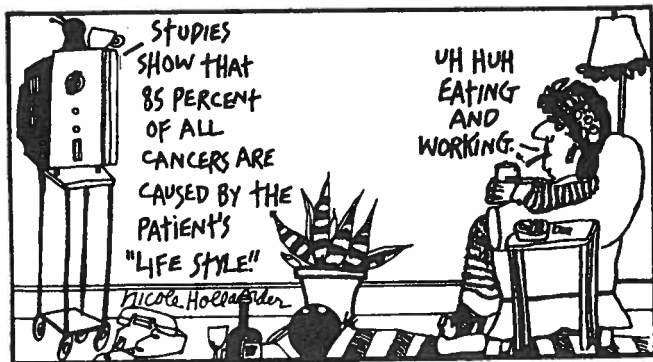
not really committed to choice on abortion, despite several clear pro-choice statements in my article. She also puts words into my mouth, suggesting that I think women having amniocentesis are personally guilty of denying the humanity of disabled people, when I explicitly stated otherwise in the article.

Unfortunately, nowhere in her letter does Miller seriously address my main point, which was that routine prenatal screening and the woeful inadequacy of social support systems for disabled people and their families create a climate in which women feel they have no choice but to abort. This is certainly not my idea of reproductive control, and I am not the first to make this point — a number of other feminists and disability activists have made it as well. Since amniocentesis is only one technique in a still-developing, highly sophisticated prenatal screening arsenal, it behooves us as feminists to take a serious look at its broad, long-term impact on society. This effort is poorly served by Miller's dismissive approach.

Finally, the article was clearly a personal statement, a sharing of the thoughts that went through my mind as I made my own decision not to have amnio, not a prescription to other women on how they should act. And yes, I suppose I am guilty as charged of using "religious imagery." Miller seems to think that spirituality and feminism are diametrically opposed to one another. There are many women both within and outside the organized churches who would strongly disagree.

Proactive Stance

I was extremely pleased to read the Collective Notes "Fighting Racism." (Vol. 9 No. 4) since it showed a growing awareness of the role that white women must play in the



Nicole Hollander/"My weight is always perfect for my height — which varies."

struggle against racism as well as sexism. Since for the most part the barriers to equality and privilege have been erected and supported by white people in Canadian society, it is heartening to learn of a group of women who are committing themselves to dismantling some of those barriers in their field of activity. Your proactive stance is a commendable first step.
*Kamala-Jean Gopie
North York, Ont.*

Fighting Racism

I am writing concerning your Collective Notes, "Fighting Racism" (Vol. 9, No. 4). You start off your notes by saying "In recent years Women of Colour have been raising their voices in the Women's Movement . . ." Have you all been sitting with your fingers in your ears? Women of Colour have been raising their voices for many years, it is apparent that these voices have not been heard. We've been calling for change for too long now, within the Women's Movement we've all but separated and started our own Women's Movement.

If you are so concerned with Women of Colour's oppression, how can you use an oppressive move to have us write and submit photos? We know that we are Black and that we also live daily lives knowing that we are poor. Offering to pay us for things we submit you is showing prejudice. Excluding white women from your bribe, will do nothing but make these white women, not only angry with your collective but also at us. You cannot pay Women of Colour and not pay the white ones, too. You want to change, but you are going about it in the wrong way.

White women also have obstacles in their way and also are poor. I'm not sure how you see this move as a beginning. I personally feel that you all sat around thinking how can we

pacify these Women of Colour and came up with this "Brilliant" idea, let's pay them off.

If you are seriously willing to take your fingers out of your ears and listen to what our message has been for more years than I've been born: we want all people to be equal, regardless of sex, religion, race and sexual preference. Wanting to pay us is just your "unknowing" way to keep us separate.

I personally would not take your blood money. I don't want you to feel sorry for me, because I've had a hard life.

Your first step should be speaking to Women of Colour to see how you could come to another decision, let Women of Colour join your collective, let them write and help pick out articles and photos that should be published. Bribery will not work. I was so disappointed to find out that an organization that does such wonderful work can have their politics so fucking backwards.
*Still Struggling,
Debbie Gough
Toronto, Ont.*

Inspired to Subscribe

Upon reading "Fighting Racism" (Vol. 9 No. 4) I've been inspired to subscribe to *Healthsharing*.

It is crucial to recognize and to develop an understanding of how race, class and sex intersect to form a different oppression in the lives of Women of Colour. It is just as crucial, however, to recognize that Women of Colour should not be "written, spoken, thought of, and researched into" . . . solely in the context of our oppression.

Our colour is a source of oppression — YES — it is also a source of pride! As we struggle in our day to day lives, we also celebrate our beauty, strength and achievements. A balanced view of our reality must be

reflected in the pages of your magazine.

*Ravida Din,
Ottawa, Ont.*

Medicalization Continues

I was invited to one of two concurrent press conferences (in Montreal and Toronto) to announce the existence of a new Canadian Menopause Foundation. The press conference was convened by Greycom, the public relations firm employed by Ayerst Laboratories, manufacturers of Premarin (conjugated estrogen). At the Toronto conference, co-founder Dr. Robert Casper admitted that \$250,000 had been accepted from Ayerst as "seed money" for the Foundation. At the Montreal conference, co-founder Dr. Rodolphe Maheux spoke about menopause as a natural event in a woman's life, not an illness, and then listed the founder members — 14 medical doctors and a representative from Status of Women Canada.

This news is dismaying for those of us who have worked hard to foster the de-medicalization of menopause and to encourage more open discussion about the effects of menopause and the potential ramifications of over-generous use of hormones (see Winter 1986 issue of *Healthsharing*, page 17).

If you share our dismay, would you please communicate this to: Canadian Menopause Foundation, Place du Canada, Suite 1850, Montreal, P.Q. H3B 2N2.

*Janine O'Leary Cobb,
Montreal, P.Q.*

Important Job

I have just read the Fall issue [Vol. 9 No. 4] of *Healthsharing*. It is the first time I have seen the journal, and I would like to comment on the Collective Notes "Fighting Racism" from the perspective of a global Peace

Our Cover



The cover photograph was taken by Stephanie Martin, an artist, photographer and health worker living in Toronto.

and Justice activist . . . For the last year I have watched Women of Colour in North America move in the western peace and feminist movement trying to talk about racism. They are now saying they have failed, or rather white women have failed to hear them, or succeeded in not hearing them . . . It is worth noting that aboriginal rights are under unprecedented attack in North America at present, and racism is generally rising.

Journals like *Healthsharing* do an important job. I am not suggesting that it take up global issues, there are countless others that do, but much more work needs to be done in laying bare racism and its causes, otherwise the magazine will not stay healthy.

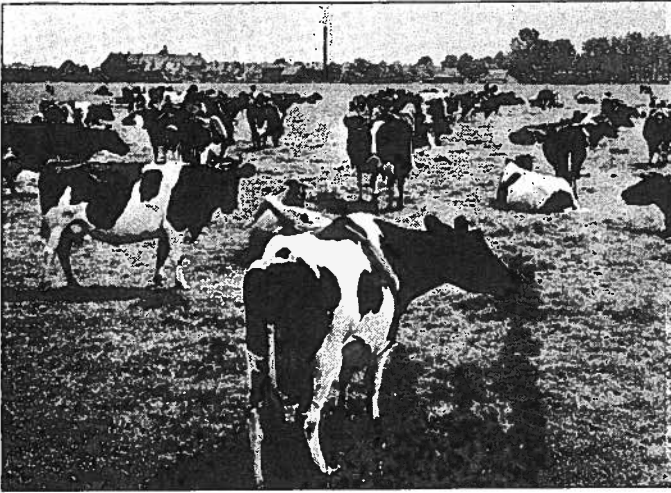
*Josie Wallenius,
Thunder Bay, Ont.*

Unsafe Procedure

The photo which accompanied "New candida diagnosis and treatment" (Vol. 9 No. 4) was unclear but appears to depict a lab tech mouth pipetting which is no longer considered a safe procedure. Loved the Women and AIDS article!
*Cathy Crowe,
Toronto, Ont.*

*You are absolutely right!
WHS*

UPDATE



TV Ontario

An ounce of cow's milk

Between 3 and 4 million Canadians suffer from allergies. As some of them know, cow's milk and related products can cause a lot of problems for many sufferers. The newest information, presented at an International Conference of the Toronto-based Allergy Information Association held last May, is that early introduction of cow's milk and even milk-based infant formulas may not only aggravate existing tendencies for babies to become allergic to the milk itself, it may also predispose the infants to develop other allergies.

As a cautionary measure, some allergists suggest that women whose babies will have either a maternal or a paternal background of allergies and/or asthma should avoid dairy products entirely while pregnant and breastfeeding. Breastfeeding for as long as possible, delaying the introduction of solid foods until the infant is six months or older, and avoiding common allergy-producing foods such as milk products, eggs, wheat and

citrus fruits until the child is older than one year, may inhibit allergic tendencies further by allowing the child's immune and digestive systems to develop fully.

However, because these suggestions are based on retrospective observations rather than scientifically designed studies, many medical doctors do not consider the advice valid. Of the three doctors approached — one allergist, one pediatrician and one clinical ecologist — none wished to comment. Reasons cited were: "There is not enough evidence to support that idea," "I can only give you my personal bias," and "For political reasons, I will not be quoted by the media." Because of this reticence, parents may only stumble across this information after they have been confronted with violent allergic and asthmatic reactions in their children.

Meanwhile, it is the very young allergy victim who suffers the most. Nurses on the isolation ward at B.C.'s Children's Hospital have noticed an increase in allergy

Confidentiality breached

At the beginning of August 1988, the Health Insurance Board of Quebec (RAMQ) announced its intention to conduct an investigation into extra-billing for abortion procedures performed in private clinics in the province. Had the investigation gone ahead, many women would have received unexpected phone calls from the RAMQ asking them whether they had been extra-billed for the abortion they had undergone. Once an extra-billing procedure was confirmed, a woman would be asked to testify in court. The Board claims it would not have discussed the nature of the call with the answering party had a woman not been home nor would they have left any messages.

Following an onslaught of opposition from the public as well as physicians' associations, the RAMQ has backed down and withdrawn

the intended project. Critics pointed to the blatant disrespect of the confidential patient-doctor relationship such an investigation would entail.

One physician has called the proposed investigation "a disguised attack on access to abortion," asking why private abortion clinics are being targeted by the RAMQ now when some have existed for more than ten years.

In light of the fact that only 20 per cent of abortions throughout Quebec are performed in private clinics, the really burning issue is improving the quality and increasing the availability of publicly-funded abortion services.

In the meantime, the RAMQ is contemplating other methods of proceeding with their investigation of extra-billing.

MARION LOKHORST

and asthma admissions in recent years. Among the most severe are babies who, as their mothers discover after weaning, are allergic to every food except human breast milk. They live on bottled breast milk pumped and donated to the hospital by nursing mothers in the Vancouver area. More common are the young children who subsist on extremely limited diets, coping daily with eczema, digestive discomfort, behavioural problems, respiratory difficulty, general malaise and side effects of drugs such as ventolin, which induces a temporary artificial state of hyperactivity, and corticosteroids, prolonged use

of which can lead to birth defects.

As conservative allergists point out, there is no way to know whether these children would be suffering less if physicians had advised their mothers to avoid cow's milk and breastfeed for as long as possible.

Perhaps it was the mother of an allergic or asthmatic baby who wisely said that an ounce of prevention is worth a pound of cure. As no cures for allergies and asthma have been discovered, it is even more worthwhile for doctors and parents to be open to innovative, no-risk preventive measures.

LYNNE MELCOMBE

Sexual harassment complaints in Nova Scotia

Twelve Halifax women were recently interviewed by the Provincial Medical Board in regards to complaints about the behaviour of a gynecologist. That may sound like no big deal, however, this story has its roots in the past.

In 1987 two women who had complaints about a Halifax gynecologist had written formal letters of complaint to the doctor in question, the referring physician, the Chief of Gynecology at the Grace Hospital and the Medical Society. The complaints were acknowledged but no further action was suggested.

In Nova Scotia, the provincial medical board is the official body with which complaints should be lodged. Neither woman was informed about the existence of the board or the process of filing a complaint. The two women then approached the Nova Scotia Advisory Council on the Status of Women

(NSACSW) who offered support as well as accurate information about the process of filing a complaint. A timely newspaper article on sexual harassment and a column which described how several women were treated by their doctors prompted 60 people to contact the NSACSW office over a two week period!

"It was obvious women didn't know where to go. We got more complaints (against doctors) in two weeks than the Medical Board got in a year," says Debi Forsyth Smith, president of the advisory council.

The NSACW held a meeting to provide women with accurate information and an opportunity to question various resource people. From this meeting Advocates for Medical Ethics Now (AMEN) developed. For many women this has given them an opportunity to talk about negative experiences with doctors that they may have

internalized and felt guilty about and a chance to discover that other women have had similar experiences.

AMEN supported 12 women in a preliminary hearing with the medical board regarding complaints about a particular gynecologist. The board found that there was not enough evidence to support a formal hearing and will not be disciplining the doctor.

This inaction angered many women. But it does not come

as a great surprise, despite the professional misconduct guidelines contained in the provincial medical act, which include breaking confidentiality and committing adultery with a patient.

For more information about Advocates for Medical Ethics Now (AMEN) contact Vicki Trainor, #6, 5227 Kent St., Halifax, N.S. B3H 1P7.

ALEXANDRA KEIR

Women's health clinic opens

Woman's Choice Health Clinic is a new women's health clinic in Toronto providing abortions and related services. The non-profit clinic, which opened on September 27, 1988, emphasizes a woman's control over her health interactions in a supportive environment. The clinic provides non-judgemental pre- and post-abortion counselling; individual and group counselling on the various forms of contraception and their risks; sexually transmitted disease screening, treatment and preventative education.

The clinic also plans to expand services to include other woman-centred health care and is currently establishing a community advisory board and a health advisory committee to develop future programs. These groups will be comprised of a wide range of health care providers and recipients and will actively promote women's participation in their own health care.

Clinic staff consist of experienced doctors, nurses

and counsellors all of whom will have an equal say in decisions regarding all aspects of the clinic's management. Like many workers in the service and public sectors, they believe that those who are actually providing care and services must have a strong voice in how these services are delivered. As providers and recipients of women's health care, they believe the cooperative structure with active community input, will ensure sensitivity to client's needs. Clinic staff envision a place where health decisions will be guided by a process of informed choice rather than informed consent, where barriers of language and culture are addressed, and where disabled women will have full access.

For more information, contact the Woman's Choice Health Clinic, 597 Parliament Street, Suite 207, Toronto M4X 1W3. (416) 975-9300.

WHS

Clear as mud

On September 2, 1988, Justice Minister Ramon Hnatyshyn responded to reporters questions about whether the federal government planned to introduce new abortion legislation before or after a Supreme Court ruling on Joe Borowski's 'fetus-rights' case. He made himself perfectly clear:

"The Borowski case is, and I underline this fact, a matter of dealing with the current state of the law. So we're dealing with Borowski. It's a question of finding out what the law now is with respect to this issue. The question of policy, of what the law should be and what directions Parliament

might take, are matters of policy which are matters which are within the normal purview of the Government and of Cabinet and therefore there's no inconsistency with respect to dealing as the Attorney-General, as I must do, on arguing what the law is before the Supreme Court of Canada and dealing on a policy issue in Cabinet with respect to what the law should be."

And Ramon thought that there was some misunderstanding about what the government's intentions were!

WHS

Overhaul of welfare system proposed

The Ontario government should pay income supplements to the working poor, increase the minimum wage and recognize that social assistance is a basic right of all residents. In its report, *Transitions*, the Social Assistance Review Committee has challenged the Ontario government to overhaul its social welfare policies and practices. The committee released its report in September after two years of study and after hearing submissions from 1,500 groups and individuals in 14 Ontario communities.

Social welfare legislation has hardly changed in the past 25 years and is now clearly outdated. The committee concluded that the current system is often unfair, arbitrary, inequitable, and overly complex. Many rules

penalize people trying to get off assistance and hold recipients captive, isolated and marginalized.

The social assistance system envisioned by the committee would improve opportunities for self-reliance and attempt to remove the stigma attached to receiving assistance. Recommendations range from increasing housing supplements, increasing eligibility, providing subsidized day care for sole support parents trying to move off assistance, ensuring Native control over the design and delivery of social assistance for Native people and removing children and people with disabilities from the social assistance system by providing alternatives. These alternatives include disability insurance and disability benefits and a new income-tested child tax credit for all

low and some middle-income parents.

The report has been positively received by many community groups, social agency officials and workers, and politicians. While the Ontario government may try to delay making changes to the system until it prepares its budget for next year, public awareness about people's desperate need for more money *now* may force the government to respond more quickly.

While the report has been called "gutsy" and "radical," it can also be seen as a compromise between a radical alternative vision of a society that meets its obligations to the needs of its people and one which shores up the existing political and economic system.

The committee hasn't forced

us to evaluate what kind of work we as a society feel is valuable for people to do. Do we really want more low paying, non-unionized service jobs or are there other support, advocacy, caregiving and organizing activities that we want, value and need?

Like many government initiated proposals for reform, we find ourselves in the position of fighting for small changes, rather than strategizing for big ones. Perhaps the real value of the report is in the discussion, public awareness and questioning it promotes about society's obligations and about how people can achieve real power and make real choices to control their health and their lives.

DIANNE PATYCHUK

Demand for appeal in assault case

The media-saturated trial and sentence of Kirby Inwood has confirmed what women's groups already knew — that the woman is still on trial in assault cases.

Last month, Provincial Court Judge Gordon Hachborn gave Inwood a suspended sentence for assault causing bodily harm to his wife, Tatanya Sidorova, and 30 days

for assault against their infant son. The trial exposed Sidorova's personal history, and that of three other women who came forward to testify that Inwood had assaulted them in the past. "We felt that Sidorova was on trial," said Lynda Davies, Executive Coordinator of the Assaulted Women's Helpline. In passing sentence, the judge said

Inwood had a "sick mind and twisted personality," but "would not make him a scapegoat for all battered women."

The light sentence given to Inwood for assaulting his wife has angered women's groups. "Attitudes about women were upheld in the sentencing. [The sentence] saw assault on the child as more serious than the woman," said Davies.

"Sentencing is supposed to have a detrimental effect. This one did, but it was to the victims," said Pat Marshall, Executive Director of the Metro Action Committee on Public Violence Against Women and Children.

Women's groups such as Education Wife Assault are now demanding that the Attorney General appeal the case, and a decision must be

made within 30 days from the sentencing.

The Toronto Rape Crisis Centre has circulated a petition demanding that: Ian Scott undertake an immediate review of sentencing procedures and practices — in particular relation to violent crimes against women and children; that the Attorney General begin an investigation into the treatment of women by defence lawyers and judges in court — and that women's organizations be a part of that investigative team; that ethical guidelines be established so that women will not be further assaulted by male personnel within the legal system.

HELEN ARMSTRONG



Smokefree

Teaches Women to Quit Smoking

Phyllis Marie Jensen, R.N., PhD.

183 Munro Street, Toronto, Ontario M4M 2B8

(416) 465-1323

N.W.T. control of medical services

On April 24th, 1988 the government of the N.W.T. was given autonomy over its medical services from the federal government of Canada. It is hoped that this move will secure sovereignty and self-determination for the indigenous people of the North (who comprise 80 per cent of the population), and help them regain decision-making capacity over their specific health care needs.

The traditional Native means of healing and well-being have been severely eroded over the last 30 years by the intervention of medicine — as defined by the West and administered by Ottawa. One of the major issues has been childbirth, which has been removed from the sphere of the family and community and placed into the realm of medical technology within an alien culture.

Prior to the 1950s, two-thirds of all children were born at home in the small Native communities. The local infrastructure included traditional midwives, family, friends and knowledge passed down from mother to daughter, sister to sister. Infant mortality rates had been high in the first half of the century due to social and cultural upheaval that resulted in poverty, poor nutrition, infectious disease and inadequate housing. In response to these grim conditions the federal government set up nursing stations staffed primarily by European-trained nurses with midwifery skills.

During the 1960s and 70s, infant mortality rates dropped considerably, and, although births took place outside the home, the majority still took place within the community (except for high-risk women who were flown out). From

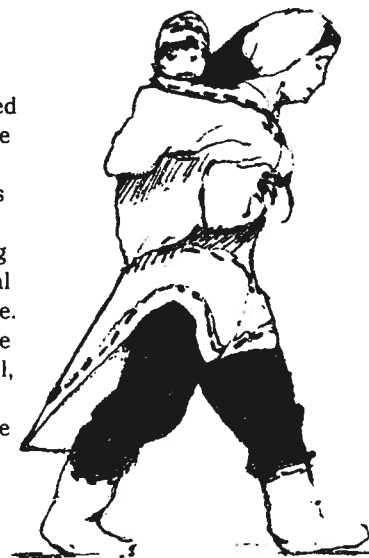
the mid-70s until now, federal policies changed dictating that *all* expectant mothers be sent out from smaller communities. They are flown to hospitals in Edmonton or Yellowknife from the western Arctic, and to Winnipeg or Churchill from the eastern Arctic.

The women usually travel alone, leaving their husbands and children behind for a separation period ranging from 2 weeks to a couple of months. The implications of this total removal are numerous for most young women: the food, climate, culture and language are completely alien to them; they are lonely and isolated; at the birth they undergo an institutionalized medical birth without the support of their families; if and when procedures are explained they are in a language unfamiliar to them. During pregnancy a young Native woman no longer turns to her elders for information or support — for they are too ill-equipped to foresee the standard interventions and stresses that she will undergo in the South. In short, the cultural context bears little or no resemblance to her own cultural identity or experience.

Young Native women have shown their displeasure with current maternity services. Some avoid pre-natal check-ups, or mix up the due dates (so the babies will be born within the community) and some flee and hide when the transport plane comes. The scenario is further exacerbated by the current shortage of nurses in the N.W.T. It is estimated that close to 40 per cent of the nursing positions in the North have been vacated with little hope that half of the empty positions will be filled. This is due primarily to the switch in N.W.T. policy from sliding scale

wages (higher for longer periods of service and isolated communities) to a single scale for wages.

Although the road towards a holistic and co-operative approach to childbirth is long and arduous there are several concerted efforts taking place. On November 14 — 16th there was a conference in Churchill, Manitoba that focused on Northern obstetric issues. The "Povungnituk Experiment" was highlighted, in which Western-trained midwives have joined forces with traditional Native birth attendants and work together in a community clinic. As a result, the majority of births take place within the community and more Native women choose pre-natal care



Joann Lowell

earlier and more regularly by making their contact through the traditional birth attendants.

JOANN LOWELL



An experience that lasts a lifetime.

CUSO offers you a challenge. The chance of a lifetime. Two years living in another culture and an opportunity to work with others who are striving to improve their lives.

It's hard work, but rewarding.

We need someone special. Someone who wants more than 9 to 5. Someone willing to try something different.

If you are an experienced doctor, nurse, nutritionist, physio- or occupational-therapist, we probably have a job for you.

The person we're looking for has skills and experience and can live on a modest salary.

For further information, send your resumé to CUSO, BH-11, 135 Rideau Street, Ottawa, Ontario, K1N 9K7.



Pat Kaufert

Through Women's Eyes

THE CASE FOR A FEMINIST EPIDEMIOLOGY

Last April, Health and Welfare Canada hosted a symposium — Changing Patterns of Health and Disease in Canadian Women — in Ottawa. Researchers, scientists, policy makers, health care workers and activists and government representatives came from across Canada to share information and ideas. The focus of the conference was women's health from an epidemiological perspective: participants examined factors determining the frequency and distribution of diseases which affect women.

Sociologist Patricia Kaufert presented a paper on the importance of developing a more woman-centred approach within medical research. Kaufert broadens our definition of epidemiology to look not only at the distribution and causes of disease but to examine what within a disease is important to us as women.

The following is a slightly reworked version of Kaufert's speech which she entitled "Ensuring Our Voice is Heard: Knowledge, Coping and Caring."

The papers at this conference show how important epidemiology is to women. For it is this discipline which can provide us with the information and the facts we need when making decisions about our health or our health care. If women are to take control over their bodies, political rhetoric is no longer enough; we must become better informed. This conference is unusual in that most of the epidemiologists here are women, although like other branches of medical science, epidemiology is essentially hierarchical and patriarchal in structure and orientation. Experts speak and women listen, even when the discourse is about women, their health and disease.

What would happen if the pathway of communication was re-

versed? What if women spoke back to the researchers, demanded to participate in the research process, demanded their rights to choose the problems to be investigated, demanded to have the results presented in an accessible form? We have feminist lawyers and feminist philosophers, psychiatrists, sociologists and anthropologists; I want to advocate the emergence of a feminist epidemiology.

As a discipline, epidemiology is concerned with the distribution and causes of disease, but its focus is on the general population rather than the individual. For example, epidemiologists do not treat endometriosis, but they can tell us what proportion of women share the same condition; they do not treat pelvic inflammatory disease (PID), but they

have pointed to the association between PID and using an IUD. Epidemiologists can tell women the odds on becoming pregnant through in vitro fertilization, or on developing cancer after taking Depo-Provera. It is epidemiologists who have calculated the risks for coronary heart disease among women clerical workers under occupational stress.

I confess to choosing examples which are under-researched, but of critical importance to significant groups of women. As earlier speakers at the conference noted, research in occupational epidemiology has focused on men at work rather than women. Research on the risk factors for coronary disease have been similarly male-oriented. In the medical excitement about in vitro



TVOntario

and to treat other women not as objects of research but as participants.

We need a feminist epidemiology which is defined by a new willingness to take experiential knowledge, women's own knowledge of their situation, into account at all stages in the research process. Experiential knowledge is the sort of knowledge in which we all share; it comes from our direct experience of our bodies and from sharing vicariously in the experience of other women. Medical researchers tend to downgrade the value of knowledge based on experience, treating it as subjective data of dubious validity or reliability. My criticism of this approach is that the experience of women gets left out of the research process, with serious results for both women and epidemiology. Let me take an example from my own research on menopause. The medical literature generally advises that menopausal women should

They prefer to take their data from medical records rather than talking to women.

be given hormone replacement therapy as protection against osteoporosis. This advice is based on the assumption that women will take estrogen for as long as prescribed by a physician. In my own research in Manitoba and in another study in Massachusetts by Sonia McKinlay, we found that women taking hormone therapy do so only intermittently. They start, stop for a few months, may restart, only to stop again. The consequences of this 'on-off, on-off' use pattern for bone loss have not been investigated, partly because epidemiologists assume compliance; if they see a physician has prescribed a hormone, they presume it is being taken.

In a feminist epidemiology this sort of mistake would not be made, because women would not be seen as passive patients, but as autonomous actors. Once the perspective

fertilization scant attention has been paid to the psycho-social cost/benefit analysis which must be performed by the individual woman and for which she needs facts. Only a fraction of total research dollars has gone to projects investigating the long term effects of any contraceptive and only a trivial portion of that amount has been spent on the risks associated with the long-acting injectable contraceptives. PID and endometriosis, while creating misery for women, do not attract major quantities of research money.

The choice of research topics might better reflect the needs of women if more women were epidemiologists. But a new direction in epidemiological research requires more than the recruitment of women scientists; these women must have

power to bring about change, and this must include playing a larger role in making research policy and allocating research monies. [The importance of increasing both the representation of women on the Medical Research Council and the amount of money spent on research pertinent to women's health was subsequently discussed at the conference. It was a first step in recognizing the importance of epidemiological research and exerting pressure to ensure it reflected women's needs.]

Yet, good scientists with adequate funding doing good research on issues affecting the health of women are not enough. We need a new feminist consciousness among researchers, a willingness to ground research in the experience of women

on women changes, then a researcher would not presume compliance, but would ask women not only what they do, but why they are reluctant to take hormones continuously.

As a general rule, epidemiologists prefer to take their data from medical records rather than talk to women. They also prefer "hard" data to soft, the objective, quantifiable "fact" to the subjective, qualitative experience. The result (as in the hormone replacement example) can be bad science, because it is based on an inadequate understanding of how things actually work in the real world of women.

Due to the same unwillingness to start from the experience of women, epidemiology can be very narrow in its definition not only of what is data, but also of what the problem is to be investigated. I am currently working on a project in Keewatin which is looking at the evacuation of Inuit women for childbirth to hospitals in the South. Going through the reports and published papers describing obstetric policy in the area over the past 15 years, I found a relatively substantial body of epidemiological research describing perinatal mortality and morbidity rates, obstetric risk factors and outcome measures,

the number of women evacuated each year, where they were sent, for how long and so forth. I also found occasional references to the objections that Inuit women had made against a policy which forced them to leave their families, particularly when they have young children. No one looked at the consequences of the stress of separation to the children left in the communities. No one



TV Ontario

and voices of women seriously. Rather than making women the objects of research, they would participate in the research process.

Participation must mean women having a say in determining what problems are researched, how they are defined and what information is collected from whom! But a feminist epidemiology would also mean that the results of research are returned to women in a useable form. To illustrate the relationship between women and research as it presently exists, I have taken an example from an interview with a woman who describes the problem of trying to find out from her physicians whether to rest or exercise: "I don't know where to begin, you see if they told me in words of one syllable I could adjust accordingly, but at the moment I'm completely in the dark." This woman had suffered from arthritis for many years; she "knew" her arthritis in the experiential sense, but she also wants to "know" it in the sense of having medical labels for it, a medical history and prognosis. She was asking for access to scientific knowledge, but in a form she can use to make sense out of her condition. Simply providing data is not enough; it must be in language she can understand.

Having medical information (whether to exercise or not to exercise) is important to this woman's ability to actively participate in the management of her arthritis. Research on the relative value of exercise or rest may not be the most trendy in terms of grant getting from the Medical Research Council (MRC). Communicating results to women with arthritis is not as prestigious as publishing in the *New England Journal of Medicine*. Questions such as whether exercise or rest are best for arthritis may not lie at the frontier of medical knowledge, but they are critical to women who are trying to cope with this disease. I do not decry the MRC grant, the prestigious publication or the pursuit of knowledge, but I do want a feminist epidemiology which sees the needs of women as a legitimate priority for scientific endeavour.

The critical problem is to create a linkage between the world as seen by epidemiologists and the world of

looked at the stress of being alone in a strange hospital for women in childbirth. No one listened to what women were saying about the dangers of leaving community nursing stations without nurse midwives (one of the effects of the evacuation policy). In sum, no one had listened to women nor defined the problem to be researched by the concerns they expressed. For me, the contrast between current standard epidemiology and a new feminist epidemiology would be primarily in a willingness to take the experiences

NATURAL HEALING SEMINARS



with

Catherine Goetz-Gadon
Master Herbalist and Certified
Reflexologist

**Herbal Remedies
Gynecological Problems**
Sunday, January 29, 1989
10 a.m. — 3 p.m.
\$45

**Herbal Remedies for
Pregnancy, Childbirth and
Breastfeeding**
Sunday, February 26, 1989
10 a.m. — 5 p.m.
\$60

For more information call
Toronto (416) 766-6821

women. Women have always shared knowledge among themselves. They have exchange tales about giving birth, about how to avoid, achieve or end a pregnancy, or how to sooth the aches and pains of old age or sickness. The constant thread running through my interviews with menopausal women was the comparisons they made between their own experiences and those of other women. Comparison and sharing experience are the basis of self-help workshops for menopausal women run at the Women's Health Clinic in Winnipeg. Similar exchanges take place through the pages of the newsletter

If we want a more feminist epidemiology then we have to make our voices heard.

for menopausal women, *A Friend Indeed*. Such comparisons serve partly as a validation of the normalcy — or else the extraordinariness — of one's own experience relative to that of other women. A feminist epidemiology would be similarly rooted in the real experience of women, but would allow sharing on a larger scale than the local self-help group.

If we want participation in the research process, want a more feminist epidemiology, then we have to make our voices heard. Again I would look to the example of self-help groups. There is a particular form of strength and support which develops only between those who share the same experience. Self-help groups may originate in the search for shared experience, but out of the processes of sharing often comes a new consciousness and a new set of definitions of the common and critical problems. From being collectors and disseminators of information, groups such as DAWN and the Alzheimer's Society become lobbyists, pursuing goals defined out of group experience and priorities. They are demanding improved services, new medical programs and research,

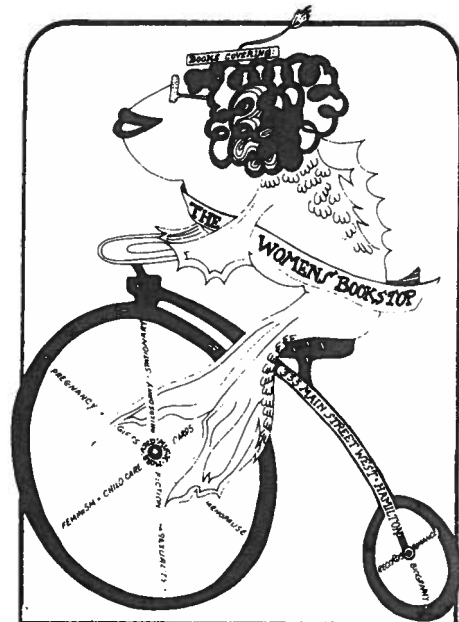
housing, transport, educational programs and employment.

My suggestion is that there is much to be learned from groups like DAWN and the Alzheimer's Society about networking, about making the voice of the group audible to the research community and the funding agencies, about demanding that research should be from the perspective which takes the needs and experiences of the group into account and that information comes back to the group. The Coalition on Depo-Provera which formed to challenge a move to license that drug as a contraceptive for use in Canada is an example of the way in which women's groups can coalesce and organize around an issue important to the health of the women's community.

I do not know what the next coalition should be about, but whatever it is, it will depend on the same things; that is, networking between women, collaboration, a combination of political activism, expertise, and the willingness to be a public nuisance until we are heard. This conference is a rare opportunity. It is more than the sum of its formal sessions, but is providing the opportunity for researchers, policy makers and practitioners to meet and discuss the priorities in women's health, always thinking, however, of how women themselves define them. I want to close with a quotation from Adrienne Rich.

I know no woman — virgin, mother, lesbian, married or celibate, whether she earns her keep as a housewife, a cocktail waitress, or a scanner of brain waves — for whom her body is not a fundamental problem; its clouded meanings, its fertility, its desire, its so-called frigidity, its bloody speech, its silences, its changes and mutilations, its rapes and ripenings. There is for the first time today a possibility of converting our physicality into both knowledge and power.

Patricia Kaufert is an associate professor in the Department of Community Health Sciences at the University of Manitoba.



333 MAIN STREET WEST,
HAMILTON, ONTARIO
(416) 525-2970
RENEE ALBRECHT

THIS MANUAL:
ACTION ON HEALTH BARRIERS HEALTH PROMOTION WITH LOW INCOME WOMEN

- Describes barriers that prevent low-income women from taking effective action on their health concerns and provides ideas for meeting some of these challenges.
- Discusses the importance and benefits of groups and outlines some required facilitation skills for a group leader.
- Provides the structure of the ACTION ON HEALTH BARRIERS group model and session design.
- Gives a session by session plan of a group program that has been offered to and developed by low-income women who have participated in the ACTION ON HEALTH BARRIERS project.

COST \$20.00 for organizations
\$10.00 for individuals
plus \$2.00 for shipping & handling



OPPORTUNITY FOR ADVANCEMENT

801 EGLINTON AVE., WEST, SUITE 301
TORONTO, ONTARIO • M5N 1E3 •

HEALTHWISE

Caffeine Alert

Jeane Van Breuckelin

Aside from the vague notion that we shouldn't have too much, is there a whole lot to know about caffeine?

I used to be a major league coffee drinker and all I knew was: too much meant nervousness, none meant headaches.

My motivation to give up caffeine, coffee and chocolate in particular, wasn't the result of research (which I did after the fact). I'd gone to see my doctor because of excruciating pain in my left breast and arm, palpitations, headaches and fatigue. She found a breast lump and told me unequivocally to get off caffeine because it exacerbates breast problems.

The mammogram showed it wasn't a malignant lump, but fibrocystic breast disease, which makes the breasts lumpy and tender before menstruation. They can, as with mine, remain so thereafter, eventually producing a constant, severe pain. According to some researchers, caffeine inhibits the natural breast processes, making it difficult for the breasts to reabsorb the cysts.

Although the cysts in a fibrocystic breast are not cancerous, women with this condition are at higher risk of developing breast cancer (estimates have been as high as four times greater risk). Whatever other reasons there may be for this, if your breast is full of lumps it will obviously be difficult for you to detect the emergence of a new and/or potentially malignant lump.

What else does caffeine do? When you have a cup of coffee, the caffeine in the coffee goes straight from the cup to your brain where it stimulates the central cortex and the medulla, affecting thought processes, heart rate, respiration and muscular coordination. It also causes a nerve centre at the top of the spinal cord (locus ceruleus) to malfunction, over-

stimulating that group of neurons. (Hard drugs, like heroin, affect the same neurons by slowing them down.)

Caffeine makes your heart beat harder, raises the metabolic rate, dilates coronary arteries and constricts blood vessels in the brain.

After a cup of coffee the muscles in the digestive tract, respiratory system and kidneys relax, causing the kidneys to become congested. They respond by increasing urination in an attempt to rid themselves of the poisons.

There are women whose blood-pressure increases when they take birth-control pills and this can cause greater water retention and slower elimination of caffeine.

Caffeine reaches the fetus through the placenta, causing fetal stimulation and some research indicates that high caffeine consumption by pregnant women can contribute to miscarriages and birth defects.

Amphetamines or diet pills may double the adverse effect that caffeine has on the central nervous system.

Caffeine raises blood-sugar levels. In response, the body produces insulin to drive them down again, resulting in feelings of hunger and

fatigue. It also destroys vitamin C and the water-soluble B's.

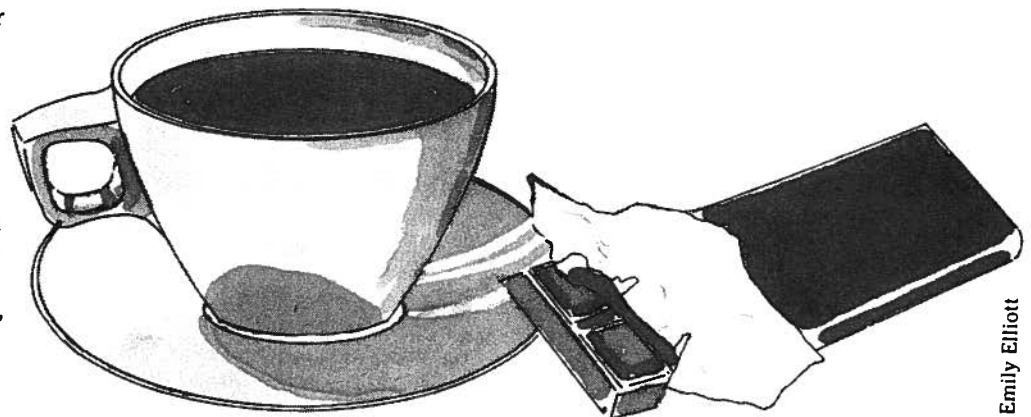
Nicotine, cross-addictive with caffeine, doubles the rate at which the body metabolises caffeine, creating the tendency to drink twice as much coffee.

Caffeine also impairs sleep, notably during the first few hours when the body is eliminating the caffeine consumed during waking hours.

For most of us, caffeine means coffee, but in fact caffeine lurks in a number of products, including tea (even some herbals), various soft drinks, chocolate and a range of drugs, among them some pain relievers, stimulants, diuretics, menstrual pain drugs, allergy drugs and cold and asthma medications. It's important to check the product's list of ingredients.

A 5.5 oz cup of brewed coffee contains anywhere from 97-153 mg of caffeine. Instant coffee has somewhat less. Decaffeinated coffees contain some caffeine (up to 5 mg per cup), and ordinary teas have up to 107 mg in a cup. Caffeine-free herbal teas are labelled as such, but unless you check you might end up with an herbal tea that has even more caffeine than coffee (for example, Morning Thunder is said to be 33% higher in caffeine).

Caffeine extracted from coffee beans in the decaffeinating process is sold to the soft drink industry which then puts it into some of its products. Colas and Dr. Pepper-like drinks have the highest levels of caffeine, whereas drinks like 7-Up and carbonated fruit-flavoured drinks have none. (For a list of how much caffeine is contained in different soft



L. Emily Elliott

drinks and medications, check the Winter 1986 issue of *Healthsharing*.)

Is there a safe level of caffeine consumption? You won't find anybody recommending more than about two cups of coffee a day. My doctor tells all her women patients to get off caffeine, or at least cut back. Of her patients with fibrocystic breast condition who have stopped consuming caffeine, almost all show remarkable improvement.

Getting off caffeine isn't easy since caffeine is an addictive drug, but quitting is worth the effort. After I gave up caffeine my breasts returned to normal, the headaches stopped, the heart palpitations stopped and I was full of a boundless energy I hadn't felt since I was a kid.

If you're a coffee drinker, don't throw out your coffee pot and stock up on herbal teas. Coffee drinkers like a certain kind of drink, and fruity teas are not usually it. In addition to gradually diluting your coffee with decaffeinated coffee, try the

following in order to reduce your caffeine intake: Get an interesting, "coffee-ish" tea and have that after dinner instead of coffee. My favourites are Roastaroma, Almond Sunset and the carob teas.

However, my *real* coffee substitute isn't tea, it's a grain product called Caf-Lib (available in some large supermarkets or health food stores), or Caro (mainly available in health food stores). They both taste much more like coffee than other coffee substitutes do and the trick to getting a good cup is to use at least twice as much as the directions say. I've moved from drinking espresso coffee to drinking "espresso Caf-Lib."

In any case, there's nothing to be lost and something to be gained by giving up caffeine. But even if you don't, knowing its effects and the sources of it can make you a wiser, healthier consumer because you'll be able to regulate your intake.

Jeane Van Breuckelin, a writer and mother of two school-age children, lives in Waterloo, Ontario and is caffeine free.

Sharing Health Information



We occasionally exchange our mailing list with other organizations. We are selective and choose organizations we think will benefit from learning about *Healthsharing* and which we think you might want to know about.

If you do not wish your name and address exchanged, please write us and we will withhold your name during exchanges.

Further Reading

For a detailed list of the caffeine content of various products, as well as clear discussions of the effects of caffeine on the body, look at *The Caffeine Book* by Frances Sheridan Goulart.

The Caffeine Book by Frances Sheridan Goulart. Dodd, Mead, New York, 1984.

The Ms. Guide to a Woman's Health, by Cynthia W. Cooke, M.D. and Susan Dworkin. Doubleday & Company, Inc., New York, 1979.

WOMANCARE, by Linda Madaras and Jane Patterson, M.D., F.A.C.O.G., with Peter Schick, M.D., F.A.C.S. Avon Books, New York, 1981.

No More Menstrual Cramps... and other good news, by Penny Wise Budoff. Penguin, New York, 1980.

Eve's Journey, by Susan F. Lichtenorf. Berkeley Books, New York, 1983.

Managing the Drugs in Your Life, by Stephen J. Levy. McGraw-Hill, New York, 1983.

The Women's Press

AN APPOINTMENT
CALENDAR AND
HANDBOOK
FOR 1989



\$9.95

*Everywoman's
Almanac 1989*

highlights the efforts of *The Women's Press*, a feminist publisher, to keep up with a changing and challenging feminist community.

feminist perspectives

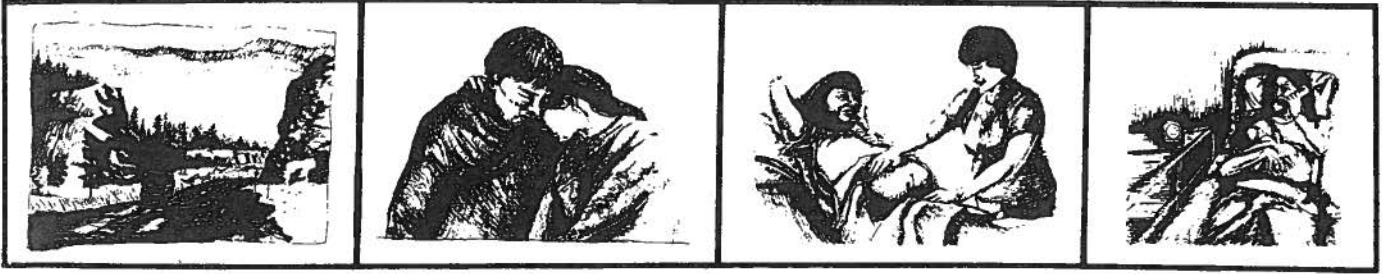
No. 11, Getting Older and Better: Women and Gender Assumptions in Canadian Society, by Susan McDaniel. Explores and questions some assumptions about gender and gender differences which guide much thinking, including supposedly scientific thinking. Some of the challenges and opportunities for women in an aging Canada are highlighted.

No. 13, Some Advice for Overcoming Barriers to Women's Achievement in Non-Traditional Occupations, by Barbara Carroll and Frances Cherry. Provides women contemplating non-traditional careers with information about the types of barriers they may encounter and advice to overcome them. Based on interviews with women already involved in such careers.

Price: \$2.50 + 75c postage each. Order from:

CANADIAN RESEARCH INSTITUTE
FOR THE ADVANCEMENT OF WOMEN

151 Slater, Suite 408,
Ottawa, Ontario K1P 5H3



Holly Rupert and Dianne Lai

Long Distance Delivery

Near midnight one evening last June, a young couple from Nipigon, Ontario, started out by car for Thunder Bay, 120 kilometres away. They were in a hurry. They were going to one of the large hospitals in the city for the delivery of their baby — a baby they expected would arrive very soon.

It was an anxious trip along a highway that follows the north shore of Lake Superior through rugged bush country. About half an hour before they would have arrived at the hospital, the couple's car hit and killed a moose calf. They were not hurt, although the man was shaken. Strangely, the woman felt a deep calm, as if putting aside her fear at being stranded on the highway late at night. It was obvious their car was too damaged to drive any further.

The birth was to be a VBAC — a vaginal birth after Caesarean. The Nipigon doctor who assessed the woman before they left, felt the baby would come quickly. While they could have taken an ambulance to hospital, the couple chose not to. Fortunately, before long a motorist did stop and drove them to hospital.

After labouring for many hours, the woman was unable to dilate fully, and the baby was born by Caesarean section. The reasons her labour did not progress normally are unclear, but the woman now wonders if underlying stress related to such a frightening experience could have played a role in that outcome.

This story is both shocking and symbolic. It's shocking to think that women in areas without birthing ser-

vices, who may be at risk, are not automatically taken to hospital by ambulance. It's symbolic of how vulnerable women feel they've become as, increasingly, birthing services are centralized in large, often distant, urban centres. The story typifies the worst fears of pregnant women in isolated communities.

The *Project on Out-of-Town Birth*, a research project which began in December 1987, grew in response to those fears. It represents a collaboration between two women's organizations — the Red Lake Women's Information Group and the Northwestern Ontario Women's Health Information Network based in Thunder Bay. The project is funded by the Health Promotion Directorate, Health and Welfare Canada.

We wanted to find a tangible way to help women in Northwestern Ontario (roughly an area stretching west from Wawa to Kenora, near the Manitoba border) deal positively with the demands of birthing away from their community.

Our main focus has been the writing of a booklet based on the birthing experience of regional women, which would provide useful information about out-of-town birth. While our first commitment has been to women in Northwestern Ontario, we hope the booklet will prove relevant to others living in isolated regions across Canada.

We started with the premise that women can help one another by sharing their experiences. In the initial stage of the project, we presented public workshops in places

such as Red Lake, Ear Falls, Vermilion Bay, Nipigon, Ignace and Manitouwadge. Whenever possible, we contacted community women affiliated with the Women's Health Information Network, and public health nurses for help with local publicity.

Our intention was to learn as much as possible about the issues and the problems women have encountered, as well as workable solutions that could be valuable to others.

We learned a tremendous amount. Certainly not all the stories were as frightening as the experience of the Nipigon couple who hit the moose. But it was through the workshops that we realized the effects of fear, and separation from familiar people, on women in labour or late pregnancy. Those who travelled by air ambulance under emergency conditions talked of being swallowed up by events beyond their control. A woman from Marathon described the hurried decision to transfer her to Thunder Bay by airplane when she began to hemorrhage with her fourth baby, now a healthy two-year-old.

"My husband stayed with me until they put me in the ambulance. When I got to the Thunder Bay hospital, I was alone. My husband was left behind, so were my three other boys. You're really alone and lost. I asked the nurse who went with me for a hug — I really thought I was going to die, or that the baby would die. That's why I was willing to get a hug from anyone.

"The thing I remember most was they had the fetal monitor on me, listening to the baby's heartbeat. Someone said 'Well we better hurry up before we don't hear that anymore.' I was so frightened and no one was there to help me make the decision to have a Caesarean. I had to make the decision alone."

Many women participated in the workshops, understanding that their experiences and advice would serve as the basis for the booklet. We were often moved by their courage in facing the difficulties of birth away from home.

In the second stage of the project, we sent surveys to health professionals in a variety of medical settings — small community hospitals, large urban hospitals and public health units. This gave us a clearer understanding of the medical reasons for out-of-town birth, and the specific problems in ensuring continuity in the obstetrical care women receive.

The lack of local birthing facilities is probably the most common reason for out-of-town birth. In most instances, the local doctor provides prenatal care, but another doctor in a large urban hospital will likely assist at the delivery. If that facility is far away, it may be impossible to have prenatal visits with the doctor before the birth. Women find this makes it hard to feel confidence in the doctor who attends them.

These circumstances are especially common for Native women living in reserve communities. The health worker on the reserve provides information and support during a woman's pregnancy, but before her due date, she must travel, usually alone, to a distant hospital and a different culture. There she is cared for by people who may be unfamiliar with her language, or her people's traditional birthing practices. The

women in this situation are often very young; they feel lonely, displaced and bored as they wait for their baby's birth.

" . . . no one was there to help me make the decision to have a Caesarean"

In some places, such as Nipigon, a community of 8,000 people, the doctors have chosen not to deliver babies although there is a local hospital. In 1985, the Nipigon doctors decided the number of babies they delivered the previous year — about 25 — was too low to ensure a necessary competency level for obstetrical care. That is, the doctors weren't getting enough practice at delivering babies to feel that they could do it safely. They announced they would be referring all maternity cases to out-of-town physicians for labour and delivery. They did agree to assess women before they started the trip to Thunder Bay.

Some women were angered by the loss of the familiar, personalized care they had known. They formed a committee to lobby for the reinstatement of birthing services and began publicizing the situation through a letter campaign in the local press. They approached their federal and provincial members of parliament, who helped to maintain media interest in the issue. A petition was circulated in the community which their MPP presented to the Minister of Health in the provincial legislature.

In March 1986, the hospital was

obliged to call a public meeting. The debate between the medical representatives and 150 townspeople who turned out was heated; the committee had gained community support for continued birthing services, but the doctors stood firm. The committee requested the office of the Ontario Ombudsman review the situation. The Ombudsman's report indicated that there is no way to force doctors in private practice to do deliveries.

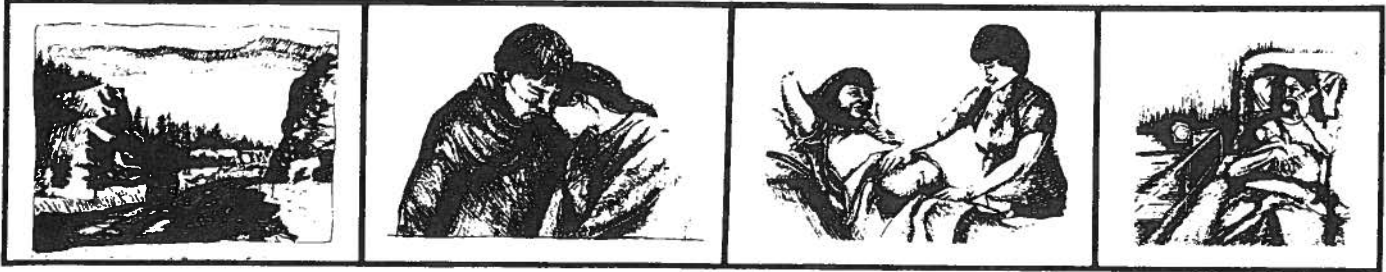
An informal survey of Nipigon women conducted in 1987 by the Northwestern Ontario Women's Health Information Network, found there were at least 68 births that year. Despite this apparent increase, birthing services have not been reinstated.

There has been a growing trend in the last decade, in Northern Ontario as in other parts of the country, to apply a regional model in the delivery of obstetrical care. Within a given region, hospitals provide obstetrical care based on their geographic location and the presence of specialized staff. The smallest obstetric units may even be closed in order to consolidate services. This means women with greater medical risks are transferred to facilities which can offer more specialized care. Supporters of the regional model believe this approach ensures a higher quality of perinatal care and fewer baby deaths.

The unfortunate effect of regionalization, which tends to centralize services in large urban hospitals, is that more women have to travel away from their home communities to give birth. This makes it difficult to retain the more intimate, family-centred care available in a smaller medical setting.

A 1984 study by Dr. Douglas Black of the University of Western Ontario, found the perinatal loss rate (which is defined as the number of stillbirths





Joanne Dyck

and/or deaths within 28 days after hospital birth per 1000 newborn admissions) was the same for small northern hospitals as it was for centres with access to specialized services. He concluded that by allowing for the judicious transfer of high-risk cases, relatively safe care can be pro-

vided in small northern hospitals.

Groups such as the Advisory Committee on Reproductive Care appointed by the Ontario Ministry of Health, caution in their 1988 report, "Reproductive Care: Towards the 1990s," that the routine transfer of women to regional facilities is creat-

ing an unrealistic load for specialists who are already overworked. The committee suggests that if appropriate supports are put in place, such as opportunities for doctors and nurses to develop and maintain obstetrical skills — quality care can be provided in smaller hospitals.

In Red Lake for example, where the hospital serves a population of 4500, the physicians have a strong commitment to birth with as little intervention as possible. They work from the assumption that each woman will have the option to labour and deliver in the local hospital unless it becomes medically impossible.

We recognize that there are important medical factors which make an out-of-town birth the most prudent choice. Local doctors must err on the side of caution in caring for a mother and baby.

Before some obstetrical procedures can be done, it's critical that operating facilities and adequate staff be available for emergency surgery. This is true, for instance, if a woman chooses to have a VBAC, where the possibility of a Caesarean is considered higher. It's also true if a woman has high blood pressure which cannot be controlled, leading to a condition called pre-eclampsia. Her labour may be induced. In both situations, safe obstetrical practice requires that a Caesarean section be planned for, just in case. Many small hospitals simply aren't equipped to provide this kind of surgical back-up, or cannot offer it reliably because of staffing limitations.

Similarly, such things as diabetes, a history of premature delivery, or the fact that she is carrying twins can put the mother or baby at risk, and both would benefit from careful monitoring in a centre where specialists can act quickly if problems arise.

Women told us they sometimes prefer to be in a larger hospital because they feel more confident birthing in that setting. For example, a

Survey of health professionals

Three different surveys were sent to health professionals across Northwestern Ontario. One for those working in small hospitals where obstetrical patients are routinely transferred to larger facilities, a second for those in large hospitals providing care to women from smaller communities, and a third survey for public health nurses and prenatal instructors.

The last survey was in many ways the most valuable. We asked where women from the community are transferred, whether the health unit receives a hospital referral following a woman's discharge, and what follow-up services are available to women when they return. We also asked how women are helped to prepare for a planned or emergency out-of-town birth.

Through the public health responses we learned that, in some places, there are communication problems between the large hospital and the local health unit. When a woman is discharged from hospital, there can be a time lag of two weeks or more before the health unit receives a referral. The public health nurse may not know that the woman has returned to the community, making it hard to provide support during those first critical days at home. One large hospital has cited concern with confidentiality as a reason for refusing to make any referrals to local health units.

Prenatal instructors, many of whom are also public health nurses, expressed concern with the lack of written information about hospital policies on maternity care. Instructors would like to give women this information during prenatal classes, but few facilities in the region have actually published their policy in a readily available, readable format. And hospital policies change, creating a further complication.

In a community like Pickle Lake, where there is no local hospital and women often travel to large facilities in Southern Ontario, the prenatal instructor faces some difficult obstacles in helping women to prepare. She explained that the information given "cannot be specific to an institution because so many different places are chosen for the birth."

While the public health respondents acknowledged that out-of-town birth is an important concern in many places, they admitted they may not address it fully because there is so much other information to cover in prenatal classes. We feel instructors don't want to scare people, especially women pregnant for the first time, by focusing on "worst case scenarios," and so this discussion may be avoided.

Red Lake woman chose to have her second baby in Winnipeg because her first child required an emergency transfer shortly after birth. "The doctors here are good, but they just don't have the equipment like they do in the city. My doctor and I agreed I would go to Winnipeg. If we ran into problems, the intensive care unit would be there. I was a lot more relaxed knowing that." Access to pain medication, like an epidural, which may not be available in small hospitals, is another reason women may choose to birth in a large hospital.

It often happens, however, that an out-of-town birth is not planned at all. A woman may be admitted to hospital unexpectedly following a regular prenatal visit, perhaps showing signs of severe eclampsia. Or complications can arise quickly during labour, placing mother or baby in danger. A transfer, usually by Ontario Ministry of Health air ambulance, becomes necessary.

Once the doctor orders a transfer, events speed up. Decisions must be made quickly and a woman is no longer in control of events. If she has had the support of a partner, as one doctor put it, "his role changes from labour coach to errand boy," hurrying home to gather things which will be needed in hospital.

Unsure about her own or her baby's future, a woman may feel frightened and vulnerable as she's whisked away to the waiting airplane or helicopter. There she'll have to say goodbye to her partner or other support person, because government regulations do not allow extra passengers on the aircraft. We know of instances in which the woman's support person missed the birth because they couldn't get to a distant hospital in time.

In an emergency, the staff at the admitting hospital may appear to re-

spond to the woman's condition rather than to her as a person. They don't always perceive what impact the impersonal atmosphere of a large hospital can have on someone from out-of-town. During the workshops, participants stressed how important it is for women to ask questions firmly and to let doctors and nurses know they're away from home. This can make the staff more aware of a woman's need for support.

"The doctor said make sure you take your Visa"

It's important to stress that an out-of-town birth can be a positive experience. Many women say they are glad they chose to travel away, particularly if neonatal or specialized obstetric care was required. But most admit it was by planning ahead that they were able to make their birth a positive event. For instance, it's not always necessary to go to the closest hospital to give birth. Going "home" to the community where family and friends can offer support before and after the baby arrives may be a better solution. This was the case for a woman from Sioux Lookout who went to Hamilton, where she had family, for a VBAC with her second baby.

"I wanted to try a vaginal birth and they wouldn't give me a trial of labour here. I contacted a friend in Thunder Bay who is a midwife and she gave me the names of a couple of midwives in Hamilton. I went down when I was four or five months pregnant and found a midwife I really liked. She said there

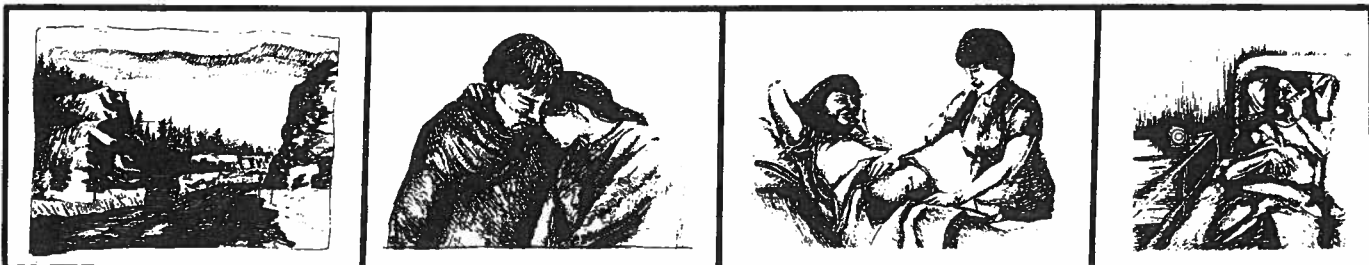
were two doctors in Hamilton she could work with for a VBAC. The second doctor did take me.

"It was worth it to me to go that far to have a vaginal birth. I didn't think VBACs were being done in Thunder Bay, and I didn't know anyone I could stay with. The birth was just wonderful. Cameron was born and we went home three hours later. The difference between my two births was like light years."

In planning an out-of-town birth it's important for women to consider their needs, and if others will be involved — a partner or older children — what they will need. Childcare arrangements may be a major factor affecting where the birth takes place, and how long a woman can stay in hospital. As well, an out-of-town birth can create an unexpected financial burden as the costs mount for travel, accommodation for family members and long distance telephone calls.

"My husband had 10 minutes to get ready," recalled a Red Lake woman who was transferred for the premature birth of her first son. "The doctor said make sure you take your Visa. Then we were on our own. My husband stayed at a hotel across from the hospital and he had to get meals. We had to pay for our own air fare home. If you don't want to sit in a car for five hours with a newborn, flying is the fastest way to get back. We figure it cost us between \$600 and \$800."

In Ontario, travel expenses for an out-of-town birth or prenatal care may be partially covered by the Northern Health Travel Grant. The Ministry of Health program helps pay for travel to receive medically-necessary care which is not available locally. However, there are some restrictions on eligibility. The claimant must be a minimum of 250 kilometres away from the required



Joanne Dyck

services, and the grant doesn't cover a companion's travel costs, unless the patient is under 18 years of age. We are aware of similar grant programs in B.C., Alberta, Saskatchewan, Manitoba and Newfoundland.

Some hospitals, such as the Health Sciences Centre in Winnipeg, have a family room or hostel on the maternity unit where out-of-town family members can stay. Usually the hospital social worker or discharge planning nurse are good contacts for information about such services. As well, there may be a labour and childbirth support group in the city. This kind of organization will be familiar with the birthing practices in the hospital, and may offer support services such as volunteers trained to help women in labour.

By including this kind of birthing information in our booklet, we hope to reduce the isolation women in outlying areas feel. We believe the booklet will be a valuable resource for women, health care providers in hospitals and public health units, as well as health advocates.

Since the *Project on Out-of-Town Birth* began, our vision for the project has expanded. We see that the workshops have raised awareness of the issue, and that women are taking

responsibility for supporting one another in planning their births. We've made our federal and provincial representatives aware of our work, and presented a brief to the provincial New Democrat Northern Caucus Task Force on Health Care in the spring of 1988. We see value in writing a parallel report, examining problems in continuity in care, which would be directed to hospital administrators, physicians and public health supervisors.

"Hope for the best, but plan for the worst"

Women affected by this issue need to join in the discussion of health care options which would improve obstetrical services and perhaps reduce the number of out-of-town births.

For example, the Advisory Committee on Reproductive Care recommends examining the role of the midwife in strengthening perinatal

care in isolated areas. There is a need for more widely established support services for birthing women, such as hostels for family members and labour coaches. And for Native and minority women in hospital, language barriers make it difficult to access services. Postpartum support in appropriate languages is especially needed by these groups.

We grappled with the issue of a Native translation for our booklet. But we understand from Native health care educators that a written publication wouldn't be an effective method of passing on the information, given the oral tradition of Native people. This was difficult for us to accept because, in Northwestern Ontario, Native women represent the majority of those travelling away to give birth. We hope our booklet can be a starting point for work Native women may choose to do.

Realistically, out-of-town birth is an issue that will stay with us. We know it shapes the birth experiences of women in many areas of Canada. While we are right to question its necessity, the key is to also find positive ways to respond to its demands. As one woman from Ignace advises, "Hope for the best, but plan for the worst." A wise motto for any woman expecting to give birth in a small town.

Dianne Lai and Holly Rupert are, respectively, the Thunder Bay and Red Lake coordinators of the Out-of-Town Birth Project.

The booklet, scheduled for publication in the spring of 1989, will be distributed free of charge to public health units, hospitals and clinics in Northwestern Ontario. A national mailing to women's groups and health advocacy organizations is also planned.

Dianne Lai is principal researcher and project co-ordinator in Thunder Bay. For the cost of postage, individuals may obtain the booklet by contacting her at Northwestern Ontario Women's Health Information Network, 8A N. Cumberland St., Suite 17, Thunder Bay, Ontario, P7A 4L1. Also available from Holly Rupert, Red Lake Women's Information Group, P.O. Box 1045, Red Lake, Ontario, P0V 2M0.

Atlantis

A WOMEN'S STUDIES JOURNAL REVUE D'ETUDES SUR LA FEMME



Some how
Atlantis
changed change

Atlantis is an interdisciplinary journal devoted to critical and creative writing in English or French on the topic of women. Published 2 times a year, **Atlantis** is a refereed journal containing scholarly articles, review essays, book reviews, photography and graphic work.

Subscriptions, submissions and all correspondence to:

Atlantis
Mount Saint Vincent University
166 Bedford Highway
Halifax, Nova Scotia B3M 2J6

Rates

1 year 2 years
\$15.00 a year for individuals
\$25.00 a year for institutions
\$ 6.00 U.S., \$12 overseas mailing

Cheryl Grossman, Leigh Hamilton and Wendy Simmons

Healing Touch



R. Foothorap

Imagine this scenario: Joan and Jane are computer operators. It's the end of the day, and their upper back muscles are sore and wrenched. They're drained from the demands of the day and still have to ace the jostling crowds.

When Jane trudges home, the apartment looks very empty. She picks up the cat, nuzzling her nose into its fur to provide the nurturing, comfortable touch she cannot get anywhere else. Joan, on the other hand, returns home to her husband. As she walks through the front door, she considers asking him for a massage, then thinks of the complex issues this request could stir up. Will he have to massage him the next time he asks for a massage? Will he see her request as having sexual implications? Will the unresolved anger surface between them again?

She too picks up the cat.

What Joan and Jane are receiving from their feline friends is appropriate, accepting, undemanding and unthreatening touch. We all need this kind of touch. As women, how we

feel about, use and respond to touch has a profound effect on how we execute our roles as mother, lover and nurturer — to our own selves and to those we love.

The use of touch in our language indicates the important part it plays in our communications with each other and in our feelings about ourselves. Are you a "soft touch" or "thin-skinned?" Do people "rub you the wrong way" or "get under your skin?" Are you "touched" by events that seem to be "touch and go" but, "touch wood," seem to "strike" you as right and "stroke" your ego at the same time?

Clearly, touch has many messages, and like other forms of communication, is open to correct or incorrect interpretation, i.e., "I'm in charge here," "Age pulls rank," "He/she is my sexual property," "This person want something from me," "Is this a come-on?" For each relationship the guidelines for touching are different, and the toucher and touchee must use their best intuition and above all, trust their own signals of comfort or distress.

At each stage of life touching becomes a learned behaviour. A young girl's experience with touch as an infant may define her future sense of self worth as a woman. Later, in her adolescence, the ground rules to sexuality develop; as she develops as a sexual person, the meaning of the touches she gives and receives from her babysitters, mother, father, uncles and peers will take on new meanings. As an adult, a woman chooses her forms of expression

through touch based on previous experience, and applies them in her roles as mother, as lover and as nurturer to her aging parents. As an elderly woman herself, her previous ability to give and receive touch in her personal relations is starkly evident. Unless she has developed or maintained a network of family and friends, she may easily become isolated and untouched in later years.

Touch, like all things, begins at birth. On our way down the birth canal, uterine contractions provide a massive stimulation of the fetal skin, giving the infant its first experience of touch. In the animal kingdom, this is followed by licking and grooming. For humans, this physical contact is just as essential if the newborn baby is to survive and further develop a positive sense of self.

Ashley Montagu, in *Touching*, relates a story about infants under the age of one in various foundling institutions throughout the United States in the 1920s. The death rate for these infants was nearly 100 per cent. Studies undertaken to determine the cause revealed that these babies received very little touch. It was found that "The handling, the carrying, the caressing, and the cuddling . . . are the reassuringly basic experiences the infant must enjoy if it is to survive in some semblance of health."

Furthermore, Montague states, "The body-feeling image we have of ourselves as sensitive or insensitive, sensuous or unfeeling, relaxed or tense, warm or cold, is largely based on our tactual experience in infancy . . ."



R. Footthorap

and that "such a close bodily relationship [between mother and child] is the basis of good feelings about oneself, and the feeling of bodily connectedness leads to a feeling of self esteem."

Certainly this coincides with what some people say about their present sense of themselves and how it compares to their early memories. Raised in various foster homes until the age of seven, one woman described how she had developed an invisible, protective wall around herself, projecting the words "keep off" with her unspoken body language. Although she has "let down her guard" a bit through therapy and a supportive relationship, she is still reluctant to make the first move in greeting people with an affectionate hug, even when the situation is a "safe" one.

This problem arises not only for people who grow up outside the "typical" family structure, but also for those raised in "average" circumstances. Many women have stated that their low self esteem is partly related to the lack of physical affection they experienced at an early age. A child who runs home crying over an incident with a playmate will be reassured if her parent cuddles and strokes her while she describes what happened. Conversely, if she hears "stop crying," or "don't worry about it," she learns that her feelings are invalid, that it hurts less to keep things inside, that it's better not to show emotion at all.

Children soon learn the impor-

tance of touch, and what it can mean when it is taken away. One woman recalls as a child "punishing" other children by staying away from them, or by holding her breath whenever she went by their house. Another recalls an incident at school when one child was ostracized by the others as they wiped off her "touch" so as not to be "contaminated" by her.

Touch cut-off time begins early, usually as children start to go to school. Asking for touch, and touching strangers, is discouraged. In adolescence, touch is often relegated to aggression in sports or to confusing sexual messages. What happened to the tender touches of communication, empathy or understanding? Many parents' unresolved sexual issues come to the fore at the time of their children's adolescence. An adolescent girl may notice a change in her relationship with her father who is no longer comfortable with his daughter's physical affection.

In *The Magic of Touch*, Sherry Suib Cohen writes about the importance of contact as young people move through childhood, then puberty. No longer comforted by their parents, they may turn to their peers instead. She quotes Dr. Elizabeth McAnarney, Director of Adolescent Medicine, University of Rochester Medical School as saying, "There is almost no data on this, but I wonder if the increase in very

young teenage pregnancies comes from the need to be held. They may be using sex for a non-sexual purpose."

One woman recalls using sex as a way to be accepted, and discovering that it also brought very negative reactions from others. The messages were confusing at the time and her parents were not able to deal with the issue, seeing their daughter as having something wrong with her instead. As well, many women recall having other adult members of the family suddenly "come on to them," and the confusion over how to respond. Both these cases foster a growing mistrust of people's intentions. Those who maintained a close and physical tie within their families, however, were able to weather these incidents without blaming themselves. This helped them to maintain a healthy attitude about touch and to discern sexual intentions when they were present.

Gradually adolescents, as they move into adulthood, become aware of the unspoken rules. An article in *Psychology Today*, "Close Encounters," outlines five categories of touch based on people's relationships: Functional-Professional touches are performed by people in a special role, such as doctors or hairdressers. Social-Polite touches are more formal, as in a typical handshake. Friendship-Warmth touches occur in more caring relationships such as family members, close work mates, friendly neighbours. This category edges on the

line between warmth and deep affection, where friendly touches move over into love touches. Love-intimacy touches occur between close family and friends and Sexual-Arousal touches occur in erotic-sexual contexts.

Most of us feel comfortable with these types of touches in our lives. However, sometimes people (like a doctor or male friend) may go beyond what we feel is appropriate and into one of the other categories of touch (like love-intimacy touches or even sexual-arousal touches). At these times, it is important that we recognize and respect our own discomfort, if possible, by saying or doing something about the other person's disturbing touch.

The *Psychology Today* article also describes how the rules about touch differ in various cultures. In Northern European cultures the touch rates are low compared to those in the Mediterranean. The United States was also found to have a low touch rate compared to Latin American countries. Canada was not mentioned in the study but we can assume it rates similarly to the U.S.

A woman from Poland who teaches English as a second language to Polish immigrants in Toronto counsels her students that Canadians are not used to being touched as frequently as they are. She therefore cautions them to be careful about how they approach others. On the other hand, two Chinese Canadian women say that Canadians are more touch-oriented than people in Hong Kong. Those of Anglo-Saxon descent often tend to be more guarded about who they touch compared with those of Jewish descent who are more comfortable with touching

people they meet and speak to in the course of their day. Of course there are exceptions to all situations, often based on each individual's experience as a child.

In most cultures the meanings of touch differ for men and women. A recent U.S. study, quoted in *Psychology Today*, illustrates that girls receive more affectionate touches than boys. Fathers use touch more for play while mothers use it more for soothing and grooming. Regardless of gender differences it was found that those people who were comfortable with touching were more talkative, cheerful, socially dominant and non-conforming. They were less afraid and suspicious of other people's motives and intentions and had less anxiety and tension in their everyday lives. Interestingly, another study showed they were also likely to be more satisfied with their bodies. Those less comfortable with touching were more apprehensive about communicating, had lower self esteem and tended to be more emotionally unstable and socially withdrawn.

Such problems become particularly evident when we look at the aged in our society. Because we have difficulty dealing with aging, we often behave as if it didn't exist. According to Ashley Montagu, this denial is behind our failure to understand the needs of the aged. One of the most important is tactile stimulation. The older we get the more we need to be touched. Sadly and ironically, it is at this point that we are apt to be touched least.

The last touches we receive are sometimes the most important. Stephanie Matthews Simonton who has made a life study of families who face grave illness, stresses the importance of touch for all family members during these times. She says in Cohen's *The Magic of Touch*, "For the patient who hates the way he looks and feels, physical affection is one of the best ways to communicate acceptance and love." It seems that unless touch is consistently maintained throughout life, it decreases critically by the time one



R. Footthorap

Healthwise

with

Healthsharing
 Women and AIDS
 Free Trade Selfour
 Fetal Tissue Control?
 Dyslexia



"**Healthsharing** serves as an invaluable tool for staff and clients alike . . . We eagerly await every new issue, and we're thankful that there's a national women's health magazine, and that **Healthsharing** is it!"

Jennifer Cooper
 Executive Director
 Winnipeg Women's Health Center

"**Healthsharing** provides a perspective on Canadian women's health not available in any other Journal. I find it invaluable both personally and professionally and I read it cover to cover."

Shirley Wheatley
 R.N., Nurse Practitioner

"As a journalist who writes about women's issues, I find **Healthsharing** to be a wonderful resource, a gold mine of ideas and information. As a feminist I believe articles written by women for women are vitally important."

Susan Schwartz
 The Gazette (Montreal)
 Feature Writer

Healthsharing

A Canadian Women's Health Quarterly



R. Foothorap

is dying. Fortunately, with the increased emphasis on the study of geriatrics today, this need is being addressed.

Therapeutic Touch and other healing massage techniques are increasingly being used in hospitals to help the ill and dying. Therapeutic Touch, a gentle stroking of the body's energy field or "aura" is practiced by many nurses to alleviate pain.

Indeed, it has been found that at all stages of life, touch can heal. In a recent study quoted in *Prevention Magazine*, newborn premature infants who were caressed and massaged for 15 minutes three times a day showed a significant increase in weight gain, neurological development and mental development.

Fortunately, among health professionals and lay people, recognition is growing that touch can often be a missing link in a person's therapeutic or healing process. As people today are becoming more interested in taking care of their own health, they are sometimes less willing to accept prescription drugs or surgery as their sole healer. Others may feel disconnected or uncomfortable with their doctor or other health professionals if they feel no real contact or connection has been made. When they seek chiropractors, massage

therapists or M.D.s who support and respect their needs, it is often the human contact they are really looking for.

One woman who was referred by her psychiatrist for massage therapy for bouts of depression informed the massage therapist that in receiving massage she was regaining a sense of body awareness, acceptance and a general feeling of well-being. Another woman, going through the break-up of a relationship, found that the combination of psychotherapy and massage helped her get back in touch with herself, and satisfied her need to be nurtured. As Jules Older states in his book *Touching is Healing*, "Touch can be beneficially used by the family doctor as well as the chiropractor, by the behavioural psychologist as well as the masseuse."

The acknowledgement of the need for touch is reflected in the variety of therapies that specifically include touch as a way to get us back "in touch" with ourselves. Biodynamic massage, Rolphing, Bioenergetics, Reichian therapy and others all address this need.

Yet even without therapy, there are many ways to improve our comfort and ability to both give and receive touch. A good place to start may be with friends or co-workers. An initial approach can be "touch by degree" — giving small touches, perhaps on the hand or the shoulder, and seeing how these touches are re-

ceived. The more we do it, the easier it should become. One caution, however. It is important to be compassionate with ourselves if we find that some people withdraw from an approach. Past experiences may prevent them from reaching out and responding with warmth.

If possible, we should go even further with family members, like bed-ridden relatives who need our touch, or children who could thrive from our warmth. We can give them a gentle back or foot rub, a shoulder squeeze, a hand to hold. If it is more comfortable to ask before giving a hug or a squeeze, feel free to hear what they have to say.

For those of us who have little contact with people, we can reach out and touch our animals more.

The more comfortable we become giving touch, the better sense of self we will have. With a better sense of self, we are less likely to censor that person inside ourselves who is afraid of other's touch.

It is perhaps a harsh way to make a point, but the following passage from Older's *Touching is Healing* clearly illustrates the importance of recognizing our physical needs:

The hugged child will thrive.

The hit child will survive.

The untouched child will die.

Leigh Hamilton, Wendy Simmons and Cheryl Grossman are Registered Massage Therapists who practice in Toronto out of their Riverdale Therapeutic Massage Clinic, formerly the Safe Space Clinic. Cheryl is also an aspiring novelist.

Anecdotes and case studies in the article were taken from their clients' personal experiences and from their own study and research.

Photographs used with permission from Gordon Inkeles, *The Art of Sensual Massage* by Gordon Inkeles and Murray Todris, published by Simon and Schuster.

MY STORY, OUR STORY

Moving Forward

Teresa Gibson

Slashing became a part of my life at 21. Shocking behaviour, some might think, but not so to me. I'd been two decades in a severely dysfunctional family and I could only guess at what was healthy. Cutting and hurting myself gave me a strange sense of elation. I was alive. I could feel. There was hope.

The first major event that led to what I now know as my non-feeling state, happened when I was in Grade 3. Mom had left Dad. So my two brothers, sister and I joined her to live with my grandparents. Overall, this arrangement was not very successful. There wasn't enough space. People fought. And there wasn't even a bathroom. How I came to need a bathtub!

One night when I was nine, I awoke to a heavy weight bearing down on me. I was shocked to discover that it was my oldest brother doing something I didn't understand — rubbing his body against mine. This was the start of a routine which was to go on for two full years. Each time it was the same. My body's reaction was spontaneous — it seemed to enjoy the sensation. But I felt horrible. What was happening to me?

Soon I became desperate to be left alone. I couldn't get clean! There was no private place to wash. And he left his smelly stickiness on me about four times a week. I couldn't stand it. But I had to. If I told Mom, she would hate me, he said. I'd be in real trouble. So I blocked out the smell and carried my ugly secret in utter loneliness.

By the time I was 11, Mom had a new husband and we had a new home. The incest was finally over because the boys were living with Dad. But nothing was really different. My stepfather hated me and Mom seemed to feel the same way.

They became sadistic and

exercised complete control over us. At home, our mail was read. We were beaten and mocked and ordered not to tell anyone. Unwanted food at dinner time was, quite literally, forced down our throats. We weren't allowed privacy of any kind — bathroom and bedroom doors were to remain open and unlocked at all times.

We were under their thumbs at school as well, ensuring we'd be laughed at there also. Allowed to



Katie Pellizzari

wash our hair only every 14 days, we were labelled "greasers." To top that off, they chose ridiculous clothes for us that were so gaudy and awful I slunk around wanting to die.

This environment forced me to split off from my emotions in many ways. I had to hide my every reaction to what went on around me. "Do you love your mother?" my stepfather asked, baiting me. I sat there remembering the cup that narrowly missed my sister's head in the last blow-up. "DO YOU LOVE YOUR MOTHER?" he roared. "Sometimes," I said. Then I was punched hard. I'd given an answer, but the wrong one.

And that required a much stiffer penalty.

In the midst of this craziness, other seeds of self-hatred began sprouting in my brain. I discovered my mother's copy of *Everything You Always Wanted To Know About Sex* and was horrified to find the word incest. That was what my brother had done to me! I was devastated. What was wrong with me? I didn't doubt what was said in the book. But why had my body felt so good? I shuddered. Even my body had betrayed me. I couldn't trust my natural reactions to anything. My head still told me I didn't deserve to be beaten with a bat for missing my bus home. And that Mom slashing my arm for forgetting to call was really bizarre. But I began to think perhaps I was wrong.

Feeling immensely defeated, I began listening to my parents more closely. Women were dirty, they said.

Our bodies were revolting — in their odours and cycles. I heard it all and let it register. What did I know anyway? They were the adults. I was just an ugly little bitch. That's what they told me anyway.

In 1981, I didn't just learn to slash. I also started to talk. I'd already been in therapy two years and was tackling a deep black depression. Telling someone how I felt was a major task. I'd stopped feeling years and years ago. So I chose my words awkwardly. Sad, mad, glad, angry — I tried each one on for size. "I don't know" and "I feel confused" became my buzz words. In retrospect, I see

HEALTH WANTED

Menstrual Synchronization

I read an article about the effects of close association on menstrual cycles (nurses sharing dormitories discovered that their menstrual cycles began to occur within a day or two of each other even though they may have started out being weeks apart). I work in a factory that employs roughly 120 women and this seems to have happened to the workers on one particular line. We would appreciate any information anyone may have about this. Anne Deshane, RR#4, Roseneath, Box 4, Ont. K0K 2X0.

PCB's in Breast Milk

For the last two years I have been trying to have my breast milk tested for PCB's and any other chemical contaminants without success. I am expecting my third child and would like to know what I am giving my babies. I am quite willing to pay for the tests and would appreciate any information about such a service. I would also like information on any possible negative effects of the hemophilus vaccine for pre-schoolers. Genevieve Singleton, Box 152, Revelstoke, B.C. V03 2S0.

Writers Wanted

NC Press, a Canadian-owned publisher, is looking for health-related books for its new Healthbooks series. You are invited to submit manuscripts or proposals on a wide variety of topics. Special interests include innovations in health care delivery, women's health, aging, cost and accessibility of health care, new technologies and ethics. Send queries to: Janet Walker, Managing Editor, NC Press Ltd., 260 Richmond St. W., Suite 401, Toronto, Ont. M5V 1W5.

myself like an abused child locked away in a dark and empty room. Cut off from all compassion and healthy signs of affection, how could I possibly learn self-nurturing? Even moving out of their house at 17 didn't make a huge difference. I was still controlled, taunted and beaten.

I let men paw at me. Not knowing how to say "No" or even what my body boundaries were, how could it have been any other way? When people made fun of me for weight problems, my lisp or my insecurities, I joined in. There was no choice really. I developed a sick obsession with putting myself down, in every possible way.

My process of therapy and healing was not an easy one — mixed up with slashing and hating myself. Pulling the plug on my "deadness" could never have created just one ripple. Not only did I experience joy, excitement and awe. Lots of other feelings surfaced as well — bewilderment, sadness, envy and rage — just to name a few.

Sometimes the whole thing exhausted me so completely that I took the steps to good health only half-heartedly. I'd call a friend when I felt like cutting myself. And together we'd deal with the thoughts and feelings of the moment. Often I'd cut myself anyway. Other times, the voice at the other end of the phone soothed me. I would get through a crisis unharmed.

Once in a while, I felt I'd been really cheated. Nobody ever loved me, I swore. My therapist was being paid to support me. She didn't really like me. She probably thought I was disgusting, pathetic. And when she suggested exercise as a means of dealing with the really intense times, I was further enraged. She was minimizing it all, I decided, wanting to smash things around me. I wanted to rage at her and my family and everybody who ever thought they knew anything about me. The angry little girl inside me sometimes went on like this for weeks. Adult Terry was nowhere to be seen.

This was when slashing was like a rare treat. Venting all that emotion was really invigorating. It was somewhat similar to freely jumping out of work-clothes the instant I got home, letting myself overstep social niceties

and be an obnoxious jerk at a party or wolfing down food without guilt.

Inevitably, I acted out my suicide impulses as well. The last was in May of 1987. I overdosed on amitriptyline (my anti-depressant) and woke up in an intensive care unit. I was hooked up to a respirator, had a collapsed left lung, pneumonia and tubes coming out of me everywhere. Amazingly enough, I survived and have grown up an awful lot since then.

Recently, I became a member of an Adult Children of Alcoholics group. Making this commitment couldn't have come at a better time. I'd been "stuck" in my therapy process for about six months. I'd analyzed the events, ugly as they were and gained an adult perspective on them. Then I thought I should be done with the past. So why did I continue to feel so awful? The answer: I'd been using my ability to rationalize as yet another way to deny or minimize my feelings. I had been setting up my failure all over again. Why did I do this? I was terrified of getting healthy and succeeding.

When I realized this, I got really stubborn. In a personal inventory, I looked at the following things: my feelings; power and control; my relationships with family/co-workers; my (and their) addictions; defense behaviours; how I handled conflict; relationships with ex-partners and friends; things I liked (and didn't like) about myself; direct and indirect ways of communicating; words (the tools I had to make myself understood); my sexual abuse, orientation and sexuality; and the child, adult, and critical and/or nurturing parent inside of me.

I discovered a lot in all of this. I found that the most sensitive issue was about my slashing. My therapist suggested this meant I really was healing. I now know that to be true.

I needed it before because it made me feel in my body again. It seemed the only way to handle the intensity of my rage and at the same time was also an indirect way of communicating the danger I was in. While it worked for a time, I've now given it up for good. I'm finally moving forward in my life.

Teresa Gibson is a Vancouver writer. She welcomes all letters.

Norah Hutchinson

No New Law!

The jubilant faces of Canadian women flashed on national television the night of January 28, 1988. Flushed, beaming faces, with traces of incredulity captured the essence of our feelings on a day few of us will ever forget. The Supreme Court of Canada had struck down section 251 of the Criminal Code (which prohibited abortions unless performed in a hospital after the approval of a therapeutic abortion committee). We could not hide our victorious emotions despite our caution to the media that the court's decision was *only* one step to making safe, easily accessible medically insured abortion services available to women in this country.

After 16 months of deliberation, seven of the nine Supreme Court justices assigned to the "Morgentaler Appeal" rendered their judgement 5-2 in favour of striking section 251 from the Criminal Code of Canada. Pro-choice activists had worked extremely hard for years to have this section of the Criminal Code removed for reasons that Madame Justice Bertha Wilson articulated most eloquently in her judgement:

"The right to "liberty" contained in s.7 [section 7 of the Charter of Rights and Freedoms] guarantees to every individual a degree of personal autonomy over important decisions intimately affecting his or her private life. Liberty in a free and democratic society does not require the state to approve such decisions but it does require the state to respect them."

She went on to state further:

"Section 251 of the Criminal Code takes a personal and private decision away from the woman and gives it to a committee which bases its decision on "criteria entirely unrelated to (the pregnant woman's) priorities and aspirations."

"Section 251 is more deeply flawed than just subjecting women to considerable emotional stress and unnecessary physical risk. It asserts that the woman's capacity to reproduce is to be subject, not to her own control, but to that of the state. This is a direct interference with the woman's physical "person"."

It took 20 years for this disastrous section to be struck down and it took fewer than 24 hours before ominous rumblings were heard from MPs opposed to abortion, the various provincial governments with a strong anti-choice agenda (particularly British Columbia), and of course, the ever present "right-to-life" movement. As Henry Morgentaler declared that evening, "this battle is won but the struggle is far from finished."

Recriminalization

The Conservative government's response to the decision was to attempt to recriminalize abortion. This past summer, the Mulroney Government presented the House of Commons with new criminal legislation on abortion, claiming a desire to "read the will of the House." The motion and all five amendments were rejected after several days of debate. The "will of the country" had been heard. However, it was an unsettling spectacle to watch one MP after another wax exhaustively about their personal thoughts on everything from fetal development, their religious beliefs, to their views on fatherhood, with the fundamental issue trivialized and manipulated.

If the government is sincerely interested in providing health care for Canadian women then it need not immerse itself in lengthy, needless debate. It should act swiftly and de-



cisively, referring to the mountain of data in existence which documents the sorry state of abortion services in Canada. The government should dismiss the idea of new criminal legislation, understanding that there are already sections of the Criminal Code that deal with the regulation of abortion. (Sections 252, 45, 198, 202, and 245 require that reasonable standards of care be met in all treatment.) The federal government should also acknowledge that it is the provincial governments that set standards for medical practitioners and the provincial medical colleges that are responsible for ensuring that physicians practice medicine according to accepted protocol. (An example of this is the recent formulation

of standards for the provision of abortion services in hospitals and in clinics by the Ontario College of Physicians and Surgeons.

Gestational Limitations

One of the issues that was raised in the debate in the House of Commons was whether there should be limitations put on how late in a pregnancy an abortion could legally be performed. Although Canada has never had gestational limitations on abortions, it is evident that women do not seek abortions after three months of pregnancy, except in extenuating circumstances. Approximately 87 per cent of abortions are done in the first 13 weeks of pregnancy. This has been the case even with the delays inherent in the therapeutic abortion committee approval system. And only 0.3 per cent of abortions are performed after 20 weeks of pregnancy. That many women have late abortions in Canada is a deceitful and disrespectful myth that the opponents of choice have tried (albeit, somewhat unsuccessfully) to perpetuate.

There have not been any reasonable or justifiable arguments posed by those that would legislate gestational limitations. The circumstances that compel women to have abortions after 13 weeks are as varied as the reasons for terminating a pregnancy at an earlier stage. To advocate that Canadians need protection from "potentially-criminal" women, not only distorts the concept of a fetus, but charges that women are incapable of making moral decisions and in fact are merely vessels in which to carry a fetus to term.

But instead of understanding the many reasons why women are compelled to have abortions after 13 weeks, the spectre of "fetal rights" is raised and promoted by anti-choice organizations. Talk of unscrupulous doctors surfacing to capitalize on "free access" is occasionally thrown into the argument. Both these arguments disregard women's physical autonomy and the rights we have as adult citizens to make choices and decisions about our personal lives in privacy and in accordance with our own beliefs. In the second instance,



D. Smiley

unscrupulous doctors wishing to perform any medical procedures are dealt with by existing sections of the criminal code and by their professional bodies. Likewise for nurses and other health care providers.

We know that with increased access to abortion facilities the overwhelming majority of women will obtain an abortion in the earliest weeks of pregnancy. We also know from the American experience, the clinic experience in Quebec and from the Morgentaler clinics, that the safe, supportive, confidential and respectful environment that clinics provide is far superior to hospital abortions. Clinics can also provide their services on a more cost effective basis than hospitals.

Shortly after the motion on abortion was defeated in the House of

Commons, the Canadian Medical Association (CMA) finally adopted a more strongly worded policy on abortion and the provision of abortion services. The resolution acknowledges that abortion should be made available outside hospitals and that "counselling services, family planning services and contraceptive information must be readily available to all Canadians."

But the CMA makes no demand for all-inclusive medical insurance coverage for these services. While the CMA policy paper emphasizes what we in the pro-choice and women's movement have been saying for years, its glaring omission on that count lessens the effect substantially.

Theoretical support is simply not good enough. The excuse by some in the CMA, that medical doctors must

steer clear of politics is ridiculous. We have ample evidence that many physicians have little concern about expressing their political opinions on other issues, especially when it directly affects them financially.

Right-wing Response

The right-wing response to the Supreme Court ruling was swift and biting. British Columbia's Premier Vander Zalm, while unequivocally on the leading edge of right-wing politicians, had plenty of followers eager to jump on the bandwagon. Antagonistic voices, mouthing ignorant statements rolled in from all corners of the country. M.P.s like Jim Jepson, Gus Mitges, John Nunziata and Don Boudria joined in with provincial politicians like Vander Zalm and Grant Devine of Saskatchewan and various church clergy to denigrate women's experiences and call into question women's integrity. It seemed like open season on the women of Canada; an opportunity to "highlight" anti-woman positions on other issues.

The inflammatory language used to promote their position no longer shocks pro-choice activists, long familiar with the "right to life" agenda, but creates untold anguish among those women who have abortions and are more vulnerable to misinformation and ghoulish imagery. For example, on July 14, 1988, a \$15,000 half-page advertisement in the national edition of *The Globe and Mail* featured a blow-up photograph of a 19-week-old fetus entitled "Baby Talk."

There was also Senator Stanley Haidasz's Bill S-16 to amend the Criminal Code which states:

"Every pregnant female person who, with intent to cause the death of an unborn human being within her, uses any means to carry out that intent is guilty of an indictable offence and liable to imprisonment of two years."

In Calgary, a demonstration held outside City Hall protesting the public funding of the Calgary Birth Control Association (CBCA) was attended by at least eight members of the Ku Klux Klan, lending an ominous note to the struggling anti-choice movement.

Said Charles Smith, president of the Alberta Pro-Life Alliance, "other opinions that KKK members hold are irrelevant. If they want to unite with us on this issue, we welcome their support. We don't have to agree on everything . . . individual members of their group who do not condone the destruction of human life should come out in support." The obvious connection in mentality did not escape many people.

As the "right to life" movement has become more fanatical and more right-wing, their support has eroded. A prominent anti-abortion spokesperson in Vancouver has indicated publicly that they have lost support because of the increasingly right-wing approach, which has included opposition to all forms of birth control and sex education, as well as continued emphasis on harassing women on their way into abortion clinics. These positions, she said, have alienated previous as well as potential supporters. The fractious infighting within their ranks continues to divide and polarize their agenda. Witness the split of REAL Women earlier in the year and the attempt by a few to form small rightist political parties such as the Family Coalition Party in Ontario. Several planks in this party's platform include a vitriolic anti-gay stance, support for capital punishment and opposition to day care funding.

While the anti-choice lobby has intensified, in conjunction with their steadfast tactics of picketing hospitals and clinics, widespread public education and high profile events organized by the pro-choice movement across the country continue to ensure that existing abortion services are maintained and expanded to meet women's needs.

Access hasn't Improved

Most centres in Canada are reporting that there has not been a substantial change in the numbers of women seeking abortions, nor in the method in which they are offered. In some areas of the country access to abortions has deteriorated and medical insurance funding is in doubt.

In response to the Supreme Court

The George Brown
Assaulted Women and Children
Advocate Counsellor Program
and
Real Eyes: the Vision
present

WORKSHOPS WITH SANDRA BUTLER

Healing the Healers
January 17-18, 1989
\$200

Personal Disarmament
January 19-20, 1989
\$120

**Women, Sexual Terrorism
and the State**
January 21, 1989
\$50

**Our Search for the Mother:
the Journey Home**
January 22-23, 1989
\$200

For more information call
Toronto (416) 654-2206

ruling in January, British Columbia Health Minister Peter Dueck responded quickly to the Supreme Court ruling by ordering an immediate cessation of funding for all abortions through B.C.'s Medical Service Plan. What resulted was a state of unprecedented chaos in the province. While Dueck and Premier Vander Zalm waged an all out attack on women seeking abortions both in financial and emotional terms, confusion reigned within the hospital system. Hospital administrators, physicians and abortion referral agencies could not make sense of the daily pronouncements coming out of the B.C. legislature.

Mary Bloom, the executive director of the Arcadia Women's Health Clinics in Seattle, Washington, an abortion-providing clinic, noticed a 25 per cent increase in the number of B.C. women seeking abortions within a six-week period. She realized that the increase was directly attributable to the confusion in B.C. Given that the cost for an abortion in a B.C. hospital now far exceeded the \$275 it cost to have it done in Washington state, women with the financial resources found it easier to

travel south of the border and have the procedure done quickly and quietly.

Barbara Hestrin, the education director of the Planned Parenthood Association of B.C. observed that, "the overturning of the abortion law produced some short-term and some long-term effects as far as Planned Parenthood is concerned. One short-term effect was that additional time was required to counsel women who were at that time attempting to resolve an unwanted pregnancy. These women, and often their partners, needed clarification regarding access to facilities, and (for a period of several weeks, in B.C.) details pertaining to the financial costs that would be involved in the termination. Additional counselling time was also required to deal with the emotional turmoil and fear that resulted from the invasion of political and very public action into the realm of personal decision-making, in an already stressful area."

There was an immense swell of support for choice in B.C. in response to the provincial government's attack on a woman's right to abortion. A demonstration held on the legislature grounds, attended by 3,000 and a petition with 20,000 signatures coupled with public forums and pro-choice editorials in B.C.'s major newspapers exposed the government to daily public derision and ridicule. Nationally, Vander Zalm and his cohorts were treated with scorn (occasionally with outright disbelief) not only by the general public, but by the major news outlets.

The culmination of weeks of pro-choice political pressure was an order by the B.C. Supreme Court, initiated by the B.C. Civil Liberties Association which forced the Vander Zalm government to reinstate funding.

In Quebec, the Board of Health is investigating abortion-providing clinics including the CLSCs for "possible overcharging." Odel Loulou of the Morgentaler Clinic, objected to "the breach of confidentiality" and said that "if the government doesn't want the clinics to "overcharge" it should give adequate funding to provide for proper equipment and other things, not just for the abortion itself."

Members of the *Coalition Québécoise pour la droit a l'avortement libre a gratuit*, the Quebec coalition for free abortions, have demanded that the government expand services, particularly in the more distant regions. As one coalition member said "the government looks for guilty parties to make the existing abortion services look bad instead of addressing the real problem of access and availability."

In Manitoba, the Conservative government refuses to provide insurance plan funding for abortions done at the Morgentaler Clinic in Winnipeg, or improve hospital access. The Morgentaler Clinic reopened in June, but clearly needs health care coverage and core funding if it is to provide comprehensive services.

P.E.I. remains the only province with no abortion access for women.

The Liberal government refuses to ensure that existing hospitals do the procedure nor will it make any efforts to provide a free-standing clinic.

Ontario remains, relatively speaking, the second best province after Quebec, in providing abortions with the least obstruction and resistance. But the Liberal government falls very short in making abortion truly accessible to all women. As is the case in all other provinces, geography plays a major role in determining who gets an abortion, how quickly and at what financial cost.

Women from the Maritimes still travel to Montreal or Toronto and women from Saskatchewan and Alberta travel to Winnipeg. In B.C., those from the north and the interior come to Vancouver or cross the border into Washington state.

United we can win

Nikki Colodny, the first woman medical doctor in English Canada to work in an "illegal" abortion clinic prior to January 28th, reflects back on her experiences:

On the day I was arrested, September 17, 1986, the clarity of the contradiction between our rights as women and the state's attempts to limit our rights was illuminated like a flash of lightning. For several weeks the Ontario Coalition for Abortion Clinics (OCAC) had been hearing that the arrests were imminent. We even had a tip that it was to be the morning of the 17th. That day I went about my morning activities waiting for the doorbell to ring. When it didn't, I assumed our tip was wrong. I left the house with the rest of my household. We were all somewhat relieved.

Just as I was about to start the ignition of the car, two plain-clothed policemen walked over. One of them flashed his badge and said somewhat apologetically, "I think you know what this is all about."

Then came the lightning bolt. For an instant, the powerful struggle between the state and the women's movement was boldly illuminated. Our side was our world, where it is our birthright to control our bodies, our reproduction and our sexuality and where we struggle to organize to force reluctant governments to recognize those rights. On the other side was the power of the state which can be forced to certain concessions but is nonetheless opposed to the full emancipation of women.

OCAC organized the pro-choice response to the attack on abortion access posed by this arrest of Dr. Morgentaler, Dr. Scott and myself. The visible and overwhelming support for Toronto's free-standing abortion clinics forced the provincial government to stay the charges.

I had packed a small bag with my women's music tapes. But on the same day that I was arrested, I was released. The important lesson that "united we can win" had never been more real to me.

REVIEWS

Activists across the country are rallying together with renewed strength to ensure that abortion is not recriminalized and that services are expanded and made more accessible. Carolyn Egan, a spokesperson for the Ontario Coalition for Abortion Clinics (OCAC) states, "We are watching very carefully what is developing and are emphasizing that a new law is not necessary. What we need is increased access to hospital abortions as well as a network of publicly funded clinics across the country providing comprehensive reproductive health care."

In May, the Pro-Choice Action Network was formed with the intention of providing a closer affiliation to pro-choice groups in all provinces. The first project of the Pro-Choice Action Network is to organize pro-choice demonstrations across Canada and Quebec for November 19, two days before the federal election to say no to any new abortion law.

It is important that federal politicians know that they cannot reintroduce legislation restricting the availability of abortion. The sentiments of Canadians are clear — over 75 per cent support a woman's right to choose and respect her right to make this decision in privacy. It must be the federal government that guarantees (through the Canada Health Act) that abortion be declared an essential medical service.

Abortion, as one component of fundamental reproductive rights that women around the world have struggled for, is a catalyst for raising other women's issues. The fact that significant support for a woman's right to choose has come from women in the labour movement, in the health care field and from immigrant women's communities, emphasizes the importance of the abortion rights movement and the drive for control over all aspects of our health care.

Norah Hutchinson is a member and spokesperson for Concerned Citizens for Choice on Abortion, a Vancouver-based organization and a board member of the Canadian Abortion Rights Action League.

Handi-Travel: A Resource Book for Disabled and Elderly Travellers

Cinnie Noble, Canadian Rehabilitation Council for the Disabled, Toronto, 2nd edition 1987, \$12.95, 147pp paper.

Reviewed by Joan Meister

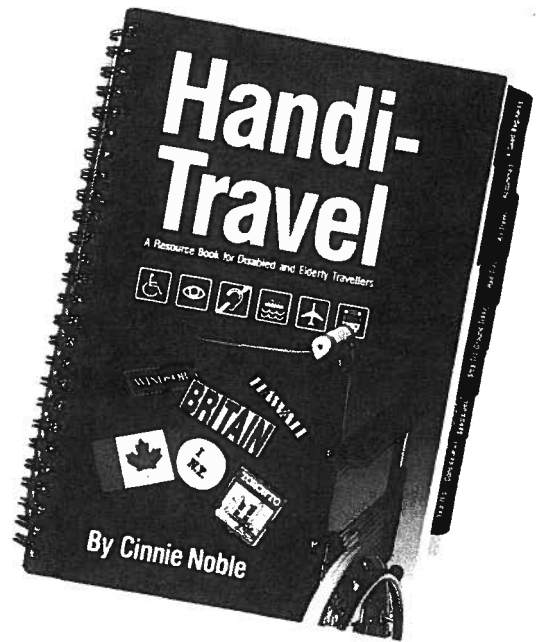
"You can't judge a book by its cover." It's one of those sayings that we've all heard lots of times and one which doesn't really mean anything. Or does it?

From the brand name on our sufficiently scuffed sneakers and the back pockets of our jeans to the way we gel or don't gel our hair, we are composing covers by which others will be judging us.

When we are dealing with a book with a title, *Handi-Travel: A Resource Book for Disabled and Elderly Travellers* not only will we judge it by its cover, it is valid and necessary to do so. This book is self-proclaimed as intended for a disabled and elderly readership with special needs. Special needs require accommodations which make otherwise inaccessible situations accessible.

Handi-Travel makes a very good attempt to accommodate the needs of some of those readers to whom the book is addressed. Persons with some physical disabilities and many elders will find this resource book to be especially informative and accessible. And some will not.

Accessibility is often gauged by whether there are ramps instead of stairs, tactile buttons instead of smooth, non-communicative buttons on elevators. It might even extend to a consideration of doorway widths and whether those same elevator buttons can be reached by someone sitting down. Rarely does it include



consideration of grab bars by the toilet, never mind whether they are the right kind and in the right place.

Accessibility however, is a far more universal notion than facilitating one's ability to use a physical space. Ask anyone who's learning disabled or blind. Access also includes the concept that a person with a disability can benefit from things like education, recreation and information, often through the print medium. If this form of information sharing is not as accessible as it can be, it denies valuable information to many users with a disability.

When one considers that approximately 80 per cent of all persons with a disability experience a mental disability, it seems somewhat inadequate that a small part of one chapter is devoted to these needs. Hidden or invisible disabilities such as diabetes and epilepsy are given the same short shrift. It is not even clear whether the book is available in large print format, on audio tape or compact disk for those with visual disabilities. Perhaps the subtitle

should more accurately read: "A Resource Book for the Physically Disabled."

For those with mobility impairments the book is very accessible since it is bound with metal rings making it possible for the book to lay flat when opened. For persons with limited hand function such as quadriplegics, arthritics and those with poor coordination due to spasticity, this is a boon. It has easy to use tabs to indicate chapter breaks, although the typeface could have been larger for the benefit of those with a visual impairment.

People with visual impairment would have been better accommodated by a larger typeface throughout. The book is generously sprinkled with cartoons ranging from the amusing to the inane, which illustrate various suggestions or cautions. If the proportion of cartoons to text were reduced, the typeface could be enlarged to enable more people with visual impairments, many of whom are elderly, to access the valuable information directed at them.

Provided that the persons to whom *Handi-Travel* is directed can access the information, it is well-organized and easy to use. The first chapter which deals with all of the basics might well be utilized by any traveller. There are bibliographical entries accompanying almost all sections and sub-sections which allow the user to pursue specific questions or areas of interest. There is a useful glossary of terms and an index.

The concluding chapter, "Your Rights," encourages a proactive approach toward travel service. It also

provides an explanation of the processes and the supports available to disabled people in case s/he does not have specific needs met and wishes to pursue a grievance. The suggestion that change will only come when consumers exercise their right to complain and seek compensation is as refreshing as it is accurate.

With the odd exception, such as only allowing 30 minutes to check in for flights, which seems tight even for someone without a disability, the information contained in *Handi-Travel: A Resource Book for Disabled and Elderly Travellers* is valuable and could provide the user with an excellent resource. It is also clear, however, that when one undertakes such an ambitious project as providing a resource for "disabled and elderly travellers," the onus is upon the author to provide the resource in forms which are more universally accessible and useable. It is hoped that in a future edition of the book, Ms. Noble will change her title to more accurately reflect the scope of the book as illustrated by its cover photo of the well-travelled wheelchair. Or, even better, perhaps she can strive towards a more truly accessible document and accommodate the needs and information requirements of all travellers with a disability.

Joan Meister is the chairperson of the DisAbled Women's Network Canada and the secretary of the Canadian Council on Rehabilitation and Work. She travels regularly between Vancouver and Ottawa and to other destinations, both national and international.

Doing It Ourselves

Video developed by Women Today, produced by Kem Murch Productions, 1988, 21 minutes. Video and manual information available from Women Today, P.O. Box 1405, Clinton, Ontario, N0M 1L0.

Reviewed by Marjorie Kort



*From the beginning of time, women have come together in circles to be nurtured, strengthened and supported. These words, spoken by one of the participants in the Women Being Well project, describe the essence of this program developed by Women Today in Huron County, Ontario. The program was designed as a tool to empower rural women to promote their own health. To do this, project leaders provided facilitator training courses for women in the community who were interested in starting their own mutual aid support groups. This process is described in a video and accompanying manual entitled *Doing It Ourselves*. Women Today, the organization which developed the Women Being Well project, is a non-profit community organization which has been providing education on women's social and health issues in Huron County since 1980.*

*The *Doing It Ourselves* manual is designed for organizations, community colleges, agencies or services that could support and sponsor facilitator training courses. It describes the necessary activities involved in starting a training course such as preparing a budget, identifying a trainer and recruiting participants. It also describes the structure and content of a one and a half day course with six weekly follow-up sessions.*

The
Womanist

*A new feminist newspaper
distributed nationally*

6 issues/year:

- \$5-\$10 individual
- \$25 sustaining
- \$15 institution

The Womanist
P.O. Box 76, Stn B,
Ottawa, Ont K1P 6C3
(613) 230-0590

In the first workshop, participants identify common health issues, create a vision of well-being and then identify and overcome the barriers to that vision. The content is primarily experiential and well-peppered with group bonding activities. The weekly follow-up sessions are designed to teach participants how to establish and maintain a group, as well as give them hands-on experience in facilitating one. To supplement the training course, the manual contains a comprehensive list of relevant resources for group facilitators.

The strength of the manual lies in the concise and well-organized way in which so much useful information is presented. Copies of all the course handouts are included so that one needs only to copy them. And the specific activities and group exercises are a joy for program developers who may be used to spending considerable time designing and testing program content. It is exciting and motivating to be presented with the course content for a program that has clearly been well thought through, has been tested and has a history of success.

In some places the manual is a little too concise. For example, Popular Education is described in only one paragraph and it is doubtful that someone new to these methods would understand how to implement the techniques. However, the resource list is excellent and contains references such as *A Popular Education Handbook* by Rick Arnold and Bev Burke, which gives a very comprehensive description of popular education. The manual also lacks information on facilitation techniques and the process of group dynamics. Once again, this information is readily available and thoroughly described in the referenced *Women's Self Help Educational Kit* available from North Island Women's Services Society in Courtenay, B.C. One has to assume that the sponsoring agencies would have the funds to purchase a good number of the reference materials, that the trainer chosen to lead the course would be familiar with these materials and that participants would "learn by doing" in the six weekly sessions.

The video is designed to motivate

people to promote their own health and the health of others by starting a self-help group. In 20 minutes, it documents the activities of the *Women Being Well* project and some of the self-help groups that were formed during the project. We hear from the trained facilitators, group participants and members of the general community. There is good representation of women — from farmers to professional women to young mothers — who formed groups to meet their diverse needs. A mothers group formed as a result of the social isolation experienced by rural farm women. A midwifery group came together to promote childbirth as a natural physiological process and People First, a group of developmentally handicapped adults now meets regularly to support each other and to lobby the government for better services for handicapped people. A women's theatre group and a menopause group were also created.

The video is professionally produced and truly inspirational and gives a real sense that the participating women transformed their lives in some way. The message is clear. To be healthy, women need control in their daily lives and getting more control is easier with the support of other women. The positive qualities of women in general are acknowledged and reinforced throughout:

"The *Women Being Well* project values these traditional qualities of women; to nurture, to share power and human resources, to think globally, to feel the connection to the earth and all living things, to take responsibility for our own well-being, to share the resources of the environment and to celebrate the human spirit."

Women Today are to be congratulated for their creativity in developing this innovative program and their competence in producing a resource that makes it available to the rest of us.

Marjorie Kort is a health educator in the health services component of the Southeast Ottawa Community Resource Centre.



all under one roof

Parentbooks

201 Harbord St. Toronto, Ont. M5S 1H6

Mon. — Sat. 10:30 — 6:00

Phone (416) 537-8334

Healing Insights

with

THE **OH** CARDS

*Health through self-awareness
and self-empowerment*

Use the OH Cards to:

- practice self-exploration
- exercise imagination
- enliven dialogue
- stretch listening skills
- express feelings in safety
- open communication lines

and... have fun as well!

The OH Cards are two decks of 88 special playing cards (one of full colour pictures, one of words) that can be used to generate insights into one's life.

For a free brochure, or a complete set at \$43 (prepaid), write EOS-hs Box 6263, Victoria B.C. V8P 5M3 Or call (604) 477-4071



RESOURCES & EVENTS

AIDS Information for Parents

Talking Openly About AIDS — Information for Parents is a new pamphlet from Planned Parenthood of Toronto which includes why parents should talk to their children about AIDS, how to become more comfortable with the subject and how to begin a conversation about AIDS. Single copies are available for \$1.00 from Planned Parenthood of Toronto, 36B Prince Arthur Ave., Toronto, Ont. M5R 1A9. (416) 961-0113.

Women, Sport and Physical Activity

Women, Sport and Physical Activity — Research and Bibliography published by the Ministry of Fitness and Amateur Sport is a feminist critique of the literature on women in sport and physical activity. Broad subject areas include sport, culture and society, psychological considerations, physiological considerations, and exercise and the reproductive function. Lists of further readings are extensive.

Copies may be obtained from: Women's Program, Fitness and Amateur Sport, 365 Laurier Ave. West, Ottawa, Ont. K1A 0X6.

Menopause Book

The Montreal Health Press has a new 52 page publication entitled *a book about menopause* and *la ménopause* in the French version. It provides basic information about the experience of menopause as well as discussing a variety of social and political issues which affect the

health and well-being of mid-life women. Different sides of issues such as hormone replacement therapy and hysterectomy are presented.

Single copies are available for \$4 payable to: Montreal Health Press, P.O. Box 1000, Station Place du Parc, Montreal, Quebec H2W 2N1 (bulk order rates available).

Multicultural Health

The Canadian Council on Multicultural Health is holding a national conference, "Multicultural Health — Realities and Needs," in Toronto on March 30, 31 and April 1, 1989. Of interest to health care professionals, health educators, social workers, community workers, health organizations and interested individuals, topics will include cultural responses to illness, barriers to equal care, immigrant women, Native people and health care, and mental health issues.

For further information contact: CCMH Conference Committee, 1017 Wilson Ave., Suite 407, Downsview, Ont. M3K 1Z1. (416) 630-8835.

Rotational Shiftwork

The Canadian Centre for Occupational Health and Safety has a list of publications available about various health and safety concerns. One of these is *Rotational Shiftwork: A Summary of the Adverse Effects and Improvement Strategies*. Shiftwork, a fact of life for 25 per cent of the working population including those in the health services, can lead to health problems ranging from chronic fatigue to digestive upset. This booklet outlines improvement

strategies both for organizations and for individuals such as shift schedule design and guidelines for diet and eating patterns. Single copies and a list of other publications are available free from: Canadian Centre for Occupational Health and Safety, 250 Main St. East, Hamilton, Ont. L8N 1H6.

Birth Defects in Canada

The Canadian Congenital Anomalies Surveillance System (CCASS) began in 1966 as a result of the thalidomide tragedy and has a new pamphlet, *Birth Defects in Canada*, which points out that for 80 per cent of the 25,000 infants born in Canada each year with at least one birth defect there is no attributable cause. CCASS supports a research and recording program to identify any unusual patterns of occurrence.

A free copy of the pamphlet may be obtained from: Birth Defects Section, Surveillance and Risk Assessment Division, Bureau of Chronic Disease Epidemiology, Laboratory Centre for Disease Control, Tunney's Pasture, Ottawa, Ont. K1A 0L2. (613) 957-0843.

Guide to Maternity/Paternity Leave

Becoming a Parent: A Guide to Maternity/Parental Leave and Benefits in Canada, a fact sheet published by the Canadian Advisory Council on the Status of Women, illustrates the highly unsatisfactory state of maternity benefits in Canada. (Canada ranks 22nd out of 23 countries in eastern and western Europe.) A large fold-out chart simplifies the vast and often confusing array of legislation at the federal, provincial and territorial levels of government.

Copies are available free of charge from the Canadian Advisory Council on the Status of Women, Distribution Centre, Box 1541, Station B, Ottawa, Ont. K1P 5R5.

From the National Film Board of Canada

WHAT PEOPLE ARE CALLING PMS

**A FILM ABOUT PREMENSTRUAL CHANGES
THE MYTHS, THE FACTS.**

This film helps to counter the misinformation and confusion about the premenstrual phase of a woman's cycle. It challenges the commonly held notion that women who experience premenstrual changes are ill, or out of control. WHAT PEOPLE ARE CALLING PMS links myths about premenstrual behaviour to historical attitudes underlying today's definition of acceptable female behaviour.

Director: Haida Paul
Producer: Jennifer Torrance
28 minutes Order no: C 0187 111

Available in person or by mail from all NFB offices in Canada. Call, phone or write to reserve your copy of this film.

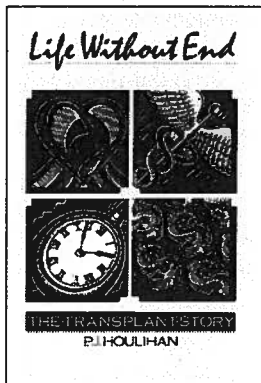
Video rental: \$2 per day
16 mm film: \$4 per booking



National
Film Board
of Canada

Office
national du film
du Canada

HEALTHBooks



LIFE WITHOUT END The Transplant Story

P. J. Houlihan

It has been called undeniably miraculous, intoxicatingly awe-inspiring, ethically treacherous and economically disastrous. And so begins the story of what organ transplantation or "spare-parts surgery" is really all about.

As a former director of organ procurement for the transplant program in Halifax Houlihan examines accountability and the ethical questions inherent in the procedure.

55021-017-3 (pa) \$12.95 + \$2.00 shipping & handling

NC PRESS LIMITED *The Health Book Specialists*
Order Department: 260 Richmond St. W. Ste 401
Toronto ON M5V 1W5 (416) 593-6284



L. Emily Elliott

Help Healthsharing and Help Yourself

Reduce your taxable income by
making a donation to
Healthsharing

You will receive a 1988 official
Income Tax Receipt for donations
over \$10

Thank you for showing your support for Healthsharing

From the National Film Board of Canada

**250 VIDEOS
AND FILMS
FOR**

ALL ABOUT WOMEN

- WOMEN'S AND OTHER COMMUNITY GROUPS
- HOME VIDEO VIEWERS
- PROFESSIONALS (NURSES, TEACHERS, AND SOCIAL WORKERS)
- PUBLIC LIBRARIANS, COMMUNITY WORKERS
- MUNICIPAL, PROVINCIAL AND FEDERAL PROGRAMS AND SERVICES

Choose from our collection of short and long documentary, fiction and animated films and videos that inform, entertain, and promote discussion on a wide range of subjects.

HEALTH, WELL BEING AND FITNESS



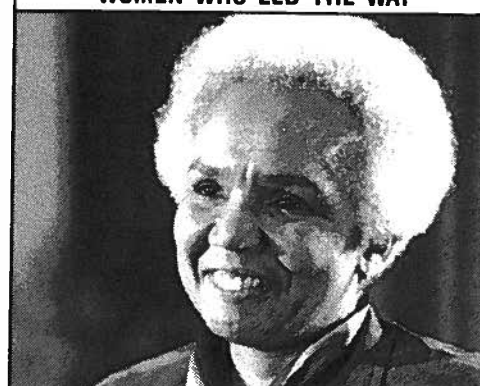
- Pregnancy
- PMS
- Menopause
- Aging
- Disabilities

CONTEMPORARY ISSUES



- Family violence, rape, incest
- Abortion
- War, peace, disarmament
- Working mothers, childcare
- Single mothers, divorce, women in poverty

WOMEN WHO LED THE WAY



- in sports, the arts, religion, politics and the feminist movement
- in rural and native communities, unions, the armed forces, business and non-traditional jobs

RENT RENT A VIDEO OR FILM!

VIDEO: \$2 EACH DAY
16 mm: \$4-\$8 service charge, valid for five days (excluding time in transit)
Available for pick-up or by mail from all NFB libraries in Canada.

BUY Buy a video for as little as \$29.95; film prices start at \$72.80.

Members of the NFB's Women's Market Development Group are located in NFB offices across Canada. They can help you select films and videos for your group or event. See "National Film Board" listed under the "Government of Canada" section in the blue pages of your telephone directory.

I'd like to know more about NFB films for women .

- Please add my name to your mailing list announcing new releases and send me a copy of your video rental catalogue.
- Please send me your new catalogue of films for women (available in early 1989).
- Please send me the new publication *Women Breaking Through*, a 28-page audio-visual guide for secondary schools.

NAME _____

INSTITUTION _____

POSITION _____

ADDRESS _____ CITY _____

PROVINCE _____ POSTAL CODE _____

MAIL TO:

National Film Board of Canada,
Women's Market Development
Group,
D-5,
P.O. Box 6100,
Montreal, Quebec
H3C 3H5



National
Film Board
of Canada

Office
national du film
du Canada