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Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

Women and AIDS

Free Trade Sellout

Fetal Tissue Control?

Dyslexia



INSIDE

Vol 9:4 September, 1988

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COLLECTIVE NOTES

Fighting Racism

In recent years Women of Colour have been raising their voices in the women's movement, dramatically initiating a new women's politics. Pivotal to their call for change has been the establishment of the fight against racism as a priority for the women's movement. In their struggle to broaden and strengthen Canadian feminism, Women of Colour have had to confront institutionalized racism and racist prejudice within the women's movement.

Racism like all prejudice and bigotry is a sickness as well as a system of exploitation and oppression. If you are Black and poor in this country you have less access to health services and if you work in the health care system you are likely to have the lowest paid jobs and worst working conditions. Racism against Native women is deep and abiding. Native women are mistreated in the health care system in an especially pernicious way. Tuberculosis is still a serious disease, women are often forced to leave their home communities to give birth, and Native healing is not understood or supported in the health care system.

But this reality has not been represented or reflected in the pages of *Healthsharing* over the past ten years. We must ask ourselves why.

Women *Healthsharing* arose out of the women's health movement — a movement which has been and continues to be dominated by white middle class women. The *Healthsharing* collective and the volunteers who produce the magazine have largely reflected these origins. While we have, over the years, acknowledged to ourselves the narrowness of our view, whatever we have done in an attempt to have the magazine reflect the concerns of all women, has not been enough.

The writers, the staff and col-

lective members remain overwhelmingly white, and articles usually represent the experience of white middle class women as the experience of all women. The appearance and functioning of our magazine and our organization has acted as a barrier to involvement by many women. This exclusion represents a tremendous loss, for everyone. Not only have Women of Colour been denied the opportunity to speak and organize through the pages of *Healthsharing*, white women have missed the chance to broaden their understanding of women's issues. These divisions along lines of class and race are increasingly becoming an area of struggle within the Canadian women's movement.

White feminists are being challenged and we hear this as a challenge to *Healthsharing*. It may be difficult for white women to recognize that we have gained from being white in this society. Confronting our privilege is a first step in the process of taking up the challenge, educating ourselves and making change.

It is undeniable that white feminists have had in *Healthsharing* an important vehicle for anger and concerns around the healthcare system. And *Healthsharing* has been a tool for organizing to control our bodies and all aspects of our health. As in other organizations within the women's movement, we have had access to the resources of, been published by, been on staff of and been supported by *Healthsharing*. The time to share these resources, to change our method of functioning to include a diversity of women, is long overdue.

Healthsharing is in the process of change. As a first step we have decided to enlist the help of a facilitator to assist us in developing a plan of

action to overcome the barriers that exist within our organization to the participation of Women of Colour, to help us find the means to make our magazine more truly reflective of the varied and different experiences of women in this country.

We recognize that we need to take on the responsibility of ensuring that all our articles contain an anti-racist perspective and a consciousness around racism. This involves not only working closely with women who write for *Healthsharing* but also developing clear written guidelines for all our contributors. The collective acknowledges that we have a responsibility to take on racism and develop a deeper understanding of ourselves.

Usually *Healthsharing* has not paid writers or illustrators/photographers. But as part of our first step in changing, *Healthsharing* has decided to pay for articles and illustrations from Women of Colour in recognition of the specific obstacles they encounter in writing for the magazine and to encourage women to work with *Healthsharing* to make it relevant in their communities. We see this as the beginning of sharing the resources that *Healthsharing* has built up over the past ten years. While we are making this a top priority, it is also our intention to share our resources equitably with other women who face barriers in writing for the magazine.

We want change at *Healthsharing*. We will continue our discussions but we also want to take action. We recognize that this process will be one that will redefine *Healthsharing* — who participates, who writes and illustrates, who works on staff — whose voices *Healthsharing* represents. We know that *Healthsharing* and the women's health movement will be strengthened. And by creating a stronger movement we will be able to fight the sexism and racism in the health care system more effectively.

We look forward to your ideas and articles, your support and involvement.

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

LETTERS

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

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

Starting Action Group

Since the Supreme Court's decision on abortion last month I have become increasingly aware of the anti-woman sentiment in this society. Oh, I knew it was there all along but it has become more intense. The ravings of the anti-choice faction have become more frightening and there are many days I come home with a sense of fear and anxiety that I have not felt so strongly before. Margaret Atwood's *The Handmaid's Tale* is a

vision of society not outside the realm of possibility.

Maggie Thompson's article, "Whose Womb Is It Anyway?" in *Healthsharing* (Vol 9:2), did little to relieve my anxiety. However, it framed the situation so clearly that it encouraged me to act. I am a registered nurse and I am concerned about the role of nurses, not only in court apprehension of fetuses, but in all types of reproductive technologies. I have written to the Canadian Nurses Association to find out if there are any policies relating to these areas. Thompson's article made me wonder what the nurses on the unit where Rose had her cesarean section had or had not done to support her. I do not want to judge these nurses but questions must be asked.

I would be interested in hearing from other nurses who have similar concerns. It

might be possible to start some sort of action group. You can write to me at the following address.

Liz Hagell
P.O. Box 89
St. Andrews, Nova Scotia
B0H 1X0.

The Story of Rose

The story of Rose (Vol. 9:2) was a most unfortunate and sad case. However, throughout this whole article I really did not see any real reference as to why this fetus was apprehended. We are told Rose had four children, all of whom were apprehended sooner or later.

Also it was pointed out that she was not capable of parenting, so from all this wouldn't it be quite obvious why this child was taken? I realize it was the way it was done that you are objecting to also. Maggie Thompson ends up by wondering what might happen if Rose gets pregnant again. I am too, but for Rose's sake and that of any more children, I sincerely hope she doesn't.

Brenda Skeith
New Dayton, Alta.

Sense of Humour?

I am a feminist and I have a sense of humour. However, the cartoon used on your renewal notice is not funny. It is offensive because it propagates a hateful myth that the unemployed are lazy and women at home do nothing but watch T.V. *Healthsharing* has set higher standards than that.

Rosella Melanson
Moncton, N.B.

Your point is well taken as to the interpretation of the Nicole Hollander cartoon on our renewal notice. We found it amusing because we felt it revealed the nature of many women's work, in low-paying, dead-end job ghettos. Sometimes, television might seem more meaningful. But we

realize that our interpretation is only one response and that we need to be more careful in the future with our use of humour.
WHS

Sharing Healthy Ideas

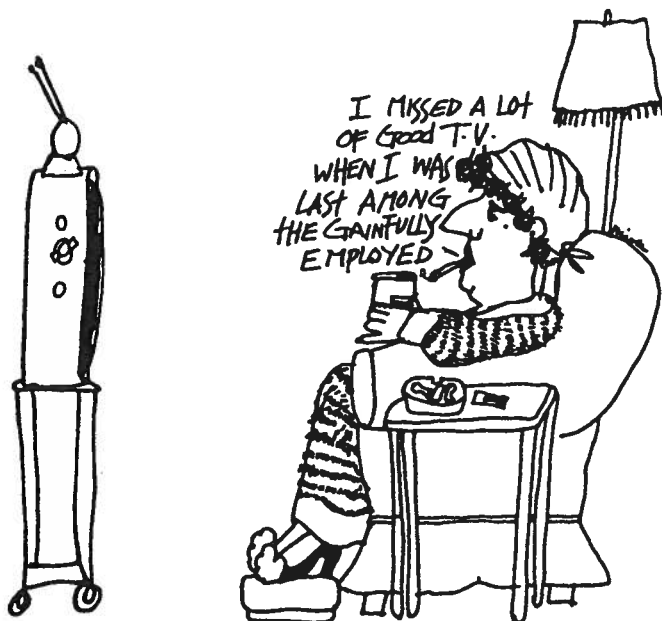
There are ideas I have been planning to knock into some kind of written form for quite some time — ideas distilled from 38 years of experience as a woman and from the 10 years experience as a nurse. One link that has become of interest to me is the link between nurses and laywomen in giving power to doctors who are usually men — why do we do that? how can we change it? why don't we want to change it? what form does it take? The article by Ruth Latta (Vol. 9:2) brought these questions to mind again. Why don't women (both patients and nurses) ask questions and demand answers?

Your magazine never fails to stimulate my thinking and require it to get out of its scientific rut. I look forward to receiving the guidelines and having a go at writing.
D.M. Robinson-Priest, R.N.
Lacombe, Alta.

Disappointed in Healthsharing

I do not wish to renew my subscription to *Healthsharing*, as I have been somewhat disappointed in your magazine. I was looking for a publication which would provide me with concrete, in-depth, up-to-date, scientific information on current health issues pertaining to women. I find *Healthsharing* deficient in this aspect.

In general, I subscribe to the point of view expressed in your magazine, and I am sure many women find it helpful, but it is just not what I was looking for. Even so, I wish you continuing success.
Nancy Goldring
Scarborough, Ont.



Nicole Hollander/In Training to be Tall and Blonde

Endometriosis

I read with interest the article on Endometriosis ("My Story, Our Story," Vol. 9:2). There is a lot more that could be added to it, although it was very well written.

I say this, after having read an article by Nancy Peterson, RN & Bobbie Hasselbring in the May-June 1987 issue of *Medical Self Care*. In particular, it's about a "pioneering study" conducted by David Redwines, M.D. of Oregon, a gynecologist. Yes, he is a male, but forget about gender!

"He discovered that the conventional wisdom about endometriosis simply did not reflect what he observed in his day-to-day practice." "The results completely changed his view of the disease."

I highly recommend this article be reprinted if at all possible. I truly found it excellent!
Patricia Jackson
King City, Ont.

Great Magazine

I am enjoying the spring issue as I've enjoyed the past issues

I've read. They are informative, compassionate, and interesting. Thank you for putting out a great magazine.
Jennifer Sicard
Campbells Bay, P.Q.

Excellent Article

I read your [Susan G. Cole's] article, "No Place to Call Home" in the Spring, 1988 issue and thought it was excellent.
Ruth Danys
Toronto, Ont.

Our Cover

The cover photograph is of two young women who have known each other since their days in daycare. It was taken by Amy Gottlieb.

UPDATE**Keep your law off our bodies**

Ever since the Supreme Court threw out Section 251 of the criminal code, the federal government has been saying that it will propose a new criminal law on abortion. But the Conservative government has never really said why abortion must be recriminalized. The Prime Minister has mused about the "need to protect the country." Protect it from what? From women making responsible decisions about their own lives?

Do we need a law to protect women's health? Hardly — all the old law ensured was inequitable and inadequate access to abortion, poor quality care and non-existent or inadequate counselling. Just as for any other health service, quality of care can only be guaranteed by sound policy, adequate resources and the promotion of high standards. None of this requires criminal restrictions.

While the spectre of

irresponsible and feckless women having abortions up to the moment of birth has been seized upon by the more lurid anti-choice organizers, the more liberal worry about an increase in late abortions without legislation. Some, as a result, have argued for a cut-off point (i.e. 20 weeks) for abortions as the solution.

It is important to remember that no one chooses late abortion. It is traumatic for both the woman and health care practitioners. Even under the old law with its cumbersome system of therapeutic abortion committees, late abortions were thankfully rare. For the last 15 years abortions performed after 20 weeks of pregnancy have constituted less than .5% of all abortions, less than 150 per year across the country.

The major reason for late abortions has been limited access to abortion counselling and services, forcing women

into time-consuming and expensive travel. Hospital quotas and approval committees cause significant delays. Recognizing that the restrictive old law was the root of the crisis of access, the Supreme Court threw it out.

A high proportion of late abortions involve young women who, for a variety of reasons ranging from self-denial of pregnancy to fear of parental reaction, find themselves in this situation.

Any legislation allowing abortions only up to a certain point would endanger those women who currently face the greatest difficulty in obtaining access to abortion.

Beyond the potentially devastating effects of legislating arbitrary cut-off points for abortion are even more ominous implications for state regulation of pregnancy and childbirth. What is the view of women lurking behind the high-minded concerns for fetal protection? It is that women cannot be capable and caring moral decision makers.

There is a deeper moral dimension to placing abortion, alone among health services, in the criminal code, defining it as a problem of special moral significance. Criminalization serves to reinforce conventional views of abortion as at best an

unfortunate necessity which must be strictly regulated and at worst as deviant and repugnant. The pervasive legal obstacles, medical control and bureaucratic hurdles which confront women are a constant reminder that in demanding this "choice" we are transgressing prevailing norms of selfless femininity and motherhood.

The reproductive rights movement believes that immediate access to safe abortion, as well as other facets of comprehensive reproductive health care, is essential to women's health and well-being. For individual women, abortion is a matter of personal choice; for society as a whole, abortion is a matter of health policy not criminal law.

Rather than seeking to criminalize women and their health care providers, it is the responsibility of both levels of government to ensure that every woman has prompt and free access to the highest quality reproductive care in her own community. The means to this goal is a network of publicly funded clinics across the country, providing comprehensive services in whatever language women need.

B. LEE

Liposuction — dangerous surgery for natural curves

Imported from France six years ago, Liposuction — the suctioning of fat mainly from the thighs, abdomen, buttocks, knees, face and other parts of the body — has become the most frequently performed cosmetic procedure in the U.S. In 1986, almost 100,000 people — more than 85 per cent of them women — paid an average of \$4,000 (U.S.) in the United States to have their bodies trimmed to a certain shape by liposuction. Information on the number of liposuctions being performed in Canada is unavailable, but the numbers are increasing.

Liposuction is the first surgical procedure claiming to reduce "saddlebag thighs" and other natural curves in the body, while supposedly not producing the scars that traditional cosmetic surgery does. The typical patient is slim, healthy and under forty, with body proportions which do not conform to an "ideal" image. Some doctors have promoted it as a remedy for "violin deformity" that is estimated to "afflict" about 75 per cent of all women. And it has been recommended as a procedure to attain "great legs" to show off under a mini-skirt.

This is another example of the medical profession making women's normal shape into a medical problem. In fact, liposuction is major, and often

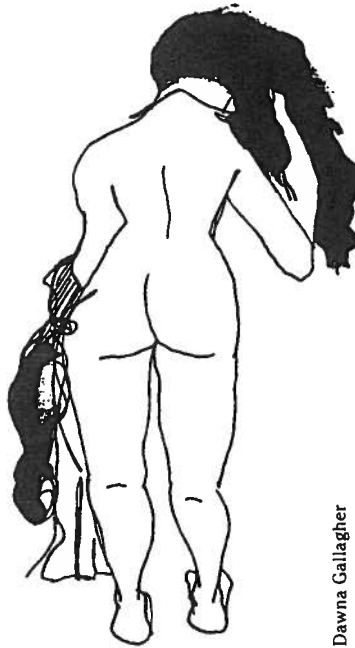
dangerous surgery. It usually requires general anesthesia and overnight hospitalization. For up to six months the patient's activity is limited by pain, numbness, bruising, discoloration, and by a girdle that must be worn in the first six weeks to prevent skin sagging.

During the operation, a small hose is inserted through a small incision into the targeted area of the body. After 15-20 minutes of "tunneling", rotating the hose beneath the skin more or less blindly, the fat is plucked loose. The fat — typically less than three pounds total — is then suctioned into a plastic tube and dumped. When the fat is disrupted many small blood vessels get torn.

Through damage to the capillaries, broken down fat cells may end up in the blood stream and the fatty acids can settle in the lungs. At this point, fat embolism may occur.

A second major complication is fluid depletion — fluid from the blood stream and body cells rushes to the "tunnel" created by the loosening of fat, potentially causing shock and unconsciousness. Further complications include massive infection caused by damage to blood vessels and internal injuries due to the rotation of the hose.

Although the American



Dawna Gallagher

Society of Plastic and Reconstructive Surgery recently called liposuction "safe and effective," so far eleven deaths and nine cases of serious illness from liposuction have been reported and investigated. At least one surgeon's license has been revoked. Another stopped performing liposuction after his first patient's death. But those who have flocked to this booming business say they are giving women a "choice to look good," while they also gratify their own egos by doing "better than God did."

EVA A. SZEKELY

Making changes in the health care system

"What Can I Do?", a new project sponsored by the Northwestern Ontario Women's Health Information Network (WHIN), is addressing women's roles in the decision-making process of our health care system.

The goal of "What Can I Do?" is to produce a resource kit, with a video component, that will enable women to actively participate in policy and decision-making in health care organizations in Northwestern Ontario.

To achieve this, information is being collected from district health councils, hospital boards and other health related organizations, on their organizational structure and procedures.

As well, workshops will be conducted throughout the region, identifying barriers to women's participation in health organizations.

Finally, through a mail survey and interviews, the "What Can I Do?" staff will be asking women who are or have been involved to assess their roles in health care organizations.

The target date for completion of the resource kit is January 1989. At that time, a training session will be held which will instruct women in the use of the kit. Kits will also be available through Northwestern Ontario public libraries and for rent or purchase from WHIN.

In its usual style, WHIN's research will emphasize women's experience and group participation. More information can be obtained from: Teresa Legowski, 8A.N. Cumberland St., #17, Thunder Bay, Ont. P7A 4L1. (807) 345-1410.

THERESA WRIGHT



Smokefree

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Phyllis Marie Jensen, R.N., Ph.D.

183 Munro Street, Toronto, Ontario M4M 2B8

(416) 465-1323

New candida diagnosis and treatment

Candida (yeast) overgrowth is a major problem for many women. Recurring vaginal infections are only one particularly troubling aspect of the syndrome. Food allergies, heightened chemical sensitivities, mental disorientation, depression, lack of energy, even MS and Lupus type symptoms are all common manifestations of overgrown candidiasis in the intestinal tract.

One of the most problematic aspects of treating yeast overgrowth has been the lack of clinical tests pinpointing what kind of candida strain the culprit is (there are 79 in all); how extensive and what kind of damage it has done within the gut and other target organs; and what drug or naturally occurring substance is most effective against the particular candida in question. For many patients and health care practitioners, hit and miss treatment is part of a slow, painful process in which many different agents, diets and nutritional supplements are tested through experimentation.

For all these reasons, two new developments from the U.S., now available in Toronto,



TVOntario

constitute breakthroughs in the struggle for restored yeast balance. Through referral from the Candida Research and Information Foundation (CRIF) or a family physician to Dr. Carolyn Dean's office, women now have access to a set of laboratory tests which answer quite precisely

whether there is overgrowth, which strain of candida it is, whether it has permeated the lining of the gut, and what anti-fungal agent is appropriate to use.

These tests were developed by Ari Wojdani, a researcher in anatomy and immunology at the University of California

at Los Angeles. Maggie Burston, Canadian candida pioneer and founder of the Candida Research and Information Foundation, worked with Wojdani to bring the tests to Toronto. She is now working to make them available across the country. "American government Medicare, and the Blue Cross, Aetna and Provident insurance companies all accept these tests as proof of candida, and CRIF endorses them because they can reduce the pain and suffering people with candida face in their struggle for health."

In relation to treatment, British trained allopath and homeopath Dr. Shruti Ghadi is now treating patients with what's known as the "candida vaccine" — homeopathically prepared solutions made with a small amount of one's own yeast. Treating candida with this kind of vaccine is considered a valuable therapeutic tool in the U.S. Like the new tests, this can dramatically improve anti-candida efforts. The task now will be to make both tests and treatment broadly available.

VARDA BURSTYN

\$\$ for babies

For the past three decades, Quebec has seen its birth rate decline at a steady rate. Quebec now has the lowest birth rate of all provinces at 1.4 (the average number of children per woman of child-bearing age).

In response to the "crisis," the Quebec government will be introducing financial incentives in an attempt to encourage women to have babies. These measures

include:

- increased child tax exemptions
- a \$500 payment for the birth of a first and second child and \$1000 for the birth of a third child
- secured loans of up to \$7000 for families with two or more children
- increased tax deductions for child care expenses

According to many women's groups, the intentions of the

government are superficial and blind to the economic and social reality of women. It will take more than meagre financial incentives to compensate for the deeper-rooted problems of low salaries, poor maternity benefits, being a sole-support mother, lack of accessible, quality day care and inadequate social support for parents. The natalist policy also demonstrates an attitude towards women which defines

us solely on the basis of our capacity to reproduce. Due to these inadequacies and because not one country has been successful in increasing birth rates through financial incentives, the Quebec project seems likely to fail.

MARION LOKHORST

Patients' rights committee

In British Columbia the Health Action Network Society (HANS) has formed a Patients' Rights Committee to deal with the right of the patient (and of the parent, if children are involved) to choose the direction of medical treatment. The Patients' Rights Committee believes that you should have the freedom to consult alternative practitioners if you prefer a non-drug or nutritional approach to health care.

This issue is particularly relevant when it concerns your children. In the case of five-year-old Tarryn Oliver, who suffers from a rare eye condition, the B.C. Ministry of Social Services is exerting extreme pressure for surgery even though eye specialists

are not recommending surgery. These specialists believe that in this case, surgery is a high-risk procedure unlikely to produce significant improvement. Even so, Tarryn's mother is being accused of child abuse by Social Services for refusing the operation.

HANS has monitored cases where children were apprehended in order to enforce conventional treatment when parents instead desired a holistic approach. The legal ramifications of this situation are profound. If the government can enforce medical treatment 'for your protection' or 'for your own good', are you losing what should be a fundamental right



to medical freedom? And in the case of children, is the refusal to accept conventional medical care a new interpretation of child abuse? For

more information, contact HANS at (604) 435-0512.

SHARON KLEIN

50 years too many

D.E.S. Action Canada launched its second major Awareness Campaign in April of this year. 1988 marks the fiftieth anniversary of the creation of the drug Diethylstilbestrol (D.E.S.). D.E.S. is a synthetic hormone prescribed for pregnant women between 1941-1971 to prevent miscarriage. Although early testing showed that the drug was ineffective, it remained available until 1971 when a direct link to cancer was discovered. Since then, health problems ranging from cancer to infertility and pregnancy problems (increased miscarriage, premature delivery, and ectopic pregnancy) have been discovered in children whose mothers took D.E.S.

The D.E.S. story in Canada began with Harriet Simand who, in 1981, learned that she had a rare vaginal cancer linked to D.E.S. exposure.

Searching for information, Simand soon discovered that there was no group in Canada to inform or support those exposed to D.E.S. With help from D.E.S. Action groups in the U.S., Simand convinced the federal and provincial governments to provide funding in order to alert the public. Today there are 10 D.E.S. Action groups operating across Canada.

The groups are still dealing with D.E.S.-influenced problems. D.E.S. is still used as a morning after pill and as a treatment for breast and prostate cancer. Widespread use of D.E.S. continues in Third World countries.

The D.E.S. story is a story that needs to be told. For information contact D.E.S. Action at: Snowdon P.O. Box, C.P. 233, Montréal, Que. H3X 3T4. (514) 482-3204

THERESA WRIGHT

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MAGAZINE BY WOMEN OF COLOUR

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HEALTHWISE

Dyslexia

Judith Derksen

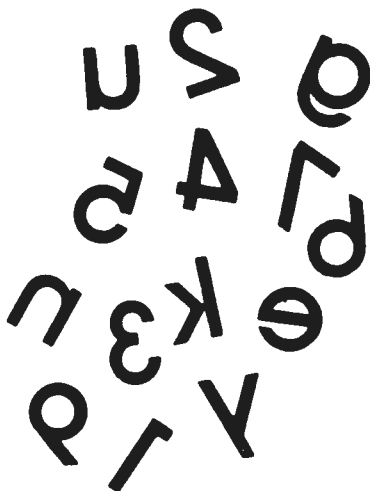
Dyslexia is a specific learning disability that affects up to 10 per cent of the Canadian population. Research into dyslexia is still in its infancy, and statistics regarding the disorder are difficult to tabulate. In fact, many cases of dyslexia go undiagnosed, especially within the female population. Dyslexic girls become dyslexic women and, without accurate diagnosis and treatment, may never become fully literate.

Dyslexia is a Greek word meaning *difficulty in mastering words or verbal language*. Various definitions have emerged to describe the disorder, and it is often included under the broader headings of *specific learning or reading disability*. The World Federation of Neurology considers dyslexia "a disorder manifested by difficulty in learning to read despite conventional instruction, adequate intelligence and sociocultural opportunity."

This definition eliminates several misconceptions about dyslexia. No connection between dyslexia and low intelligence quotients (IQs) has been established, and it is not a form of retardation. Among dyslexics there is a broad range of IQs; some dyslexics are considered geniuses. Leonardo da Vinci and Albert Einstein were known to have dyslexia, and an estimated five per cent of medical students have learned to cope with the disorder.

Dyslexia is not confined to low-income groups, and its incidence is not eliminated by superior schooling. It occurs in families that are physically and emotionally sound, and place a high value on learning.

Some experts have tried to link dyslexia with other medical factors. To date, no basis has been found for theories connecting dyslexia with left-handedness, immune disorders or middle ear disease.



Katie Pellizzari

Dyslexia has long been considered a primarily male disorder. Recent studies show that the ratio of 6 to 1 in favour of males that is often quoted may be misleading. While tests on previously labelled children indicate a higher ratio of learning disabled males, tests on unscreened children yield nearly balanced ratios. This has led some researchers to the conclusion that female dyslexics are not being diagnosed as frequently as males.

Most research into dyslexia has been conducted on male subjects. Studies including female subjects indicate that a high percentage of female dyslexics have IQs significantly lower than male dyslexics. Some experts believe female dyslexics with high IQs often remain undiagnosed and are able to cope more readily than those with lower IQs.

Causes

Despite an increase in research since the 1970s, the exact cause of dyslexia is still unknown. Theories involving physical, psychological and educational factors are still being investigated. Any combination of these factors may be responsible for individual cases of dyslexia.

Accepted physical causes include: an inefficient link between the left and right hemisphere of the brain, slow development of a particular area of the brain, or disorders in the actual structure of the brain. Heredity may also be a factor. Approximately 50 per cent of dyslexic children have family histories involving dyslexia or other learning disabilities.

Psychological problems are thought to be the cause of some cases, but many experts believe these should be viewed as symptoms of dyslexia. Undiagnosed dyslexics are often labelled "lazy," "slow" or "uncooperative." Repeated failure and lowered self-esteem can create a cycle of negative feelings and behaviour.

Teaching methods and classroom structure may also be factors causing dyslexia. The *look-say* or *whole-word* method of reading instruction has been replaced with phonetic programs in some instances. Open area classrooms, where concentration is more difficult, have also been examined as a cause. Research into these areas is limited, and is not considered conclusive.

Symptoms

Until more is known about the disorder, some dyslexics will not receive treatment during their formative years. Parents and teachers should be aware of the symptoms, and be alert for signs of the disorder in either sex. Although symptoms are as varied as the individuals themselves, caregivers can watch for the following:

In Infancy

- delays in sitting, standing, crawling or walking
- abnormally slow speech development

Preschool to Adult

- difficulty with eye-hand coordination
- left-right confusion
- confused sense of time, direction or distance
- difficulty relating events in sequence or following instructions when sequence is important
- short attention span
- reversal of words, letters or numbers

- reversal of syllables (teolard for leotard)
- consistent misspellings and mispronunciations
- inability to comprehend abstract concepts

Dyslexics usually have difficulty with reading and writing, but some may master language more readily than other subjects or principles. Due to its complex nature, dyslexia can only be diagnosed by psychologists or trained educational specialists.

Diagnosis

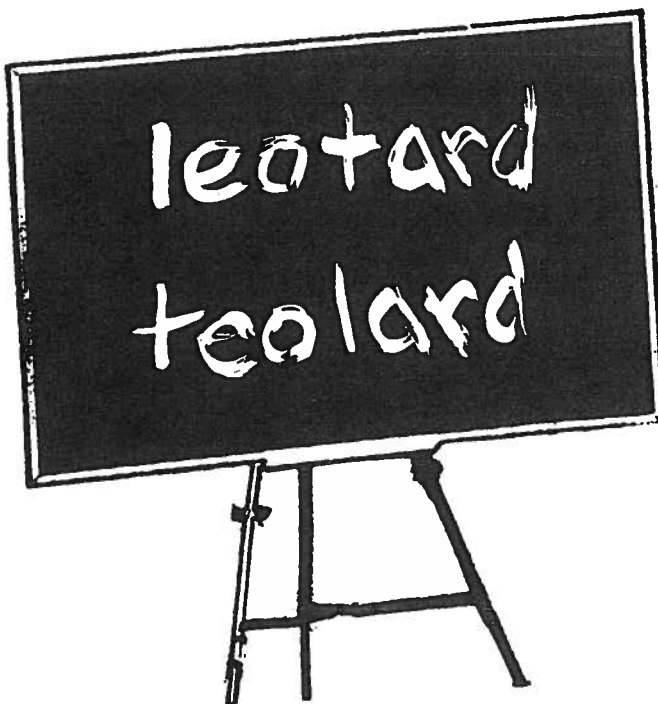
A complete medical examination should be done to eliminate medical problems before a child is referred for assessment. Once these are ruled out, IQ and language skill testing are initiated. These standard tests may be sufficient for an accurate diagnosis, but some cases may require specialized procedures.

The Bender-Gestalt Test developed by Dr. Lauretta Bender during the 1930s is still widely used as a diagnostic tool. Newer testing methods using electronic brain scanning equipment, computers, and light sequences that substitute for letters may make it possible to accurately diagnose preschoolers in the near future. Experts are also attempting to break the disorder into subtypes so appropriate testing and treatment methods can be developed for each. This research may also determine why female dyslexics score differently in test categories than dyslexic males.

Treatment

There is no cure for dyslexia, but it can be treated and overcome. Treatment usually consists of remedial and/or corrective techniques. Multi-sensory approaches, involving all the senses, have been developed for severely dyslexic children. Due to the variety and range of severity of symptoms, individualized programs are the most effective.

A developmental approach, that simply allows more time to learn through regular teaching methods, is usually not effective. This treatment may be sufficient for slow learners, but does not address the specific needs of the dyslexic child.



Katie Pellizzari

Frustration and resignation can interfere with the best treatment program and must be eliminated in order for the dyslexic to work to capacity. If emotional and behavioural problems have developed, psychological counselling may accompany the treatment process.

Prognosis

Many factors can affect a dyslexic's progress, and predictions are hard to make. The earlier a child is diagnosed and treated, the better her/his prognosis. Problems that continue into the higher grades or adulthood are more difficult to correct. Not all schools offer treatment for older children or adults, even if a need is established.

The support of family, teachers and peers can be vital to the dyslexic. Even a highly motivated pupil may become discouraged by another's lack of faith in her/his ability.

Most dyslexic children can attain literacy. Educators are becoming more aware of the symptoms of dyslexia, and special programs are now available across the country. A call for teachers to receive specialized training in recognizing all types of learning disabilities has been raised by concerned individuals and organizations.

Post-secondary institutions in most major cities have developed pro-

grams for dyslexic adults. Calculators, computers and word processors may make it possible for dyslexics to work at the same level as classmates. Self-help sessions are often included in these programs.

Although researchers have made significant gains, there is an ongoing need for research into all aspects of dyslexia. Until more is known about the disorder a higher degree of awareness must be encouraged in all caregivers. Earlier diagnosis and more effective treatments are required to enhance the dyslexic's prognosis. Without the required help many dyslexics may never achieve the literacy level necessary to become functional members of society.

Where to Find Help

Help is usually available through the school system, or for preschoolers and adults, through a pediatrician or family doctor. If referral is denied or unavailable through normal channels, non-profit groups exist across Canada and testing or treatment can be arranged through them. Some will also act as advocates for parents or adults to elicit help on their own.

Judith Derksen is a freelance writer living in Winnipeg who has herself overcome dyslexia.

For Further Information Contact :

Orton Dyslexia Society
Box 35322
Station E
Vancouver, B.C.
V6M 4G5



Katie Pelizzari

**Learning Disabilities Association of
Canada Offices:**

Alberta
1208-10025-106th St.
Edmonton, T5J 1G4
(403) 423-1360

British Columbia
203-15463-104th Ave.
Surrey, V3R 1N9
(604) 588-6322

Manitoba
201-720 Broadway
Winnipeg, R3G 0X1
(204) 774-1821

New Brunswick
c/o Learning Centre
University of N.B.
Bag Service 45333
Fredericton, E3B 6E3
(506) 453-3515

Newfoundland
P.O. Box 9988
Station 'B'
St. John's, A1A 4L5
(709) 895-3260

Northwest Territories
P.O. Box 242
Yellowknife, X1A 2N2
(403) 873-6378

Nova Scotia
P.O. Box 3444
Halifax S. Postal Station
Halifax, B3J 3J1

Ontario
304-1910 Yonge Street
Toronto, M4S 1Y6
(416) 487-4106

Prince Edward Island
P.O. Box 1081
Charlottetown, C1A 7M4
(902) 892-9664

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1181, rue de la Montagne
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(514) 861-5518

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Lisa McCaskell

We Are Not Immune

Women and AIDS

Through a glass door identified only by a street number, up one flight of stairs, straight to the back, around a corner and I'm there. It's women's hours at Hassle-Free Clinic in Toronto. I'm here to research this article and at the same time I want information to help me decide if I should be tested for the AIDS virus.

Behind the counter I see a friend who is going to interview me. The thought of being interviewed seems a little strange — I'm used to being the one who asks the questions. We say Hi and she gives me a history form to fill out, as if I'm a real patient. I know I'm nervous when I see I've filled in my nursing license number instead of my OHIP number. The form is unremarkable — age, date of last menstrual period, method of birth control, reason for visit. Reason for visit stumps me — am I risking anything by saying I'm considering being tested for the AIDS virus? Who might see these records? I know Hassle-Free doesn't give out names of clients who have been tested for AIDS but could my "reason for visit" somehow make my anonymous result easier to trace? And what if my test was positive? Governments in some countries and in some Canadian provinces are seriously considering putting people with AIDS into quarantine. "Don't be ridiculous," I tell myself. "You probably won't ever be tested and besides you're here to see what the issues around AIDS are." Bravado prevails. I write down HIV test counselling.

Waiting, I check out the bland grey walls, a few arty prints, a good

supply of magazines and my fellow patients. There is a mixture of women in their late teens and early 20s today — some dressed quite conservatively, others less so. A young male skinhead all in black waits for his girlfriend. On other days a few middle-aged white women might occupy these chairs, or perhaps a woman of colour or a new immigrant. The clinic has no "typical" client. What we all have in common though is concern about some aspect of our sexuality. Some of us want information on birth control or sexually transmitted diseases. Others may be waiting for test results or counselling to cope with the sometimes traumatic aftermath of an abortion. I know that these days many women are coming to talk about AIDS and what it has to do with us as women. I am one of them.

AIDS, Acquired Immune Deficiency Syndrome, is a disease in which part of our body's immune system is damaged. Our bodies become open to infection by a number of serious, often fatal illnesses which do not normally affect healthy people. Two of the most common AIDS related diseases are pneumocystis carinii pneumonia (PCP) and Kaposi's sarcoma, a rare kind of cancer. It is these and other infections, not the AIDS virus itself that can cause death.

AIDS is believed to be caused by a virus known as Human Immunodeficiency Virus (HIV). To transmit the virus either blood, semen or vaginal fluid has to go from one person into

the body or bloodstream of another person. This usually occurs during sex or by sharing needles used to inject drugs. Since adults may carry HIV in their blood for years without any symptoms, they may unknowingly pass HIV on to others with whom they engage in high risk activities (see box). In countries where blood is not screened for AIDS it is possible to catch AIDS from a contaminated blood transfusion. But in Canada, since November 1985, the Red Cross has screened all donated blood making it almost impossible to receive blood containing the AIDS virus. AIDS may also be passed from a pregnant mother to an unborn child, during the birth process or perhaps by breastfeeding.

AIDS is not easy to catch. It is not spread through casual contact or through sweat, tears or saliva. It cannot be caught from toilet seats, bathtubs, doorknobs or clothing used by a person with AIDS. There are no known cases of a person catching AIDS even from close daily contact, over extended periods, with a person who has AIDS. At this moment there is no cure for the illnesses associated with AIDS although some drugs and therapies appear to be effective in reducing symptoms and prolonging life.

In Canada, by mid-April this year, there were 1,719 diagnosed cases of AIDS; 86 of these were adult women. Of these 86 women, one was an IV drug user, 28 came to Canada from geographic areas where HIV is found in a high percentage of the population; 28 had had sexual contact with



Buseje Bailey

swers. Your answers to these questions will be more useful to you than mine.

Counsellor Bonnie Benedik begins the interview by explaining AIDS counselling at Hassle-Free. "We like to see people three times," she says, if they are considering the HIV test. "The first visit is for approximately a half-hour to give you information, to get information from you, to explain how the virus is transmitted and to find out whether or not you're at risk." Hassle-Free counsellors are educators: their role is to provide information which will allow their clients to live their lives as safely as possible. They try to focus the discussion on education about AIDS and how to prevent it — safer sexual practices are discussed in detail. Clients often

Pregnant women will occasionally get a false positive test result.

need to know what kinds of sex are considered low risk, how to use condoms and how to talk to their partner about using one.

Many women are determined to have the AIDS test on the first visit, something clinic counsellors strongly discourage. Counsellors want to be able to assess what effect either a positive or negative result will have on a woman before she is tested so that they can offer appropriate counselling and help. Also there is no guarantee that an HIV test done on a first visit will be accurate. This is because there may be a two to three month delay between infection and the production of antibodies that will show up on a test. To overcome this, workers at Hassle-Free ask a client when she last had unsafe sex or may have been exposed through shared needles or other high risk activities. Then, "if you do opt to have the blood test done, we would recommend that the only accurate test you can get would be three months from your last at-risk contact," says Benedik. "So if you want to have an accurate blood test, any further sexual

a person "at risk", and 22 got sick as a result of a blood transfusion, prior to 1985. Seven women had no identified risk factors. Thirty-three infants and children also had AIDS. Twenty-nine acquired the illness perinatally, that is before they were born or during the birth process. The other four had received contaminated blood transfusions, also prior to 1985.

On the surface these numbers are not overwhelming. In Canada women represent only a fraction, 5 per cent, of the diagnosed cases so far. Yet in the U.S. women are proportionately the fastest growing group of people with AIDS. And in New York City, AIDS has recently become the primary cause of death for women 25-29 years old. In Africa and the Caribbean 50 per cent of people with AIDS are women. AIDS is not a gay male's disease — it can affect anyone who is exposed to the virus. Since we can no longer deny that this fatal illness has anything to do with us, it seems most

sensible and empowering first to learn as much as possible about it, then to decide if we need to change our behaviour and if so, how and when.

Sitting down, tape recorder on, the interview under way, I am introduced to one of the most important aspects of AIDS education — frank talk about sex — a conversation that looks at practices, ideals, risks and changes. I have excerpted here small pieces of our interview. These excerpts in no way represent a total counselling session at the clinic but instead are used to highlight information I chose as important to this story. I have also chosen to move much of the vital information about safer practices out of the story and in a box on page 14. Much of the other information I got from Hassle-Free is found throughout the article but not in quotes. Also for reasons of personal privacy I have at times changed or deleted my an-

contact you have with the person should be wearing condoms. We would be medically irresponsible to do the test without waiting that long.

"The second time we like to see you," says Benedik, "is if you have decided you do want to have the blood test done, to have you come in for that and to review your risks and talk about how long it takes for the test to be done." The third visit is to get the results and to receive further counselling. Results are never given out over the telephone.

We need to talk seriously about sex with our partners and make decisions about what we will and will not do.

One of the problems with HIV testing though is that it is not 100 per cent accurate — both false negatives and false positives are possible. A positive test means you have been exposed to the virus and have developed antibodies to it which are in your blood. Unlike other illnesses, having antibodies does not mean you're immune to AIDS, just that your body has tried to fight it off. Researchers have also found that pregnant women will occasionally get a false positive reading. If you are pregnant and have tested positive you should be tested again.

Every person who is doing AIDS counselling performs many functions; two of the most important are to allay the fears of the "worried well," and to determine who is engaged in high risk behaviour, giving them the tools and knowledge to protect themselves. After describing the way Hassle-Free works, Benedik starts to identify risk factors and fears.

BB: What are your concerns about the virus? I would like to know why you're here, whether you're healthy or not, or if you're with somebody you're concerned about.

LM: I don't have any health prob-

Safer Sex

The AIDS virus known as Human Immunodeficiency Virus (HIV) is transmitted through intimate contact such as sexual activity and sharing any needles. The virus lives mainly in semen, blood, menstrual blood, and vaginal and cervical juices. Either blood, semen or vaginal secretions have to go from one person into the body or bloodstream of another person to spread the virus. HIV can also live in breast milk, saliva, urine, feces or tears. AIDS cannot be transmitted through saliva or tears. It may be transmitted through breast milk. It may be possible, although there are no proven cases, to catch AIDS if urine or feces of an infected person gets into an open cut or sore of an uninfected person.

Risky Sex

- Vaginal intercourse without a condom.
- Anal intercourse without a condom.
- Sharing sex toys from one person to another without condoms on them or without cleaning them in between.
- Any kind of sex where blood including menstrual blood is shared between people.
- Using several fingers or your hand inside the vagina or anus followed by intercourse without a condom.

Low Risk (Some cases of AIDS may be from these)

- Oral sex on a man without a condom if he comes in your mouth.
- Oral sex on a woman during her period if a barrier is not used.
- Using several fingers or your

hand inside the vagina or anus, if a glove is not used and you have open sores on your hand.

Very Low Risk Sex (may be possible but no known cases)

- Oral sex on a man without a condom if he pulls out before he comes.
- Oral sex on a woman when she is not having her period.
- Sex acts with urine or feces (because blood may be in them) if they get into the bloodstream (through eyes, mouth, vagina, anus or open cuts, sores or rashes).
- One or two fingers in the vagina or anus if you have open cuts, sores or rashes on your hands.

Safer Sex

- Protected vaginal or anal intercourse using a condom. It's even safer if spermicidal jelly or cream containing nonoxynol-9 is used with the condom.
- Touching or masturbating each other, body rubbing, hugging, dry kissing, licking nipples or skin, massage, fantasy.
- You could use latex barriers for oral sex on women during their periods and for oral-anal sex. There are no known cases of women catching AIDS from oral sex.
- Use condoms on your sex toys. Clean them between people with soap and water, then soak them for 10 minutes in rubbing alcohol and rinse well with hot water.

Excerpted with some modifications from a draft pamphlet on Women and AIDS to be published by the AIDS Committee of Toronto.



Alison Bechdel/Making It, Firebrand Books

lems at the moment. But I have had a number of partners over the last 10 years, although I have been monogamous for about four years.

BB: Has your partner had other partners during this time?

LM: Yes, but I'm more worried about a relationship I had just over four years ago with a man who came from an area where AIDS is now very common. He had also been sexually active there.

BB: Was he a heterosexual?

LM: Yes.

BB: Did you use condoms?

LM: No.

The next questions attempt to narrow down how risky this affair had been long before most Canadian or American women started worrying about AIDS. Was it vaginal intercourse? Did you have anal intercourse? What about oral sex? Did he have any male partners? Did he use injection drugs? Is this person well? When was your last contact with this person?

Subsequent questions examine the intimate details of my present relationship and lifestyle. Any gay or bisexual partners? Any partners who use IV drugs? Blood transfusions prior to November 1985 to either you or any partners? Do you use condoms now? Do you know if your partner uses condoms with his other partners? Do you have vaginal or anal intercourse?

Although I've been working as a nurse for years, exposed to the intimate details of people's emotional and physical lives and even though the interviewer is my friend, I feel a certain amount of resentment and sadness as I answer her questions. I feel like I'm going back in time, slipping beneath old worries and guilt about what I've done, when, and with whom. At some point in my early 20s, birth control pills, IUDs and a notion of sexual liberation had, I thought, put an end to these years. Since I was the one who looked after birth control (it was my body, after all), sex wasn't a thing to talk about, it was something to do. And I believed my actions had larger implications than just sexual gratification. I'm sure I wasn't alone. For many of us our sexual behaviour was a jab at conventional morality, traditional assumptions about the

family and a symbol of a different, more open way of being. And here I was in 1988 feeling guilty and slightly regretful because I had a short relationship with someone I failed to keep in touch with.

BB: Have you thought about how a positive result might affect you?

LM: I don't think it would be devastating but it would be very upsetting. I don't know what it would mean in terms of my day-to-day life. I suppose it's a little easier for me because I do have friends who are HIV positive, male friends that is. Benedik questioned me carefully about how I would cope with a positive test result wanting to know what kind of help I might need, how I thought my life would be affected in the long-term, and what I knew about the health of people who have tested positive. I wanted to know what effects a positive test might have on pregnancy. This, I learned from Benedik and from further research, is a controversial discussion.

In the U. S. and Britain, HIV testing has been proposed as mandatory or "routine" for all pregnant women. While many women might want to know if they are HIV positive when they are considering pregnancy, the implications of mandatory testing are far-reaching. This March, Ruth Schwartz, coordinator of the San Francisco-based Women's AIDS Network was interviewed by *The Exchange*, a U.S. AIDS publication. She talked about pregnant HIV positive women and abortion, explaining that since pregnancy suppresses the immune system, an abortion may help to prevent the progression of AIDS in HIV positive women who have few or no symptoms. "At the same time, the choice to abort must be an individual decision, and for many women with AIDS the concern is the right *not* to abort," says Schwartz. Later in the interview she expanded on the health risks to the mother and the fetus. "Infants can become infected in utero or during the birth process. It is clear that if the baby is (HIV) positive, so is the mother. What is not clear is what percentage of infants merely retain antibodies for several months and are not carrying the virus. Researchers roughly estimate that rate of infection to be 50 per cent, although studies to date

have been too limited to yield conclusive results."

Schwartz says it is dangerous to propose that HIV positive women not be allowed to have babies. "The problem is that if you start advising seropositive (HIV positive) women to have abortions the specter arises of advising women to abort fetuses with any 'defect'. Also this country has a history of coercively sterilizing poor and minority women, and the issues of abortion and sterilization for seropositive women can't be separated from that history." This issue is even more gripping when we consider that the majority of American women with AIDS are poor and minority women — 51 per cent of all U. S. women with AIDS are Black, 21 per cent are Latina and 50 per cent are also injection drug users. Ninety per cent of U. S. children with AIDS are children of colour.

In New York City, AIDS has recently become the primary cause of death for women 25-29 years old

While the situation in Canada may not be as extreme, class and racial bias certainly affect issues of AIDS testing, education and provision of care. Over one third of Canadian women with AIDS have immigrated from areas where AIDS is endemic — that is Africa or Haiti. Women who use injection drugs may often be poor and lacking in adequate medical and social services. Poverty and racism may be better hidden here than in the U. S. but they affect the way women with AIDS are treated medically and socially.

Next Benedik wants to know whether I would tell my partner if I got a positive test result. I assure her that I would. Hassle-Free asks for a commitment from clients to tell their sexual contacts of a positive test. "We would be quite prepared to help in any way possible," says Benedik. "We would be quite prepared to tell that person for them or to help tell that person. We would be prepared to do anything necessary but

Injection Drug Use

Doing injection drugs (intravenously, intermuscularly or under the skin) can spread the AIDS virus. Traces of blood in shared needles, works and/or cookers can spread the virus. Be sure not to share needles if you use drugs. Drugs may damage the immune system making it easier for the AIDS virus to get into your system.

Safer Drug Use

You could do one of the following:

- Switch to drugs that do not use needles.
- Stop sharing needles and works.
- Buy clean needles and syringes at the drugstore and only use them on yourself.
- If you share or rent, clean the cooker first.
- While the drugs are cooking down, clean your needles well and rinse well.
- "Pumping" — drawing blood in and out of the needle while shooting up, to get all the drug in you, is really dangerous if you share.

Cleaning Needles and Works

- Clean your cooker first, then clean your needles well with bleach.
- The bleach solution should be nine amounts of water to one amount of bleach.
- Rinse the cooker.
- Fill a glass with bleach and draw the bleach into the syringe and squirt out. Do this three times.
- Draw clean water into the syringe and squirt out. Do this three times.
- Wash everything well with clean water before shooting up.
- Never shoot or drink the bleach.

Excerpted and modified from a draft pamphlet on Women and AIDS to be published by the AIDS Committee of Toronto.

people have to know what they are being exposed to if they are to protect themselves," she says.

The interview turns to talking about sex with your partner — in my case a heterosexual partner.

BB: Talking about this stuff is very important. It's certainly something most of us have been brought up not to talk about. There are a number of difficulties that become very emotionally triggered.

LM: If I was starting a new relationship, it would be much easier somehow because that would just be one of the ground rules. To change something that's been ongoing is very difficult. You can't really imagine how to start it.

BB: To me to be pushing the issue with condoms requires a great sense of security in the relationship, self-esteem, a whole lot of things; I don't know a whole lot of women who have all that stuff together. Certainly when I think of the AIDS virus, it's one of the most political issues I can think of.

Because of AIDS, women, whether lesbian or heterosexual are now faced with some very personal and political questions. In order to protect ourselves and others we need to talk seriously about sex with our partners and make decisions about what we will and will not do. It means choosing our partners carefully and learning how to talk to them about our own sexual histories and theirs. It may mean saying no to a partner who won't agree to practicing safer sex. These conversations, whether with an old lover or a new one, with a woman or with a man, will not be easy at first. Many men don't want to talk openly with women about sexual behaviour and history. They may not want to tell about previous homosexual experiences or injection drug use. They may not want to divulge information about previous lovers. Many women do not feel free to ask their male lovers about these things and often they may not want to know the answers. Talking about sex may be particularly difficult for some women for whom cultural patterns of subervience to husbands is basic to the relationship. This may also be true for older women who have been

married for years and who have never openly questioned their partners' fidelity or admitted their own affairs.

Lesbians may have a slightly easier time talking about sex to their partners since power in the relationship may be more equally shared, making honest conversation more likely. However, because lesbians have been considered at low risk for AIDS it may not seem important to change behaviour or even to talk about AIDS. This attitude ignores the reality that lesbians may, like anyone else, have been infected by a blood transfusion, had sex with an infected male or have used injection drugs at some time. Lesbians may also be at risk if they have had artificial insemination. Both lesbians and single women may have difficulty getting sperm from official sperm banks which now screen sperm donors for AIDS. Instead women may get sperm from male friends who could be HIV carriers. There are documented cases of women who have contracted AIDS this way. If they use the informal route, women should ask that men who are considering donating sperm to them be tested twice for HIV with a period of three to six months between tests. Potential donors should practice safer sex and not share needles between tests.

Although talking about sex may not be easy at first, it gets easier and it is a positive step for all women. Cindy Patton, a lesbian activist from Boston has been active in community AIDS organizing since the early '80s. In an interview with Toronto feminist Mary Louise Adams earlier this year, she described how talking about sex empowers us. "What you have to do is move away from the idea that you need to feed women certain AIDS information and actually move to the level we might call self-empowerment . . . to get women to feel good about their sexuality, to feel that it's worth negotiating safe sex, that it matters whether they live or die, it matters whether they're healthy and that they have some choice. If men refuse to practice safe sex then they should have the option of saying, "I'm not going to have sex with you." And that's actually the bigger part of the battle with women, to get them to

Condom Sense

Condom instructions are simple but must be followed carefully. Condoms seldom leak or break due to faulty manufacture. The main reason they fail is because they aren't used right.

- Use condoms every time you have sexual intercourse. Latex condoms should be used since the AIDS virus cannot pass through latex.
- Keep a supply of condoms in a cool, dry place.
- Do not test condoms by inflating or stretching and then using them.
- Open the package carefully.
- Gently press the air out of the receptacle tip before putting on the condom. Air bubbles cause condoms to break.
- Unroll the condom so that it covers the entire erect penis.
- If lubricant is used, make sure it is water soluble, like KY Jelly or Lubafax. Oil-based lubricants such as Vaseline and Crisco are not safe. Lubricant helps prevent condom breakage.
- You or your partner should hold onto the base of the condom when you need to so that it won't slip off.
- After ejaculation, he should pull out immediately, holding the condom around the base to avoid spilling semen. If you want to be even safer, he can withdraw before ejaculation.
- Throw used condoms away in the garbage.

Excerpted and modified from *Women and AIDS: What Does It Take To Be Safe?* published by AIDS Vancouver.



Alison Bechdel/*Making It*, Firebrand Books

understand that they can empower themselves in sex in general. And then once they're able to do that, I think the safe sex stuff comes fairly easy."

Talking sex will come easiest to those of us who have begun to take control over our lives. At least we know where to begin. Many women can talk to their women friends, plan their strategies and role-play their conversations. Prostitutes' groups together with AIDS organizations in some urban areas have produced pamphlets and distributed them to other women whose business is sex. Pamphlets are easy to read, use explicit street language and seem to be effective. Often, however, outreach attempts miss young hookers who have no connection to these groups and who may work only occasionally. Some of these young women may be reached by youth outreach programs whose workers walk the streets and let kids know about available services. AIDS Vancouver has produced and distributed a comic style pamphlet featuring King Condom. This may sound hokey but it is full of pictures that tell a story about safe sex, drug use and talking about sex. The organization says it has been well received on the street. Most large Canadian cities have AIDS organizations and hotlines that give out information that is easy to understand and non-judgemental. Public health departments are also getting involved — running information hotlines and seminars.

Controversy continues over AIDS education in the schools, a normal extension of controversy over sex education — how much, what age, what if any moral values should be taught.

The largest group of women who are missed by attempts at AIDS education are probably immigrant women and women whose first language is not English. Until recently there was little government funding available to pay for this work. Some resources are now being translated by government agencies. More importantly, women within their own groups and cultural organizations are beginning to produce materials that are appropriate for them. So far much of the information for heterosexuals has been aimed at women

who traditionally have been responsible for birth control methods. Although many feminists may disagree with this emphasis, it has been used because it is effective. As Ruth Schwartz from the Women's AIDS Network says, "Women have traditionally been saddled with responsibility for birth control, and we have targetted them because they are the group most likely to push for safe sex practices. Our primary function at the Foundation is to eradicate the spread of AIDS not to eradicate sexism." This strategy may not be appropriate in some cultural groups where women's voices have not been heard about birth control. Men too may become the targets for some educational material.

Although talking about sex may not be easy at first, it gets easier and it is a positive step for all women.

Whatever strategy is used, people will have to start thinking and talking about sex (and other activities) in a more open way. We must look at behaviour that is risky whether it is sex without a condom or sharing needles. By learning to take better care of ourselves and our partners we are gaining control over our lives.

As I leave Hassle-Free, I feel overwhelmed. When I was first sexually active in my teens I never dreamt I would be dealing with some of the same questions in my 30s. At first I'm sad and feel like I've gotten nowhere. Then as I begin to put this story together, talking with my men and women friends, I realize that I'm not going backwards, I'm getting a second chance to think through some issues and make decisions that I have ignored for years.

Lisa McCaskell is a registered nurse and a freelance journalist who is a member of Women Healthsharing.

Judy Darcy

A Futuristic Nightmare

The U.S./Canada "free" trade deal was signed January 2 amidst a storm of controversy. Debate rages over what the pact will mean for jobs, sovereignty, Canadian culture, and all aspects of our lives. But one aspect of the deal which has received little attention is the trade pact's impact on public services and social programs. In this excerpt from a speech, Judy Darcy shares her vision of what life could be like under free trade.

I'd like to take you with me on a futuristic fantasy trip — or perhaps I should call it a futuristic nightmare. I'm going to imagine the world of public services, social policy and equality programs in the year 1999 — eleven years after the Free Trade Deal was signed.

All the issues that were unresolved back in 1988 — like the definition of an unfair subsidy — were settled three or four years ago, not surprisingly, in favour of the United States. "What were we going to do, pull out of the Deal after seven years? That would be economic suicide," said Pat Carney, in justifying Canada's cave-in to the U. S. (You remember that Pat took over as Prime Minister from Brian Mulroney in the 1993 general election . . . but things sure didn't get any better for women. Far from it.)

Anyway, back to the future. It's 1999 and I'm now a hospital worker. I used to work in the print shop at the Metro Toronto Library — running the xerox, collating, stapling and folding machines (no, library workers don't sit around and read books all day!) — but they contracted out all the printing, cleaning, and maintenance work, and the comput-

erized data processing too . . . and I got laid off.

After I lost my job, I decided I needed a "marketable" skill, so I got my RNA diploma through night courses at George Brown. You may remember that the Mulroney Trade Deal opened up vocational schools to private American competitors, and the price of courses has shot up so much that lots of working people and their kids can't afford to go to them any more. University tuition fees are even further out of reach.

As I'm getting ready for work this particular morning in 1999, I still turn on CBC Radio — out of habit, I guess. You know, I never thought I'd miss local CBC morning shows, but I really do. Most local and regional programming bit the dust several years ago. The CBC is strictly national programs now, with lots of canned shows from the U. S. There are no more original radio dramas or documentaries and all the international news comes from U.S. network feeds.

On my way to work I can't help but notice the sorry state of the city's roads. The municipal tax base shrank so much after we lost so many industries to "free" trade, that

our municipal services are in the same sorry state of neglect and decay that you find in many U.S. cities. The so-called "soft" services like libraries and arts and cultural centres went first, of course. But before long, cutbacks hit the "hard" services like garbage, road and sewer maintenance. The streets are full of litter. Snow plowing and paving crews have been cut way back. Street light and hydro pole repairs often take weeks.

I work at Toronto Central Hospital — that's the big downtown hospital that was formed when they amalgamated the former Queen Elizabeth, Mount Sinai, Sick Kids, Toronto General, Toronto Western, and Women's College hospitals into one mega-hospital. Government spending on health care was cut way back, you know, so that it is now about equal to the U. S. level of spending. (It used to be that 75 per cent of Canada's health care costs were paid by the government, compared to only 42 per cent in the U.S. — not anymore.) So centralization, cutbacks and privatization became the name of the game . . . with devastating effects on patient care and labour conditions.

There used to be over 6,000 hospital workers in the Canadian Union of Public Employees in Metro Toronto, the majority of them women, with a large percentage of immigrant and visible minority workers. We're down to less than two-thirds that number now.

Things had already been going downhill for a while. In fact, several years before "free" trade, the huge



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collage: Katie Pellizzari

U.S. firm, the American Medical International Corporation (AMI), had already taken over management of a small Ontario hospital, the Hawkesbury District General. Under its 12-year agreement, signed in 1983, AMI was paid \$300,000 a year. It guaranteed the hospital that it would save it at least 11 per cent of its budget (\$750,000 a year) and AMI was to receive half of any savings it could make over and above that figure. An estimated 80 per cent of the savings were to come from staff cuts. The AMI also said it would make money for the hospital by selling services like fitness programs and diet counselling to the community.

When unions were publicly fighting against this AMI management

take-over, we warned of the dire consequences for our health care system if this were to spread, calling Hawkesbury the "thin edge of the wedge."

I can still remember Mulroney and Reisman claiming that public services and social programs were not on the table in "free" trade negotiations with the U. S. Yet they went so far as to code the list of 25 health and social services which were part of the deal, hoping that the public might not catch on. The deal explicitly allows for American private sector management of all hospitals (general, children's, psychiatric, or extended care), ambulance services, various types of clinics, nursing homes, homes for the disabled, single

mothers and the emotionally disturbed, together with all aspects (i.e. not just the management) of other social services like medical labs, and trade, vocational, arts, and business schools. Back in 1988, some people accused those of us who questioned or spoke out of being alarmist when we said the Mulroney Trade Deal would dismantle much of our public sector. But when U. S. multinational profit-making chains started taking over our hospitals, nobody said we were "crying wolf" any longer. What better way to copy the U.S. model of public services than to let U.S. management firms run ours?

The giant American Humana Corporation was already taking in a billion dollars a year before moving

How Will Free Trade Affect Your Health Care?

Patient Name: Innocent, Constance Faith
 Nursing Unit: D5
 Bed Number: 12
 Registry No.: 00-547-138
 Admitted: 01/01/89
 Attending MD: Trade, Dr. Free
 Admit Diagnosis: Post-impoverishment trauma,
 episodic despair

Home Address: 953 Wellborn Rd.
 Boomtown, Ontario
 M2J 4C5

Next of Kin: Innocent, John Michael
 Date of Birth: 16/05/47
 SIN: 424 356 784
 Account: EM br. 342 DIC 5463-687
 Bal: 15,049.45

Trtmt: 24 hr monitor, Ativan 2"

0600h: pulse 69, resp 12, pres 120/85, temp 37.4

0630h: pulse 69, resp 12, pres 120/85, temp 37.4

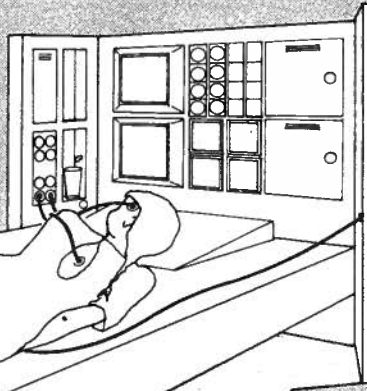
0655h: pulse 69, resp 12, pres 120/85, temp 37.4

0815h: pulse 69, resp 12, pres 120/85, temp 37.5

0830h: pulse 69, resp 12, pres 120/85, temp 37.6

0845h: pulse 69, resp 12, pres 120/85, temp 37.4

0845h: pulse 69, resp 12, pres 120/85, temp 37.4



L. Emily Elliott

The Tories claim that public services and social programs were not part of the deal they signed with Reagan. But that claim is both misleading and false. Certain public services are directly affected by the deal; all government services and programs could be affected in the long-term.

- The Mulroney Trade Deal opens things up right away in 25 specific health and social service areas — sectors which employ 80 to 90 per cent women.
- The greater "harmonization" and "integration" promised under the Deal makes it only logical that our public sector will gradually be reduced by one-quarter to one-third — to equal the size of the American public sector. (It's pretty unlikely that the U.S. public sector will *increase* to the size of ours!)
- A sure outcome of "free" trade will be intense business pressure

to cut corporate taxes to match U.S. levels, further reducing the tax base for our already inadequate services and programs.

- Ominously, the most critical issue affecting public services and social programs — the definition of a "subsidy" — has been left unresolved. Over the next five to seven years, Canada and the U.S. must try to agree which government programs amount to "unfair subsidies," that is, which subsidies give one country's companies an unfair competitive advantage. The U.S. has already charged that 50 different federal and regional programs — including seasonal unemployment insurance benefits for unemployed fishermen — are unfair subsidies. Some U.S. companies claim that our government-subsidized OHIP system (which costs \$600 per family per year) gives "unfair" advantages

to Canadian companies, since comparable private U.S. coverage can cost U.S. companies up to \$6,000! What's to stop them from saying the same for maternity benefits paid for by Unemployment Insurance?

- In several critical areas where public ownership should be expanded — like nursing homes, child care, denticare or auto insurance — the Free Trade Agreement is in fact a powerful deterrent. Why? Because our governments would be required first to consult with the U.S. about it, and then compensate every private operator down to the very last nickel.
- Finally, what about the legislative gains that women have won through years of struggle, like equal-pay laws, workers' compensation, minimum wage, maternity leave, unemployment insurance, and government pensions? There will be immense pressure on governments to slash these programs (which despite their short-comings, are superior to what exists south of the border) all in the name of keeping business costs and government expenses down. And let's not forget about "de-regulation" — it's one of Reagan's and Mulroney's favourite catchwords. But it's a dangerous one for women and for all workers. We know only too well, from experience, that it has never been the sacred "free market," but rather *increased* regulation in the form of employment standards and labour laws, that has *forced* employers to give us the rights we have today.

What the Mulroney Trade Deal does through the back door is what Canadian people have not allowed them to do through the front — dismantle public services, social policies and equality programs we have fought long and hard to maintain and improve.

into Canada in 1994. (Its chairman David Jones, received a salary and benefits totalling \$2.4 million in 1985.) When Humana took over the management of Toronto Central Hospital in 1994 one of the first changes was the introduction of a "patient classification system" which categorizes patients according to their illness and uses a computer program to indicate the type and amount of care needed. There are very few full-time regular nursing staff left — most of us are temporary or part-time and constantly on-call. We have very little discretion in giving the patients the care we feel they need, much less that extra bit of personal attention that can make all the difference if you're sick. Patient care is all pre-determined by a computer program based on what makes financial sense to head office in the U.S.

There's only one big emergency department in place of the six that existed before the merger, and it's really scary what goes on there sometimes. My friend who works in emergency says if you're not near-fatally injured or obviously dying, you're just told to wait 'til the next day and see your own doctor! The ambulance service has been privatized too and, because there are far fewer in the field, preventable tragedies are commonplace.

The laundry, cafeteria, food services, security, and cleaning are all contracted out. Bed linens don't get changed very often. The food we serve (and, I'll grant you, it was never gourmet quality!) couldn't possibly nourish a healthy person — much less a sick one! And cleanliness has gone way down. Cleaning contractors are changed almost every year, so the workers' wages and jobs are constantly on the auction block. These immigrant women, mainly older women, are extremely vulnerable. They're essentially forced to bid against each other, saying: "I'll work for \$6 an hour." "No, I'll work for \$5." "I'll work for \$4 an hour." Sold, to the lowest bidder!

Our health care system resembles the American one in almost every respect now. Back in 1987, 36 million Americans had no health insurance at all. They couldn't afford the private insurance plans, but they didn't qualify for so-called "charity" either.

I remember reading a shocking story back then about a lung cancer patient in Nashville named Joe Bennett who was referred for treatment to a private hospital owned by the Hospital Corporation of America, and was told that no treatment would be given until \$500 had been paid. His family scraped together \$300, but he was still refused care. Finally, they came up with the \$500 and treatment began, only to be told that unless he paid another \$500, the treatment would be stopped. By then the man was in great pain and coughing up blood, and a Legal Services Attorney threatened legal action against the hospital, which finally relented.

It's time to wake up now. This is not an impossible nightmare.

Today this is not an exceptional story. Many women have equally horrific tales to relate. "Human" services such as welfare, crisis centres, women's health clinics and women's shelters were devastated by government cutbacks which began in the 1980s. We can all remember how even well-established women's health clinics like the ones in Vancouver and Winnipeg were forced to close. The last issue of *Healthsharing* was published five years ago in 1994 after a valiant struggle to stay afloat after the government women's program was dismantled.

It's time to wake up now. This is not an impossible nightmare. Mulrone and Reisman keep telling us in true macho style that we should be "optimistic" about the future under free trade, that "we can compete." "There will always be winners and losers," they say. But the winners, as usual, are Mulrone's and Reagan's big business backers. The losers? Working people and their families. Women. The poor.

Judy Darcy is Ontario Regional Vice-President on CUPE's National Executive Board, and President of the Metro Toronto District Council of CUPE.

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HEALTH WANTED

Study On Disabilities

DAWN CANADA: DisAbled Women's Network Canada is conducting a project to determine the needs and priorities of Canadian women with disabilities. A questionnaire, designed to discover the obstacles facing women with disabilities in parenting and child care, violence against women with disabilities, employment equity, isolation, and recreational needs, is being circulated. Interviews with women in the Atlantic provinces, in Northern B.C., Alberta, and the Yukon will be conducted. The studies will add to the limited available information on Canadian women with disabilities.

If you would like a copy of the questionnaire, could provide assistance in distributing it, or would like more information on the project, write to: Jillian Ridington, Researcher, DAWN-Canada, 3464 W. 27th Ave., Vancouver, B.C. V6S 1P6, or call DAWN-Canada at (604) 254-3485 (Voice and TTD).

Politics of Reproduction

Resources for Feminist Research (RFR/DRF) is calling for papers, annotated bibliographies, book reviews and graphics for a theme issue on the Politics of Reproduction. Work exploring and debating Mary O'Brien's philosophy of birth, women and mothering in social and political thought, and issues around the new reproductive technologies are welcome. Submissions should not exceed 3,000 words and must be received by February 1, 1989. Send contributions in either French or English to: Somer Brodribb, Guest Editor, Resources for Feminist Research, O.I.S.E., 252 Bloor St. W., Toronto, Ont. M5S 1V6, (416) 923-6641 ext. 2278.

What You Can Do To Stop Mulroney's Trade Deal

The trade agreement doesn't take effect till 1990, so it's not too late to stop it. But there's no time to spare. The actions we take in the next few months can make a critical difference.

CANADA

does not belong
to these two men.



CANADA

belongs to all of us.

- Write your MP and MPP. Sign petitions. Send in postcards.
- Join in any rallies, lobbies or days of protest against the deal.
- Seize every opportunity to express your views against the deal; by writing letters to the editor, phoning in to radio hot-line shows, and talking to as many people as you possibly can.
- If and when an election is called, get actively involved. Help make sure that the Mulroney Trade Deal becomes the number one issue.
- Join your local Women Against Free Trade Campaign or form one in your community (15 Gervais Dr., Don Mills, Ont. M3C 1V8) or join your provincial Coalition Against Free Trade and take part in its activities:

B.C. Coalition Against
Free Trade
#203 — 1104 Hornby
Vancouver, B.C. V6Z 1V8

Cape Breton Coalition
Against Free Trade
84 Union Street
Sidney, N.S. P1P 4X5

Coalition Québécoise
d'opposition au libre échange
2236, chemin Ste-Foy
Ste-Foy, Québec G1V 4E5

Manitoba Coalition Against
Free Trade
57 Maralbo Avenue East
Winnipeg, Man. R2M 1R3

Ontario Coalition Against
Free Trade
1260 Bay Street
Toronto, Ont. M5R 2T1

Saskatchewan Coalition for
Social Justice
2267 Albert Street
Regina, Sask. S4P 2V5

Victoria Coalition Against
Free Trade
Office of Social Justice
Suite #1 — 4044 Nelthorpe Street
Victoria, B.C.

Metro Halifax Coalition Against
Free Trade
2277 Brunswick Street
Halifax, N.S. B3K 2Y0

Newfoundland Coalition for
Equality
Office of Social Action
Box 986
St. John's, Nfld. A1C 5M3

New Brunswick Coalition
Against Free Trade
P.O. Box 1135, Station A
Fredericton, N.B. E3B 5C2

P.E.I. Pro-Canada Network
81 Prince Street
Charlottetown, P.E.I. C1A 4R3

Pro-Canada Network
c/o 90 Parent Street
Ottawa, Ont. K1M 7B1

CAW

MY STORY, OUR STORY

Saying No To Amnio

Kathleen McDonnell

I'm pregnant. I'm forty years old. I'm not having amniocentesis.

This places me in a distinct minority since amniocentesis, the prenatal screening procedure used to detect Down's Syndrome and other fetal abnormalities, has become standard procedure for pregnant women my age.

During my first pregnancy, at age 34, I became disturbed by the wholesale, largely uncritical way the procedure was being adopted. I also learned from reading and from women friends about the downside of amnio — the painful aspects of the experience a woman usually doesn't find out about until she's in the thick of it. Having decided to have amnio, for instance, she naturally holds back from celebrating her pregnancy or announcing it to friends and family. Yet the test cannot even be done until she is well into her second trimester. Afterwards she has an agonizing wait of two to four weeks until the results come back, a wait for which she receives little preparation or support from the medical system. If the results show the fetus to have Down's or some other genetic abnormality, she faces the even more distressing prospect of a late abortion, in which she must undergo labour and deliver a dead fetus. There is also the distinct possibility that having amnio will itself cause her fetus to spontaneously abort. This happens in about one in 200 cases, and, for women under 35, is a greater risk than bearing an abnormal child, a fact that doesn't deter increasing numbers of younger women from seeking the procedure, or their doctors from recommending it.

Another "side effect" of amnio that gave me pause was the fact that it reveals the sex of the developing fetus. Not long ago I received a card from a friend telling me that another

mutual friend was "expecting a little boy any day now." Perhaps I'm hopelessly backward in my thinking, but it seems to me that something basic and integral to the childbearing experience — the mystery, the discovery and celebration of the child's sex at birth — is being tampered with here.

Once I found myself pregnant again all these concerns came home to me with renewed force. I instinctively rejected what I saw as yet another medical invasion of women's bodies. I knew I was not interested in letting this procedure distort my whole experience of pregnancy, nor was I prepared to have an abortion at this point in my life, though philosophically I'm completely committed to choice on abortion. But I also found myself thinking more and more about the wider social implications of amniocentesis, and was somewhat surprised at the impact this had on my decision.

A common assumption about amniocentesis and other prenatal diagnostic procedures is that they are important medical advances which increase our range of reproductive choices. But with prenatal diagnosis the choice is not about whether to have a child, as it is with birth control or abortion, but whether to give birth to a particular kind of child. This decision has implications that are more than just personal. As individuals we might decide, understandably enough, that we don't want or can't cope with the demands of raising a child with physical or mental disabilities. Collectively, however, these choices add up to something much more chilling: a wholesale societal rejection of disabled people, a kind of reproductive "quality control."

Not that this is anything really new. We've always rejected the disabled in one way or another: stigmatizing them, warehousing them in institutions. But prenatal testing attempts to go one Orwellian step further: to eliminate the disabled from our midst and from our collective gene pool. Of course, we're far from having the technological means to achieve this in the immediate future. Yet I worry that discrimination against the disabled might become even worse when their disabilities are seen as preventable.



L. Emily Elliott

The Changing Family

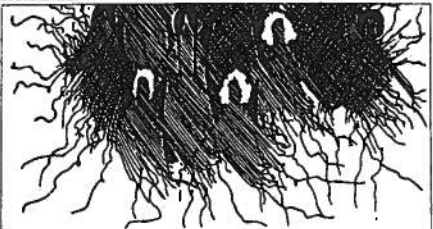


Catherine O'Neil

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WOMEN'S CENTRES

Interweave Steering Committee, a group formed as an outcome of the 1987 prov. conference for women's centres, is distributing an assessment to investigate the needs of women's centres in Ontario, possibilities for a prov. coalition and to connect centres with specific priorities for political action. Centres may also participate in an optional workshop. We invite participation from any women's organizations operating from a feminist philosophy, who define themselves as women's centres. For more information and to find out whether we have you on our list, please contact:

INTERWEAVE NETWORKING PROJECT
Northern Women's Centre
184 Camelot St.
Thunder Bay, Ont. P7A 4A9
or call Anna collect:
(807) 345-7802.

Given the choice, of course, most of us would quite understandably choose *not* to bring a handicapped child into such an unwelcoming world. And what kind of choice are we given anyway? Most doctors now assume that pregnant women past a certain age will have amnio. It's not even a subject for discussion. And parents contemplating amnio are given virtually no counselling on the realities of raising a child with disabilities. How many are told, for example, that prenatal tests like amnio do not distinguish moderate Down's syndrome from severe? That children with moderate Down's have greater possibilities for learning and successful integration into society than ever before? A book I came across as I was turning these things over in my mind was Oliver Sacks' *The Man Who Mistook His Wife for a Hat*, which has several chapters on profoundly retarded adults who have extraordinary musical, artistic and mathematical abilities. I was moved by Sacks' accounts of these people — their sensitivity, their appreciation of beauty, their deep spiritual awareness. I came away realizing that far from being a burden to society, the disabled may have much more to teach us "normals" than we have to teach them.

Perhaps we need to start imagining a different kind of progress than the technological: a society which rejects the quest for the "perfect child," which accepts the limitations of being human, which welcomes all human beings as unique and precious without regard for their ability to pay their way. Marsha Saxton, a disability rights activist, has said that "the suffering experienced by people with disabilities is primarily a result of not enough human caring, acceptance and respect." It seems to me that *this* is what we should be working to change, rather than eliminating the inconvenience that disabled people pose to a society obsessed with competition and productivity.

Of course, it's fine to wax philosophical, but in the end there's no denying that it *is* a personal choice, often an agonizing one. I don't want to minimize the difficulties of raising a disabled child, or to sentimentalize their plight. And I certainly don't fancy myself any stronger or better

able to face these difficulties than anyone else. I, too, am frightened of the prospect, a fact that was brought home to me one day early in my pregnancy. I had just come from discussing my partner's and my decision not to have amnio with my doctor (who, as we anticipated, was completely respectful of our decision). As I sat on a crowded streetcar I looked up to see a young man with Down's Syndrome standing inches away from me. He was probably in his early twenties, though it was difficult to tell, and he was accompanied by a slightly older man, perhaps a relative. For the first time the cold reality hit me: *this* is what my baby might look like, might *be* like. I turned away, then forced myself to look back at him again and again, until I stopped, aware that I was staring, violating his privacy. At some point in this encounter my initial fear and horror changed. I cannot say how — it was certainly not through any intellectualizing or conscious effort on my part — but bit by bit I began to simply see him, to take in his humanity. It wasn't much, a moment of acceptance, a small epiphany, but it somehow helped strengthen my resolve not to have amnio. I'm still afraid, but I also know that I will open my heart — already have, in fact — to this child I'm carrying, whoever she or he is.

I'm convinced that we've been sold a bill of goods about amniocentesis, that far from increasing our choices, prenatal testing and other reproductive technologies are all too often used to increase medicine's control of our childbearing capacity. But my decision also comes from a deeper place — a growing spiritual conviction that there are times when it's better *not* to exert control, to accept what life sends us and respond as honestly, as courageously, and as humanly as we can. I believe that this is where the best part of our humanity really lies. And maybe — just maybe — it is also the place from which unexpected gifts come to us.

Kathleen McDonnell is a Toronto writer and playwright. She gave birth to her second child in May, 1988.

Karen Weisberg

Board Games

Sexist Bias at the Workers' Compensation Board

Loretta is a 63-year-old worker who now lives in a small Ontario town. She was employed for most of her adult life in the printing industry. In the 1970s Loretta developed chronic dermatitis on her hands as a result of exposure to chemicals in her workplace. She filed a claim with the Ontario Workers' Compensation Board (WCB). The WCB initially agreed that her injury was work related and awarded her disability benefits. In 1982, her benefits were terminated. She appealed the decision but her appeal was denied at the lower levels of the appeal process. Finally in 1985 she appeared before the Appeal Board. This is an excerpt from the transcript of that hearing. Loretta was questioned by three male panel members:

Panel: Do you have any problem taking care of the house?

Loretta: I don't do dishes because I have a dishwasher, and I don't wash floors. I'm not to put my hands in water, so I don't.

Panel: Seems to me I've had help around the house that told me the same thing.

Panel Chairman: A typical cleaning lady reference.

Panel: Including a wife.

Loretta: I don't do windows either.

Panel: I don't think you're unique in that. Now, I have to ask you a question that you might think is un-gallant, but how old are you?

(Not only do the Appeal Board panel members address her by her first name, but they also carefully question her on the nature of the work she has done for 26 years.)

Panel: Now, would you classify yourself as an unskilled plant worker?

Loretta: Well . . .

Panel: You're not a carpenter, lathe operator, somebody that has long training and skill. You don't have any special skills at this time? You're not a bricklayer, you're not a carpenter. . .

Loretta: I always worked in printing. I was a skilled machine operator. Is that what you mean?

Injured workers and their advocates frequently describe the experience of dealing with the massive bureaucracy of the WCB as "crazymaking." Most workers experience endless delays in the processing of their benefits, the fallout from inconsistent policies, and insensitive treatment.

Women claimants experience additional hardships and indignities because they are women. The institutionalized sexism at the WCB has an impact on the lives of women in significant and subtle ways.

The workers' compensation system was originally established in Ontario in 1915. Based on employer contributions, it is designed to insure workers against "lost income" due to work-related injury or disease. Workers no longer have to prove in court that a work accident resulted from employer negligence. This no-fault system was a giant step forward for workers. However, there are many problems with the legislation, including definitions of who is covered under the Act and the types of injuries recognized as work-related.



The devaluing of women's work render these problems particularly harsh for women. In addition, the establishment of a legal system which relies heavily (in practise) on the judgements of the medical establishment holds particular risks for women.

Household Injuries

Industry propaganda frequently reminds us that the workplace is safer than the home. For most women, the



TVOntario

home is our workplace, or at least one of them. The hazards of housework, including toxic fumes, injuries due to falls, and the stress due to the constant demands of child care have been well documented. Although the economy is dependent on this invisible and largely unpaid workforce, women who work in the home are not protected under the Workers' Compensation Act (WCA). Most of us who work outside the home still bear primary responsibility for housework and child care; we work a "double day." If we are injured on the "second shift," at home, and can't return to our paid employment, we are not eligible for compensation benefits. We must cope with the loss of income, rely on employer sick leave plans or apply for social assistance.

In fact, the possibility of "household" injury often becomes a major issue in determining a WCB claim. Adjudicators are careful to determine exactly where an injury occurred. If there is a suspicion that a

woman injured herself while bending to do the laundry instead of at her place of paid employment, the adjudicators will rule that she not be compensated. This is clearly the "correct" decision according to the legislation; injuries incurred in the course of "housework" are not compensated. This is a powerful social statement on the value of housework and on society's view of "women's work."

The issue of housework surfaces in another form at the WCB. Janet was

her record that she reported being unable to do housework and that she spent part of the day "lying on the couch." The adjudicator noted that the worker sought increased help from her husband. This was interpreted as maintaining a "sick role" for the purposes of "secondary gain," not as a legitimate work-related psychological disability.

Coverage Under the Act

Leanna works by sewing at home. She has an industrial sewing machine set up in her basement. The contractor for whom she works brings her loads of pieces to sew. Some of the materials are very dusty and the lint from the cloth is everywhere in her house. The lighting is poor and after many hours her eyes are very sore. Sometimes she wishes she could go out to work but, at least, she says, this way she can care for her two pre-schoolers whose demands she must balance with the ever present pile of sewing to complete.

Laura Johnson in her book, *Seam Allowance*, has documented the plight of homeworkers who are a particularly vulnerable part of the women's workforce. Immigrant women who sew garment pieces in their own homes for contractors form an invisible part of the garment industry. They often endure dangerous working conditions and long hours. Many try to combine child care responsibilities with homework. Dust, bad lighting, and stress are serious problems for these workers. But, because they do the work in their own homes and on their own equipment, they are not protected under the Workers' Compensation Act.

Women who work in other people's homes have only recently been included under the Act. In 1985, major amendments to the WCA extended coverage to new categories of workers — the "cleaner," the "housekeeper," the "nanny." For the first time, women employed in traditional women's work were eligible for benefits (provided that they worked at least 24 hours per week at this paid work). This is an important reform, but it remains to be seen how many domestic workers will actually file

called to an appointment at the WCB in order to determine the extent of her disability. Her short medical assessment by a WCB doctor was followed by an interview with an adjudicator. In the course of her interview, she was asked if she was able to do "housework." She hesitated before answering. In fact, it was extremely difficult for her to carry out household work, but she had no choice. No one in her family helped out, and her home was a matter of pride for her, a reflection of herself. "Yes," she told the adjudicator, she did housework. The adjudicator noted this "inconsistency of complaint" and recommended that benefits be terminated since she was obviously not totally disabled.

Women are damned if they do and damned if they don't...do the housework. In another case, Marlene had established a claim for psychological disability as the result of an injury and was being reassessed at the end of a two-year period. It was noted in

claims. Many domestic workers are immigrants, dependent on their employers for their immigration status as well as for a place to live. How many can risk conflict with their employer without the protection of a union or support organization?

Stress and the WCB

Laura is a telephone operator with 12 years of service. Like her co-workers, she has experienced the sense of total lack of control over her work. Electronic monitoring, machine pacing and management style have been sources of acute stress. Several years ago, Laura began to suffer from a disabling psychological condition diagnosed as "clinical depression," causing her to miss several months of work. With the help of her union, she filed a claim for benefits at the WCB. The appeal was heard before the Workers' Appeal Tribunal in December 1986. No decision has yet been reached.

Work-based stress tends to be stereotyped as the problem of the high-powered male executive, responsible for millions of dollars and hundreds of employees. The stress that accompanies traditional women's work — especially the "helping professions" or those performing highly routine, high-speed tasks — is largely ignored or trivialized. A disability such as that experienced by Laura, is often not even acknowledged to be stress-based. The WCB does not recognize stress claims per se. In order to establish a claim for psychological disability, a worker must prove that the disability resulted from an organic injury or relates to an organic injury. Thus, a major occupational injury resulting from the work that women do has not been compensated. Laura has challenged this interpretation of the WCA. She has argued that her injury is serious and work related and that she should be compensated.

Sexist Bias

Sexism can preclude the recognition of a stress-based claim, even when the stress does result from an organic injury.

Rena was a food service worker who sustained a back injury. She was seeking to establish a psychological disability resulting from her organic

injury. As part of her assessment she was sent to the WCB's Hospital and Rehabilitation Centre where she was assessed by a series of WCB doctors and consultants. The report of one of the WCB doctors described Rena as a "normally developed, generously nourished white female who looks her 39 years. She wears a perpetual frown and speaks with a long-suffering whine of perpetual misery." The conclusion was that her psychological problems were unrelated to the work incident.

Sexual harassment is also a source of stress which has not been recognized by the WCB. In a precedent-setting case in 1985, the Quebec WCB recognized sexual harassment as a work-related injury. The Quebec board held that sexual harassment had resulted in an occupational injury to the worker, including extreme stress, depression and physical symptoms caused by sexual harassment. In an Ontario case, Bonnie Robichaud, a Department of National Defence worker, filed a lost-time accident claim of stress resulting from sexual harassment she had endured at work. The decision in this case is pending.

Women and the Psychiatric Assessment

Workers have access to their own WCB files. However, it can be a very disturbing experience for a worker to read her medical and WCB reports. She may feel that she has had a conversation with a very sympathetic adjudicator, only to find in his report references to her evident "overreaction," "hysterical nature," and "exaggeration of injury." Many women who are attempting to establish psychological claims meet face to face with the basic misogyny of the medical and psychiatric professions.

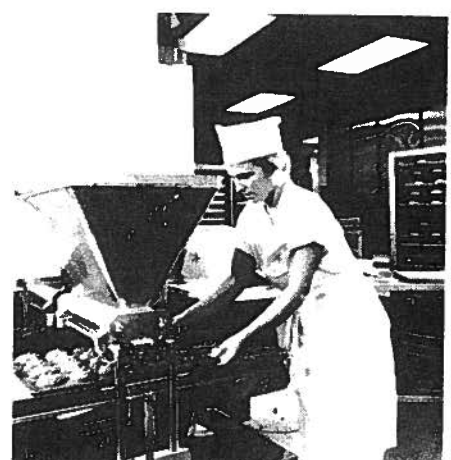
The WCB perpetuates the exclusive use of medical-psychiatric systems for women in need of psychological support. WCB benefit coverage, like OHIP, does not include women-centred services or feminist counselling programs. Women who want or need psychological help have no option but to use what the WCB makes available.

Who's Minding the Kids?

Luisa spent two hours on the phone trying to find someone who could explain why her benefits were being cut. Finally, the anonymous voice at the WCB told her to "just come down to the Board and see someone. They'll answer all your questions." Without her full benefits, Luisa could no longer afford her babysitter. So with a baby and a three-year-old in tow, she set out for the WCB office. She went to the designated area and waited in the small seating space. Injured workers moved uneasily in the uncomfortable chairs; others paced the floor. Luisa's children grew restless and began to whine. The baby was tired and Luisa's shoulder injury made it exhausting to hold him. She was tense. She didn't want the children disturbing injured workers or the WCB staff. Finally someone called her name. Then there was a further wait to find someone to speak to her in her own language. By then Luisa's anger at the unexplained loss of her full benefits and the tension of trying to control the children in a formal setting surfaced. The WCB officer saw her as uncooperative and argumentative. He explained that her benefits had been cut because she no longer met the criteria of a totally disabled claimant.

This was the beginning of an appeal process which would take months to complete. Luisa left the office, overwhelmed by what lay ahead, in a panic about money and exhausted from the ordeal with the children. At some point, Luisa, like other workers, will probably be ordered to the WCB Hospital and Rehabilitation Centre for assessment. This is mandatory; refusal results in termination of benefits. Who would look after the children? That was her problem.

In myriad ways, the institution has an affect on the real day-to-day lives of women and children. Attending appointments and often waiting hours at the WCB accompanied by young children makes a stressful interview even more difficult. (In early 1988, the WCB re-organized services in the central offices, combining claims, pensions, and rehabilitation into single units in a effort to improve efficiency and case coordina-



TVOntario

tion. Hopefully this will cut down on the excessive waiting time required of injured workers.) Hundreds of women share these experiences, yet no emergency child care funds exist; there is no supervised child care area for use by clients.

The Emotional Work

Ann stayed at home to take care of the children. From the day her husband injured his right arm and shoulder at work, their lives changed. First there was the immediate loss of income. It took several tense weeks before details of the claim were sorted out. They began to receive benefits. Her husband was in a great deal of pain. He didn't have to be hospitalized, but required a lot of help and encouragement. She wanted the children to understand and to be especially well behaved. As time went by, her husband grew more depressed and irritable. Money was short, and she had to stretch meals and children's clothing. Her husband's employer grew impatient. Since there is no law forbidding it, the employer decided to fire him. Ann's husband grew increasingly angry and withdrew from the family. The letters from the WCB began to suggest that there were problems with the claim. Within a short time, Ann had to get a job. While she was glad to contribute financially to the family, the changing dynamics in the family caused tremendous tensions. At times, she felt too worn out to continue.

Ann's story is a typical example of another side of women's experience with the WCB — the emotional work

resulting from a spouse with a job-related injury.

When a worker is injured or suffers from an industrial disease, whole families are affected. The physical toll and suffering of a worker may go on for years, and medical treatment and hospitalization will ensue. Often the worker loses his or her job. Once a claim is filed, the worker faces long delays in receiving benefits, incomplete information, and complicated appeals. This imposes great stress on a family already coping with serious health problems as a result of the injury and disability. Women do much of the emotional work, keeping their families together, supporting their spouses, and making financial ends meet. But the partners of injured workers have no formal, recognized financial or social support.

Women whose spouses suffer from industrial disease may face years of watching the spouse's health deteriorate. They also face endless battles with the WCB to get recognition that the disease is job-related. Some summon the energy to research the link between industrial hazards and their spouse's health problems, while coping with the tragedy that has struck their families.

Survivors of workers who die as a result of a work-related injury or disease are officially recognized under the WCA. Since 1985, the financial situation of some survivors has improved. In order to qualify for survivor's benefits, however, a worker must have died in a traumatic accident or have been considered 100 per cent disabled by an injury or

industrial disease. The WCB's assessment of a worker as 100 per cent disabled is extremely rare. Though a family may have struggled for years on a severely limited income, in most cases they will not be entitled to ongoing benefits after the worker's death.

Further review would reveal many more dimensions of sexism in the policies of the WCB. The integration of medical and psychiatric structures with legal systems poses particular dangers for women. As feminists, it is important for us to articulate the larger theoretical issues in law, as well as the practical day-to-day ways in which these institutions affect our lives. Involvement with the WCB, and its application of policies and procedures affects the quality of life of thousands of injured workers. Women as injured workers, as family members, and survivors face tremendous difficulties.

Women who encounter the WCB have already been injured and disabled as a result of their employment. We must learn from their experiences and fight to prevent further injury from the legal and medical institutions which should serve them.

Karen Weisberg was a community legal worker at a legal clinic in Toronto that represented injured workers in their WCB claims.

The names of some of the claimants and their situations have been altered to avoid identification.

Bonnie Lafave

Who's in Control?

Eggs, Embryos and Fetal Tissue

Reproductive technology continues to advance at a rapid rate. Ethical and moral considerations have not been adequately discussed in the public arena. Women have little individual or collective control over reproductive technologies yet they often involve experimental practices with our bodies and the use of fetuses and eggs from our bodies.

Among women health activists there is considerable informal debate. In Quebec, a reproductive technology conference heard a wide range of views: strong differences were expressed. Infertile women called for a greater understanding of the pain of infertility from women who questioned the use of reproductive technology. At the recent conference of the National Action Committee on the Status of Women resolutions were presented on this issue.

Healthsharing hopes to help facilitate this discussion in the women's movement by continuing to publish a variety of views from women.

In the article, "Eggs, Embryos, and Fetal Tissue — Who's in Control?" Bonnie Lafave discusses the implications of reproductive technology. She raises the frightening possibility of the abuse of women's bodies and the misuse of fetal tissue and embryos. Others have argued that any negative problems associated with the new technologies are outweighed by the positive value to human health.

We welcome your views on all aspects of this new and controversial debate. —WHS

Currently in Canada, no laws exist to regulate the use of embryos and fetuses in research and experimental therapies. Yet human eggs, sperm, embryos and fetuses are increasingly used for medical and technological experimentation. Because eggs, embryos and fetuses come from women's bodies, it is essential that we participate in discussions about how these tissues are used in current biotechnology. We must also be active participants in decision-making about the direction biotechnology will take in the future.

Decisions about what kind of research is done, how it is done, and who is doing it, are too often made

only by scientists, governments and big business. There has been little public discussion about egg harvesting, embryo freezing or the use of fetal tissue in transplantation.

Women require awareness and understanding of medical procedures, which, while often presented to us as benign therapies or liberating choices, may be insidiously threatening our control over our bodies.

Human gametes and embryos are in demand because of their value in research and product development. In research, they are used to refine methods of freezing eggs and embryos, and to develop tests which predict the normalcy of fertilized

embryos. They are used for diagnosing chromosomal or genetic disorders and in cancer research. However, their best known uses are in the refinement of experimental reproductive technologies.

Fetal tissues are used by pharmaceutical companies in the manufacturing of vaccines for poliomyelitis and rubella. Fetal tissue also is desirable because of its ability to repair itself. It may prove to be of benefit as transplantation tissue for victims of Parkinson's disease, Alzheimer's disease, Huntington's chorea, spinal cord injuries, diabetes, leukemia, aplastic anemia and radiation sickness. Dr. Robert Gale of

the University of California at Los Angeles (UCLA), used fetal cells to treat six of the victims of the Chernobyl nuclear accident in 1986. In January of 1988, Dr. Ignacio Madrazo of Mexico City, transplanted fetal brain cells into the brains of two individuals who were suffering from Parkinson's disease, and has since noted a reduction of clinical signs of the illness in both patients.

The cosmetic industry is involved in fetal research for product development. In a recent report to the Parliamentary Assembly of the Council of Europe, Mr. Haase, a member of Parliament for the Federal Republic of Germany, cited several examples of corporate purchase of fetuses. In 1981, for example, French customs seized a consignment of fetuses from Romania being shipped to a cosmetics firm. Similarly, California police discovered in 1982 more than 500 fetuses preserved in formaldehyde, "allegedly intended for a clinic specializing in cosmetic surgery." We routinely use cosmetic products made from various parts of various animals as well as from human placenta. How long will it be before it becomes routine to use products made with human fetal tissue?

"Little embryo research is being done in Canada at present," says Connie Clement, family planning coordinator for the Toronto Department of Public Health. "But as of 1988, funding for such experimentation is available from the National Research Council following the release of Guidelines on Research Involving Human Subjects."

Some doctors performing abortions have been reported as donating fetal tissue for medical research without informing the women involved. It may be that most women who undergo abortions do not want to know or make choices about how their aborted fetuses are disposed of. Others may want to know what kinds of research are being done and may want to choose whether or not to give consent for their fetuses to be used. Even where the individual woman having an abortion or using the services of a fertility clinic is given the right to choose and to know how the fetus or embryos will be used, she could feel pressured to comply with the doctor's wishes since she is

in a vulnerable position at that time. In any case, regardless of the question of individual rights or choices, the larger social and ethical questions involved concern all women.

There is a potential for misuse of new techniques used to obtain embryos. In particular, In Vitro Fertilization (IVF) is used more than other

late. Clomid has a chemical profile similar to that of DES, a drug given to women in the 1940s and 1950s to prevent miscarriages. DES caused a previously rare and invasive form of vaginal cancer in a small number of the daughters born to women who used DES. The long-term effects of Clomid are not known, however



procedures to help women get pregnant because it produces a greater number of embryos than are implanted at one time. IVF is being used in Canada, the U.S., Great Britain, Australia, and other countries as a fertility therapy although it is still considered by many health professionals to be an experimental procedure with a very low success rate and a very high cost.

Women may be taking both physical and emotional risks because of researchers' desire to get embryos as drugs such as Clomiphene Citrate, more commonly known as Clomid, are used to make them hyper-ovu-

animal studies are showing effects similar to those of DES.

Hyper-ovulation with Clomid produces up to 15 eggs per cycle although IVF only requires two to three eggs per cycle. The "spare" eggs, which have been fertilized to create embryos, can be destroyed but instead are frozen for later use or for experimentation. Infertility clinics across Canada are currently freezing embryos.

England's Patrick Steptoe, one of the founding "fathers" of IVF has said, "I would like to build up a panel of forty women ready to donate eggs." He once even offered free ster-

ilization operations to any women who would donate eggs to his IVF patients, and incidentally, to his research. Yet it is not only "services" that are being exchanged: money changes hands as well. Fertility and Genetics Research, Inc., a Chicago-based biotechnology company paid \$100 per egg to donors in 1984. The

grams indicate that they are not totally convinced of the value of embryo research. The infertility group, Concern, in Perth, Western Australia found that the donation of embryos for experimentation was not acceptable to 35 per cent of IVF couples responding to a survey, and a further 25 per cent were undecided.

Here in Canada, it is illegal to buy or sell human tissue, according to the Human Tissue Gift Act. But it is *not* illegal to give or accept reimbursement for losses incurred by the donor, such as loss of wages. It may be that nobody buys eggs, but donors can be paid nonetheless. Clearly, lower-income women are most vulnerable when eggs, embryos or fetuses become commodities for sale or for donation.

The desire for fetal tissue is as strong as that for embryos. There is already concern from researchers and the public that some women might get pregnant for the purpose of providing aborted fetuses to researchers in exchange for money. Arthur Caplan, a specialist in medical ethics at the University of Minnesota says he "already knows of American women who are prepared to breed fetuses for spare parts."

The demand for fetal tissue is increasing, and according to the April 15 article in the *Montreal Gazette*, there is already evidence of an underground market. It was reported that a woman whose husband has Parkinson's disease attended a medical conference in Boston hoping to find help for her husband. She left her card on the bulletin board. She then received a phone call from a person who offered to arrange a fetal cell transplant at a private Mexican clinic.

How we view abortion may also have a direct bearing on how we view fetal and even embryo experimentation. Daniel Callahan in *How Technology is Reforming the Abortion Debate* notes, "the cumulative impact of a number of otherwise limited scientific developments could lead to a shift in public opinion, moral thinking and court decisions about abortion." These include the temporary separation of the egg, and subsequently the embryo from the mother, raising its status, even for a short time, to that of a separate en-

tity; the increase in public awareness of and concern for fetal health, (to the extent that the fetus is now, on occasion, considered to be a patient, whose needs may supersede her mother's, as in the case of Baby R [see "Whose Womb Is It Anyway" in *Healthsharing*, Spring, 1988]); and the increased "clinical efforts to improve the outcome for fetuses, premature infants, and otherwise distressed infants." In 1973, at the time of the Roe vs. Wade abortion decision, the age of viability was 28 weeks. At present, the age of viability has been lowered by the World Health Organization to 22 weeks.

We must continue to insist on our right to choose abortion. At the same time we are being threatened that if we elect to abort, we should be required to give up our right to determine what becomes of the fetus. Charles H. Baron, professor of law at Boston College Law School says, "Even if a woman has a right to be free of an unwanted pregnancy, she does not necessarily have the right to determine what shall be done to the fetus before, during or after its removal from her body."

Clearly, the use of eggs, embryos and fetal tissue gives us much to think about, even more to debate. We must continue to make ourselves aware of the advances being made in reproductive technology and biotechnology. Yet we must also be conscious of the potential for coercion and manipulation of women in the advancement of such research, technologies or products. Although women will disagree on the relative benefits of new technologies or research, our strongest defense is the collective opportunity for consent: if eggs, embryos, and fetuses from our bodies are used, then we must have the right of consent. As 52 per cent of the Canadian population, and 100 per cent of the bodies in this country producing eggs, embryos and fetuses, women are in a unique position of strength to make their voices heard on these issues of such ethical and moral importance.

Bonnie Lafave is a psychiatric nurse at The Clarke Institute of Psychiatry in Toronto.



Dawna Gallagher

money reimbursed the donor "mainly for the inconvenience of coming to the clinic," said Richard Seed, a live-stock breeder and co-owner of the company.

According to Robyn Rowland, author of *Making Women Visible in the Embryo Experimentation Debate*, "Intimations are constantly given that IVF women are in fact in favour of embryo experimentation." Yet for many women, each embryo is perceived as an extension of her own body, her own being. It is not surprising then that women in IVF pro-

REVIEWS

When Someone You Know Has AIDS: A Practical Guide

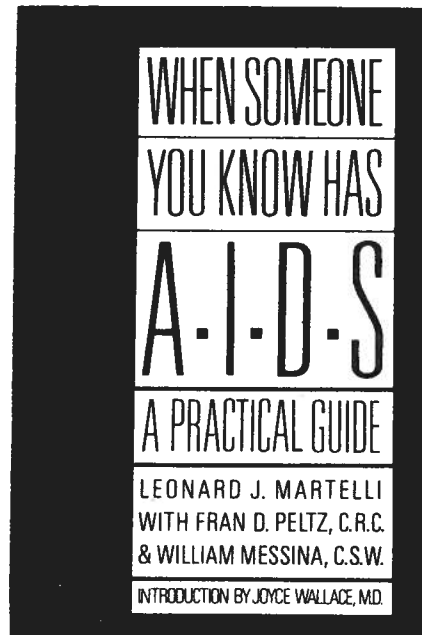
Leonard J. Martelli with Fran D. Peltz and William Messina, Crown Publishers, New York, 1987, \$9.95, 238pp paper.

Reviewed by Sheryl Pollock

In the confusion of self help books available today, it is unusual to find a publication which exceeds your expectations. *When Someone You Know Has AIDS* fits that category by being both specific to the issues particular to AIDS, and general in the way it deals with illness and death. It is superb reading for anyone involved with someone who has a chronic illness, and/or is dying. This generality does not detract from the guide's usefulness as a valuable AIDS resource. It is written with an overall tone of optimism: an optimism that care-partners, friends and the person who is ill, all have have an opportunity to grow through during very difficult times.

The authors have avoided the trap of being too clinical and academic by having individuals with AIDS and their care-partners describe their own experiences. This promotes the inclusion of practical and creative solutions to the many problems encountered, and encourages the reader to follow these individuals through a range of situations. By illustrating statistics with human stories, the authors force you to deal with AIDS, illness, death and dying. Often this is a touching and intimate process for the reader.

The content ranges from discussions of the medical aspects of AIDS through a range of psychosocial issues and dilemmas. For example, I have found that healthy people often want to be helpful with a person who is ill, but are not sure what to



do. This often results in avoidance when closeness is wanted. The authors deal with this primarily by pushing the reader into being clear about what is wanted and what is possible. Very practical and realistic suggestions always follow. One scenario describes how two men worked out ways to get favourite foods to an ill man and not destroy the limited finances of his care-partner.

Because our universal health insurance relieves some of the costs of health care, the economics of illness are something that Canadians usually do not have to think about. However, there still can be major financial problems for Canadians, especially if the person is receiving treatments which are not covered by health insurance, for example, certain drugs or massage therapy. In addition, those who are ill must deal with trying to maintain their housing while on a decreased income. This is a major problem in areas of the country with limited affordable

housing. A Canadian fact sheet with regional income maintenance and health care information would be valuable. However, the book's American fact sheet raises some pertinent issues and it is worthwhile to skim. Canadian readers should turn to their local AIDS groups for more information.

I am impressed that the authors look at relationships which break up. We often believe the myth that all relationships are strong enough to withstand the immense pressures of illness. In fact, it is sometimes best for both partners to make major changes in their relationship.

The authors also stress the need for care-partners and friends to meet their own needs. This matches my experience. If you don't look after yourself, you won't have anything to give to anyone else. Like many of the suggestions, this is easier said than done. The authors understand this and constantly present small steps to improve your situation rather than a series of platitudes.

The Guide's content is presented in the context of basic humanistic principles including the individual's right to respect her/his individual needs, and to determine who will be the primary care-partner. By doing so, *When Someone You Know Has AIDS* earns its place on every bookshelf. Contact your local AIDS Committee, gay positive bookstore and/or Public Health Department to find out how to obtain it in your community.

Visiting Someone Who is Ill

At Home:

- offer to do a task by saying, "I'm doing my grocery shopping today. What can I pick up for you while I'm there?" If asked directly, "What can I do for you?" most people will say, "Oh, nothing."
- bring healthy foods, e.g. small amounts of ready to eat fresh fruit and vegetables.
- bring prepared meals that can be frozen and reheated as desired.
- eat with the person if they are alone for meals and/or while their care-partner takes a break.
- depending on the individual, helping with housework may or may not be appreciated. Find out.

- flowers often brighten a room but too many can make it look like a funeral home. Dying flowers are depressing.
- plants need taking care of, therefore are appropriate only if you visit regularly enough to do it.

In Hospital:

- check with the care-partner to see if visits are wanted — length of time depends on the needs of the person at that time.
 - space is very limited so think small — single silk flower in a small vase — won't spill or die.
 - small amounts of favourite fresh fruit or veggies or any other favourite treat.
 - skin cream for dry skin.
- [Adapted from *When Someone You Know Has AIDS* and my own experience.]

Sheryl Pollock is a Toronto feminist and health care worker who has been both a caregiver and a care receiver.

Ethics and Human Reproduction A Feminist Analysis

Christine Overall
Allen and Unwin, Winchester,
MA, 1987
\$19.95, 245 pp.

Reviewed by Ann Pappert

The last decade has brought an astonishing increase in reproductive options. It's only ten years since the birth of the world's first test tube baby. But in that time reproductive technology has moved from scientific theory to practice, transforming motherhood in the process.

Consider this:

- In South Africa a 47 year old grandmother gave birth to triplets after carrying eggs from her daughter who had no womb.
- A British woman gave birth to a baby from an embryo that had been retrieved and frozen some 18 months before. Another embryo, retrieved at the same time, had been immediately re-implanted and produced a successful birth. The baby from the

frozen embryo was dubbed the "frozen sister."

- Eggs have been flushed from women's wombs and re-implanted in women unable to produce eggs of their own.
- The sex of babies has been pre-selected before implantation of the embryo.
- In vitro fertilization has spawned the science of human embryo research. In some centers human embryos are already being assayed for hereditary and genetic disease before implantation.



Dawna Gallagher

Other areas of reproduction — childbirth, pregnancy and attitudes to abortion — have undergone tremendous changes as well. Techniques like in vitro fertilization, pre-conception contracts, sex selection, genetic screening, and fetal surgery put more power into the hands of doctors and scientists. Human reproduction is no longer the sole concern of the individual or couple who wish to have a child. As reproductive choices expand, they bring with them a wide range of social and ethical considerations.

In her book, *Ethics and Human Reproduction*, Christine Overall discusses the serious implications that this shift in power has for women. She demonstrates that increased options aren't always beneficial and that none of the issues raised by them are easy. The challenge presented by this range of choices is to

HEALTH WANTED

P.I.D. Support Network

Anyone interested in being part of a self-help telephone support network for women with P.I.D. (Pelvic Inflammatory Disease) please contact the Canadian P.I.D. Society, (604) 684-5704, or write: Box 33804, Station D, Vancouver, B.C. V6J 4L6. If a phone call presents a hardship, women can call collect.

Pelvic Infection

I have a chronic low grade pelvic area infection which I suspect began as cervicitis caused by a painful pap smear. I would appreciate hearing from anyone who has had or heard of infections caused by pap smears. M. Schmidt, Box 2377, Huntsville, Ont. P0A 1K0.

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develop a feminist approach both to these new technologies and to our underlying assumptions of motherhood, birth and children. Without a well thought out feminist approach, it is all too easy to see only the benevolent face presented by these new options.

Perhaps nothing illustrates this better than the developing perception of the fetus as a patient in its own right. Proponents of fetal rights promote the right of the fetus, not only to life, as do those opposed to abortion, but to treatment. All too often they see the mother as an adversary whose needs are counter to the needs of the fetus. This adversarial position taken on behalf of the fetus is often extended to intervention by a third party contrary to the wishes of the pregnant woman. This is done in the name of ensuring a healthy and safe transition for the fetus into the world.

The results of this philosophy can be seen in court apprehended fetal intervention for everything from fetal surgery to forced caesarean section.

The power and control allegedly passed to the fetus is an illusion; the real power belongs to the courts and the medical profession, both male dominated, who promote fetal rights at the expense of women's control.

Overall deals with all of these issues from a clearly woman-centred perspective. She begins her analysis by defining the difference between feminist and non-feminist approaches to reproductive ethics. She argues that a feminist approach "focuses attention upon what reproductive technology really is and upon its potential effects on children and women."

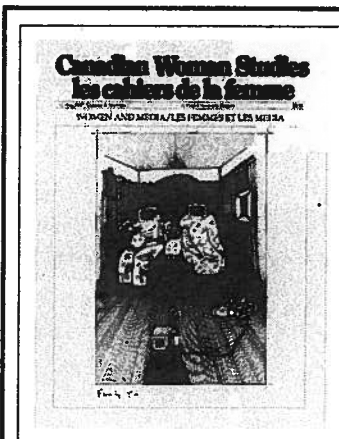
The analysis is strongest when Overall deals with the new reproductive technologies. She understands, for example, the connection between fetal rights and the slippery slope of embryo research that is quickly leading us to a future where fetal intervention is taken to its ultimate conclusion — a society where only perfect embryos and perfect children will be acceptable. She sees the danger that children are quickly

becoming just another commodity and that the commodification of children commodifies women and diminishes their status.

Overall is less successful in developing new approaches to abortion and childbirth. Although her ideas in the section on abortion are not without merit, they seem unrealistic. Her suggestions of dialogue and discussion come too late in the context of the overcharged emotions of the highly polarized abortion debate in which both sides have such firmly entrenched positions.

But in the main, any criticism of *Ethics and Human Reproduction* is really nit-picking. Her chapter on the embryo/fetus alone is essential reading for any feminist concerned with this issue. Overall has produced a thoughtful and exciting book that is an important contribution to the growing body of feminist analysis of reproduction.

Ann Pappert is a Toronto journalist with a special interest in reproductive technology.



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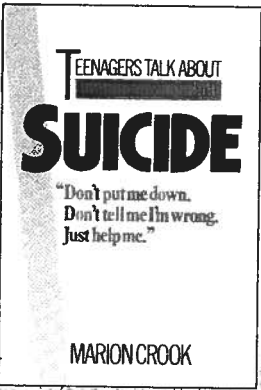
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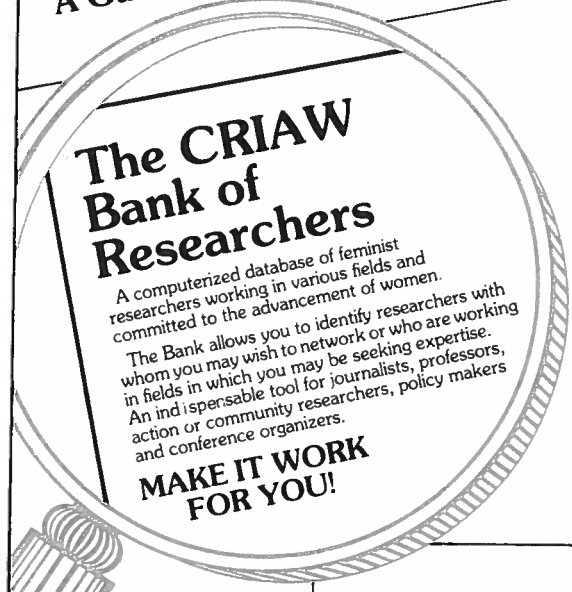


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N.B. We encourage all feminist researchers to register in the bank. Application forms available from CRIAW.

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RESOURCES & EVENTS

Newfoundland/Labrador, 203
Merrymeeting Road, St. John's, Nfld.
A1C 2W6, (709) 579-1009.

NOIVMWC

The National Organization of Immigrant and Visible Minority Women of Canada (NOIVMWC) will hold their biennial general meeting in Vancouver, November 11-13. The NOIVMWC Status Report 1988 outlines the national position in each of seven target areas, one of which is health. For a copy of the report, a newsletter, or information about the general meeting, write: NOIVMWC National Office, 251 Laurier Ave. West, Suite 1102, Ottawa, Ont. K1P 5J6, (613) 232-0689.

Outreach Abuse Prevention

Outreach Abuse Prevention is a non-profit organization providing seminars and workshops that focus on sexual abuse prevention for all ages. Educational materials, books and a newsletter can be ordered. For a free catalogue contact Outreach Abuse Prevention, P.O. Box 1271, Station "B", Oshawa, Ont. L1J 5Z1, (416) 728-3163.

Sex and AIDS

MAKING IT — A Woman's Guide to Sex in the Age of Aids by long-term AIDS activists and journalists Cindy Patton and Janis Kelly is an informative and often humorous book "designed to present facts and help promote an understanding of how

copied with AIDS is different for each woman — heterosexual, bisexual, lesbian, rich, poor, single, married, of colour, or white." Both English and Spanish versions are included in the same volume. 55 pp. \$3.95 U.S. plus \$1.50 shipping for the first book and \$.50 for each additional book, Firebrand Books, 141 The Commons, Ithaca, New York, 14850.

Date Change

The Manitoba Committee on Wife Abuse has rescheduled its National Conference on Shelters and Transition Houses to November 12-15, 1988 at the International Inn in Winnipeg, Manitoba. For more information contact Ms. Joey Brazeau, Manitoba Committee on Wife Abuse, 1823 1/2 Portage Ave., Winnipeg, Man. R3J 0G4, (204) 885-3302.

Sexuality Conference

Planned Parenthood Newfoundland/Labrador is sponsoring a two-day conference *Sexuality Throughout the Lifespan* to be held in St. John's Nfld. September 22 and 23, 1988. Designed for nurses, group home leaders, teachers, physicians, social workers and psychologists, workshops include *Sexual Concerns of the Elderly*, *Preventing Teenage Pregnancy and STDs* and *Sexual Assault and Preschoolers*. For more information contact Planned Parenthood

Post Polio Conference

Canada's first National Conference on the Late Effects of Poliomyelitis will be held at l'Hotel, Toronto, November 3-5, 1988. For medical and allied health professionals, topics will include the latest research findings, techniques for assessment and treatment, and a forum for discussion to strengthen and expand the Post-polio support group network across Canada. For more information contact Shirley Teolis, Ontario March of Dimes, 60 Overlea Blvd., Toronto, Ont. M4H 1B6.

Maternal and Child Health Resources

A new giant annotated resource guide on the health of mothers and children is available from the U.S. *Starting Early: A Guide to Maternal and Child Health* is divided into several sections, but the most potentially useful section is a bibliography of publications and audio-visual materials produced by federal government agencies and federally-funded projects. Information about these materials can be obtained free of charge. The resource guide is free and can be obtained from the National Maternal And Child Health Clearing House, 38th & R. Street N.W., Washington, D.C. 20057, U.S.A. (202) 625-8410.