Summer, 1988
$2.50

Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

The Economics of Health

Homeless Women Organize

Welfare: Far From Well

Philippine Prostitution

Refugee Health

INSIDE

FEATURES

Collage: Katie Pellizzari

ALWAYS IN HEALTHSHARING

Bernadine Arsenault

Vol 9:3 June, 1988

Collective Members
Susan Elliott, Alice Grange
Diana Majury, Lisa McCaskell

Administration
Amy Gottlieb, Katie Pellizzari

Advertising
Alice Grange

Circulation/Promotion
Lynn Goldblatt, Amy Gottlieb, Tara Toutant

Copy Editing/Proofing
Elizabeth Allemang, Susan Elliott

Design/Production
Alice Grange (coordinator), collective members, Bernadine Arsenault, Amyra Braha, Pam Bristol, Connie Clement, Katie Pellizzari, Barbara Muirhead, Pam Russell

Editorial
Amy Gottlieb (coordinator), collective members, Heather Allin, Frumie Diamond, Sue Kaiser, Bonnie Lafave, Heather Ramsay, Linda Rosenbaum

Typesetting
Lynne Fernie/Type A

Printing
Delta Web Graphics

Cover Photo
Amy Gottlieb

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) should 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.

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 financial support from Women's Program, Secretary of State and Employment & Immigration.

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 $9/year, individuals; $17/year, organizations and groups. Add $2.00 to all foreign subscriptions, including subscriptions to the United States.

COLLECTIVE NOTES

The Privilege of Health

In this thematic issue of *Healthsharing* we have begun to examine some of the connections between economics and women's health. It is a dismal fact that in 1988, women on average still earn only 67 cents for every dollar that a male earns. And that amount is even lower for immigrant women, women of colour and disabled women.

Economics has a direct impact on women's health. Many of us view such a statement as a truism — one which is so overwhelming that it can render us powerless. Where should our work begin? Should we spend our energy trying to change an inequitable economic system, a system where, as writer Joanne Doucette notes, "a native disabled woman who drops out of school has a better chance of winning a lottery than she does of getting a job"? Or should we be trying to make our present health care system meet the needs of the majority of Canadian women? Perhaps we have to do both. The articles in this issue demonstrate that change is possible, that we are powerful enough to be heard.

Health should not be a privilege. Money is directly related to quality of life, from healthy housing to nutritious food. Money and class position in society grant access to many health resources and services and to the knowledge that these services are available. The health promotion movement and its resources are often biased toward white middle class women who have a strong sense of themselves as individuals and their responsibility for their own health. Available services are often provided in the image of the service provider — educated, highly motivated and literate in English.

And what about less privileged newcomers to the Canadian health care system? In "Not Quite a Refuge: Refugee Women in Canada," Christina Lee examines the availability of health services for refugee women and offers some suggestions as to how their situation could be improved. Health providers must provide care in ways that are culturally sensitive and accessible to all Canadians.

Although in the long run a healthier population will mean decreased health care costs, there is an immediate need for money to be invested into new health initiatives. But that isn't happening. Instead, federal and provincial governments are trying to pare down budgets in the hospital sector — cutbacks that translate into fewer nurses and deteriorating working conditions as described by Pat Armstrong in "Where Have All the Nurses Gone?". And those groups that take the initiative like Gatekeepers in Thompson, Manitoba are finding their funding cut off just as they were getting a number of self-help groups off the ground. As Kathy Fitzpatrick explains in "Gatekeepers: A Challenge to Health Promotion", more than just a facility is at stake — people were determining their own needs and setting up services to match. Groups like Low Income Families Together, described in Doucette's article, "Welfare: Far from Well", find their efforts to obtain funding so draining that many members simply burn out before they can achieve their objective.

Endeavours like Gatekeepers prove that women aren't merely consumers but with proper funding can also determine our own needs and develop our own health services. Halfway around the world, some women in the Philippines are also refusing to be just health care consumers. "The Daughters of the Dispossessed" describes a cafe where prostitutes can get information on AIDS, contraception and free health care. These women are proving to us that it is possible to work for change and see it start to happen in our lifetimes. Health does not have to be a privilege.

This issue Healthsharing welcomes our new managing editor, Amy Gottlieb. A long time reader and supporter of *Healthsharing* as well as our proofreader for the last 2 years, Amy comes to us with both enthusiasm and experience. Amy has been involved in the women's movement for many years and is an experienced writer and editor. All of us are pleased to have found such a capable and energetic replacement for Connie Clement.

It is with sadness at the same time that Healthsharing members, staff and readers say goodbye to Connie Clement. A founding member of Women Healthsharing in 1978 and our managing editor for the last three years, Connie has been an integral part of the magazine for its entire history. For the past 10 years she has devoted countless hours to fundraising, grant writing, editing, networking and all the jobs involved in publishing a national magazine. As a member of Healthsharing, Connie has been one of the driving forces to establish a Canadian women's health network as well as being active in the campaigns against Depo Provera, DES and the Dalkon Shield. Connie continues her work as a women's health advocate as the Family Planning Program Coordinator at Toronto's Public Health Department. All of us thank Connie for the energy, commitment and love she has offered Healthsharing and the women's health movement for the last 10 years.

Susan Elliott
Alice Grange
Diana Majury
Lisa McCaskell

More Collective Notes . . .

PLAGIARIZE vt [plagiary]: to steal and pass (the ideas or words of another) as one's own; use (a created production) without crediting the source; vi: to commit literary theft: present as new or original an idea or product derived from an existing source.

How is it that when feminists speak so much of respect for one another, we don't credit and respect each other's work? Time after time we have discovered articles and artwork from *Healthsharing* in other feminist and progressive periodicals without our knowledge or consent. Drawings especially have a way of showing up in magazine after magazine with no recognition of the artist. As the definition above (from *Webster's New Collegiate Dictionary*) makes clear, plagiarism is illegal. Our masthead states our policy clearly: "Authors and artists retain copyright, 198_. No part of this magazine may be reprinted without prior permission." Granting authors and artists copyright is very important to us. Although we can't always pay our contributors, recognizing their ability to control future reprinting is one small way that we credit them and value their work.

We say 'thank you' to those of you who do ask. Authors and artists have granted reprinting requests, forwarded by us to them, to numerous publications, e.g. *New Internationalist, The Optimist, Iranian Woman* and Australia's *Lesbian News*. Numerous service and action organizations, university publishers and faculty have also reprinted with permission.

In fact, we can't think of a situation when permission was not granted. We *want* materials from *Healthsharing* to be reprinted far and wide; our artists and authors want the visibility for their work. But we do expect the courtesy of being asked — illustrators and authors should have the right to say when and how work should be used.

The most recent example of work being plagiarized from *Healthsharing* is indicative of much reprinting we have encountered. An editor of a Canadian feminist periodical wanted to supplement a short, general article with "more strongly worded material"; a credit was typeset for *Healthsharing*, but not for the author; that credit wasn't used during paste-up because volunteers didn't know its importance, but paragraphs and photographs from the original *Healthsharing* article were used.

What distresses us most about this incident is the primary reason given by the editor in her letter of explanation to our author. She says, "The reason I did not contact you for permission to use parts of your article was because I had assumed that women working in this field would be anxious to share as much information as possible with other women." What is this? The implication is that the author, not the periodical staff, is at fault! . . . if the author was truly feminist, really cared about women, she wouldn't mind that no one asked her permission to use something belonging to her, she wouldn't mind that no one credited her labour and thinking, she wouldn't mind that no one knew she was sharing "as much information as possible with other women" by having done the research and writing in the first place!

We're not talking about hoarding knowledge; we're talking about basic courtesy and respect. The example cited is all too common. We know that small periodicals and feminist organizations work under restrictions of small budgets, few (if any) staff, and yesterday's deadlines. But we don't think these are any excuse for not finding a moment to telephone or write a short letter. We've become fairly efficient at sending on requests; if you phone, we can give you the phone number of the artist or writer whose work you want to use.

Our volunteer artists and writers work hard for the feminist health movement by contributing to *Healthsharing*. Please offer them, and us, enough respect to ask us first and credit us second. Permissions *are* granted.

Plagiarism is illegal; it's more than that: its unsisterly.

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.'*

Inaccurate Information

I am writing concerning Susan Cole's article, "No Place To Call Home" in your spring 1988 edition. I compliment this undertaking from the standpoint of giving visibility to psychiatrically disabled women. I believe that giving attention to gender issues when considering the chronic psychiatrically disabled is long overdue. However, I must correct a piece of information that was taken from my discussion with Susan Cole for the purpose of this article; information that is inaccurate, was taken out of context and is unjustly inflammatory regarding the staff at the hospital at which I work.

Ms. Cole noted that I am planning a study to examine psychiatric patients' histories of sexual abuse. She presents this endeavor as a direct response to my being "so dismayed by the hospital's inaction" concerning an incident when two females were raped on a ward by the same patient. She notes that

there was no hospital protocol, and that therefore no action was taken. These facts are highly misleading.

The study which I am about to conduct concerns female patients' experiences with physical *and* sexual abuse, with a particular emphasis on these forms of violence in the family. The hospital administration endorses this project and is cosponsoring it with the province's Interministerial Research Committee on Wife Assault. This support attests to the concerns of hospital administration for the particular vulnerabilities of female patients.

During our discussion for this article, the issue of women being assaulted within the hospital during their stay was addressed. I told Ms. Cole that this was not an issue that I intended to address in the research, and advised her that the Patient Advocate at Queen Street Mental Health Centre would be a valuable contact for first-hand information if she wished to pursue this subject. I told Ms. Cole that the Advocate had recently been involved in a case on a ward in which two women had been raped by a patient. I had no first-hand knowledge of this incident however, and so laid no claim to certainty concerning the details and outcome. Since then, I have discussed this event with the Patient Advocate. I understand that a) there is indeed a protocol for sexual assault and b) several actions were taken to protect these women. These included the transfer of the assailant to Penetanguishene Mental Health Centre, a high security facility. I would rather Susan Cole had followed my advice and pursued this information first-hand, rather than disregarding my uncertainty and misrepresenting the facts.

Given the inflammatory nature of the erroneous

statements made by Susan Cole, I hereby request that a retraction be printed.
Temi Firsten
Toronto, Ont.

Susan G. Cole replies: Plainly, there has been a miscommunication regarding the details of sexual assaults at the Queen Street Mental Health Centre. I had never intended to damage the reputation of the centre by incorrectly reporting an absence of policy. Readers should be aware that there was a policy at the time of the incidents of sexual abuse, that action was taken and will be in the future.

More important, it would be truly disastrous if Ms. Firsten's study of female patients' experiences of physical and sexual abuse were jeopardized. Her research is badly needed and endangering the project runs counter to my reasons for writing the article in the first place.

Great Help

I was given a copy of your magazine from the Midwifery Conference "Politics of Midwifery," and a friend lent me a copy of a back issue . . . [with articles] . . . on post-partum depression and toxic shock syndrome . . . very needed issues. I feel your magazine will be of great help in my studies and work of helping other women, mothers and babies.
Karen Mountain
Englehart, Ont.

Kudos

I very much enjoy each issue of *Healthsharing*: keep up the good work!
Madelaine Comeau
Halifax, N.S.

Elderly and Able

Healthsharing is an excellent publication. I found the article by Haley and Hauprich [Winter 1987] interesting, factual and well researched. To-day in my 77th year I am happy, enjoy life, play golf, travel . . . elderly and able — yes!
Mary Hay Connolly
Chase, B.C.

Royal Commission?

In the Spring, 1988 issue of *Healthsharing*, Diana Majury and Connie Clement, two members of the Healthsharing Collective, discussed their views on the Canadian Coalition for a Royal Commission on New Reproductive Technologies. The coalition asked to be given this space to respond, although we would have preferred to be part of the original dialogue. It is essential to stress two points: both the coalition and Majury and Clement approach the technologies from a concerned, women-centred perspective; and we differ on only one aspect of a feminist response — calling for a Royal Commission.

The Coalition was formed by feminists one year ago out of concern over rapidly advancing technologies and the various provincial and federal governments' desires to regulate them, all of which was, and still is, sadly lacking a feminist perspective.

The coalition is run by a steering committee which meets in Toronto approximately every three weeks. The steering committee has a flexible membership with a central core of women who provide continuity, and currently includes women from Toronto, London and Montreal. There are numerous group and individual supporters who lend their names and are contacted on a regular basis through mailouts. There is a healthy correspondence between endorsers and the steering committee for the exchange of ideas and sharing of information. Some of the group endorsers include the

National Action Committee on the Status of Women, Canadian Abortion Rights Action League, the Canadian Advisory Council on the Status Women, as well as various provincial advisory councils and regional women's health organizations.

Marc Lajoie, ministère des Communications du Québec

We are all concerned that any government initiatives on the new reproductive technologies will ignore and further exploit women. We are certainly aware of the inherent risk in women asking the federal government to study issues directly affecting women's control over our own bodies. We have also considered that the government might use us as pawns, appearing to respond to us while actually pandering to the profit-makers and other interest groups. For these reasons, we have been clear from the very beginning that we will only support a royal commission that is comprised of a majority of women committed to women's issues. We have also upheld that the chair of the commission should not be a doctor or a lawyer, nor should the majority of commission members, as these professions have the most to gain from advancement of the new reproductive technologies.

In keeping with our feminist perspective, the coalition has proposed a mandate for the royal commission. We would like the focus of a national study to be on the social implications of the reproductive technologies, as opposed to the legal or medical aspects. We recognize that these technologies change rapidly and, therefore, include an open-ended list to be reviewed including: in vitro fertilization, embryo transfers, prenatal screening techniques, genetic manipulation, sex selection techniques, embryo experimentation and fetal tissue transplants. We would also include an examination of social and legal arrangements concerning the production of children, such as preconception contracts for the production of children (so-called surrogate motherhood arrangements), judicial interventions during pregnancy and birth (the Baby R case), and the commercial marketing of semen, eggs and embryos.

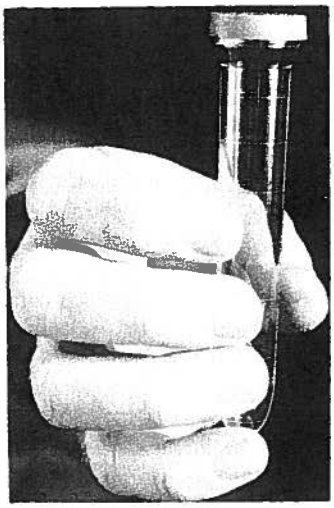
We add that the commission should investigate all of these issues in terms of their separate and joint implications for women, men, the resulting children, other relatives, and the professional or other personnel involved.

Our proposed mandate also makes it very clear that any commission should actively seek input from women's groups, health groups and women, both fertile and infertile.

A critical component of the commission is to conduct an independent research program. Therefore we have called for the commissioning of feminist research on all relevant issues. Wide publication of the findings of the commission is also essential, including interim findings. We have asked that any groups wishing to make submissions be given access to preliminary findings to enable them to remain informed.

Why do we want a royal commision in particular, as opposed to a parliamentary task force or a ministerial study? A royal commission serves several important functions. It will give the new reproductive technologies a high profile across the country and will serve to raise awareness of Canadians of the issues surrounding these technologies. One of our primary purposes in calling for a commission is public education. Canadians are woefully ignorant of the impact of the new reproductive technologies on our changing social structures, and in particular on women. We also hope that such a national study will engender wide debate on the issues, something our very call for a commission appears to have begun in the women's health community.

We are interested in the kind of national forum that a royal commission could provide in order to set national standards for the termination, regulation or development of any new reproductive technologies. There are difficult issues of jurisdiction which should be addressed which arise from the provision of health services, the overseeing of contractual arrangements and prevention through criminal law. Neither a task force or a ministerial study have the same kind of national impact.



Marc Lajoie, ministère des Communications du Québec

There are two other vital reasons for requesting a commission. A commission has the ability to extensively fund research. It also has the power to issue subpoenas in order to gather data from the practitioners of the new technologies such as sex selection clinics. Currently, this data is generally unavailable to independent researchers. Neither task forces or ministerial studies have such broad powers.

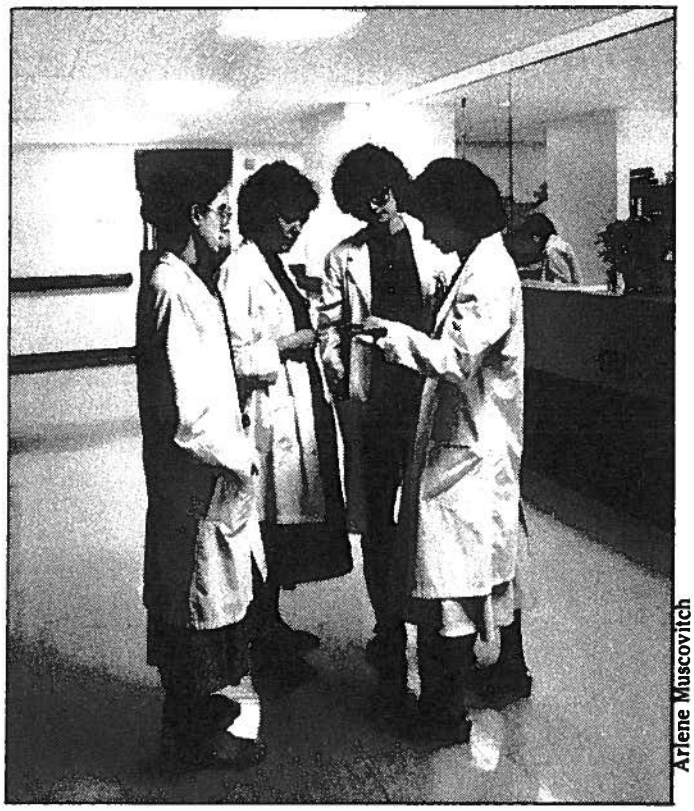
It is true that the technologies are galloping ahead of feminist thought and action. We may not feel ready for the state to act on these issues, but it already is. Ontario is in the process of formulating legislation with very little feminist input. Other provinces are following suit and the federal government is likely close behind. Requesting a moratorium on the most harmful technologies for the duration of a royal commission is a good strategy. The feminist community must discuss, share ideas and information, but we must also act.

Calling for a royal commission is only one response. It is up to all of us to work together to find other effective solutions and develop a concerted plan of action to prevent the exploitation of women through the new reproductive technologies. The coalition is continually receiving input and revising its thinking. A cooperative and quick response to looming state and medical intervention is clearly necessary.

Coalition for a Royal Commission on New Reproductive Technologies

At the recent Annual General Meeting of the National Action Committee on the Status of Women, a workshop on this issue was offered by the Health Committee of NAC and included members of the coalition and Diana Majury. This was another step in open discussion. Start the debate in your region and contribute your ideas to the coalition and to Healthsharing.

UPDATE


Arlene Muscovitch

Promoting the image of nursing

"I don't see a sick person . . . I see someone who wants to be healthy." This was the opening line of a message that was heard over four television networks and printed in most daily newspapers in Quebec during the month of November, 1987, as part of a $400,000 media campaign. The campaign was launched by the Order of Nurses of Quebec (ONQ) which represents 56,247 active members.

The goal of the campaign was to project an image that accurately reflects the primary role played by nurses in the health system which, in the words of the ONQ, is "to help people acquire, recover and/or preserve their good health."

The messages of the ads sought to destroy the image of the nurse as doctor's handmaiden and to promote the autonomy of the nursing profession — "it should be emphasized that nursing is not simply second-string medicine. In opposition to the strict treatment of illness, nursing is involved to a greater extent with health care. Nurses work primarily in the hospital setting but we are everywhere, in local community service centres, community health departments, schools and in the workplace."

Fewer and fewer women are entering the nursing profession and many anglophone hospitals are experiencing nursing shortages. While 12 years ago, the nursing profession ranked third among career choices for women, today it occupies the 91st position. According to some nurses, it will take improved working conditions as well as a better public image to attract and keep nurses in the field.

MARION LOKHORST

Update on abortion in Alberta

In response to the Supreme Court ruling on abortion, the government of Alberta resurrected an old Hospitals Act regulation requiring two medical opinions to approve an abortion. Hospitals defying the regulation will be fined up to $500 a day and physicians will not be reimbursed by medical insurance for abortion procedures.

The provincial government apparently holds the view that therapeutic abortion committees should be disbanded. However, it refuses to penalize three rural hospitals still operating abortion committees, saying, "they more than meet the requirement for a second opinion."

The Alberta Medical Association opposes the government's "obsolete" regulation requiring a quasi-therapeutic abortion committee, arguing the need for consultation on abortion should not be different from any other medical procedure.

Pro-choice supporters have criticized the introduction of more delays in the process of seeking an abortion. The decision to have an abortion they assert, is a private one. Anti-abortionists, on the other hand, favour the limitation though it still falls short of their desire to eliminate the element of choice.

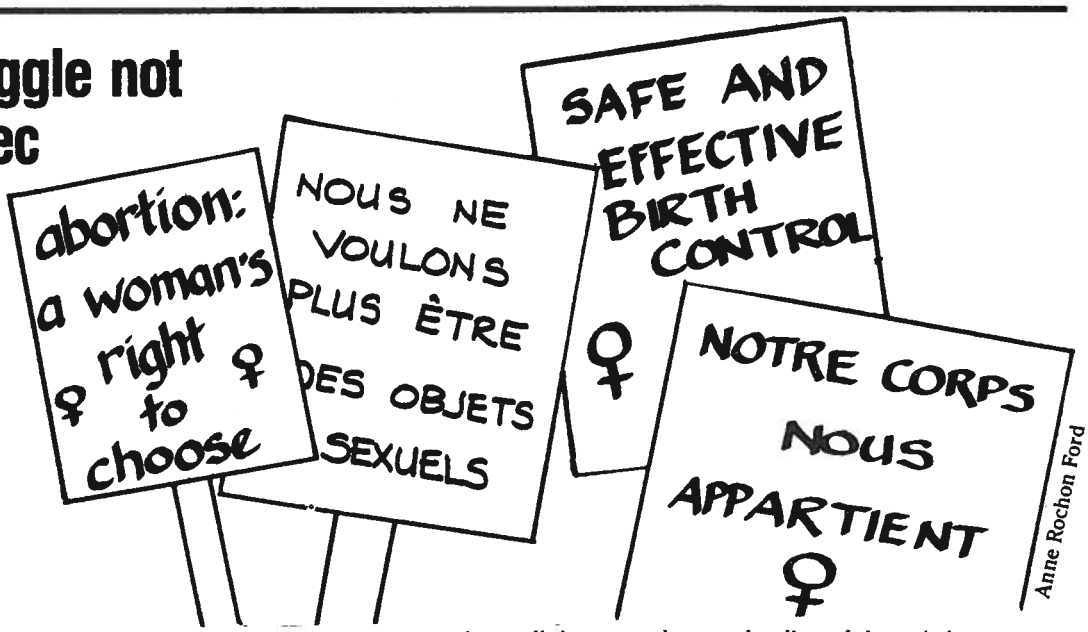
Meanwhile, the province has indicated it will provide $300,000 for a reproductive centre at Edmonton's Royal Alexandra Hospital, through which education, counselling and abortions will be accessible without physician referrals.

ANN GOLDBLATT

Our Cover Photograph

Our cover photograph was taken by Amy Gottlieb, our new managing editor, while she was in the Philippines attending an international conference on women workers in the micro-electronics industry.

Abortion struggle not over in Quebec



Anne Rochon Ford

Women's groups throughout Quebec celebrated jubilantly the day of the Supreme Court decision on abortion. However, it wasn't long before the spectre of the forthcoming battle set in. The day following the ruling, Thérèse Lavoie-Roux, Minister of Health and Social Services, announced that despite the landmark decision, the situation concerning abortion in Quebec would not change.

Although most therapeutic abortion committees have been abolished in Quebec, regional and financial accessibility to abortion are still pressing issues. For example, only 12 of 170 local community service centres, the cornerstone of Quebec's primary health care system, provide abortion services. Twenty hospitals in the province do 72 per cent of all abortions while four women's health centres and a few private clinics provide 20 per cent of services. Private clinics charge between $50 and $900 for the service. In 1988, two new private clinics opened, adding to the historical trend of concentration of abortion services in Montreal and increased privatisation of services.

In the meantime, the pro-choice movement continues to press for improved state funding of the existing women's health centres and the creation of abortion services within local community service centres throughout the province.

MARION LOKHORST

Healthwise . . . with

Healthsharing

Keeping you informed with up-to-date women's health information

Want To Be More Involved With Healthsharing, But You Don't Live Near Toronto . . .

There are lots of ways you can help us, and help yourself by making *Healthsharing* a stronger magazine.

Let us know about upcoming conferences, write a letter in response to an article you loved or hated, offer to staff a Healthsharing display table at a local conference, International Women's Day events or the like. Ask for *Healthsharing* at your local library and bookstores . . . get your friends to ask as well.

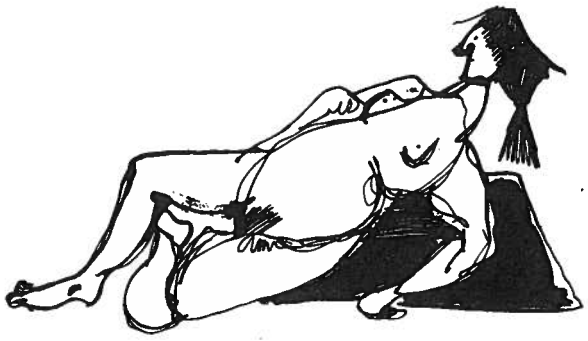
We're currently strengthening our regional reporting mechanisms. Let us know if you'd like to become a regional reporter — tell us about yourself, your involvement in women's health, your writing experience if you have any. As we finalize regional reporting process, working in conjunction with our present reporters, we'll get back in touch with you.

Interested in Writing For Healthsharing?

Have you thought about writing a personal column, or re-working some research into a journalist-style article? Have you been wanting to prepare a piece but weren't sure if we'd accept it?

Drop us a line . . . and we'll send you our *Writing for Healthsharing* guideline. It will tell you what kind of proposal we find best to work with, what steps your proposal goes through once you've sent it to us, and the format we prefer for article submissions.

Chlamydia testing inadequately funded


Dawna Gallagher

Despite the fact that it has become a disease that physicians are obliged to declare in Quebec, not enough is being done to tackle the leading threat to fertility among Quebec women: chlamydia infections. So states a report made public this past fall by the Regional Board of Infectious Disease and the Association of Community Health Departments of Montreal. The report recommends that routine testing for chlamydia, a sexually transmitted disease, be made available for women at risk as is presently the case in British Columbia, Alberta, Manitoba and Ontario.

According to the report, between 1985 and 1986, in Montreal alone, 20 per cent of women from the ages of 14 to 19 and 11.5 per cent of women aged 20 to 24 suffered from chlamydia infections. Often chlamydia occurs without symptoms, yet left untreated, it can lead to infections of the Fallopian tubes, ectopic pregnancies and sometimes infertility.

It is estimated that for the Montreal region, at a cost of less than a million dollars, chlamydia testing could be made available at all levels of the health care system including community health clinics, doctors' offices, hospital centres and university health services. At present, many hospitals do not have adequate budgets to cover the laboratory costs of the test and most doctors' offices do not have access to laboratory testing for chlamydia.

The report stressed the need for increased government funding to cover the costs of routine chlamydia testing as well as making provisions for the test to be available free of charge.

MARION LOKHORST

Abortion in Newfoundland

Hospitals in Newfoundland disbanded their Therapeutic Abortion Committees following the Supreme Court of Canada's ruling which declared Canada's abortion law unconstitutional. The parameters set by the committees had made access to abortion difficult. Of the 46 public hospitals in Newfoundland, only three had abortion committees. Of these three hospitals, only the General Hospital in St. John's held a regular weekly therapeutic abortion clinic. Many women who were able to afford it, chose to go to Montreal or Toronto for the procedure — some to assure anonymity, but many because they did not want to invest a lot of emotional energy and delay the procedure when there was the chance of being turned down by the committee.

Since the dissolution of the therapeutic abortion committees, access to abortion has not increased remarkably. Daphne MacLean, a physician and board member with Planned Parenthood, Newfoundland/Labrador, says "One hospital in St. John's is still performing the majority of abortions; there has been no real increase in access. There are still women in Newfoundland choosing to go out of the province for abortions, mostly for reasons of anonymity."

Although there are no known plans to set up a free-standing abortion clinic in Newfoundland, there is the potential for improved access to abortion within the hospital system. Wendy Williams, Newfoundland executive member of NAC says "there is now the possibility for this procedure to be available in more areas of the province. All our hospitals could now legally offer this service. We know this will not be the case as two hospitals in St. John's have already said they will not allow physicians on their staff to do this. But this leaves 44 hospitals which could." Williams says women will have to find a physician who is qualified and willing to perform abortions. Finding such a person may be difficult since most Newfoundland physicians anticipate negative repercussions if they perform the procedure.

Planned Parenthood is using the opportunity created by the Supreme Court ruling to increase public awareness of the importance of birth control information. MacLean says "Our primary emphasis is on promoting healthy sexuality throughout the life-span. On a long-term basis, we hope to continue our work in birth control and sexuality information. Our intention is prevention."

DEBORAH REDFERN

Women overlooked at aging symposium

There are twice as many women as men over the age of 75 and almost three times as many women as men over 85. The First International Symposium on Research and Public Policy on Aging and Health, held this February in Saskatoon, gave little recognition to the fact that the majority of older people are women. Although this fact was noted by several of the keynote speakers, only one of the more than 85 sessions specifically addressed the needs of older women. Only one of the 11 key note speakers was a woman.

Most women live longer than men, yet accumulate less income over their lifetimes and have less entitlement to pension income when they reach retirement age. Poor women have shorter lives, more disabilities and fewer resources with which to cope. For example, middle and upper class women have a life expectancy of eight years longer than working class and poor women. Women who have never married, who are widowed, separated, or divorced, are financially the most disadvantaged segment of the population — 60 per cent of this group are living below the poverty line.

Women provide most of the formal and informal care in our society. Women often give up or interrupt employment to care for family members at home and in doing so give up future pension entitlement. Women also make a significant voluntary contribution to community service activity.

The main objective of the symposium was to overcome the gap between policy and research by promoting decision making which is based on "the insights of sound research." Clearly, future research and public policy, in discussion and practice, must recognize that aging is a women's issue. Priority and affirmative action must be given now to research, social policy, and legislative changes which will address the problems of women both as providers of care and as older people.

DIANNE PATYCHUK

Nicole Hollander

Dalkon Shield update

For the past 15 years, women have been fighting for compensation for injuries caused by the Dalkon Shield IUD. It is now more than two years since people around the world began to file compensation claims with the U.S. bankruptcy court in Richmond, Virginia. Since then, the court has been gathering and evaluating information, but today women seem to be only marginally closer to a resolution of this issue than they were at this time last year.

On December 11, 1987, Judge Merhige, who is overseeing the bankruptcy proceedings, ordered A.H. Robins, manufacturers of the Dalkon Shield, to establish a 2.5 billion dollar trust fund. No terms or schedule for payment of the fund were set; it was simply stated that the money would be "payable over a reasonable period of time." By January 1988, no information about how the court arrived at this figure or about how the money will be raised or dispensed had been released. Without this critical information the figure is virtually meaningless.

There is however, one aspect of the court order that is immediately clear. It confirms how grossly Robins underestimates the enormity of its liability. The 2.5 billion figure is more than double the maximum estimate of 1.2 billion dollars made by Robins.

The December 11 court order has forced Robins back to the drawing board to develop a way to raise the money. In August 1987, Robins accepted a merger offer from the Rorer Group, a U.S. pharmaceutical company. However, on December 31, Robins apparently broke that agreement and approved an offer from a French company, Sanofi. It seems that Robins is doing everything it can to confuse and prolong the bankruptcy proceedings and is no more trustworthy now than it was in 1971, when it knowingly put a dangerous device on the market.

Robert Manchester, a Vermont lawyer who has represented claimants against Robins for 12 years, estimates that money could be made available to claimants as early as January 1989 or as late as 1990, depending on future buy-out offers and how negotiations proceed. The saga continues.

MAGGIE THOMPSON

Joanne Doucette

Welfare: Far from Well

Bernadine Arsenault

Sometimes you can't eat because every time you sit down to a meal it's like eating money.

Poverty is increasingly a woman's place. In the seventies, feminists said, "Every woman is only one man away from poverty." Now one third of poor households are composed of single older women and families led by sole support mothers fighting to survive on social assistance. Women with disabilities also compose a large proportion of those receiving social assistance. Minority women are much more likely to be poor and the greater number of oppressed minorities you belong to, the greater your chances are to be poor. University of Regina researchers calculated the odds and found that a native disabled woman who drops out of school has a better chance of winning a lottery than she does of getting a job.

Since the 1970s, the number of poor people has increased dramatically in Canada. Inequality has increased. The bottom 20 per cent of Canada's population gets 3.6 per cent of all income; the top 20 per cent gets 43.3 per cent. The rich get richer, the poor get poorer. They get the Club Med; we get the rescue missions. A permanent underclass of single mothers, racial minorities, seniors, unemployed youths and disabled people is evolving.

Poor people have much higher health risks and reduced access to health care. According to the Ontario Advisory Council on the Status of Women in its brief to the Ontario government on sole support mothers, "Poverty is the single most important factor in the perpetuation of ill health in our society."

There are three factors which contribute most to ill health for poor women — hunger and malnutrition, unhealthy environments, and stress — according to the National Anti-Poverty Organization (NAPO). Stress produces cardiovascular disease, infections, and cancer and drives us into addictive and unhealthy coping tactics like smoking, alcohol and drug abuse, and over eating.

◆◆◆◆◆

People who live below the poverty line (euphemistically called the low-income cut-off level) spend 58.5 per cent of their income on the bare necessities: food, shelter and clothing.

◆◆◆◆◆

Deborah Sharpe of Low Income Families Together (LIFT), a Toronto based self-help group of low income women, says: "Welfare mothers develop a weird kind of anorexia. Sometimes you can't eat because every time you sit down to a meal, it's like eating money."

If poor people get cancer, our survival rate is 10 to 15 per cent lower than the affluent. We are more likely to get cancer because many poor women are forced to live near factories spewing industrial pollution, mercury, lead and other dangerous chemicals. We suffer from accidents and disease caused by the poor housing and wretched neighbourhoods, and from the overwhelming stress of fighting for day to day survival, all of which can contribute to a depressed immune system. We do not get enough protein or fresh fruits and vegetables. We live on cheap empty calories and suffer from malnutrition, obesity and anemia. Our children, starved in the womb, have low birth weights, increasing their odds of having physical and learning disabilities.

Hunger robs poor women of their ability to "interact with the environment so as to enhance their health," as NAPO puts it. Usually the housing we live in is poorly maintained by slum landlords, public or private, who do not maintain their premises or respond to our demands for improvements. Stairways are unsafe. Lighting is poor. For many, especially those of us in rooming houses, there are poor cooking and bathing facilities. It is hard to keep clean and eat properly in such circumstances.

We have reduced access to health care because of cost. User fees, incomplete coverage by drug plans or services and the indirect costs of getting health care (such as costs of transportation and childcare) are effective barriers. For example in British Columbia, only one-half of the quarter-million people on welfare receive automatic medical coverage. In Saskatchewan, some recipients must pay the first $125 of drug costs a year. In many provinces, because reparative and preventive dental care is not covered, recipients must have their teeth pulled with destructive results for self-esteem and nutrition.

We have no access to alternative health care because it is not covered under health plans and most sliding scales start so high that they slide right by us. The attitudes of mainstream health care providers are effective barriers for poor women. "Doctors," according to Jane

◆◆◆◆◆

Over 60 per cent of female-led, single parent families are poor.
Single mothers are five times as likely to be poor.

◆◆◆◆◆

Bremner of Opportunity for Advancement, "often give totally unrealistic advice." For example, they will tell a sole support mother with three children and a bad back to spend a week on bed rest or, if she is depressed, to take a week off and go on a holiday somewhere nice.

Too often efforts to help us or improve our health are moralistic or simplistic. They do not recognize the realities of poverty. Health promotion literature is written in jargon or at a literacy level of university. Programs are planned by people who have never been on social assistance and have little direct communication with us. They do not know our needs or believe us, or even ask us. Health promotion efforts aimed at us talk about better budget planning, better meal planning and more exercise. They do not look at our living conditions, the environments we endure, and our lack of choices. They are middle class solutions for poor women's lives. They don't work.

One disabled woman says, "It's a deadly curse." Her only escape from social assistance would be, in her opinion, to "marry a rich man."

The amounts paid by social assistance are simply inadequate to live on. You either pay your rent or you eat. You can't do both. Most often adequate food is given up for housing, perpetuating malnutrition and all the health problems it leads to. As well, recipients are often intimidated and unaware of their rights to health benefits and nutritional subsidies. Too often workers refuse to supply basic information or do not have access to the information themselves. Often there is no printed matter to explain rights, benefits, etc.

Many social assistance recipients are talented survivors. No one knows budgeting better than a mother on social assistance. They get the best they can out of an intolerable situa-

tion. But woe betide you if you are shy, unable to speak English well, illiterate or so depressed you can not stand up for yourself.

The petty indignities of bureaucracy can drive one to despair almost as quickly as the gross injustices. Welfare workers often act as if the money was coming out of their own pockets and treat recipients in contemptuous and humiliating ways, concealing information and even lying. It is a common conviction of recipients that the system lies to them. Workers can buy into the negative stereotypes and treat us like dirt. They can get burnt out and pass their resentment for their poor working conditions onto us. They can get burnt out by the sheer pressure of huge caseloads and inadequate resources and settle for a dehumanized approach to poor women. Victoria Hilderman, President of OPSEU Local 586, a union local for fieldworkers, says, "The case loads are so high that it is almost impossible to give high standards of service to our clients."

Yet many welfare workers *are* sympathetic to the needs of their clients. They know what is going on, but their hands are tied by regulations set from above which do not recognize the realities the worker sees every day. Worse, management watches caseworkers carefully to weed out the "shit disturbers" or those who too vocally point out the inadequacies of the system. The social welfare system, according to one former worker, "is not a neutral place." She was working very closely with a poor woman's self-help group and found herself under police investigation. Management had tagged her as a subversive.

Those on social assistance often see social welfare workers as "soft cops" whose job is to regulate us — not serve us or protect us from poverty. We think they are mostly there to look for "welfare cheaters." They walk into our homes without a momen'ts notice, looking to see if there's a man around. Yet if the workers are "policed", is it any small wonder that those at the very bottom live in fear.

Often government departments which are supposed to assist us do not communicate with each other, and recipients have to go through endless red tape to get what is needed immediately. One woman who uses an electric wheelchair woke up one morning with a dead battery. She spent three days trying to get her caseworker on the telephone. The line was always busy. It took her worker another month to process the red tape before the disabled woman could get a new wheelchair battery. For all of that four weeks, she sat in one spot looking out of her window, completely robbed of mobility and independence. Cruel and unusual punishment. But for what was she being punished? For being disabled? For being on social assistance? For being poor?

Most women on welfare or social assistance are very well aware of the barriers within the system to our full social and economic equality and participation, but very tired of individually challenging the system. Things have not improved since the Royal Commission on the Status of Women in 1970 met with low income women. Those women spoke of inadequate housing, poor nutrition, health problems, chronic illness, lack of education and training, the high cost of living, stress, lack of day care and decent jobs. Poor women's group organize, fight for equality and die slow or fast deaths. Outside the mainstream of feminism, without money or prestige, without operating funding or support, it is an uphill battle against hopelessness. We resign ourselves to perpetual, permanent poverty. In a competitive economy which values maleness, youth, physical perfection and white skins, someone is designed to be the losers and it's us — "poor sisters", sole support mothers, disabled women, older women without men, native women, immigrant women, women of colour and women in the north and rural areas.

Sometimes we feel that the affluent and powerful wish poor women to simply die quietly behind closed doors. But then who would clean their toilets?

This is written from the "we" point of view. It was the concensus among low income women I talked to and the women that work closely with them that the "objective" narrative voice so often used by middle class writers helped to distance them from poor women. Usually middle class women speak of women's issues in such a way that "women" really means "women like us", that is, middle class women. The use of "we" is to challenge the use of language to obscure difference and, also, to recognize the input from women on social assistance, fieldworkers, and women working in health care.

Joanne Doucette is a feminist philosopher, writer, cartoonist, library board trustee, lecturer and social welfare recipient.

What Can You Do?

While researching this article, Joanne Doucette spoke with Deborah Sharpe of Low Income Families Together.

Joanne: Is there anything the readers of *Healthsharing* could do to improve the situation for women on social assistance?

Deborah: Keep an eye on the rich. There are lots of studies done about poor people, but no one gives a long hard look at the rich — at who's got money, how did they get it, what are they doing with it? Middle class women can do this better than welfare mothers. We need to know this information.

Support grassroots initiatives by poor women to organize themselves. Give money. Do child care so women can go to meetings. Provide attendent care for disabled women. Do the shitwork and the nitty gritty stuff like typing. Leave the glory to us, visiting the politicians, speaking publicly, dealing with the media. We can speak on our own behalf.

Assess your own lifestyles. How much of the world's resources are you using. The poverty of women on social assistance profits the middle class. Poverty is no accident. It is not something you "fall into." It is the result of our economic system.

Christina Lee

Not Quite a Refuge:
Refugee Women in Canada

"Thousands of refugee cases reflect the pain and suffering of someone disappeared or a member of the family tortured or killed on the streets of our beautiful country. Now I ask myself when will it all be over, when will we be able to live in peace with some freedom," says Maria Rosa Ramirez from Toronto's New Experiences for Refugee Women (an agency assisting Latin American refugee women).

The past decades have seen a dramatic restructuring of Canadian society. Since the Second World War, almost half a million refugees have settled in this country. In the recent years, the majority of refugees have come from Third World countries, mostly in Southeast Asia, Latin America, and Africa. Many new refugees arrive in Canada with little or no ability in either French or English.

Before arriving in Canada, a refugee may have spent a period of anywhere from six months to two years in transit from country to country. Particularly for those from Third World countries, this flight to asylum has been preceded by months or years of war, persecution, and torture in their country of origin.

The physical and psychological effects of a prolonged process of terror, migration, and resettlement are well documented. The difficulties are especially pronounced for Third World women, for whom the sense of cultural, socio-economic, and sexual dislocation is most extreme. Despite the diversity of their cultural and socio-economic backgrounds, refugee women tend to share a common thread of experience — that of escaping from life-threatening circumstances, and being forcefully dislocated from family and homeland. Many are widows or single parents, others are unaccompanied minors. Before arriving in Canada, many women are subject to physical and sexual violence, family separation and death, or long stays in refugee camps with little protection. There is also the "double back" effect which occurs in many cultures when the violated women are considered worthless by their own families. In addition to the loss of homeland, the physical and psychological scars of torture, violence and deprivation may make it very difficult for refugee women to adapt to their new country.

The undeniable benefits of safe political asylum, better health care and education are often largely outweighed by difficulties created by lack of language skills, relevant work experience, and problems of educational accreditation. These sobering realities are often compounded by family responsibilities, social isolation, and the loss of self-esteem.

It is in this context that the plight of refugee women in a predominantly white society must be understood. Three factors define their situation. They are disadvantaged because they are women, because they are often of a different racial origin (and therefore visibly different), and because most of them come from either uneducated or highly educated backgrounds, both of which pose many employment difficulties.

A further complication arises because many of these women arrive in Canada as "sponsored class" immigrants. This entry category enforces their dependence on their sponsors, who may be their spouses, for a period of up to 10 years. During this time they are not eligible for some of the major subsidized language training (for example, the federal government language training with six month allowances), legal aid, or social assistance.

All these conditions combine to cause physical and mental health difficulties for refugee women. Depression is high among refugee women. Other stress-related problems include anxiety, psychosomatic disorders, insomnia, and menstrual irregularities. These symptoms often tend to go un noticed because of the deeply rooted reluctance to let outsiders know about personal problems. Some develop homesickness or guilt feelings at having survived and left their family behind; others resort to self-inflicted injuries or suicide. Some develop paranoia and great fears of authority as a result of escape from military governments or police states. Most women have a fear of the future, coupled with a general sense of hopelessness and helplessness. They feel that they have no control over their lives. Others are

Barbara Pasternak

preoccupied with raising large families as a response to witnessing complete genocide.

The problems of adapting to a new society are increased by the extreme dislocation of traditional family roles. Domestic change may manifest itself in marital and other family conflicts, worry about the future, and underemployment. A recent Montreal study of Vietnamese refugees revealed sudden role reversals within families. Housewives and school children were forced to assume the role of primary economic providers, as their husbands and fathers were lamenting the loss of occupational status or properties in their homeland. Due to the time constraints of having to work several jobs outside the home, the women were progressively unable to fulfil their traditional duties of mothers and housewives. At the same time, the men were displaced from their traditional dominant role as the breadwinner of the family and were having difficulties finding jobs.

Other reports on refugees in the United States also indicate that while men tended to be most concerned with problems of finance, employment and learning the language, women were more concerned with such domestic problems as conflicts between spouses and children, and the often present threat of physical violence. The sharp contrast in women's roles between Western and non-Western cultures becomes a major stress when entry into the work force exposes the women to values that are diametrically opposed to that of their traditional cultures.

The problems of adjustment are further compounded when women move from the relative isolation of traditional home-based work to a highly socialized and industrial work force. As low-paid, nonunionized workers in such fields as the garment and service industries, they are subject to long hours, poor working conditions, and often to employers who display a flagrant disregard for occupational safety and employment standards. Illegal refugee women who fear being deported are placed in vulnerable and exploitative situations.

There are a number of barriers to refugee women seeking help from health care and social services. Many cultures attach a stigma to mental illness. Family pride and the fear of deportation prohibit the discussion of domestic and personal problems. Other barriers include a lack of familiarity with available services and the skills to access these services.

Currently, mental health needs of immigrants and refugees are served by community-based services in four relatively distinct service sectors. These include settlement agencies such as the Ontario Welcome House; multicultural or immigrant women's agencies, such as MOSAIC in Vancouver or the Calgary Immigrant Women's Centre; and ethnospecific mental health services (for example, Toronto's Hong Fook Mental Health Service for the Chinese and Southeast Asian refugees); as well as such mainstream institutions as Public Health Departments in Toronto, Vancouver, and Edmonton. However, non-English-speaking refugee women seek help from community centres or immigrant women's agencies which are staffed by ethnic community workers or paraprofessionals who are sensitive to their needs.

But what happens when these women turn to health professionals for help? A 1979 study showed that if an immigrant woman approaches her doctor with complaints of nervousness, headaches, and abdominal pain as a result of stress, the physician is likely to prescribe valium, sleeping pills or tranquilizers. Since most mainstream agencies or hospitals have no trained interpreters or bilingual/bicultural counsellors, the patient can generally expect to receive nothing more than medication or custodial care.

"If family violence occurs, women are further traumatized when they resort to emergency shelters," states Marilee Reimer, who researched

immigrant women's use of these shelters. Since most shelters are developed for English-speaking clients, there are no trained multilingual staff. When immigrant and refugee women stay in a shelter, they are often forced into a dependent role, not being able to function or articulate their own needs. With the exception of Toronto's Shirley Samaroo Immigrant Women's Shelter, most regions of the country do not have suitable facilities with multilingual staff. In the case of sponsorship breakdown and wife assault, women are placed in extremely vulnerable situations legally and economically.

Most professionals view the mental health problems of refugee women — of all immigrant women, for that matter — in terms of adjustment difficulties created by the conflict between the women's cultural background and their new environment. Positive mental health is conceived primarily in terms of white, middle class values, such as individual fulfilment, competence, and resistance to stress. This definition places the onus of blame on the individual's inability to cope with her new situation. Psychological problems of the refugee women are attributed to clash of cultures. The assumption is made that problems will be overcome once the woman and her family learn to adapt to the demands of (white, middle class) Canadian culture.

Refugee women who have been tortured have a past that is exceedingly vivid and painful. Often, professionals react to stories of torture with suspended disbelief or suspect exaggeration. Rather than discounting such important experiences, it is essential to validate them and to encourage refugee women to work at resolving their feelings. In addition to the lack of understanding of their past, most professionals tend to overlook the realities of the lives of refugee women, including language and employment barriers, and racial and sexual discrimination.

Many counsellors are unable to counsel effectively because they don't understand their clients' backgrounds. There is also a shortage of professional translators. Often, interpreters are recruited from the ranks of clerical and cleaning staff. Women's husbands or children are sometimes assigned the responsibility for translating personal and family problems. It is unrealistic to expect a young child to translate the complexities of family relations, and equally unrealistic to expect the husband to objectively translate marital conflicts.

Current mainstream services are not able to serve refugees adequately. Most services are plagued with little in-service training, which if appropriately provided, would help develop the cross cultural understanding and skills of people working with refugee women. On the other hand, services which are sensitive to these women's needs, ethnospecific and immigrant women's agencies, are constantly struggling with unstable and insufficient funding. Most agencies lack adequate staffing and resources. Ethnic counsellors and paraprofessionals may have the cultural sensitivity, however, they are often placed in extremely responsible and stressful positions, having to cope with crisis situations with minimal supervision and training.

Only with a concerted effort and cooperation at all levels (individual, community and institutional) can the needs of refugee women be appropriately addressed. As Sharon Rusu (from the United Nations High Commission for Refugees, Ottawa Branch) emphasizes, the needs of refugee women should be considered "as distinct from men, . . . as workers and mothers, as heads of households and providers, and not exclusively as victims . . . ; but as individuals with special roles, special strengths, and special responsibilities."

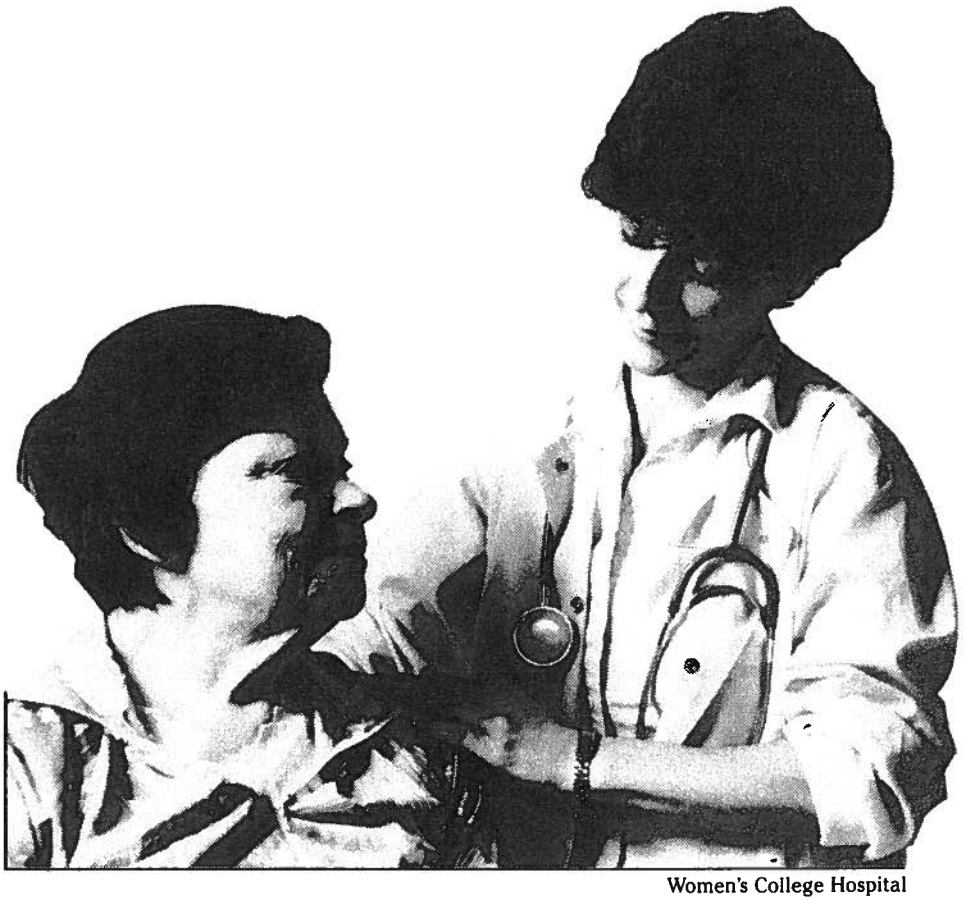
Dr. Christina Lee, psychologist, is currently a Policy Analyst with the Ontario Women's Directorate. In addition she is a member of the Federal Task Force on the Mental Health of Immigrants and Refugees. The opinions expressed here are her own.

What can we do to assist refugee women?

- Existing services must be changed and expanded to meet the needs of refugees and to accommodate to the changing multicultural reality of Canadian society.
- This improvement of services must involve both the co-ordination and development of existing resources, and the development of new services where necessary.
- Refugee clients must have equal access to all services, including multilingual outreach and information on existing services.
- There should be development and distribution of culturally-sensitive health and mental health related materials, for example, brochures and audiovisual aids.
- Present services should incorporate bilingual/bicultural professionals and the use of volunteer resources within the respective communities.
- It is important to develop culturally sensitive mental health programs for refugee women, taking into account their experiences, the need for child care, transportation, and flexible hours of access.
- Alternative support structures should be developed to help compensate for the loss of the extended family. These could take the form of self-help support groups or peer counselling services. Such groups provide an opportunity for women to share common experiences and lessen their sense of social isolation, while encouraging them to make positive changes in their lives.
- It is crucial that refugee women themselves participate in the planning and development of programs, so that the mental health services offered truly reflect *their* needs and priorities.

Pat Armstrong

Where Have All the Nurses Gone?



Women's College Hospital

Across the country nurses are making the headlines: the recent strike by the Alberta nurses union, the severe nursing shortage in Ontario, and the continuing aftermath of the Grange Commission inquiry into the deaths at Toronto's Sick Children's Hospital. What is happening to nursing?

Recent media coverage focusing on the nursing shortage has blamed governments, hospitals and educational institutions for lack of planning. The argument goes like this. With the massive introduction of new technologies requiring special skills, more skilled nurses are needed. At the same time more nurses are needed to care for the growing numbers of elderly filling hospital and nursing home beds. The colleges and universities have failed to prepare a sufficient number of nurses to meet the demand.

But nurses are finally making themselves heard. And theirs is a different story. It suggests a much more fundamental problem — one that is much less easily solved. For nurses, the problems stem from deteriorating working conditions: the emphasis on tasks, not on caring for people, the long shifts and most importantly the lack of power. Nurses are held accountable despite having little control over their patients' care or their own working conditions. The most blatant example of this combination of blame and lack of authority is the recent Grange Commission.

In this inquiry into the deaths at Sick Children's Hospital in Toronto, nurses alone were interrogated about their performance. This happened in spite of repeated suggestions from nurses that low staff ratios and the limited time spent by high-risk children in intensive care were endangering lives. Nurses were prime suspects despite the fact that they were the first to draw attention to the alarming rise in deaths.

The subordinate position of nurses is not new. But the caring work of nursing is being transformed, making it increasingly difficult for even the most dedicated nurses to stay in the job full-time. In our study of a large metropolitan hospital in Quebec, we spoke with hospital workers about their work experience and examined the overall changes in hospital structure. This article presents some of our preliminary findings and explores the ways in which these changes are impacting on nurses and the nursing profession.

Hospitals are cutting costs and increasing managerial control. Nurses' work has become both more intense and less satisfying. They are working harder for fewer rewards. According to one nurse in our study, "You don't have time to talk to patients. Your work is much more compartmentalized. You do this and then you do that and then you do that." "Work has triplicated," said another. The job is

HEALTH WANTED

Lesbian-Positive Obstetrician

We would like to find an obstetrician in the Toronto area who would be supportive of a lesbian couple, and we'd like to hear from other lesbian couples who have had this experience, as this is our first child "together." We are looking forward to a natural birth within a hospital setting. Please write: Joan McKenzie, 83 Albert Ave., Apt. 5, Toronto, Ont. M8V 2L6.

TIPS

Adverse Drug Reactions

Consumer experience with adverse drug reactions has been notoriously unheeded in Canada. However, there is a federal program to document reports of adverse reactions to drugs, vaccines, cosmetics or food products. If you have experienced an adverse reaction, write to Adverse Reaction Program, Product Related Disease Division, Health Protection Branch, Health and Welfare Canada, Tunney's Pasture, Ottawa, Ont. K1A 0L2.

Fever Relief

According to the *American Journal of Diseases of Children*, a feverish child should not be sponged with rubbing alcohol. Nerve damage including unresponsiveness, coma and in rare cases death, can result. They suggest using water only, either on a cloth or in a warm bath.

fragmented into a series of discrete tasks, the work involves "more doing things to people, not for people." There is litte time for the caring work that nurses have learned to do. Under such conditions, it is not surprising that there is a shortage of people willing to take up or stay in these jobs. With short patient stays and heavy workloads for the caregivers, nurses and patients have no time to get to know each other. Patients leave long before they have made significant progress toward recovery. Consequently nurses not only work harder, but, as one nurse explained, nurses "no longer feel that they have helped patients get better and that was the satisfying part of the job, that made the rest worthwhile."

Both the intensification of the work and the alienation from the patients are reinforced by the increasing use of part-time workers, registry nurses (nurses who work for an employment agency), and "floaters". Nurses are allocated according to a formula based on time-motion studies of nurses' tasks. With this formula, administrators calculate the minimum number of nurses required in each area. Part-time, registry and "floating" nurses are used to fill in gaps, ensuring that there is no slack in the system. Gone are the days when nurses could relax their pace because fewer babies were born last night. Fewer babies means fewer nurses. The application of the formula and the manipulation of personnel have been made possible by the new microelectronic technology, which simplifies scheduling, payment and hiring.

When nurses work part-time or with a registry, they seldom follow their patients through their hospital stay, making it difficult to develop any rapport. Nurses request temporary assignments as a means of creating variety in their work or as a way of escaping close supervision. For many, it is a strategy for coping with their jobs at home. But these nurses are pressured to work very hard in shorter hours and often derive little satisfaction from the care of patients. In addition, workers who travel from ward to ward have few opportunities to develop relationships with other nurses. They often eat lunch and take coffee breaks alone and seldom gain the support and stimulation that long-term relationships on the job can provide.

The increasing use of part-time, registry and "floating" nurses also has consequences for the nurses who work regularly on a particular ward. Regular duty nurses spend more time training and introducing those temporarily assigned to the area, leaving all nurses with less time for patient care. Furthermore, it is difficult to develop team work and group morale when the work force is constantly changing. In this situation nurses share less and have fewer possibilities to get together to organize for change.

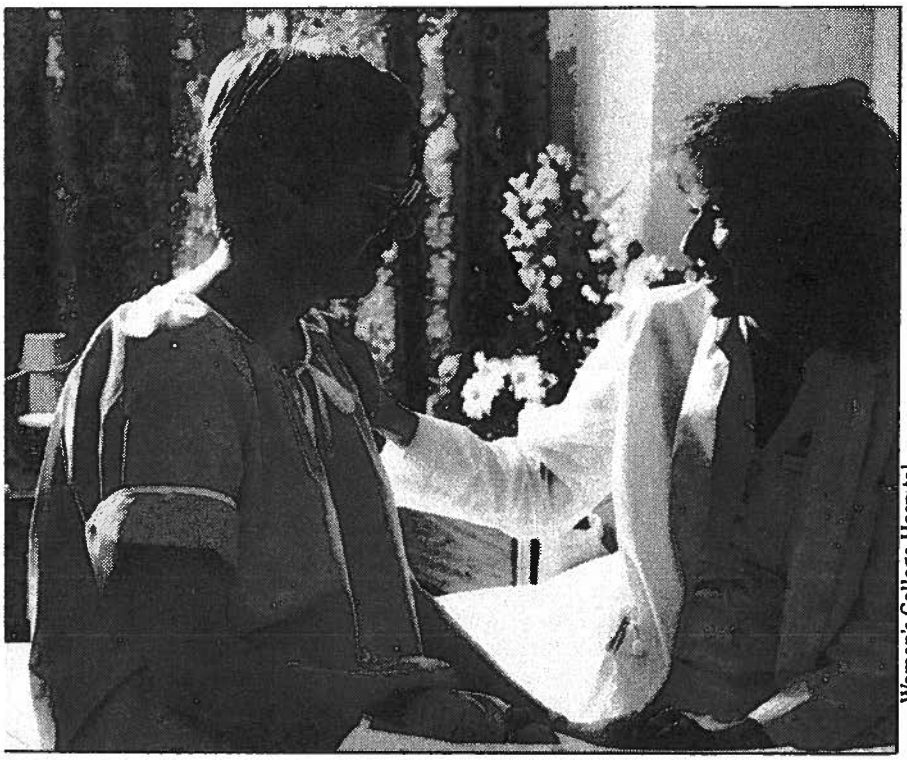
Cutbacks in capital and operating expenses mean that nurses spend more time soothing patients angry about waiting in halls, and more time searching for equipment and materials. Those we interviewed had tales of trading sheets for hospital gowns, of running upstairs in search of extra syringes. Such shortages result in both more tension and less time for patient care.

Efforts to save money have also led to reductions in non-nursing personnel. Many of the nurses aides and orderlies have been dismissed. There have been significant staff reductions in the laundries, kitchens and offices. It is nurses who have to take up the slack; nurses who move the gurnies previously moved by orderlies and who change the beds previously changed by nurses' aides.

Not only has the workload increased, but the new technologies are transforming the nature of nursing work. Some of the new equipment requires new skills and knowledge, making the job more challenging. But much of the technology reduces the skill required which often means the work is less interesting and rewarding. For example, nurses no longer have to read thermometers. They simply have to record the digital readout. In some cases, the technology is simplified to such an extent that patients or patients' relatives can do the monitoring. Like self-service gas stations and banking machines, the equipment allows clients to do the work themselves. Even when particular skills are necessary to operate and monitor equipment, nurses frequently find the job less satisfying because they

are "tending machines not patients." And some of these new machines can be used to monitor nurses' work speed and volume.

Patient care isn't the only aspect of nursing being affected by technology. The ways in which nurses document their care is being computerized. Computer terminals are being installed in nursing stations to record nurses' activities and patients' conditions. This produces more noncare work for nurses to do and greater possibility for error.



Women's College Hosp tal

The emphasis is on tasks not on caring for people.

Errors are particularly likely when a nurse is working on an unfamiliar terminal at the end of a 12-hour shift.

Cost cutting and new technologies have also contributed to the growing numbers and increasing powers of nonmedical administrators in the health care system. Consequently, health care workers find that they must respond to two bosses: doctors and managers. With lines of authority not always clear, nurses often find themselves caught in the middle.

These changes in the organization of nursing work have played a part in growing numbers of nurses suffering from what is diagnosed as burnout. Often defined as an individual problem that can be treated with therapy, diet and exercise, burnout frequently has more to do with the structure and process of work than to individual failures or habits. The increasing incidence of burnout is also related to the fact that most nurses are women. In the past, only single women without family responsibilities worked in nursing full-time. Most nurses were young and stayed in the job for a short period of time. Now more and more women with children and other domestic responsibilities remain in nursing. Many have agreed to take on the exhausting 12-hour shifts because these schedules allow them more days off to do their work at home.

Changes in nurses' training — changes which reflect management strategies, new technologies and nurses' demands — divide nurses from each other and increase tensions on the wards. Some nurses are trained entirely in hospitals, some in colleges, others in universities or management schools. With such varied background and different possibilities for promotion, team spirit is difficult to develop.

Nurses are responding individually to these transformations. They switch to part-time, registry or "floating" work, or they drop out of nursing for years, even for life. Many are retraining for other jobs. Nurses' collective response is, to some extent, limited by these individual solutions as well as by management strategies designed to hire more part-time workers and to move full-time nurses around. But nurses have made gains. They have won some significant improvements in pay, power and conditions of work in the post-war years. Current trends in the organization of work and the consequent shortage of workers may well strengthen nurses' opposition, leading to new directions in the organization of work. The recent strike by Alberta nurses clearly indicates nurses are prepared to put up a fight.

At the same time as new management strategies are creating the conditions for rebellion, they are also creating the possibility for signficant improvements in work. The new technology has the potential to free nurses' time, allowing them to care for rather than to do things to patients. Primary nursing, which makes nurses responsible for the total care of patients, could expand the job in more satisfying ways, making it possible for nurses to employ their expertise and to develop a relationship with their patients. Whether this potential will ever be realized will depend, to a large extent, on nurses' collective response.

Pat Armstrong is a teacher, writer and researcher currently teaching at York University. Her research focuses on women's labour in the home and in the workforce. She and her research partner Hugh Armstrong have just finished their study of working conditions and overall structure in a large metropolitan hospital in Quebec.

MY STORY, OUR STORY

Organizing Homeless Women

Members of Women for Change

Flip through a magazine, or a local newspaper. Watch the 6 p.m. news, or listen to the radio. Walk into a bus shelter or drive along a street in any downtown core. How long does it take before you notice that homelessness is fast becoming a Canadian vogue? Politicians talk about it. Journalists write about it. And social planning councils in nearly every urban centre from St. John's, Newfoundland to Vancouver, B.C., compile statistics about it. But it is time for all these institutions to move over because there are those of us who think, write and talk homelessness because we've experienced it and we want to change it.

We are Women for Change, a Toronto-based group of women who believe that the health problems of the homeless are rooted in our country's system which proclaims that profit comes before people. In the next few paragraphs we will tell our stories about ill health. These stories range from having a cold to dying on the street. The point is that every moment of unhealthiness in our lives erodes our mental and physical capacity to survive. It is this kind of lifekilling cycle that we, as Women for Change, want to break.

In 1985, Marie Demers lived in a Toronto rooming house. She had been suffering from a bad cold compounded by lack of sleep because the radiator in her room was broken. The feistiness of Marie gave her the courage to confront her landlord. Instead of fixing the radiator, he "fixed" Marie by evicting her for making such a ridiculous demand as adequate heat. Now, in a state of constant paranoia, Marie continues to roam the streets of Toronto.

Evelyn Glentinni still lives in a rooming house which also has broken radiators. She too suffers from flu problems and lack of sleep but is afraid to confront her landlord because he had previously raped her. She would not receive the complete eviction that Marie did because roomers are now protected under the Province of Ontario Landlord and Tenant Act. Since June of 1987, landlords of roomers must now abide by the same eviction standards that other tenants have had for years. Even so, Evelyn's landlord beats her and abuses her. It's no big deal if he loses her. His rooming house, broken radiators and all, is still in great demand. There are lots of people desperately waiting to take her room at any cost.

In fact, vacancy rates in many Canadian cities are extremely low. For example, in 1987, for every 1,000 rooms or apartments in Toronto, only one was available for rent — and that one was rarely affordable! A song written in the fall of 1987 for Toronto's No Place Like Home conference, a meeting where over 300 homeless people joined together to share their experiences, echoes the tragedy of Evelyn's story:

Evictions still are happening
Please don't be deceived
There are landlords fucking women
Who have no choice to leave
People in the streets
No place to call home
No money for more housing
But plenty for the dome
Cate Friesen, Capac 1987

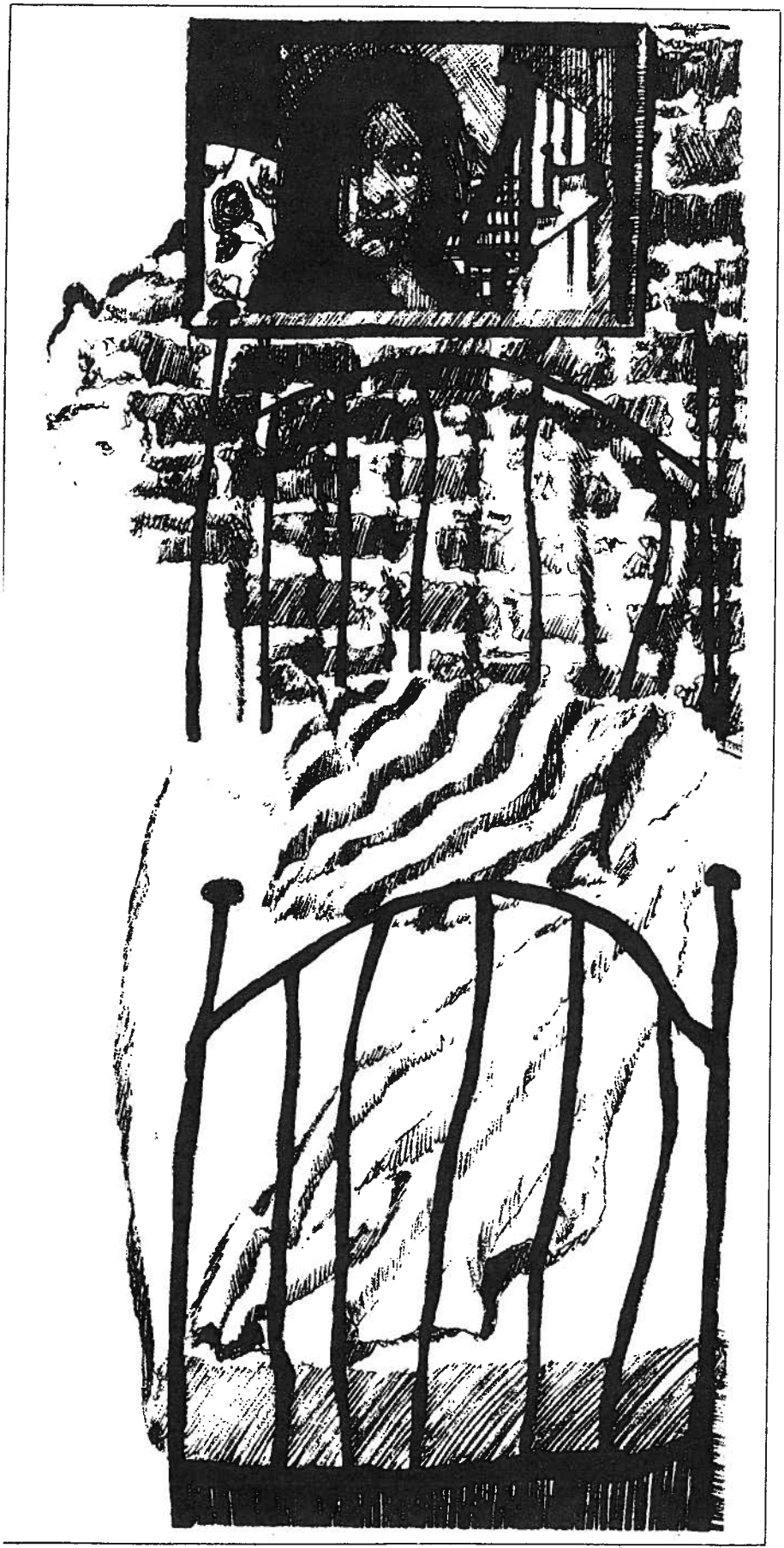
Lori Malabar sleeps outside on the damp concrete directly underneath a bridge. A persistent cough developed but only after a number of weeks was she diagnosed with tuberculosis. Lori's wet living situation, when combined with poor diet and polluted air, infected her lungs. The medical treatment for "the shades" (tuberculosis) takes one to two years. But basic survival for food and shelter, which Lori faces day in, day out, makes it extremely difficult for her to fight this disease. It is common knowledge on the streets that the disease spreads through hostels and soup lines. In 1987, a report made official to the Toronto Board of Health the horrific statistic that "184 cases of tuberculosis were found in the city." That means a rate of 31 cases per 100,000 people. For Ontario the rate is around 10 cases per 100,000. In the downtown core of Toronto, where the poor and homeless are, the 1987 rate for tuberculosis was 60.3 per 100,000.

Nirmalla Somwaru, a member of Women for Change, has a cough too. This cough, however, is not related to tuberculosis, but to the dust and dirt of hostel living. "You can take a shower in most hostels," Nirmalla says, "but you have to put on your old dirty clothes — most hostels don't have washers or dryers." Keeping clean is also a problem for women living in rooming houses. Many roomers don't have access to privacy because the landlord refuses to put locks on the bathroom doors.

Being dirty is not the consequence of bad habits or because of personal choice; rather it is an outcome of the conditions women are forced to live in. Subsequently these unsanitary conditions cause infections of cuts and sores, coughs, skin problems, vaginal infections and low self-esteem. When cleanliness is next to impossible on the street or in a hostel or a crowded rooming house, self-confidence hits bottom in a society which proclaims that cleanliness is next to godliness.

Homelessness means ill health. Ill health means we die earlier. Here are a few stories of women we have known who have died. Their stories are similar to the hundreds of us who die each year. Their deaths were caused by homelessness.

Bonnie Gallagher depended a lot on the protection of men. Living in the insecurity of rooming houses and the exposure of the streets, combined with social and economic pressures, force many women to be dependent on men. This drove Bonnie to a dependence which at times turned on her. In the summer of 1987, Bonnie was found raped and unrecognizably beaten to death.



Barbara Pasternak

A number of months later, Carol-Anne Charest was found dead. She had been living in an abandoned truck and had to drag her belongings from place to place because she couldn't lock the truck door. In the meantime, she lost her medication which resulted in a massive epileptic seizure.
At Carol-Anne Charest's memorial service, Bonnie Loewen, a member of Women for Change, spoke about some of the reasons for Carol-Anne's death from homelessness:

Carol-Anne, you were cut down.
Our Canada told you what you should be as woman and then cut away all those chances of being that woman.
Never called by name just:
Woman your belly must grow from seed to birth but children's aid will uproot your young ones your tender saplings.
Woman you must grow into relationship with men but we will let them break and splinter your limbs your soul.
Woman you must cover yourself with the colors of the vibrant forest but the wintery coldness of your welfare cheque will leave you bare and embarassed.
Woman you must be barefoot, pregnant and "get into the kitchen" but you cannot have a home, such shelter bears little fruit for the landowner.

There are many layers to the cause of homelessness which creates our ill health. Different sectors of our society contribute to this. For example, "gentrification" — the new word for urban redevelopment — has reconstructed homes and hotels by sandblasting, gutting, and neatly manicuring the insides with blinds and white walls. Approximately 250,000 Canadian homes a year are turned into mansions for single family dwellings for the upwardly mobile — the young urban professionals. In the meantime, thousands of people are thrown into homelessness. Homes are being taken away from us at the fastest pace in history while next to nothing is being done to replace them. The 1987 Inquiry on Health and Homelessness reported

HEALTH WANTED

Yeast Aftermath

After having a yeast infection 2 1/2 years ago, I am left with a continuing irritation of the vulva, sometimes severe, accompanied by dryness of the vulva and vagina. Doctors suggest I may "have to live with it." I would appreciate hearing from anyone who can give me hope for improvement. Write: R. Patriquin, Box 482, Oxford, N.S. B0M 1P0.

Mental Health Anthology

I am writing an anthology of "consumer" experiences with mental health services. I want to provide all individuals who have had direct experience with transitional employment programs, clubhouse programs, drop-ins, social activity centres and workshops, etc. with the opportunity to express their feelings in writing. Mail submissions or questions regarding submissions to Angela Browne, Box 161, St. Catharines, Ont. L2R 6S4.

Vacations for Women

I would appreciate any information on vacations for women with a health emphasis — preferably in Canada. A scenic place where single working moms like myself can relax, eat wholesome food, retreat from the "doing" world and revitalize physically, emotionally and spiritually. Please write: Madeline Comeau, 1249 Wright Ave., Halifax, N.S. B3J 1C6.

that "during the 1960's the Canadian government built four to five times more low income housing in a six to seven year period than has been built in the last 15 years."

According to private developers, a profit line on housing provision must be maintained because housing is a privilege not a right. Across Canada, developers are heavily subsidized to construct moderate to upper income residential and non-residential buildings. They are encouraged to build or renovate for the middle and upper income brackets only.

When we look to our government to provide affordable and safe housing, we find that they too understand housing to be a privilege, not a right. The system works . . . for those at the top. While there are any number of reasons cited by the various levels of government for their failure to address the housing crisis, the real reason seems to boil down to this: spending public money on poor people's housing doesn't win votes.

Even though millions of dollars are spent each year constructing and maintaining hostels, hostels really reinforce and perpetuate our homelessness. "Every two weeks we have to gather up our bags and move on to another hostel," Nirmalla Somwaru says. The management of hostels argue that this is to encourage our search for permanent housing and employment. Meanwhile we are exhausted and confused because we aren't eligible for social assistance — without an address we can't get welfare. We are also discriminated against when looking for a job because we don't have a permanent residence. It becomes impossible to put together the first and last month's rent. Hostels are revolving doors to nowhere!

And yet decision makers like John Jaght, manager of Toronto Hostel Operations still say that hostels are like "staying at a summer camp; a summer camp that you did not ask to attend." He goes on to say "the majority of people who use hostels are homeless only on a temporary basis." Nirmalla Somwaru, who moved from hostel to hostel, disagrees. She argues, "John Jaght is saying people use hostels once or twice. We see the same faces again and again." According to Judy Channing, another member of Women for Change, "the conditions are holding us back . . . two weeks in a hostel and then you have to move on to the next, that's poor. You meet one set of friends. Rules are different. You just get settled in one place and then you have to move on . . . that's inhuman." Doris Power, a community activist, pushes this reality one step further by explaining that "if we put rats in overcrowded conditions like that [hostels] they will eat each other." Finally, with anger and conviction, Nirmalla Somwaru sums up the Ontario government's bandaid solutions for the homeless with this statement: "If you are going to shove people around from hostel to hostel with their belongings, people will never get out. With the housing crisis, only more people will come in. The government might as well open up big mental hospitals."

It's been said before. But we'll say it again. How come large amounts of money suddenly become available to bulldoze parkland and poor people's homes in preparation for Exploitation '87 in Vancouver; or to build the Saddle Dome in Calgary for the 1988 Winter Olympics; or to convert waterfront land to luxury condos and elite businesses for the rich in Toronto, and in St. John? But when it comes to affordable housing — suddenly the government pockets are empty! Meanwhile . . .

Put another pot on
Cause the soup line's getting longer
Don't be fooled
By all the glitter you see
The theory is this wealth
Will some day trickle down
I say, that will be the day
Until we turn things around.
Cate Friesen, Capac 1987

Women for Change believes that there will be a day when politicians, journalists and social planners realize that those of us who are "sick" of living in homelessness have turned things around. We will turn hostels into safe and affordable houses, children's aid into childcare, Kraft dinner and beans into real cheese and real vegetables, divorce which leads to welfare and homelessness into divorce which gives us support and freedom.

Groups of women across Canada are turning things around. The women of the Downtown Eastside Women's Centre in Vancouver are breaking down stereotypes Canada has placed on them. They told the Ottawa Conference on Homelessness that they are not addicts or alcoholics but are women existing in downtown east Vancouver on annual incomes less than $8,000. In Halifax, a number of angry and passionate moms got together. Called "Mothers United for Metro Shelter," the women in the group are described as "gutsy" by some, "bitchy" by others. The guts of this group comes from women like Brenda Thompson who asked Edmund Morris, the Social Affairs Minister of Nova Scotia, to resign because, "He stood up in the legislature and told people that no welfare child is hungry in Nova Scotia." In response, and in order to discredit her, Morris leaked information from Thompson's welfare files to the media. Outrage at his actions was so strong that he was forced to make a public apology to her.

In the winter of 1988, a rally was organized so that homeless people could talk with the Ontario Minister of Housing, Chaviva Hosek. Even though Hosek cancelled the public meeting, over 100 homeless people still gathered together. While some sang songs and others made speeches about the desperate need for public housing, Women for Change put on a short play which remembered the stories of women and their children who have suffered and died because they were forced to live on the streets. Women for Change knows that the health and happiness of women across Canada will improve only when our stories are told, listened to, and responded to:

. . . from hostel to hostel
we're always on the move
let's build more housing
let's get the government in the groove
that means they must listen
that means they must understand
that means they must see that
"Women for Change" has taken
a stand!

We are a Toronto-based group of women. This article was collectively told and written by Nirmalla Somwaru, Judy Channing, Bonnie Loewen and Pauline Charlebois.

Freda Guttman Robert Majzels Colette St-Hilaire

Daughters of the Dispossessed

Prostitution in the Philippines

Collage: Katie Pellizzari

The majority of Filipinas working in the sex industry are the daughters of poor peasants.

AIDS, the deadly disease, has now reached the Southeast Asian Archipelago of the Philippines. The Philippines Government presently estimates there are 200 carriers of the AIDS virus in the country; six of these have already been diagnosed as actually having the disease. Although this may not seem like a large number in a country of over 55 million, the general health and sanitary conditions of the Philippines make these initial statistics more than alarming. Where does the AIDS come from? Thirty-four of the first 49 cases of AIDS carriers to be diagnosed originated in the U.S. military bases. (*Buntag Newsletter*, March 1987)

In 1986, a U.S. Navy doctor, Lieutenant Commander Thomas O'Rourke, who had been conducting research into AIDS, concluded that it was indeed U.S. servicemen who were spreading the disease among Filipina bar workers in Olongapo, the city which has grown up around the U.S. Navy's Subic Base. Very soon after he recommended the Navy fund a program to train infected women to do other jobs, O'Rourke was charged with illegally dispensing regulated pain killers to AIDS sufferers in Olongapo, and brought up for court martial. (*Health Alert* 56, August 31, 1987)

The potential for epidemic growth of AIDS is aggravated by the extent of prostitution in the Philippines. Today more than 150,000 Filipina women are servicing the tourist industry and the U.S. military in a vast network of sexual exploitation which ranges from mail order brides, call-girls, and hospitality girls, to massage parlour employees, and street walkers. In Manila, 75,000 women, 5 per cent of the female population of the city, are working as prostitutes, and this does not include a further 5,000 child prostitutes, male and female. In Olongapo, there are another 16,000 registered "hospitality girls" in over 500 clubs, bars, hotels and other entertainment establishments, and countless unregistered street walkers. These are the women who are not only among the first victims of AIDS, but generally suffering the effects of acute degradation, disease, and physical hardship.

Poorest of the Poor

Where do so many prostitutes come from? They are certainly not imported by the U.S. Navy; nor are they part of a long established underclass in the urban jungles. In fact, the overwhelming majority of Filipinas working in the sex industry are the daughters of the poor peasants of the rural Philippines, drifting into the cities out of desperation and hunger, or, as is more often the case, actually being shipped in to the urban centres by the ruling elite of the countryside. Sophie Dick, an English volunteer working with Bagwis, a drop-in centre for prostitutes in Manila, recently traveled to Samar and Leyte. It is from these two remote rural regions that many of the prostitutes have been emigrating to the big cities.

Why do they leave their homes?

One reason is cultural: (All quotes which follow, unless othewise indicated, are taken from an interview with Dick conducted by Freda Guttman in May 1987.) "Samar and Leyte have possibly the most protective cultures in the Philippines, in terms of their attitude toward very young women. The peasants of Samar and Leyte are very, very protective of virginity, and of fairness of skin, which affects a woman's chances of marriage. It would be very rare to see a young woman walking in the fields, except possibly if her mother were with her. On the family farm, the mother and father work fairly equally, in terms of working hours. But the mother is also responsible for the little vegetable garden around the house, if there is one, and for the animals. The daughter is very much more home-based .... It's daughters who take care of younger children, and cook, and clean house .... In the hierarchy of employment opportunities, fathers, mothers, and sons are about equal; daughters have no chance at all."

But cultural oppression, the patriarchal character of feudal relations, alone does not explain the exodus of young women from the countryside. Even should they be allowed to seek employment, there are no jobs. The economies of Samar and Leyte — and this is typical of the entire country — are in ruins. In recent years the market for the major export oriented crops of the area has collapsed, and the small local industries have vanished. As a result, the individual peasant's labour on his small plot of land is the only remaining source of revenue. "The majority of these people are small feudal tenants caught in the traditional relations where a percentage of the crop is given to the landlord, and where your entire existence depends on whether you have a better landlord or a very, very nasty landlord."

Oppressed by cultural factors which exclude her from production, and by an economic situation which condemns her to poverty, the young woman of Samar or Leyte is also faced with a growing militarization throughout the Archipelago. Dick recalls: "In Samar, in 1981, there was one soldier for every fifty civilians. When I first came to Samar, there was a soldier in the back of every church on Sundays, with an armalite [machine gun]. The priests in Western Samar are famous for their human rights work, and the army's strategy seemed to be to keep the people away from the priests, intimidating the people into not going to church, frightening those that could be frightened into believing that all priests were subversive .... Later the army imposed a six o'clock curfew, on the grounds that the military had had an encounter, somewhere far away in North Samar; sometimes, three, four or five or six months before. Since it takes up to two days for most of the peasants to get to their plots of land, they inevitably end up on the road after curfew. And anyone on the road after six o'clock is considered NPA [guerrillas] and shot on sight."

Prostitution is big business and a critical part of the economy of the Philippines.

Militarization, thus, has greatly increased the economic hardship of the small farmers, and put pressure on the young women to leave their homes in search of some source of income. But, beyond even this effect of militarization, Dick discovered that the military are directly involved in the growing phenomenon of prostitution: "The military's power is huge. The military are involved in the recruitment of prostitutes. All the stories I heard in Samar about recruiting women involved military officials. One peasant had two of his daughters recruited direct to Japan from Samar. A military officer had a book full of pictures of young women. He took the pictures in Samar and brought them to Manila.

"In Leyte, the recruiting is done by big landlords. They recruit among the daughters of their peasants. There are also sordid stories, like the one about a teacher who was recruiting girls among her students for a bar which she owned in Manila .... things like that are horribly clear in the Philippines.

"The daughters of the poor are the poorest of the poor; the daughters of the dispossessed are the most powerless people in the world. I think their fate is sealed right from the outset. When you visit the bars of Manila, it is the young peasant women you see there."

The Sex Industry

It would be a mistake to assume that prostitution is merely an unfortunate side effect of the social inequities and upheavals in the islands; it is big business, and a critical part of the economy of the Philippines: "Tourism is the fifth most important source of revenue for the country. This year, 40 per cent to 50 per cent of the government budget was taken up in foreign debt repayments. Tourism, and the foreign exchange it brings in, is therefore critical to the economy. And, in the tourist industry, there is one thing which actually makes a profit: prostitution. The women who sell themselves in the bars are therefore the ones who are paying for the soap and Nescafe imported and consumed in the Philippines.

"Hired as receptionists, hostesses, waitresses, and dancers, the hospitality girls almost always end up as prostitutes. A hospitality girl in Manila rarely receives any set salary from the bar owner. She can make some commission on drinks she is offered by customers (50 cents per drink). Without any salary, and with only her commissions on drinks, she has no choice but to go with the customer.

"If a customer wishes to take a woman for the night, there is usually a bar fine. The woman must negotiate her share with the barowner. The bar fine can go up to 200 pesos ($15) for a Filipino customer and 400 to 600 pesos ($30 to $50) for a foreigner. The prostitute's share usually does not exceed $5 per customer."

The Filipinas must learn to serve their clients' whims. Some bars offer special performances: mudwrestling or "coin sucking" (women inserting money into their vaginas). They are led on by the possibility of a job in Japan, where they might earn up to

Collage: Katie Pellizzari

U.S. $1000, a fortune in the Philippines, or some American GI might marry them; in any case, they have nothing to return home for, and no alternative means of survival. In the meantime, they live crowded together in small rooms above or behind the bars where they work. Many try to conceal what they are doing from their families back home; yet they mail back money for the education of their younger brothers and sisters, or for their own children which they have left behind or sent back.

U.S. Imports

AIDS is only the most recent health risk Filipina prostitutes must face. STDs (Sexually Transmitted Diseases) have long been taking their toll. In 1980, STDs in Olongapo reached a prevalence rate of 15.22 per cent, considered epidemic in contrast to the National norm of 4 per cent. Hepatitis B, which is 35 times more infectious than AIDS, has continued to claim an increasing number of lives in spite of the fact that a vaccine exists. The cost of the vaccine makes it virtually inaccessible to the vast majority of Filipinos.

Although the Government officially maintains that prostitution is illegal, all "hospitality girls," dancers, and bar waitresses are registered and obliged to take biweekly serological tests at a Social Hygiene Centre in order to obtain the certification, commonly referred to as "papers", required to work in the industry. Twice a year, the women of Olongapo must take a complete physical examination. The City Health Officer is responsible for the clinics, but the U.S. Navy 'generously' supplies technical and medical personnel to conduct the testing. The biweekly tests cost Filipinas 2 pesos and their biannual exam 50 pesos. The navy may subsidize the testing of Filipinas for STDs, but its generosity does not extend to financing treatments: clearly the U.S. military is interested in identifying the infected women; not in treating them. The testing makes it possible for the navy and air force to post pictures of infected women on the bases for the protection of the American men. U.S. military personnel, on the other hand, are not required to take any tests, nor is the Navy required to identify any AIDS-infected men to Philippine authorities.

Of the 300 to 500 women examined every day, 50 per cent are found to be infected by some STD. Many have been taking antibiotics before sex in the mistaken belief that this will reduce not only the risk of infection, but of pregnancy as well. In fact, this merely increases the immunity of STDs to the medicine. Prostitutes will clean their vaginas with Colgate, Sprite or carbonic acid after sex, which damages vaginal linings upsetting the natural lubrication and increasing the likelihood of lacerations which lead to cervicitis and cancer of the uterus. The U.S. military has refused to subsidize pap smears of Filipina sex workers in the health clinics — cancer is not a threat to the men at the bases. As for the thousands of unregistered streetwalkers and child prostitutes, they receive no medical attention whatsoever.

Contraceptives are expensive and not easily obtained, and customers rarely accept the use of condoms. Women are not paid while they are pregnant. They work as long as they are able, and then they are thrown out into the street, unless they can negotiate a loan from the bar owner. Of course, they will have to pay back this loan when the baby is born. Women often seek abortions from Hilots, healers who apply herbal medicines and abdominal massages for 300 pesos. Backstreet abortions are available at 600 to 1000 pesos, depending how many weeks one is pregnant. Some abortionists will install catheters in a woman's uterus to be removed after 24 hours. If the patient doesn't bleed to death, such an abortion may be successful. But not always: it is estimated that one Amerasian baby is born every day in Olongapo and Angeles, the R & R playground for Clark Air Force Base. There is a market for this too: "Caucasian looking children fetch U.S. $50 to $200; Negro-fathered children go for U.S. $25 to $30." And then, beyond the abortions, and the baby selling, there remain the street children, about 3,000 in Olongapo alone.

Women Get Organized

In recent months, a new kind of cafe has begun to appear in Manila and Olongapo. These cafes, like the Bagwis centre in which Sophie Dick is working, are frequented by prostitutes but they are not there to work. Women are meeting here to talk among themselves, to get information on contraception, or AIDS; to take courses, and to receive free health care. GABRIELA (an acronym which was also the name of a 19th century female leader of the armed revolution against the Spanish colonialists), a coalition of women's or-

ganizations in the Philippines of which Bagwis is a member, has chosen this method to begin the organization of prostitutes. The bar employees are easier to regroup than the streetwalkers, because they have a stable and legal status, not so different from other women workers.

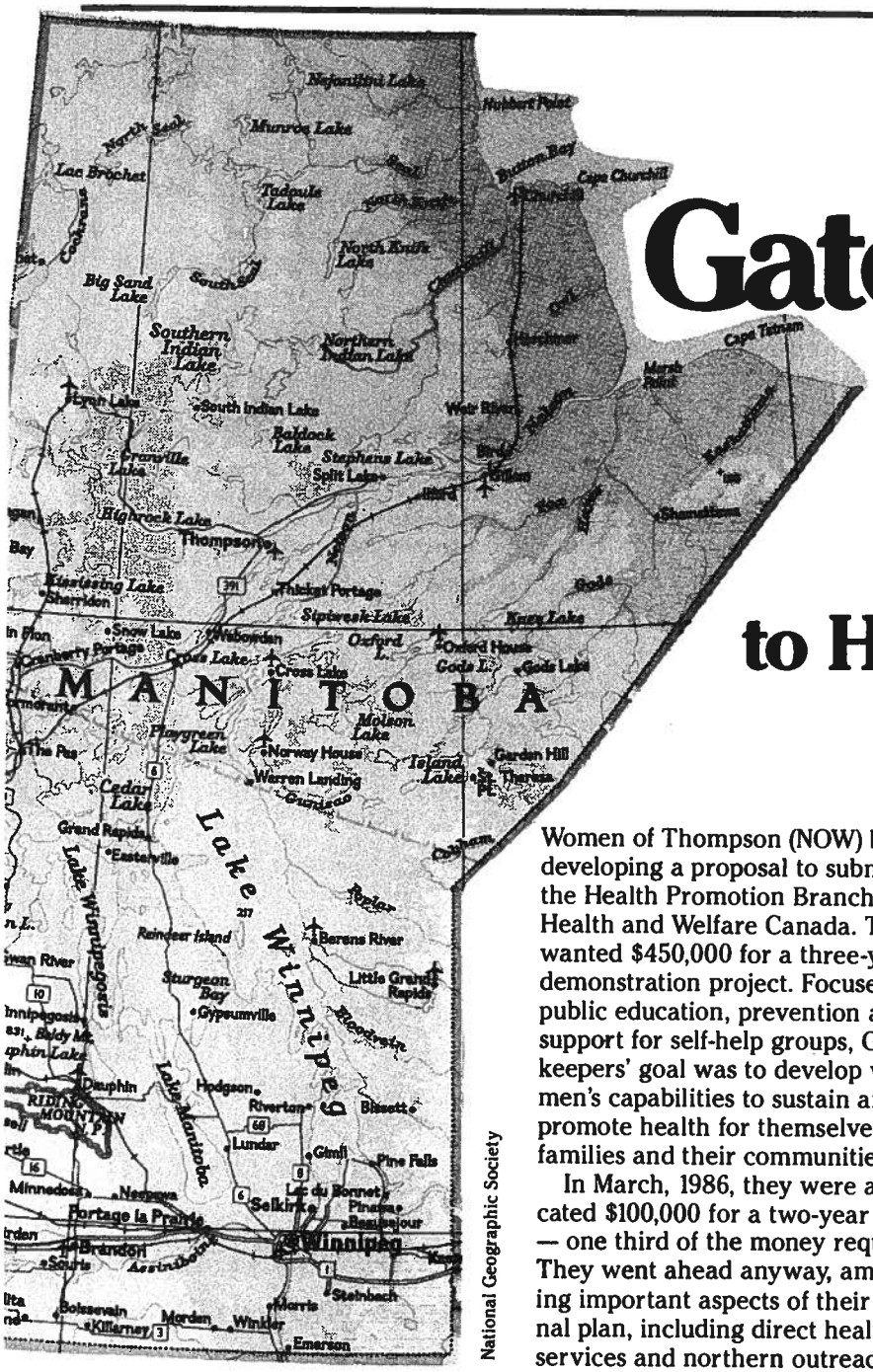
GABRIELA is doing social investigation into the conditions of prostitutes and educating the rest of the people's movement in the Philippines about their situation and demands. "Guided tours" of the bars are being offered to sensitize progressives from community and trade union organizations. During the latest International May 1st Conference held in Manila, a delegate from West Germany was expelled by the participants for having used the services of a prostitute. This marks a first for the trade union movement, and an important victory for women in the progressive movement as a whole. Others have tried to "rehabilitate" prostitutes in the Philippines. But GABRIELA's work constitutes a radical break with the humanist, puritan, and contemptuous attitudes of the past. GABRIELA aims to educate prostitutes about their rights as women, and to facilitate their collective struggle for better conditions. The women's movement knows that prostitution provides the most lucrative, and, in most cases, the only source of income for these young women. The movement's goal is to allow the bar workers to take control over their own lives, and understand their situation in the overall Philippine context. Prostitutes are not seen as guilty or sinful, nor as victims. The decision to quit or continue working as a prostitute belongs to each woman alone; it is a conscious and informed decision which she will make for herself.

Through the cafes, women have been gaining information and education. They have begun to organize their resistance. The workers of the Casa Blanca del Mar Hotel recently went on strike for an end to the mud-wrestling matches organized by the hotel management. A coalition has been formed to demand the U.S. government assume its reponsibility towards the victims of AIDS in the Philippines. A petition is presently circulating in the bars and across the country, demanding free health care and compensation for victims of AIDS and their families and compulsory testing of servicemen and employees of the bases. The petition also demands the removal of the U.S. bases, the major external source of disease and sexual exploitation of Filipina women. This remains a difficult step for sex workers to take — the bases are, after all, their primary source of livelihood. Yet, in 1987, a group of prostitutes participated, for the first time, in a demonstration demanding the removal of the U.S. bases. Gradually, as they gain strength and confidence through organization and education, the Filipina prostitutes are demanding, seizing their rightful place in the struggle for national liberation.

Freda Guttman is a Montreal artist and teacher at Dawson College. She has been active in support work for the Guatemalan people's struggle and her art reflects this engagement. In May, 1987 Freda visited the Philippines where she interviewed Sophie Dick, an English volunteer involved with organizing prostitutes in Manila.

Robert Majzels is a graduate student and part-time lecturer at Concordia University in Montreal. He was in the Philippines in 1984 and is a member of the Committee for Philippines Concerns. He is the editor of The Guerilla is Like a Poet, *an anthology of Filipino poems to be published by Cormorant Press in the fall of 1988. Robert did the transcription of the Sophie Dick interview and the translation and adaptation of Colette's article for* Healthsharing.

Colette St-Hilaire is a sociologist and teacher at College Edouard-Montpetit in Montreal. She visited the Philippines in 1984 and has taught a course in the History of the Philippines at L'Université du Québec a Montréal (UQAM) in the winter of 1987. She is a member of the Comité de solidarité Québec-Philippines. The present article is based on one written by Colette for La Parole Métèque, a feminist journal in Montreal.



National Geographic Society

Kathy Fitzpatrick

Gatekeepers

A Challenge to Health Promotion

Picture a hole in the ground with the concrete walls of a basement jutting out. Now imagine a bulldozer filling it in with dirt, knocking the walls over in the process, leaving only a bare patch of ground where the foundation of a building once stood.

This is what supporters of the Gatekeepers Health Project in Thompson, Manitoba feel has happened to them. In 1983, a group of women from Northern Options for Women of Thompson (NOW) began developing a proposal to submit to the Health Promotion Branch of Health and Welfare Canada. They wanted $450,000 for a three-year demonstration project. Focused on public education, prevention and support for self-help groups, Gatekeepers' goal was to develop women's capabilities to sustain and promote health for themselves, their families and their communities.

In March, 1986, they were allocated $100,000 for a two-year project — one third of the money requested. They went ahead anyway, amputating important aspects of their original plan, including direct health care services and northern outreach. Now, their funding from Health and Welfare has ended and there are no alternatives in sight.

Gatekeepers' workers and clients feel their project has become a symbol of federal and provincial government foot-dragging in providing funds for preventive and community-based health care services. In November, 1986, federal health minister Jake Epp released the discussion paper, *Achieving Health for All: A Framework for Health Promotion*. It sketches a utopian vision of a Canada where all people enjoy health in the broadest terms; where health inequities between rich and poor are eliminated; where prevention is emphasized; and where there are supports to help people cope with illness. Unfortunately, the paper does not mention where the dollars to achieve these goals will come from. "To me the government wants to accomplish [Health Promotion], but not spend any money on it," says Kathy Connors, president of the National Federation of Nurses' Unions, formerly based in Thompson.

Ironically, the Gatekeepers project was inspired partly by a suggestion made by an official in the Health Promotion Directorate, says Gatekeepers co-ordinator Carol Hiscock. During a 1983 conference in Thompson, sponsored by NOW, there was a panel discussion on patients' rights. The official said NOW could do something in Thompson to promote the ideal of self-health, and from there the Gatekeepers idea was hatched.

Gatekeepers is loosely modeled on two other demonstration projects funded by the Health Promotion Directorate, one in Labrador, and the other a woman's health information network in northwestern Ontario. NOW took the best of what these projects offered, says Hiscock —

information exchange between non-professionals and the use of the World Health Organization definition of health, "more than just the absence of disease." And then Gatekeepers went further, encouraging the idea of self-help by treating information sharing as a step in a larger process of taking personal responsibility for one's own health.

Project staff set up shop in a 500-square-foot, third floor office in the heart of town. Three part-time staff, often working full-time hours, set to work developing programming, information resources and a public profile in the community. Provincial job creation programs provided three additional term positions. One worker concentrated on outreach within Thompson and in Nelson House, a neighbouring native community, 53 miles to the northwest. The staff also linked up with tribal councils, womens' organizations, public health nurses and other groups. Highlights of the job creation programs include a group facilitators training workshop, a survey to identify health care topics of interest to local women and a series of self-health workshops. Workshops that have been held over two years have included stress, smoking cessation, women's preoccupation with weight, Depo Provera, premenstrual syndrome, patient's rights and responsibilities, menopause, adolescent sexuality, and women and addictions.

A number of self-help groups also emerged: one on allergies, another on weight control and body image, another on PMS and a smoking cessation group. Work began on setting up self-help groups for women going through menopause, grieving parents and those suffering from emotional distress. Gatekeepers also worked with the Committee on Unplanned Pregnancy to develop and test a presentation kit on adolescent sexuality.

Thompson resident Vicki Klementson feels Thompson is an ideal setting for a project such as Gatekeepers. A mining town of 15,000, Thompson is 500 miles away from Winnipeg, the closest large city. The community suffers from all of the strains of a typical northern town: lack of specialized services and alternatives, and difficulty in attracting and keeping health care professionals from the big cities.

Klementson believes that overworked local doctors are so used to seeing a never-ending parade of sick people that it hasn't occurred to them that recurring illness in otherwise healthy people is not normal. "I don't know anybody whose children are not sick on a continuing basis," she says. She suspects pollution caused by the Inco smokestack could be part of the cause. Some days the air is so charged with effluent that people can taste the sulphur, like stale peanut butter lingering on the tongue and the back of the throat.

These two factors — a harried medical community and the environment — make self-awareness all that much more important. Although providing public education on health care is seen as part of the mandate of local public health nurses, Klementson feels it is unrealistic to expect that they can do the whole job by themselves. Also, many people are wary of the medical system because of failures in the past.

Gatekeepers encourages the idea of self-help

Klementson believes Gatekeepers can fill a gap by acting as an ongoing alternative source of information. To make informed choices, people have to know the alternatives, she says. "Education takes a long time. It has a number of small impacts over a long period of time which mount up," she explains. "Taking personal responsibility for health is still a radical notion for most Thompson residents," she adds.

Marilyn Lamontagne, another Thompson resident, has learned both the need and the value of self-health. Her involvement began by attending a series of Gatekeepers workshops on menopause. She later took the facilitators training course, which gave her the confidence she needed to help form an allergy self-help group, one of Gatekeepers strongest.

The training gave her a feeling of "tremendous closeness and power." 'We're losing a big part of a community in losing Gatekeepers," she says. "Women are just starting to get to know this place. This is all we have."

Allergy group members, who number about a dozen women and men, help each other cope with feelings of hopelessness. They exchange tips on cooking with food substitutes and shopping for good medical advice. Lamontagne says general practitioners are often poorly informed about allergies, and she urges people instead to see one of the province's seven immunologists/allergists. The group's biggest problem is getting access to good information. Most of Lamontagne's knowledge came from her own research and she is happy to pass on what she has learned. Not content with sticking to what they have achieved so far, the allergy group's next step is to spread the information they have accumulated by helping to set up other self-help groups across northern Manitoba.

In fact, Gatekeepers set out to provide service to some of the other communities scattered across the north, an area which often seems cut off from the southern part of the province by the two great prairie lakes. Thompson is the main hub of a network of two smaller mining towns (Lynn Lake and Leaf Rapids), Gillam, a hydro and railway town, and the Arctic seaport of Churchill. (The population averages about 1,750 in each community.) Dispersed among these towns are 23 Indian reserves and adjoining Metis communities. There are also commercial, administrative and social links between Thompson and the resource towns of Flin Flon (pop. 7,243), Snow Lake (1,837) and The Pas (6,283) to the southwest.

Most government departments with offices in northern Manitoba routinely dispatch officials from central offices in Thompson, The Pas or Flin Flon to deliver services to smaller surrounding communities. But when it comes to funding, government officials tend to overlook the need for northern outreach. The result is that services like Gatekeepers, which are intended to provide region-wide service, instead receive funding as a "Thompson" project.

We're losing a big part of a community in losing Gatekeepers

That has been frustrating to Gatekeepers supporters, particularly when health care delivery has been identified by several different women's groups as one of the top concerns among northern women. With the sparsity of services in some communities, it is little wonder that women who have to truck sick children hundreds of miles for treatment or wait weeks in a hostel far from home to give birth, are preoccupied with health matters. Despite the tight budget, Gatekeepers has managed to provide some service to the communities of Churchill and Leaf Rapids.

Nestled at the mouth of the Churchill River on the shore of Hudson Bay, Churchill is accessible from Thompson only by rail or air. It's a 14-hour trip by rail — the trains must travel slowly over muskeg and permafrost. Wendy MacDonald, administrator of the Churchill Health Centre, says Gatekeepers has proved to be a useful resource to both the centre and the community at large.

It is little wonder that women who have to truck sick children hundreds of miles for treatment are preoccupied with health matters

She praises Gatekeepers for being "by northerners for northerners, by women for women." Most of the health centre workers are transplanted urban, non-native southerners. When they come face-to-face with poorly educated natives, communication can often break down. Gatekeepers greatest value is to provide role models for the caregiving community, she says.

MacDonald emphasizes the importance of self-health in a community such as Churchill. Alcoholism and child abuse are major problems, and she believes they can only be tackled if the community develops its own sense of direction. She describes Gatekeepers as "an effective cog in the system." If it goes under "something important to keeping things going on the right track will be missing."

The Leaf Rapids Health Centre, 130 gravel miles away from Thompson, has looked to Gatekeepers for guidance and assistance in several ways. The two exchange information and last year one of the staff attended the facilitators training workshop. This year the centre is planning to do a survey on the community's health education needs and turned to Gatekeepers for advice since they had done a similar survey in Thompson the previous year.

Sylvia Stard, Leaf Rapids' executive director hoped Gatekeepers would be able to present workshops and carry out public awareness campaigns right in town. Although the health centre has been trying to increase its own public education efforts, Stard says the real expertise in that area lies with Gatekeepers.

Hiscock is deeply disappointed that Gatekeepers could not realize the original plan to create a real northern health-sharing network. Under the original proposal, the goal was to offer facilitator training in several northern communities. Local facilitators would then act as community women's "wellness" advisors, providing workshops and channeling other information and resources locally. There was also no time to educate health care professionals about women's health issues, as proposed in the original plan.

Despite the strides made in two years, she says it simply has not been long enough to create a permanent place for the project in the spectrum of health care available. It was not until its second autumn that the community began to understand what Gatekeepers is all about, Hiscock says. With funding due to expire six months later, there was no time to

accomplish the rest of what staff and volunteers had set out to do.

In trying to salvage Gatekeepers, its managment committee has looked at different alternatives, although Hiscock notes that following up funding leads consumes much time and energy. Becoming a self-help clearing house was one avenue that was considered. Although a viable alternative for the project, it's still not clear where the funding would come from.

Another avenue was to become a health centre. The drawback is that Gatekeepers would need to include a physician, and Hiscock believes that "more doctors are not the answer for women in Thompson." Although it was not included in NOW's original proposal, Hiscock says she would have liked to have had funds to contract a nurse practitioner. Of all the alternatives considered, the group prefers to continue focusing on health promotion.

When it comes to funding, government officials tend to overlook the need for northern outreach

Gatekeepers is not the only one to question the future look, shape and feel of health care delivery. In late December, 1987, former Manitoba health minister Wildon Parasiuk made a sweeping announcement that he intended to overhaul the health care delivery system in the province. The message is clear — the provincial government is searching for ways to keep health care costs from spiraling out of sight. Parasiuk said he would examine greater use of community health clinics, health promotion, salaried doctors, and other health care providers such as nurse practitioners and midwives.

Hiscock says Gatekeepers could be of value to the province in trying to bring health care costs under control. "If projects such as Gatekeepers were around for long enough to establish some credibility, you would ultimately change the demand on physicians and ultimately influence the Medicare dollar expenditure," she says.

But for now, expanded funding is required. Even though the Canada Health Act allows for these types of expenditures, supporters of the *Achieving Health for All* document may have a tough time prying the extra cash out of the federal government coffers. Federal support for health care used to be cost-shared 50/50 with the provinces. By 1990 the ratio is expected to reach 37 per cent for the federal government, with the provinces picking up the remaining 63 per cent of the tab.

Although federal health minister Jake Epp got money for his new child care initiative, his cabinet colleagues may balk at undertaking any more megadollar initiatives.

Despite the gloomy picture, there are some small indications that there could be greater support at the federal level for community based preventive health care in the future. Kathy Martin, assistant to NDP health critic Margaret Mitchell, believes Epp is committed to achieving the strategy mapped out in *Achieving Health for All.* And, she says finance minister Michael Wilson has indicated that he is interested in moving back to a 50/50 cost-sharing arrangement with the provinces as well as funding more community-based facilities. Finally, the Standing Committee on Health, Welfare and Social Affairs will be examining funding for these new types of health initiatives. The committee will be holding a series of hearings across the country, as well as examining Western European models of health care delivery.

Unfortunately, says Connors, the groundwork laid by Gatekeepers will have to be done over again when governments are finally ready to adopt new approaches. She expresses regret that for the moment there is no follow through for this successful community initiative. "The seed money won't be allowed to bear fruit," she laments — and positive results will disappear for lack of nourishing.

Kathy Fitzpatrick is a writer and consultant based in Thompson, Manitoba.

REVIEWS

An Error in Judgement: The Politics of Medical Care in an Indian/White Community

Dara Culhane Speck, Talonbooks, Vancouver, 1987, $14.95, 281 pp.

Reviewed by Nancy Pollak

It's 1979, and the native Indian community of Alert Bay, B.C. has chosen a timely theme for their annual June Sports Day Parade: the United Nations International Year of the Child. Waving children hang from the vehicles edging along the island town's main street. The cars and trucks sport banners which declare rights the UN says these children have: the right to a name and a nationality, to nutrition and education, to be loved. One float bears moaning, screaming children. They are bandaged and fake-bloodied. Their banner proclaims: Every Child Has A Right To Adequate Medical Care.

All is far from well with the Nimpkish of Alert Bay.

By the time Dara Culhane Speck presents this scene — midway through *An Error in Judgement* — we are primed to grasp what an immensely complex event this was for the people, native and non-native, of the island. Speck guides us through the earlier months of that year, months in which the death of an 11-year-old native girl precipitated a crisis that led, eventually, to a federal inquiry.

More than a case study, *An Error in Judgement* is a panorama, scanning centuries of historical and political dynamics, the minutiae of a community struggle, the politics of native health care, of colonialism, and of racism.

On January 18th, 1979, Renee Smith entered her local hospital, St. George's, in Alert Bay, complaining of severe abdominal pains. Four days later, she died of peritonitis due to a ruptured appendix. The physician in attendance — the island's only long-term doctor, Jack Pickup — never diagnosed Renee's condition and was plainly drunk the night she died.

The girl's family, prominent members of the Nimpkish band, were devastated. Other band members were appalled that something so terribly familiar had happened *again*: a young person's seemingly unnecessary death, substandard treatment from a clearly troubled, overworked white doctor, and an apparent cover-up. There was no cause of death listed on Renee's death certificate and no autopsy ordered.

Speck was one of the community activists who launched the petitions protesting Renee's death which led to the sensational media and government buck-passing that characterized the "Alert Bay — Dr. Pickup" case. Of Irish/East European Jewish descent, Speck is married to a Nimpkish man. She has lived and worked on the Alert Bay reserve since 1973. The Nimpkish are Kwakwaka'wakw, a coastal people who numbered about 11,000 in 1835. The toll of epidemics and oppresion has reduced their population to approximately 3,500 today.

The author painstakingly analyzes every ingredient of the crisis. The native and white 'poles' of the small island are presented, as are the nuances of their middle ground. Kwakwaka'wakw society is described as it was prior to European contact, with particular attention to native concepts of health and healing. Speck scrutinizes the impact of colonial attitudes and policies on native government and culture, assesses Alert Bay's position as an economic centre, and convincingly sketches the politics of St. George's Hospital as a microcosm of our racist society.

Speck demonstrates how the field of native health has created a body of 'expert' knowledge that is itself a once-removed source of health problems. A report by a provincial/federal committee (Dr. Pickup contributing) entitled *Indian Health Problems and Attitudes* lists these distinctively native behavioural patterns: Indians fail to recognize early symptoms and present themselves in acute or fatal stages of illness; Indians have a higher tolerance for pain and a fatalistic attitude towards life.

During the inquest into Renee's death, Dr. Pickup's lawyers used these assumptions to build a defense that *blamed* Renee for her own death — she had initially refused to stay in hospital; she must have 'masked' her pain. Speck analyzes how this widespread belief that Indians neither want nor avail themselves of health services obscures the fact that sympathetic, quality care is rarely available to them. Or that, as in the case of St. George's, the care is incompetent, racist and exploitative.

The Alert Bay story does not have a happy ending. Dr. Pickup remains the Chief of Staff at St. George's. Although the federal government did provide funds for an Indian-run health clinic, not all community activists wanted it. They feared a token sum for the clinic would enable the government to wash its hands of all further responsibility and that such a poorly supported clinic could only fail. Others thought the clinic a necessary step towards the goal of "Indian Control over Indian Health." Speck's outline of this difference is brief and the reader can only sense the complexities: issues of short-term local power vs. long-term aboriginal self-government.

Although Speck goes to considerable lengths to describe the political/cultural dimensions of people's interactions, she is less than expansive about her own role. She does describe how being a "white wife" who was a leading spokesperson on this matter led some Indian people to view her as having "too big a mouth." But she makes no mention

of people possibly resenting her *privileges* as a white woman or her privileges as an acquirer of Indian status through her marriage to an Indian.

Speck also fails to include the dimension of gender in her analysis. That the Nimpkish women of Alert Bay were strong players in this drama, as they are within their community, is evident. As we know, women are the caregivers, both professionally and within their private and communal spheres, yet their *public* powers are rarely commensurate. Speck doesn't comment on this, or bring any of her usual insights to bear on the particular gender dynamics within Nimpkish society.

The controversial Nimpkish Indian Health Centre opened in 1983. And this is where Speck ends the book. Unfortunately, we are not offered any sense of that clinic's success or problems. However, the portrait of Alert Bay that Speck provides is massive and she had to stop somewhere. That she gave as much as she did makes *An Error in Judgement* an excellent book.

Nancy Pollak is a feminist journalist and graphic designer living in Vancouver.

No Way! Not *Me*

A National Film Board of Canada production; produced by Silva Basmajian; directed by Ariadne A. Ochrymovych, 1988; 30 minutes.

Reviewed by Alexandra Keir with Taking Control, Making Changes

No Way! Not *Me* is a video of feminist educator and human rights activist, Rosemary Brown, addressing an auditorium full of high school students. She is talking about women and poverty. This video, the first in a series of five videos on the feminization of poverty, provides an introductory overview of the issues. The lecture, given from a feminist perspective, is accented with scenes of poor women and their children as well as historical clips of women working in factories.

Brown opens with an historical overview. We see how industrialization forced women to become superwomen, with full-time jobs in addition to caring for their families. Despite these jobs, women stayed poor. Although women were trained from infancy to sew and cook, this work was classified as unskilled and therefore low paying.

The Depression meant no jobs for women until they were needed again during the Second World War. When the men returned after the war, "women could once again be women," that is they were forced out of the paid labour force and back into the home. However, in the '50s, more and more women with families took jobs outside the home and, finally, in the '60s the women's liberation movement brought the issues of women in the paid labour force to the forefront.

In bringing us into the present, Brown makes a good point with her audience when she says that women are still encouraged to wait for a handsome rich man to take care of them. "How many men," she asks, "wait for a beautiful rich woman to take care of them?" Although education does not equal wealth, certainly a lack of education among women does equal poverty. Brown stresses that the young women of today must develop their potential and set long term goals for themselves.

Teenage mothers are more likely than any other group to become the poorest of Canada's poor. This is emphasized in the video through the use of black and white photos of young mothers and their infants in cramped, inadequate housing. Brown uses statistics here to further emphasize her point: 85 per cent of single parent familes are led by women and 60 per cent of these women and their children live below the poverty line; when marriage breakdowns occur, women's standard of living drops by 70 per cent while men's rises by 43 per cent; 75 per cent of fathers do not pay their child support orders.

Rosemary Brown is an elder passing on her perceptions to today's youth in the hope that they will "turn things around." The lecture is followed by a question and answer period.

I viewed this video with six women from Taking Control, Making Changes, a low income single mother support group in New Glasgow, Nova Scotia. I have recorded their responses to No Way! Not *Me*:

- This is an important video to show to young women in high school as we try to break down the romantic notion that maturity and independence are achieved with motherhood and quitting school. However, the format is a little humdrum in the first half and, although the information is good, it may not hold the attention of a young audience.
- The video presents a problem; poverty among women. It presents the problem clearly and offers a possible preventive education but it does not offer solutions.
- The illustrations of women in low paying industrial labour in the 1940-50s are good but would be more effective if they were shown in contrast to present day low-paying industrial labour. As it is, one is left feeling that this is history and today things are somehow different.
- We felt in general that the photos were good but very stereotypical. For example all the women shown were poor and at home, many with children, whereas all the men shown were business men and the only successful relationship depicted was very middle class and heterosexual.
- This video is about how you may become a poor woman, not how the system will keep you poor. There is no mention of the state of the welfare system or of the lack of affordable daycare. But it does make one thing very clear — poverty is a woman's issue and must be put on the agenda.

Taking Control, Making Changes is a low income single mother support group that meets to share experience and information as well as to work toward changing the present social service system.

THEMATIC RESOURCES

Economics and Women's Health

Unfortunately there are few resources specifically focused on women's health and economic issues.

Statistical and sometimes analytical information about poverty and health is often available from government and government-funded agencies.

Organizations working on behalf of the elderly, individuals with disabilities, immigrants and people of colour will provide information about economic and health issues. Except for material that is written from a feminist perspective, information available often fails to distinguish between men and women or to consider that economic issues might differ depending upon someone's gender.

Progressive and socialist health organizations are among those analysing failures of our current health systems to provide services equitably. Literature is available which documents the impact of class position on disease, longevity, etc. Places to check are community health centres, unions and environmental groups.

Organizations

This is not an exhaustive list, but includes a few key organizations having a Canadian-wide focus which deal with concerns related to economics and health.

Coalition of Visible Minority Women

579 St. Clair Ave. W.
Suite 203
Toronto, Ontario
M6C 1A3

DisAbled Women's Network

122 Galt Ave.
Toronto, Ontario
M4M 2Z3
(416) 466-2838

MATCH International Centre

205 — 200 Elgin St.
Ottawa, Ontario
K2P 1L5
(613) 238-1312

National Action Committee on the Status of Women (NAC)

344 Bloor St. W.
Suite 505
Toronto, Ontario
M5S 1W9
(416) 922-3246

National Anti-Poverty Organization (NAPO)

456 Rideau St.
Ottawa, Ontario
K1N 5Z4

Resources

The Poverty Game

This a day-long simulation game developed by Branching Out, a self-help anti-poverty and welfare rights group. Designed to educate both professionals and lay people, The Poverty Game conveys to participants what poverty is really like.

For more information contact: Branching Out, 2-956 Cornwall Cres., Dawson Creek, B.C. V1G 1N9 (604) 782-5642.

Health Barriers

The Action on Health Barriers project of Opportunity for Advancement is in the final stages of editing a manual. The project has identified and assessed barriers to health experienced by low-income women and developed health promotion programs to help women lessen these barriers. A manual, at low cost, that looks at the project and provides information for other groups wanting to start similar women's support groups will be available late summer, 1988.

For more information, contact Opportunity for Advancement, 801 Eglinton Ave. W., Toronto, Ont. M4N 1E3 (416) 787-1481.

Sex and Status

This report, the full title of which is *Sex and Status: Hierarchies in the Health Workforce*, illustrates sex discrimination in the health labour force of the U.S. While weak in analyzing the interrelationship of race and gender bias, it is an excellent analysis of how work structure changes are affecting women's work in the health sector.

Published in 1985, the report costs $5.00 U.S. and can be ordered from the American Public Health Association, 1015 Fifteenth St. N.W., Washington, D.C., U.S.A. 20005.

Vital Signs: News from the National/Black Women's Health Project

This is the newsletter of the Black Women's Health movement in the U.S. Published quarterly, it looks at a range of personal and social health issues for black women.

It is available from Vital Signs, 1237 Gordon St. S.W., Atlanta, Georgia, U.S.A. 30310.

The Unequal Society

A video tape and report of the same title were produced in 1983 and 1984 by the Department of Public Health in Toronto. A source book and leader's guide are available with the video. Also available are a series of pamphlets about unemployment and health.

For more information about *The Unequal Society* materials contact Norma Drummond, Department of Public Health, 815 Danforth Ave., Toronto, Ont. M4J 1L2 (416) 392-0927. Available in VHS or 16mm film.

RESOURCES & EVENTS

Conference for Shelters

The Manitoba Committee on Wife Abuse is planning a *National Conference on Shelters and Transition Houses* in Winnipeg for September, 1988. Contact: Ms. Joey Brazeau, Manitoba Committee on Wife Abuse, 1823 Portage Avenue, Winnipeg, Manitoba R3J 0G4, (204) 885-3302.

Post Partum

Post Partum Depression and Anxiety — A Self-help Guide for Mothers is published by the Pacific Post Partum Support Society which began in 1971 when a small group of women met to share their experiences and to support each other. This 77 page book "empowers the depressed woman and helps her to engineer her own recovery" with strategies for dealing with her feelings and reassurance that she is not neurotic or crazy. Available for $6.95 from: Pacific Post Partum Support Society, #104-1416 Commercial Drive, Vancouver, B.C., V5L 3X9.

Feminist Community Organizing

Plans to document feminist organizing in Canada and the United States are in the works. The editors are seeking contributions from activists about their own experiences as well as theoretical overviews. Interested individuals are invited to send a brief description of their proposed submission as soon as possible. Completed manuscripts to be received by July 1, 1988. Send all materials to: Jeri Wine and Janice Ristock (Eds.), Department of Applied Psychology, The Ontario Institute for Studies in Education, 252 Bloor Street West, Toronto, Ont. M5S 1V6.

P.I.D.

Pelvic Inflammatory Disease, P.I.D. is a booklet written to provide information for women who have P.I.D. and their families, for healthcare professionals and interested individuals. Women can recognize and avoid some of the causes of P.I.D. or identify the disease should they contract it. Available from the Canadian P.I.D. Society, P.O. Box 33804, Station D, Vancouver, B.C., V6J 4L6, (604) 684-5704. The cost is $2.50 per copy, but this will be waived if it presents a hardship.

Dilemmas

Dilemmas: When Technology Transforms Motherhood is a thought provoking 40 page English publication by the Conseil du statut de la femme. The disruptive effects of the new reproductive technologies (NRT) on motherhood are clearly analyzed. It is a well documented synthesis intended for those who feel that a major debate is needed to define clear rules for NRT. Send your cheque or money order for $3.95 payable to Les Publications du Québec, C.P. 1005, Québec, Québec, G1K 7B5. (Mention code no. EOQ23611-7.)

Quality Child Care

Vancouver Status of Women is distributing their latest information pamphlet, *Quality Child Care . . . Will the Promise be Kept?* in response to the new government proposals on child care. Vancouver Status of Women join parents, broad based community groups, women's organizations, unions, child care coalitions, and several government commissions in recommending a publicly funded non profit child care system. If you, or your group is interested in this leaflet or need more information, contact Vancouver Status of Women, #301 — 1720 Grant St., Vancouver, B.C. V5L 2Y6, (604) 255-5511.

Women and Development

Laval University's multidisciplinary research group on women's issues, invites you to the 12th Annual Conference of the Canadian Research Institute for the Advancement of Women (CRIAW), to be held in Quebec City on November 11, 12 and 13, 1988. The theme of the conference is Women and Development: Women from Here and Elsewhere. For further information, please contact: Service des Communications, Faculté des sciences sociales, Bureau 3446, Pavillon Charles-De Koninck, Université Laval, Québec, G1K 7P4, (418) 656-2832.