

SPECIAL ISSUE

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# Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

healthshock · mental health · assault ·  
childbirth · traditional healing ·  
N.R.T.'s

immigrant &  
refugee women's  
health



# INSIDE

# Healthsharing

Vol 12: 3 Fall, 1991

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# HEALTHLINES

## It's A Start

**T**HIS ISSUE OF *HEALTHSHARING* reflects the need to focus on immigrant and refugee women's health, not to isolate their experiences, but to call attention to the inequities immigrant women face in the health care system. One of our objectives in publishing this thematic issue is to provide information to immigrant women about their rights and responsibilities as users of health care services.

Immigrant women living in Canada face racism and sexism on many fronts. We see one of the most significant reflections of this in the provision of health care. Difficulties with the health care system takes many forms, from poor diagnosis, insensitive treatment, over-prescription of drugs and an overabundance of unnecessary surgical procedures. Immigrant women lack access to services that are culturally and linguistically sensitive to them, both as women and as immigrants. Barriers to fair and equitable treatment within the health care system can have grave consequences for many immigrant women in their work and family life and in their contribution to their community and society as a whole.

Mental health, new reproductive technologies, childbirth and wife assault are areas of importance for all women. But the implications for immigrant women are different. For them, the counseling and health services they receive from the health care system are, for the most part, culturally insensitive and inappropriate.

Profiled in this issue are four women's groups working towards providing health care counseling and family planning to immigrant women. Staffed with counselors who speak the languages of the

women they serve and who are also from their communities, they provide a comfortable base and the sensitivity needed to deal effectively with the issues which confront immigrant women.

But these kinds of agencies are few. Continually threatened by government funding cutbacks to women's groups, the struggle to survive is matched only by their commitment to continue to serve the needs of immigrant women. What is even more frightening is the proposed federal legislation (Bill C-20) to further reduce funding to the provinces for education and health care under the Established Programs Financing. If Bill C-20 is passed, it could mean even further funding cuts for provincial women's health groups, many of which are already underfunded.

Why is it that there are so few agencies equipped to deal with these concerns? Why is it that in most cases there is one agency in a province to respond to the needs of immigrant women? Despite government talk about multiculturalism, funding for community-based health centres is lacking. This means that the majority of immigrant women are dependent on the mainstream health care agencies and institutions which have neither the staff nor the programs to deal effectively with their needs.

There should be no funding cutbacks here. There should be more community agencies and groups established across Canada with more than just culturally-sensitive staff, but staff from immigrant communities who speak the languages and know the cultural beliefs. We need fewer band-aid solutions and more long-term commitments from the health service

system, its providers and from government in order to change the quality of service immigrant and refugee women receive.

Canada often boasts about its mosaic society, its multiculturalism. Yet, it has failed so far to provide a basic necessity to the women who have come to this country—an equal and non-discriminatory health care system, which provides counseling, information and help.

This special issue of *Healthsharing* does not address all the health concerns which affect immigrant and refugee women in Canada, but it is a start. If this issue can begin to shed light on the fears, abuses, tragedies, the racism and sexism, the failures in our health care system; if we can draw attention to the insensitive approaches to health care that cause all immigrants to experience healthshock; if we can educate health professionals and activists about the difficulties immigrant women face and how they can be part of solutions to ensure greater access, sensitivity and health; if we can help immigrant women to affect positive change in relation to their social, physical and emotional well-being; then we would have succeeded in trying to convince our readers of their uniqueness in our society—and why the health concerns of immigrant women warrant special attention.

Our many thanks to Amy Gottlieb who recognized the need for *Healthsharing* to focus on this issue and to our guest editorial committee (Monica Riutort, Eva Szekely, Serafina Hui and Jennifer Khong) for providing input and discussion on the content. Special thanks go to Fauzia Rafiq, our guest editor, who provided further focus and direction and helped to shape the five features and four profiles you are about to read.

Hazelle Palmer

# LETTERS

*We encourage readers to write. Your comments and criticism are just as important as the original articles and columns published in the magazine. Please take the time to share your opinions with other readers.*

*Healthsharing reserves the right to edit letters for length, and print them, unless they are marked "not for publication."*

## **Mother Bears**

To this well written and informative article [*Healthsharing*, Summer, 1991], I have one comment to add in the way of a "p.s."

This relates to the list of resources Maureen Gans offers in closing. While I find these sources of much value, I would caution consumers approaching these agencies to proceed with the same caution that Maureen advises with respect to the medical system.

Unfortunately many of these agencies operate within the same male-dominated medical system that, sadly, continues to negate our experiences as mothers, consumers and women. Many receive their funding from large bureaucracies and have become condi-

tioned to operate within the constraints of these, often very binding, systems. Some of these agencies have been seriously criticized by the persons they claim to serve for operating in much the same authoritarian fashion that these consumers experienced within the medical structure. It was with a sense of feeling betrayed that people shared these discoveries with me.

So, while I continue to search out and use these agencies myself, and encourage my clients to do so, I do not throw caution to the wind when I contact anyone. Using this approach, I have been delightfully pleased to find wonderfully helpful contacts "out there".

I am a recent subscriber to *Healthsharing* and thank you for your insights, wisdom and broad interests. I wish you continued success in your very important work.  
*S. Hornstein,  
Vancouver, B.C.*

## **Making the Link**

Thank you for the article "One of a Kind" from the Montreal Assault Prevention Centre! [*Healthsharing*, Summer, 1991] For some time now I have been feeling impatient with activities such as Take Back the Night which have left me with the futile and disempowering feeling that no amount of marching in the streets will

actually reduce the violence. It was wonderful to see work being done that addresses directly the prevention and reduction of assaults, that acknowledges the importance of men working on what is, after all, a "men's issue," and that makes the link, in the programming itself, between violence of all kinds (racist, heterosexist, ageist, etc.). I cheered right through the article.

*Y. Belanger Mennie,  
Ottawa, Ontario*

## **After Reading Healthsharing**

Don't want to miss any issues—please keep up the good work. My partner and I just had a great conversation about TSS [Toxic Shock Syndrome] and tampons, etc after reading Margot Henning's story [*My Story, Our Story, Healthsharing*, Summer, 1991]. Have had many other wonderful and enlightening conversations, experiences, thoughts, actions after reading *Healthsharing*. Thank you all.  
*L. Cockburn,  
Toronto*

## **Menopause Issue Well Read**

I have enclosed my cheque to renew my subscription, and whilst writing should mention that the Winter 1990 issue on Menopause has been well read, lent out to friends and copied!  
*S. Sinclair,  
North Bay, Ontario*

## W.A.N.T.E.D

### Regional Animators for the Canadian Women's Health Network Project

Women are needed for the following regions: Prairies, Ontario, Quebec and the North to coordinate regional reports on a short term contract basis

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# UPDATE

## Même implants "safe"?

The Canadian Medical Association (CMA) Journal has released a report on the controversial Même breast implant that leaves many skeptical about its findings. The report, which states that "the very high [cancer] risk estimates are not scientifically valid and best regarded as speculation," concludes that surgical removal of the implants for reasons of potential risk of cancer "does not appear to be indicated." The expert panel was organized by the CMA at the request of the Department of National Health and Welfare to study the link between breast cancer and the Même implant.

Joy Langan, MP for Mission-Coquitlam, B.C. and co-founder of Je Sais/I Know, the national support network of women with breast implants, calls the Canadian report a whitewash. "There is absolutely nothing new in this report. This is just another example of how the

government is running around patching things up to look OK instead of putting in some serious research," she said in a phone interview from Ottawa. According to Langan, Je Sais/I Know has sent a number of letters to Health Minister Benoit Bouchard stressing that the risk of cancer is just one of many concerns women have about the implant, and not necessarily the most worrisome.

The Même, a gel-filled silicon sack covered with polyurethane foam, has been implanted in more than 17,000 women in Canada. The foam surrounding the implant breaks down in the body releasing a chemical called TDA which is known to cause cancer in mice and rats and is suspected of causing cancer in humans. More immediate effects of the Même, however, can include symptoms of arthritis, immune-system diseases, connective tissue

disorders, generalized fatigue, chills and fevers, burning, tingling, dry eyes and mouth, swollen lymph nodes and hardening and internal shifting of the implants. Once implanted, the Même is extremely difficult to remove.

Pierre Blais, a former scientist with the Department of National Health and Welfare, who was fired in 1989 after advising the department to ban the Même, says there is no basis for the report's findings. "You could hide a diesel truck in this data," he said from his Montreal home. "What the panel completely ignored is what happens to a woman who gets cancer and we know that one in nine women get breast cancer after the Même is implanted. The Même appears to speed up the dissemination period and therefore cancer can get into the lymph nodes more easily. Once that happens it's hard to remove or even establish if there is cancer because it's hidden by the implant."

Blais also has some serious concerns about the independence of the panel. The only two panel members who knew anything about plastic surgery were former affiliates of Surgitek, the company that produced the Même, Blais contends. He also says the CMA was clearly out of line in accepting funds from Health and

Welfare for the report as it is a conflict of interest.

Despite the growing number of lawsuits against Surgitek, and the voluntary withdrawal from the market of its breast implant by the company in October, Health and Welfare Canada has consistently denied any serious health risks with the Même. Its refusal to take action has fuelled the anger of thousands of Canadian women who claim to suffer health problems caused by the Même. Marcella Tardif, spokeswoman for Je Sais/I Know, says she is outraged at the government's inaction. "Why wasn't this product properly tested? Why were thousands of women used as guinea pigs? We want answers and we won't back down until we're satisfied."

Ironically, the report was released just days before an expert panel recommended to the American Food and Drug Administration (FDA) that it refuse pre-market approval applications for silicon-filled breast implants until enough research has been done. Due to the perceived health need for breast implants, however, they will remain on the market until research is complete.

For more information about the Même implant, contact Je Sais/I Know at (613)996-2767 or (514)956-1262.

MEGAN WILLIAMS

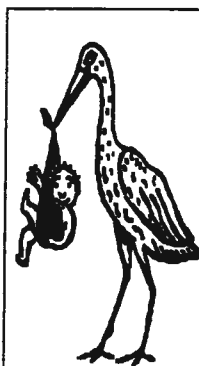
## In crisis

After almost 20 years of local health support for women, the Vancouver Women's Health Collective is in crisis and may have to close its doors.

A women-controlled organization, the collective has held public speaking engagements and workshops, spread health information and offered

referral counseling. Although it is in the process of financial restructuring, funds are desperately needed for the short term. Donations can be made to the Vancouver Women's Health Collective, #302-1720 Grant St., Vancouver, BC, V5L 2Y7

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Toronto (416) 923-6641 ext. 2443

## Pandora needs help NOW to fight sex-discrimination dispute

You may or may not have heard by now that *Pandora*, a feminist publication published in Nova Scotia, is embroiled in an alleged sex-discrimination case initiated by a man who claims *Pandora* discriminated against him by not printing a letter he wrote, in the editorial section of the paper.

The onset of this attack against *Pandora* began in June, 1990 when a formal complaint was filed with the Nova Scotia Human Rights Commission. For the past one and a half years, *Pandora* has been utilizing vital resources to challenge this allegation of sex discrimination. We have maintained from the beginning that *Pandora* has in no way discriminated against this complainant. We also believe that women-only organizations should not be

required to apply for human rights exemptions as a means of protection from claims of sex-discrimination.

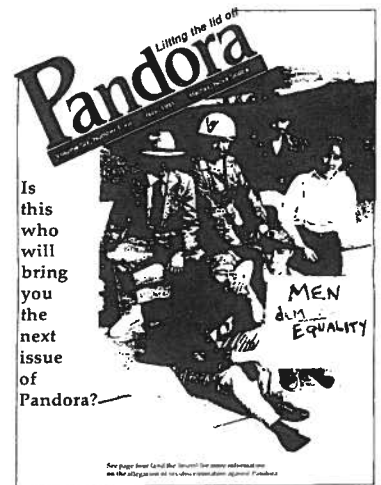
It is our contention that the Nova Scotia Human Rights Commission should not be using its resources to process a complaint by a white, heterosexual, privileged male against a feminist equality-promoting and affirming organization. We feel that this position is contrary to the purpose of the Human Rights Commission, which, in theory, is supposed to protect minority and disadvantaged groups.

*Pandora* anticipated that the Human Rights Commission would acknowledge the commitment which *Pandora* has demonstrated in providing a space for women to voice and share their/our experiences. It was a great disappointment

when *Pandora* learned a Board of Inquiry had been called to hear the complaint. It means the efforts of *Pandora*, and every other women's organization, are trivialized and subject to government controls.

There is no Canadian case law in which Human Rights legislation has been used in this fashion. This means that the *Pandora* case will be precedent-setting. The implications of this case of sex-discrimination against *Pandora*, to other feminist organizations are clear. If *Pandora* loses, every other women-only organization across Canada will lose too. It will mean we have lost our freedom to determine who and what we are.

*Pandora* is desperately seeking the assistance of any women or organization to help us fundraise to pay



for the significant legal costs associated with this case. We are also desperate for women volunteers to assist in the production of *Pandora*. The sex-discrimination case has drained all of our financial resources and thus made producing the newspaper more difficult than it usually is. Contact *Pandora* at Box 1209, North, Halifax, N.S., B3K 5H4

AMANI WASSEF

## Ontario guides for rape cases

In response to the Supreme Court decision in August to allow women to be questioned about their sexual history during sexual assault trials, the Ontario government has issued its own guide-lines for rape

cases. Howard Hampton, the Ontario Attorney-General, says he wants to ensure that sexually assaulted women are not victimized a second time in court. The guide-lines instruct crown prosecutors

to: oppose any attempt to force a woman to testify in voir dieres—small trials within a trial held to determine whether a woman's sexual history is admissible; ensure that a woman's sexual history is kept confidential and order reporters not to publish such evidence; argue that crown prosecutors be given "reasonable notice" by defence lawyers planning to raise such evidence; and to recruit expert witnesses who can "identify the sexist myths and stereotypes" surrounding such evidence.

Anna Willats, a counselor with the Rape Crisis Centre in Toronto, says that although she is pleased with the guide-lines, they are not

a replacement of the Rape Shield Law. "This is a positive step in that crown attorneys will be made more sensitive to sexual assault and women may have more support within the courtroom, but the fact remains a woman's sexual history may still be used against her."

Willats says she believes it would be more effective for the Attorney-General to put pressure on the Federal government to pass new legislation which would protect women from having to disclose their sexual history in court.

MEGAN WILLIAMS

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## Bylye Avery speaks about black women's health

"In the U.S., white women are twice as healthy as black women," said Bylye Avery, an African-American health activist in Toronto recently for the "Women Helping Women" speakers series, sponsored by the United Way's Black Community Committee. "This," said Avery "is due to the way racism interacts."

Health priorities for women in America have been defined according to the concerns of the mainstream white establishment. And these concerns are not always the same for black women. Says Avery, "We can't worry about Paps and BSE (breast self-examination) when we have no food to eat, when our sons are in prison, when you can get

killed walking down the street."

Avery advises that both American and Canadian black women need to get together to find out how their medical systems can suit their needs, and to determine their own health priorities. It's advice she has followed as well.

Avery became actively involved in health issues after her husband died of a heart attack in 1970 and at the age of 33, she found herself a widow with two small children to support. She realized then that she and her husband had ignored existing risk factors, such as high blood pressure and a high fat diet. "I kept meeting young black women with health problems they

should not have had yet—diabetes, high blood pressure, kidney disorders," she said. But Avery believed their problems were more than a matter of diet and exercise. "It's hard to take care of the physical body if the emotional and mental well-being are not there," she pointed out. So she organized a self-help group. Soon there were 10 like it, then 40. She took her kids and moved to Atlanta where, in 1983 she organized a conference on black women's health issues, out of which the National Black Women's Health Project evolved. But the main focus of the organization is still the self-help groups which meet on a regular basis to discuss everything from

nutrition and exercise to child-rearing and financial difficulties.

Stress is a major source of health problems for all women, but, says Avery, "when black women internalize racism and sexism [without an outlet for venting our anger], we get sick." Creating self-help groups, such as Avery's, will give black women the opportunity to talk and to offer each other support and validation. And that, says Avery, we can get from each other.

HAZELLE PALMER

## Toronto host program

The Metro Toronto Host Program is a befriending program between Canadian volunteer hosts and newcomers to our country. Individuals and groups in Canada responded with powerful support to the plight of the Vietnamese people in the 1970s. In part to harness that energy, host programs were created across the country. In Toronto, the host program has been in operation for over two years.

Both hosts and newcomers participate in the program on a voluntary basis and share the opportunity to develop rewarding friendships. Women who volunteer as hosts are matched with immigrant women or families. It is a unique way to know someone from another culture and "to travel without leav-

ing Toronto." Hosts can offer support by providing information about this city and its services and by helping the newcomer gain access to those services and other supports.



Women are particularly vulnerable as new immigrants to Canada because of cultural traditions. As well, their roles as caregivers and homemakers can often isolate them in their homes

more than their spouses and children.

Hosts assist in easing the adjustment process by offering social support, language practice and information about libraries, day cares, drop-in centres, skills development courses, and most importantly of all, by offering friendship. This link can be an empowering one for the Canadian host who usually has limited contact with people new to Canada and their experiences of this country.

For more information about the program, contact: The Metro Toronto Host Program, 1339 King St. W., Toronto, ON, M6K 1H2, (416) 538-8280.

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## Health centre staff locked out by board

Close to 30 community supporters demonstrated outside the office of a Toronto women's health centre October 29 to protest the unfair dismissal and treatment of four staff members by the board of directors.

The board of directors of Women's Health in Women's Hands served termination notices and locked the staff out by changing the locks of the centre after talks broke down between staff and board members over the recommendations of an organizational review conducted by a private consulting company. In its recommendations, the report called for the immediate termination of the Executive Director, Anne Marie Gardner, and suggested the two community health workers, Joan Grant-Cummings and Carolann Wright and the health promotion coordinator, Vuyiswa Keyi, be offered secondments to other health centres, noting if they refused this option, they would be terminated.

Women's Health in Wo-

men's Hands (WHWH) is the only community-based, government-funded health centre for women in Canada and serves immigrant and refugee women, women of colour, women with disabilities and young and older women.

A statement from staff detailing the events leading up to the terminations, says "they [the board] have decided to put health promotion and community outreach aspects of the centre "in abeyance until clinical and support services" can be operationalized." This action, says staff, "could jeopardize the whole basis of the community health care movement by prioritizing clinical /medical technological services at the expense of health promotion."

At the time of the lock out, staff had still not seen a copy of the final report which was completed in mid-October. Information regarding the report's recommendations was leaked to three staff members by a board member. In fact, staff

say they have had little involvement in the organizational review process and were not invited to be a part of the committee established to work on the report which consisted of board members and the consultants. The committee also did not solicit input from other community health centres, an oversight that has angered some members of the Toronto health care community. "We're part of the community served by this Centre," said Rhonda Hackett, a community health worker, "and we consider Women's Health in Women's Hands' board members accountable to us for their action. We want to put a stop to the actions of a few women who are disrupting health services meant for us, and we want to be involved in the process of resolving this problem at WHWH," she said.

The terminations could have other disruptions as well. "INTERCEDE (International Coalition to End Domestic's Exploitation) will be hard hit by this unreasonable action of the WHWH board," said INTERCEDE coordinator, Fely Villasin. "Three of the four women are directly involved in initiating and implementing a joint project with [the] Immigrant Women's Health Centre that provides a

mobile health clinic for domestic workers at INTERCEDE's monthly educational meetings."

"The black women staff [the health promotion coordinator and community health care workers] being separated from the centre are responsible for an important new project to establish health self-help and support groups specially for women of colour and there are already 80 women on the waiting lists. Programs like this are now jeopardized by the WHWH Board," said Simone Hammond, a health counselor.

Board chairperson, Suzanne Grew Ellis indicated that the board is prepared to meet with the staff, but believes community input would be "inappropriate."

Staff are calling on the Ontario Minister of Health, Frances Lankin, to intervene and call a halt to the process. Lankin's ministry supplies \$1.5 million in funding to WHWH and approved the organizational review process and its final report. Staff are also demanding that the board resign and that the health centre be kept open while an investigative process involving members of the community is conducted.

HAZELLE PALMER


## Anti-pregnancy vaccine

Yet another anti-pregnancy vaccine is being tested on women by the World Health Organization (WHO), with the intention to market it in Third World countries. The vaccine, which prevents a woman's egg from lodging in her womb, caused arthritis to develop in one-quarter of the Australian women it was tested on. Little is known about the length of effectiveness of the drug or long term side-effects.

Antigena, a Swiss reproductive rights group, fears that this new vaccine will be administered without full

knowledge or consent of the women involved. Already vaccines such as Depo-Provera are given to over six million Third World women annually, putting those women at risk for permanent infertility, liver and kidney damage, depression and cancer. The continual testing and administration of these drugs reflects WHO's priority of eradicating the poor rather than the poverty and exploitation of Third World women and nations.

WHS



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Michelle Andrene Lurch

## Where Does the Torturer Live?

*"Where does the torturer live?  
Husbands beating wives  
They think marriage gives them the right  
Too afraid of the bossman,  
Women's screams ease their lives"*

With a tambourine on one foot, a guitar in her hands and a series of harmonicas arranged on a nearby table, Canadian folk-blues singer Faith Nolan sang out the question during a concert at Carleton University in Ottawa. The tone and lyrics of her song revealed her outrage. Nolan repeated the question again and again. And as the refrains washed over the audience, its members, predominantly female, remained silent. But conservative estimates say at least one in 10 Canadian women can answer Nolan's question. More than this, they know who the torturer is. He is a husband, a partner, a boyfriend, a lover.

Wife assault is not a new phenomenon in Canada, nor is it particular to this country. While this type of violence crosses all cultural, educational and economic lines, it presents particular problems for immigrant women.

Immigrant women are no less likely to be assaulted than their Canadian counterparts, but linguistic and cultural barriers prevent them from getting the help that is needed.

Leaving a battering spouse is difficult enough for a white Canadian woman. "The historical explicit acceptance and regulation of wife assault and the tacit acceptance of it as a private matter," as Health and Welfare Canada explains in its 1989 study, "has effectively

silenced and emotionally isolated Canadian women victimized by male violence. For centuries, wife assault has been practised and tolerated...it remains largely a hidden crime."

And what of the immigrant woman who does not speak either official language, whose family, friends and other sources of support are thousands of miles away, and for whom the police and immigration officials loom large and threatening? For her, leaving is twice as difficult and rarely seen as a viable option.

That's what Helen (not her real name), 26, says she used to think. She immigrated to Canada in 1983 from Yugoslavia, sponsored by her Canadian fiancé. What started out as a fairytale romance soon got twisted into something very ugly. She was 18 years old, he was 27. They met while he was visiting his family in Yugoslavia. One year later Helen, pregnant, ran away to Canada to be with him. She says he said he loved her. He promised they would be married in Canada.

One week after Helen's arrival in Canada the abuse started. She remembers her head being split open after being thrown into the edge of a wall. "The baby was crying, he started yelling at me and hitting me. I scratched him. He swore at me and threw me into the wall. My night-gown looked as if it had been soaking in blood. The kitchen cupboards and the floor





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had blood all over. He was very scared I would call the police. He kept saying "I am sorry, I am sorry." He took my night-gown and cleaned up the blood in the kitchen."

Helen explains why she stayed: "You come here for him. You don't know anybody in this country and you don't know the language. You don't know anything about life here. You don't have any money. You expect everything to be fine because they promise you all those things...When we met in my country he was very nice. He wanted for us to have a baby and he wanted to have a nice wife, so I believed."

"I used to wonder why it (the beatings) would just start. He'd come home in a good mood then five minutes later he would just pop. All of a sudden he would start screaming at me and calling me names and the hands would start working. I would think, "What happened? What did I say?" You always blame yourself...think that you said something even though you didn't. I thought, "Things will change."

"I didn't know that I could make it, that I would be happy by myself. I always thought I should try again and again and again but it never worked," Helen says.

When Helen arrived in Canada she spoke German, not English or French. It was a German-speaking nurse at Women's College Hospital in Toronto, where her little girl was born, who helped her escape to a shelter. And later, as luck would have it, one of the residents at the shelter was able to translate for her.

She admits to feeling very lonely at the shelter and to going back to her abusive fiancé. "There were so many times I don't even remember myself but, it was a lot of times that I went back," Helen says. It took her two years to finally leave him for good.

When 28-year-old Nancy (not her real name), a Vietnamese woman, decided to leave for good she encountered problems at the shelter she fled to in Winchester, Ontario. Nancy's case was documented by the staff of the women's program at the Ottawa-Carleton Immigrant Services Organization

(OCISO). In its report on Nancy, OCISO says that other shelter residents had Nancy do their share of the house cleaning. There were complaints that Nancy was withdrawn because she didn't participate in group sessions even though the staff was aware that she had difficulty speaking English, that she was tired from travelling back and forth to Ottawa to see her lawyer and that she had to cope with a disabled child, the study says. The OCISO case study also revealed how the language barrier stopped Nancy from leaving her abusive husband sooner.

On one of the occasions, for example, Nancy was beaten and raped. She called the police. "When the police came, her husband pinched her from behind and told her in their language (Vietnamese) that she should ask the police officer to leave. Without an interpreter the police had not been able to pick up the threat of the husband and had left her unprotected despite her attempt to get help," the study says.

Nancy's story is one of many cases documented by the staff of the women's program at OCISO. Four years ago the women's program staff noticed that an increasing number of distress calls were coming from immigrant women who had been abused. The problem was that there was nowhere to refer them. Immigrant women had no hotlines to call, no crisis workers to talk to, no qualified translators to understand their fears and the subtleties of their various cultures.

The women at OCISO took the problem to the Regional Coordinating Committee on Wife Assault, a private, non-profit planning group in Ottawa.

Now in a small, nondescript house on Holland Avenue, the women from OCISO are running a pilot project aimed at helping assaulted immigrant women.

The house on Holland Avenue is not a shelter; there are no beds. It's a crisis service. Two part-time crisis workers and two part-time cultural interpreters share the duties along with volunteers. The client load is small and the project is aimed at Vietnamese and Spanish-speaking women. This is



In a small, nondescript house, women are running a pilot project aimed at helping assaulted immigrant women

because these two groups are the most recent immigrants to the Ottawa area. In its list of the countries from which the highest number of immigrants came, the 1986 census cites El Salvador and Vietnam as major source countries.

The women at Holland Avenue say they eventually want to reach other linguistic groups. To do this they are developing models of crisis support services and cultural interpretation for immigrant women which they want mainstream agencies in Ottawa, such as Interval House, a shelter for battered women and their children, to adopt.

It's a question of equality. Immigrant women should have the same opportunity as Canadian women to use the services available and to get the help they need.

Cindy Player a social worker and staff member at Interval house says the shelter staff has recently begun to question its ability to service all women of different cultures.

"When one of the volunteers noticed that the residents were culturally diverse and the women who worked at interval house were white middle-class women, we wondered, can we be giving the best service?," Player says. She says Interval House is now review-

ing its hiring policies.

The best service is what Jacqueline Sztein is trying to give. Sztein is one of two cultural interpreters for the pilot project.

Born in Chile, Sztein has lived throughout Latin America. She provides interpretation services for Spanish-speaking women. This means that if an abused woman needs someone to translate when she goes to court, social, welfare or housing services, Sztein will go with her.

The Ontario Ministry of Citizenship funds the cultural interpretation part of the project. Currently, more than 118 cultural interpreters are at work in Toronto, London, Kenora, the Niagara region, Scarborough and Thunder Bay. The interpretation program is part of the wife assault prevention initiatives started by the ministry in 1986.

The program involves a 120-hour training course where interpreters learn about the issue of wife assault and the role the interpreter must play as an intermediary between the abused woman and the social worker or service provider.

Sztein says her job is to ensure that the client is aware of her rights and options and to explain to the

service provider what lies behind the client's responses or decisions.

She says because culture can change the meaning and implication of words, she tries to translate the true meaning behind what is being said.

Sztein says a verbatim translation can be very misleading. "For example, sometimes in some Latin American countries the word abuse has sexual connotations. If a person is abusing you — *abuso* in Spanish — that means that there may be some sexual implications. So, when you ask a woman, "Is your husband abusing your child?" directly in Spanish—when you mean spanking the child—the woman would say "Oh, no. What do you think he is?"

This becomes further complicated when a social worker or the police know for certain that an assault has taken place. The woman's denial leaves them confused, Sztein says. "The woman is telling the truth within her own context because no sexual abuse has taken place. I explain to the police about her culture and explain to the woman how the police work here in Canada." Sztein says she makes certain that there is no misunderstanding on either side.

Culture can change the meaning and implication of words; misunderstandings can occur even when no words are spoken



And misunderstandings can occur even when no words are spoken. Szein explains that for some immigrant women if a police officer, social worker or lawyer does not reach to shake her hand this indicates that the official does not like her. Likewise, when an abused woman won't look a police officer or social worker straight in the eye, Canadian training has taught them to think that she is not being honest.

Understanding an immigrant woman's cultural heritage is important in understanding how best to help her cope with an abusive situation. Nga Nguyen and Gina Salinas understand what it is like to be an immigrant. Nguyen came to Canada in 1979 as one of the "boat people." She had been a teacher in Vietnam. Salinas emigrated from Peru in 1987, where she had been an interpreter in the courts. Both work as crisis workers at the

Holland Avenue house.

Nguyen says that the Vietnamese community, like the Canadian mainstream community, plays a part in keeping Vietnamese women in abusive relationships. "We are still at the point where abuse is seen as a private matter. The woman is still blamed for what happens. The community largely believes that the woman must have provoked it or that she is not a good wife."

In Vietnam, "you are raised knowing that the father is head of the home," Nguyen says. "He has the right to discipline. The woman's role is to keep the family together."

Most cultures share the same attitudes. "We have more statistical data here in Canada than Third World groups have but it looks like violence against women is happening everywhere," says Tracy Heffernan program coordinator at MATCH International, an organiza-

tion which links Third World and Canadian women's groups.

Under English common law for example, William Blackstone's "rule of thumb" permitted a husband to enforce domestic discipline as long as the stick with which he hit his wife or children was no broader than his thumb. Judicial decisions in the United States and England upheld this right well into the 19th century. In Canada, physical cruelty only became grounds for divorce in 1968.

As of the summer of 1991, 102 requests for help had reached the House on Holland Avenue. Twenty-nine per cent were from Ottawa's Vietnamese-speaking community and 42 per cent were from the Spanish-speaking community.

Nguyen has observed that it is not easy to leave abusive spouses. She says, "I used to feel helpless. However, I've learned a lot about our lives. I know it is not easy. I make sure that my clients know that there are options and support available to them in both situations."

Eighty-four per cent of the service's clients said they were abused at least 10 times before seeking help and 75 per cent had suffered not only physical but, mental, economic or sexual abuse.

What holds some women back? There are no quick answers but service providers have identified a few. Most of these factors are shared by women coming from the



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# HEALTHWISE

mainstream as well as minority cultures. The ones that are not shared are increased isolation, racism and language barriers.

Salinas talks about the problems the language barrier poses for Spanish-speaking women: "Women sometimes don't leave because of the language barrier. Isolation, lack of skills training programs and abuse at home lowers self-esteem of women, considerably. The only option available is to go on welfare. No one feels good about that. And job prospects for immigrant women are such that the only job that is usually available is that of domestic help."

Language and its link to employment are of particular importance to abused women. The literature on wife assault shows that poverty is a very real problem faced by a battered woman when she decides to leave the man who beats her.

Immigrant women have had problems accessing language training, says Nuala Doherty, the coordinator of a Charter challenge being launched by three immigrant women in Toronto. The plaintiffs say some of the provisions of the National Training Act discriminate on the basis of sex.

Helen says she learned to speak English on her own. She worked in a small factory inspecting film when she first left her abusive fiancé. Having a job meant she didn't have to go back to him. "I used to be scared to come out of my apartment but I had to. I didn't have a choice," she says, "You have to pretend to be strong. When you are quiet they do it (beat you) more."

She says she has learned that you have to fight back in order to stop the abuse.

Where does the torturer live? Some would argue that the torturer lives within the systems and institutions which serve to victimize all women and victimize immigrant women a second time. Luckily, women are fighting back.

*Michelle Andrene Lurch is a freelance writer living in Ottawa and an executive member of Perspectives, an African women's interest group at Carleton University.*

## Traditional Healing Practices

Mary Vargas

**T**RADITIONAL HEALING PRACTICES (THPs) are the many ways in which civilizations cured and healed their members prior to the development of modern medical science. In some societies, medical science did not totally replace THPs, though in most western countries THPs were made obsolete mainly because these practices were based on a different and distinct philosophy of life.

THPs put faith in the inner energy of human beings; its methods teach us how to use that energy for our own healing and that of others. Natural herbs are used to aid the healing process.

In recent years, some individual immigrant women have shown an increased interest in reclaiming this form of healing. I am one of them. In this article I want to share the concepts behind the various techniques used in this health system. Discussing actual techniques might not be useful without sound and visual aids. But the wonderful thing about THPs is that if a person understands the concept, she can develop a technique that works for her.

The conceptual framework of THPs is simple but because we have traveled so far away from it, it might seem way out in the beginning. So, step by step, I will attempt to take you through the process.

### UNDERSTANDING THPS

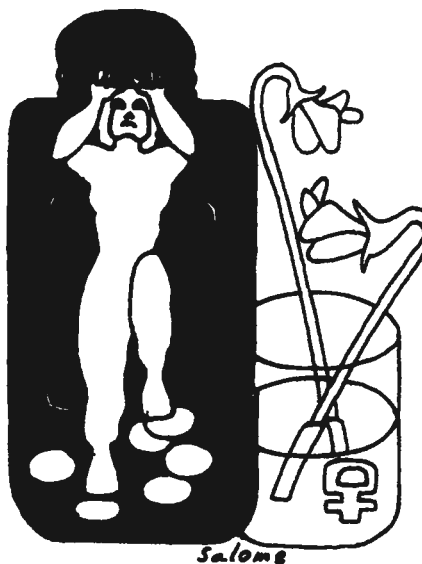
- "There are two lasting gifts we can give our children: one is roots, the other is wings." *Anonymous*
- "A person is a holistic being, more than the sum of biological,

psychological, racial and spiritual dimensions. A person's health and development are inextricably linked to the psycho-social, ecological, spiritual, cultural and physical environment." *J. Rilchie, Canadian Nursing Association*

- "The doctor of the future will give no medicine, but will interest his patient in the care of the human frame, in sensible diet and in the cause and prevention of disease." *Thomas A. Edison*

- "Health is knowledge. It is your responsibility to listen, read and then put this knowledge into practice. Make it work for you. Health is something no one can give you, nor can you purchase it at the local pharmacy. Vital health must be earned through self-discipline and knowledge. Only then can you reap the reward of a healthy body." *Canadian Natural Hygiene Society News*

- "Life can only be understood



Salome

looking backwards but it must be lived looking forward." *Anonymous*

When I first came across these concepts, I did not know how to translate them into practice and make them work for healing ailments. Later, I converted them in practical formulas for myself to live by. Following are some such points and while you are reading them, please remember that the word "you" is "me":

Learn to know yourself through your ethnic and racial origin and your cultural patterns.

Learn to accept and love yourself as you are, this will help you to accept and love others, increasing your capacity to be tolerant.

You are unique, no one is identical to you. You have your own biological life, physical life, physiological life, chemical life, electrical life, magnetic life, emotional life and psychological life. You need to care for them all.

Eat simply but sensibly so that your table is a pleasure for you, not a torture.

Work sensibly. Don't break your back. Be proud and happy indeed of the work you perform. Discover your abilities over time and then find the right thing to do.

Be curious about yourself and you will be amazed to find qualities you never imagined you had.

Always spend your leisure hours as you please and not as someone else pleases.

Give love bit by bit otherwise you will have nothing to give at the end. Save some for later.

Learn to talk with yourself every single day to keep in touch with the state of your internal balance.

Build your own philosophy of life

## TECHNIQUES USED IN THPS

**Yoga** concentrates on the physical area and helps to maintain a good mind-body balance. The mind orders, the body responds. The first order to the body could be to "keep healthy, happy, gracious and flexible."

**Mitzvah** is comprised of gentle movements which bring all areas of the body to where they actually belong, so that the body is able to function better at all levels.

**Therapeutic Touch** is also called the "laying on of hands." Basic to therapeutic touch is the concept that human beings are a highly complex field or continuum of various life energies. In a state of health all the energies of an individual are in harmony or dynamic balance. Disease within this framework is a manifestation of disequilibrium, blockage and/or a deficit.

**Chromotherapy** involves the use of colours in the treatment of disease, and may become a recognized science in the future. This technique teaches us to breathe in colour through imagination. The basic properties of colour have certain characteristics that can be internalized through imagination. For example, the following colours can help you recreate certain feelings within yourself:

Rose Red: stimulating, uplifting  
Orange : stimulating, re-vitalizing  
Green: sedative, relaxing, rhythmic  
Blue: cooling, soothing  
Yellow: stimulating, illuminating  
Violet: stimulating, purifying

White light: regenerative

**Creative Visualization** is a subjective experience which uses imagery and imagination. Images can be visual, auditory or kinaesthetic and can be based in memory or imagination. Images heal because they create corresponding body changes. The level of effectiveness is closely linked to the clarity and strength of an image and in the degree of belief in the process.

**Sonafon** is an ultrasound massager used for pain relief. It can also be used to relieve conditions of constipation, indigestion and arthritis.

**Reflexology** - In this technique I am a follower of Mildred Carter (books available). Her system is based on the art of manipulation of the reflex "buttons" located in the soles of our feet and the palms of our hands. It helps the patient achieve vibrant health and abundant physical and mental energy.

Like me, many health practitioners today are actively pursuing and including this "natural way to better health" as part of the complete and total health care philosophy. For me its value is that it helps me to rediscover my internal energy, connects me to myself as opposed to causing alienation in the process of healing and enables me to exercise positive control over my mind/body. I see it as a preventive, wholesome and comforting lifestyle that on the whole assures my well-being. In emergency conditions of the body the THPs might not offer an alternative to surgical/medical treatment.

*Mary Vargas is working as a graduate nurse at the Women's Health Centre which primarily provides counseling to women from the Spanish, Portuguese and Italian communities. She has over 25 years experience as a registered nurse in her home country of Bolivia, and is currently fighting for full acceptance of her training and experience from the College of Nurses. Mary attributes much of her traditional healing methods to her ancient Bolivian culture called Aymara.*

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Sunera Thobani

## In Whose Interest?

*New Reproductive Technologies are not necessarily in the best interests of everyone and may in fact increase the exploitation of women of colour*

**T**he Canadian Royal Commission on New Reproductive Technologies (NRTs), appointed in 1990, has sparked a much needed discussion on these technologies within the feminist movement. However, this discussion centres around the various benefits and costs of the different technologies, and not on NRTs as a package.

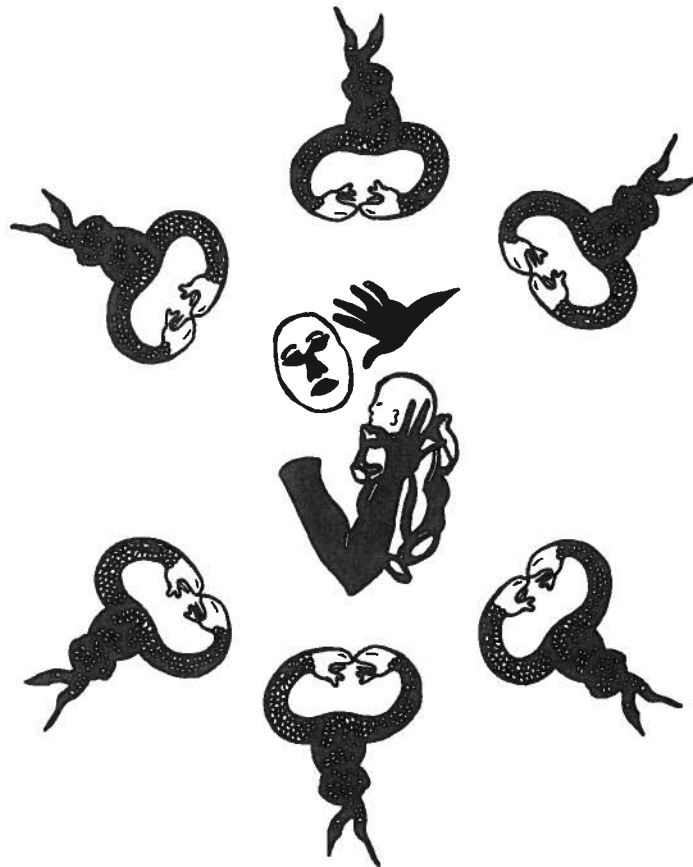
The concerns of women of colour have been notably missing from this discussion even though these technologies pose a threat to our reproductive rights and are becoming a weapon to further exploit us.

A critique of New Reproductive Technologies (NRTs) from the historical experience and perspective of women of colour reveals that:

- these technologies play contradictory roles in the lives of women by pitting them against each other along the lines of class and race; and
- they lead to a deeper understanding of the underlying consequences of such devices on the lives of all women.

The first thing that becomes evident when NRTs are considered is that the technology itself and the decisions about which groups of women will have access to what particular technology, are determined by the largely white, male, medical and scientific establishment. Women have not had any control in either the development of the technologies or in the manner in which they are being provided.

For women of colour, NRTs invoke the spectre of genocide as they create the potential for realiz-



ing the dreams of the Eugenics movement. In fact, the connections between advocates of eugenics and the developers of NRTs are disturbing. (See Gena Corea's *The Mother Machine* for a discussion on the connections between the Eugenics movement and the development of NRTs in the United States.)

We, women of colour, have learned from our history that the creation of a genetically-engineered, "superior" race will be determined by the dominant values of a capitalist society which

are based on patriarchy, racism and class. The Nazis showed the world what this "superior" race would look like. As women of colour, we understand only too well the threat posed to our very survival by NRTs as they have been developed in their present unregulated form.

The discussion on NRTs has tended to be fragmented, i.e., the virtues and costs of technologies such as in-vitro fertilization (IVF), with surrogacy and sex selection often discussed in isolation.

## NRT Glossary

**In Vitro Fertilization:** The fertilization of a human egg outside the womb. The eggs are removed from a woman's ovaries, fertilized with sperm in a laboratory and then placed in a woman's uterus. The fertilized eggs may either be placed in the uterus of the woman who produced the eggs or in the uterus of another woman.

**Sex Selection:** Choosing the sex of a child before birth. Sex selection can be done before conception, by separating male and female sperm. The woman is then artificially inseminated with sperm that are likely to produce a baby of the desired sex. The most effective and commonly used form of sex selection is done after conception. Screening techniques like amniocentesis are used to determine the sex of the fetus, and if the fetus is not of the "right" sex, it is aborted.

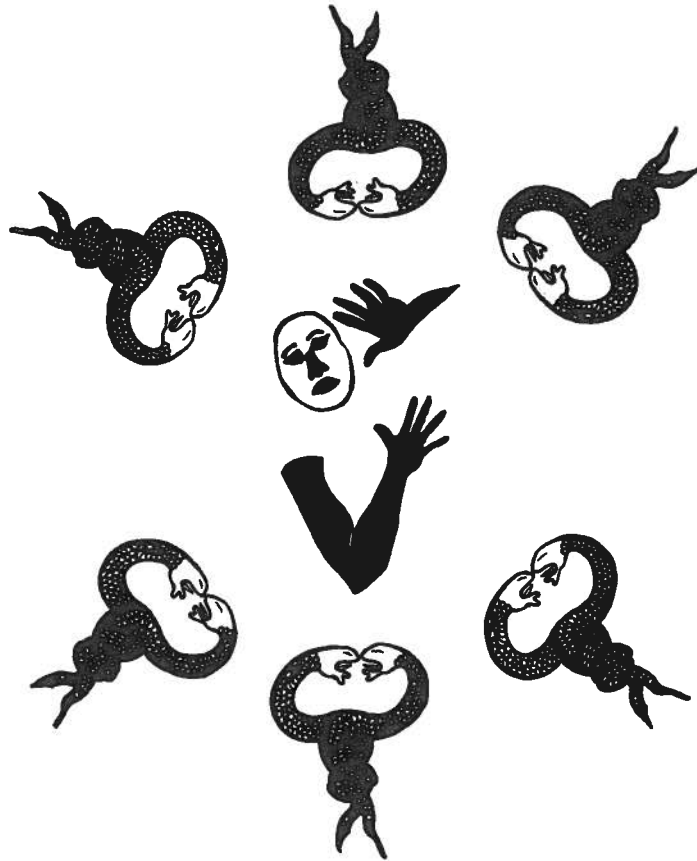
**Surrogate Mother:** A term used to describe a woman who is artificially inseminated with the sperm of a man whose partner is unable or unwilling to bear a child, and who has agreed to give the baby to the couple after it is born. She is usually paid for this service. The term "surrogate mother" is misleading in this case, because the "surrogate" is in fact the true biological mother of the child.

**Artificial Insemination:** A way of becoming pregnant without having sexual intercourse. Sperm is placed in a woman's vagina when she is ovulating.

**Gestational or Uterine Mother:** The woman who carries the pregnancy to term.

**Infertility:** Inability to become pregnant as readily as most women or couples. In North America, a couple who have been having intercourse for one year, aren't using any form of birth control, and haven't conceived, is considered by medical experts to be infertile.

*Definitions are from the CRIAW kit, Our Bodies...Our Babies? Women Look at New Reproductive Technologies*



However, the full implications of NRTs can only be understood when the technologies are analyzed as a whole, within the context of the power relations of our world.

### The NRT package deal

When considered as a package, NRTs both increase the control of privileged male interest over women's reproductive abilities as well as strengthen and recreate the divisions of race and class which exist within society. These race and class divisions are reflected in and re-created by the development of the technology itself, and in the access to NRTs. NRTs have been represented in the mainstream media as being largely an issue of a woman's "right to choose"; the technologies themselves are defined as being benign and only assisting women in "choosing," designing and planning their families.

It is on this issue of "choice" that the experience of women of colour becomes critical in exposing "choice" for the myth that it is, and in revealing the inherent func-

tion of the high-tech NRTs, i.e., the increased control of women's reproductive abilities. Let us consider, for example, in vitro fertilization, surrogacy and sex selection in the context of race and class.

### In-vitro fertilization

In Vitro Fertilization (IVF) costs about \$3,000 per attempt and has a success rate of eight per cent. In most cases, several attempts have to be undertaken before fertilization is achieved, and with the costs involved, it is only the affluent who can afford the procedure. IVF, it seems, is part of the move towards enhancing the reproductive abilities of white women through NRTs. Whereas for women of colour, the order of the day continues to be an exertion of negative control over our reproductive abilities, to regulate population growth in our countries.

Whether IVF is desirable in the interests of the majority of women, is a question open to heated debate. However, access to this technology at present is very much determined by the size of one's



income. Since women of colour face the harshest economic discrimination and are found at the bottom of the economic hierarchy, most of us are barred from access to IVF. While women's organizations have expressed concern over the use of IVF and its negative consequences on women, some infertile women have attacked women's organizations and argued that they will fight to increase access to IVF.

It is the racist exclusion of the concerns of women of colour which have allowed white women's organizations to be pitted in this way against individual white women, as these organizations have also made infertile white women the centre of their attention on the issue of infertility. The debate over infertility has been defined as being of relevance only to the white, affluent, infertile women who have access to IVF. If we turn to the experience of women of colour, it becomes obvious that this is not the case. While very little research has been conducted into the causes of infertility, the approach to infertility by NRTs has been an increase in technologically-intensive, surgically-invasive "quick fixes" for those who can afford it.

The consequences of environmental factors, the use of chemicals and pesticides, stress-related causes, the impact of sexually-transmitted diseases and the use of contraception on infertility remains less known.

In British Columbia, 78-82 per cent of farmworkers are women. The majority of these women are South Asian. And although agriculture is the third most hazardous industry, these workers are not covered by Workers Compensation Board Health and Safety Regulations. The long term effects of working with pesticides on the fertility of women is not known.

Yet the concerns of women farmworkers are not on the agenda of the feminist movement in this country. If they had been, the infertility debate would not have developed the way it has as it would have become imperative to address the causes of infertility and the reproductive hazards faced in the workplace by women.

## Surrogacy

Women who face financial hardship are "free" to undergo surrogacy and to "hire" out their wombs in exchange for the sum of \$10,000. In the U.S., the lawyers or physician-attorney teams who negotiate surrogacy relationships have been discussing the possibility of hiring out Third World women on a surrogacy basis for the past 20 years.

Since the majority of women of colour are located at the bottom of the socio-economic hierarchy, and are disproportionately represented among the poor, we are faced with the alarming possibility that the inequality we face in society will make women of colour more vulnerable to increased exploitation as "breeders."

Surrogacy reduces women to "incubators" and children to commodities who have to be delivered as stipulated in contracts. In both the cases of Mary Beth Whitehead and Anna Johnson, we have seen how bitter and vicious the fight can become when women are pitted against each other in determining the issues of motherhood and custody; when surrogacy agreements are contested upon the birth of the child. The courts have left no doubt that it is the buyer of the services who will get custody, whether the surrogate "mother" is also the biological mother, as in the case of Mary Beth Whitehead or the surrogate "mother" is implanted with an embryo in which the egg has been retrieved from the body of another woman, as in the case of Anna Johnson.

Although surrogacy costs \$30,000 to \$40,000, the women who function as surrogates get paid only \$10,000. Many "interested" parties therefore have a vested interest in the continued use of surrogacy. With the development of gestational surrogacy, a surrogate can be hired who would have no genetic link to the embryo transplanted into her womb. It therefore becomes possible for white couples to hire women of colour as surrogates. With the surrogates having no genetic links to the babies they give birth to, the babies would not be of mixed race if the ova and sperm used were



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The rise in the use of commercial surrogacy, when seen in the context of our past experiences of racial exploitation makes this situation alarmingly devastating for women of colour.

## Sex selection

In the case of sex selection technology, governments in a number of Third World countries are allowing its use as a population control measure. As with all NRTs, the language describing the technology is shrouded in jargon, making it difficult to understand exactly what the technology does. In the case of sex selection, the terminology used is downright misleading, for in practice, sex selection has proved to be male selection in over 95 per cent of the cases. And although sex selection is used cross-culturally, the South Asian community in British Columbia, for example, is being approached in the name of "culture" and "tradition." Male selection is nothing more than an expression of the hatred and devaluation of women. What is certainly not needed is the medical and scientific sanctioning of this misogyny, and the imposition of this technology on women of colour in the name of "culture" and "tradition."

Targeting the South Asian community in an aggressive advertising campaign, an American doctor has made this technology easily accessible to the South Asian community in British Columbia by opening a clinic on the U.S.-Canada border. Many South Asians are outraged by this racist definition of the community and its culture, as well as the

misogyny expressed in the use of such technology. While there has been a strong attack on abortion rights in North America in the last decade, abortion for the purposes of male selection is being promoted by professionals within the South Asian community through such discriminatory technologies.

Sex selection is another technology which clearly exposes "choice" as a myth. This technology has also been posed as an issue of a woman's right to "choose" which sex she wants to bear. Yet, as mentioned earlier, in reality it is male fetuses who get "selected". So what does "choice" mean when a woman decides to abort a fetus on the basis of that fetus being female, i.e., the same sex as the woman herself? Surely this tells us more about women's internalization of our devaluation than it does about choice!

## Reclaiming our reproductive rights

Even as NRTs recreate race and class-based divisions within society in general, and among women in particular, they have also brought about a situation where the white feminist movement can attempt to overcome its historical exclusion of women of colour and working class women from the movement.

Overcoming this exclusion can only strengthen the feminist movement, but this is possible only if women of colour and working class women take a leading role in the reproductive rights movement. Central to women of colour and working class women taking on this role, is addressing the issue of

"choice" and abortion rights. For although the pro-choice movement has confined itself only to the issue of abortion, abortion rights have always been part of reproductive rights for women of colour.

It is only by placing the experience of women of colour at the centre of feminist analysis that the consequences of NRTs for *all* women can be revealed. Reproductive rights have never been an issue of "choice," but rather the battleground on which the control of women's reproductive abilities to serve the interests of patriarchy has been fought.

NRTs have to be addressed within this context, and only if this is done will there be any basis for unity between women of colour and white women to be able to confront the threat NRTs pose to the reproductive abilities of all women.

The white feminist movement might become historically obsolete if it does not rise to the challenge that the experience of women of colour poses and if it fails to integrate anti-racism as an integral and vital part of feminism. The lines are being very clearly drawn, if the white feminist movement does not "choose" on which side it will ally itself, it would have "chosen" to support the status quo and to collect privileges for white women at the expense of the continued exploitation of women of colour. For women of colour, there is no choice but to fight back against the increased exploitation of women that NRTs facilitate. Our survival depends on our ability to fight back, with or without allies.

*Sunera Thobani is a woman of colour writer living in Vancouver.*

## SHIATSU THERAPY

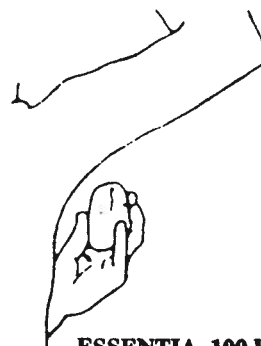
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# MY STORY, OUR STORY

## Teniendo a Mi Hija (Having my Baby)

Melida Jimenez

I was trembling. I don't know whether it was the temperature in the labour room or just my nervousness. The hospital labour room was designed in shades of green which made the room seem cold; the doctors and nurses were dressed in green as well, making them also seem cold and distant.

My husband was beside me wondering what to do. Maybe he had the same fears that I had. The night before, I was prepared for an induction (a foley catheter was inserted into my cervix to open it) and I felt the cold fetal monitor on my bare tummy and an IV needle in my arm. The doctor had broken my water bag to attach the monitor to my baby's head. I was able to hear the baby's heartbeat and my contractions started.

This was my third pregnancy and I had toxemia (a condition which distributes poisonous or toxic products throughout the body through the bloodstream). I had to stay for 15 days in the hospital before my induction. My two sons, ages five and three were staying with a friend who lived three hours away from my home. My husband, unemployed, was looking for work.

I don't know why, but as I lay there I couldn't help but think about this past year, our first in Canada. So far, it had been a lonely, isolating experience. No hope. No happiness. My husband did not have a job. I knew a little English, but not enough to get a job. We were on social assistance. We lived in a damp basement apartment. And, somewhere over the course of that year, I lost my self-esteem. I felt isolated. I felt depressed.

Sad thoughts flowed in and out along with my labour pains. Painful

memories of my country, Guatemala; I missed my family, my friends, my people. But I had to leave there. I had no choice; pushed away for political reasons like so many others who struggle for change in their countries.

I remembered when my two children, my husband and I were driving on a street in Guatemala when ten men with machine guns stopped our car, kidnapped us and after that, they put my husband in jail and tortured him. At that time I thought I would never see him again.



I know for many women, labour is a physical experience. But perhaps for me it was a way of expressing all my emotions, of knowing that this experience was an important part of my life (more than ever before), because all the fears and anxiety of fleeing my country came rushing back to me at that time.

I cried. I mourned during my labour. I grieved for the people of my country, my friends, my family, my dreams and the true meaning of my life. After seven hours of

labour, my daughter was born. It was very emotional — a frightening and isolating experience.

To be an immigrant woman and to have a baby in Canada is a stressful experience. We are discriminated against because we are poor, because our skin colour is different, because our faces are shaped differently, because our customs and language are different. Many people have stereotyped us as passive, subservient, ignorant Third World women.

Because we do not speak English, we are forced to be silent — to accept the rules; to accept the methods doctors use during the birth; to be without power. Because of the language barrier we can't say no or ask questions. Because of the environment we are afraid to challenge what the doctors are saying and doing to us. We become the objects of medical intervention.

Back home, many immigrant women have the experience of home deliveries, but in Canada many of our pregnancies are induced; women have episiotomies, epidurals and forceps and other interventions are used. We do not have many alternatives or choices. There are a few obstetricians who speak our languages, but they don't understand our problems. They don't understand what it means to be pregnant and poor. They have been in Canada for so many years that they have forgotten what it is like to be an immigrant. They check the pregnancy but not the labour. For them, it is a part of every-day life. For us, it is only one day in our life.

Immigrant women without status and without health insurance coverage are the ones who have to confront the health system in the most bitter way. No one wants to offer a real solution for this problem. The Ontario Ministry of Health does not have a policy around this, nor has a task force been struck to study the services needed for such patients. Some community health centres offer services until the sixth month of pregnancy, others until delivery. Many community health centres pay for the obstetrician, but in

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some cases, the immigrant woman without insurance coverage has to pay herself.

Paying for the delivery is another story. All hospitals are extremely expensive and I have seen many immigrant women worry more about how they are going to make the payment, than the labour itself.

After the experience of having my baby in Canada, I decided to help pregnant immigrant women by offering information on how to prepare emotionally for having a baby in this environment. Four years ago, I began teaching prenatal classes in Spanish at a women's health centre. Since then my role has expanded to include counseling, education and advocacy in reproductive health. Working with pregnant immigrant women has been a rich and rewarding experience for me. It has made me realize even more that there needs to be more programs, education and information geared to pregnant immigrant women. Even more importantly, we need additional allies—midwives who speak our

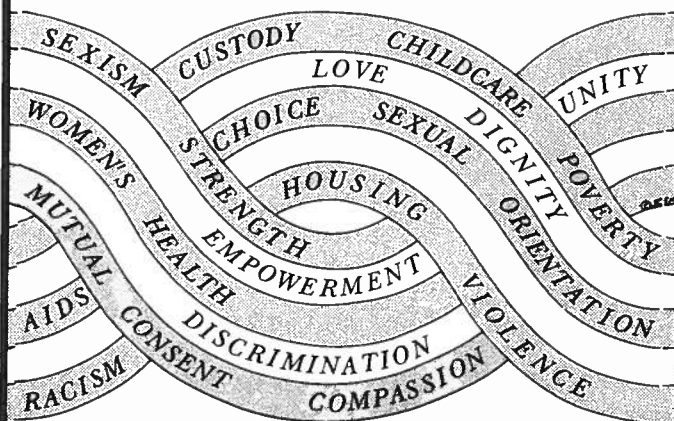
languages, multicultural birthing centres and more women working in health-related issues from our own cultures, in order to identify with how we feel.

There are many multicultural professional women with health care backgrounds that can work in community health centres or hospitals. But the institutions have to change their overall philosophy by including multicultural and community-based policies. Only then will immigrant women begin to see a positive change in the birthing experience.

**M**y experience of childbirth in Canada was a turning point for me. I cried when I knew that it was a girl, to have her, my same sex, my continuity, my showing the world that we women are strong, pure, fine wood.

*Melida Jimenez is a multicultural health educator at the Women's Health Centre at St. Joseph's Health Centre in Toronto.*

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# A Population at Risk

*Many immigrant women live in situations of continuous emotional distress. The few available studies conducted on this issue show that immigrant, refugee and visible minority women are indeed a population at risk in the field of mental health.*



Many explanations are given to account for the vulnerability that we, as immigrant women, face in developing psychosocial difficulties. Among these, stress is considered to be one of the leading causes.

Stress, in our case, often arises from the sudden changes in women's roles after moving to Canada. To my mind, the following are some of the factors that constitute stress in our lives and so make us vulnerable to psychosomatic problems.

- As immigrant women, we often find ourselves in situations where ensuring family cohesiveness becomes solely our responsibility. We help husbands and children to cope with the process of

adaptation, while our own well-being is inevitably neglected. Appropriate support systems to make our responsibilities bearable are mostly lacking.

Immigrant families often resettle in surroundings which initially have little to offer in terms of employment, social network and support. Immigrant women, like many other women, are forced to perform the double task of working both outside and inside the home. With immigration comes the loss of relationships, familiar environment and support from the extended family. These losses affect women more negatively than men.

- Poverty is frequently linked both to the development of psychosocial problems and to a higher incidence of illness and mortality. A total of 1.5 million Canadian women live in poverty. As a group, poor women have less power than other women to make decisions regarding their health.

Many immigrant women work in poorly paid jobs where they are exposed to safety hazards. Such conditions add further stress to their lives. It is not surprising then that many economically disadvantaged women become emotionally distraught and seek help at mental health agencies and hospitals.

Even though most immigrant women work outside the home, the average income of immigrant women is much lower than their Canadian counterparts, despite the fact that a large proportion of working immigrant women have a university education (*Women and Mental Health in Canada*, 1987).

Immigrant women, as a group, rank among the lowest paid groups in the work force. When compared to other groups, we earn considerably less than Canadian-born men, Canadian-born women and immigrant men (Pilowsky & Mor, 1990).

- Violence against women in the form of wife battering, intra- and extra-familial sexual abuse, physical abuse and rape are key issues that have been used to explain emotional distress in women in general. Additionally, traumatic experiences like rape, torture, camp internment and incarceration, suffered in our countries of origin, affect our well-being.

## Areas of Need

Despite the fact that we remain in high risk situations, there are limited mental health support programs for us. The following areas of need were identified from a community consultation report prepared by myself through in-depth interviews with 36 organizations serving immigrant women. The

pable of returning to regular lifestyles otherwise.

**Depression:** Depression, in part, is a result of the relationship between social conditions and women's mental health difficulties. Immigration increases depression by adding extra stress factors, such as changing family roles, and language barriers.

At the time of migration, we leave behind traditional support



interviews were conducted for the Multicultural Mental Health Women's Clinic at Doctors Hospital.

**Sexual assault:** Emotional reactions of trauma experienced by victims of sexual assault includes, among others, symptoms of anxiety, insomnia and flashbacks. The need for counseling and follow-up is essential since such emotionally disabling experiences often render survivors of sexual assault inca-

systems crucial to the maintenance of our emotional well-being during transition periods and stress. In most cases, new support systems are not in place yet. Immigrant and refugee women often find ourselves isolated and deprived of social support, a situation which can cause emotional breakdowns and depressions. Immigrant women are more affected by this situation than immigrant men.

**Therapeutic programs for survivors of wife assault:** Conservative statistics indicate that in Canada one million women are assaulted every year by their male spouses and that between 10 and 50 per cent of all women who live with a male partner will be assaulted at least once during the relationship.

Immigrant women, like many other women, are frequently

*Immigrant and refugee women are often isolated and deprived of social support, a situation which can cause emotional breakdowns and depressions*

involved in socio-economically dependent relationships. Wife-battering is a long-existing problem in the immigrant communities as well as in mainstream Canada. But the factors which keep immigrant women from accessing services force them to stay in abusive relationships, heightening the risk to their well-being and mental health.

**Incest survivors:** Incest has been defined as any act with sexual overtones perpetrated by a needed

and/or trusted adult, whom a child is unable to refuse because of age, lack of knowledge or the context of the relationship (O'Hara & Taylor, 1983).

Incest affects both male and female children. Even though reliable statistics regarding incest are lacking, conservative statistics compiled on female incest survivors (without isolating any particular ethnic group) indicate that 25 per cent of female children have experienced incestuous sexual abuse before the age of 14. Well over 33 per cent have had such an experience by the age of 18 (Russell, 1984).

Incest survivors, repeatedly and over long periods of time, are subjected to coercion by their abusers. This coercion, which ranges from subtle to brutal forms, makes them prone to developing an array of emotional difficulties. It has been pointed out that some of the psychological difficulties that incest survivors experience are phobias, severe difficulties with intimacy and trust, sexual problems, poor body image and fear of losing control.

**Low self esteem:** Therapy or support groups for women with low self-esteem should be a component of mental health services for immigrant, refugee and minority women.

Self-esteem is the ability of an individual to value and feel proud of herself, her skills, qualities and traits. Moreover, a high level of self-esteem is a powerful component in our personal life, social interactions and roles. Our self-esteem is developed through our interactions with others. It has been argued that feeling good about one's self or having a high level of self-esteem is directly related to believing in one's self, that is, one's capacity to exert power.

Many immigrant women, as a result of our social experiences, have been devalued and punished if we take control over our own bodies and lives. For example, some immigrant women come from cultures where the hold of patriarchy does not allow us to make decisions. I believe this directly contributes to feelings of worthlessness and low self-esteem.

Refugee women who have been tortured, experience psychological trauma and feelings of vulnerability and powerlessness which can reduce self-esteem. Often we find ourselves needing psychological treatment geared towards building a more positive view of ourselves.

**Coping with loss:** Many immigrant women have left behind family, friends and relatives in our countries of origin. For many women, direct contact with these significant others is limited to a "once in a lifetime" visit to their countries. In addition, many immigrant women, particularly refugees, have experienced many other losses ranging from cultural traits, material possessions, support networks and systems and of course, loved ones. It is not surprising then, that loss and grief are common themes experienced by immigrant women.

**Parenting:** There is also a need to assist immigrant and refugee women with some of the difficulties we experience with our children. For example, mothers who have experienced incest are in need of psychological assistance, to enable them to deal with the aftermath of their trauma.

Moreover, some of our cultures regard physical punishment of children as an acceptable method of discipline. In Canada, when immigrant women are chastised for using such methods, we are left without alternative ways of dealing with the problems of discipline—left to cope with our guilt and a sense of maternal incompetence.

**Anger:** Immigrant and refugee women encounter many sources of stress and anger, largely resulting from poorly paid jobs, family difficulties, adaptation to new roles, racism and discrimination.

It has been argued that women lack legitimate, socially-sanctioned outlets for our anger and traditional societal views of femininity reinforce the notion that women must not experience or express anger.

Psychotherapists and other mental health professionals serving women acknowledge that many women experience difficulties with anger. These difficulties include turning anger inward to the point of becoming severely depressed,

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showing self-destructive forms of anger such as suicidal gestures and being unable to express anger or expressing it in a negative and uncontrollable manner.

## Addressing the Needs

Despite the enormous need for therapy and support programs for immigrant and refugee women, there is a clear under-representation of counselors and personnel who have the necessary language capabilities and knowledge of women's issues to serve this population. Also there is a lack of culturally-appropriate services and culturally-sensitive personnel serving immigrant women.

It is essential that mainstream and community agencies develop therapy programs to address all of these needs—filling the long-existing gaps in mental health services for immigrant and refugee women. This can only be achieved if mainstream and community mental health agencies hire non-sexist, culturally-sensitive, women-centred staff, who have languages other than the two official languages and who are aware of the dangers of racism in mental health. Mental health services must also be affordable, assuring that all women have equal access to those services.

*Originally from Chile, Judith Pilowsky is currently a doctoral student at the Ontario Institute for Studies in Education in Toronto. Much of her research and practical*

*work with women has been in the areas of mental health and violence against women.*

### Further Reading

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Eleni Skodra and Eva Szekely

# Immigrant Women and Psychiatrists

*The following is an excerpt from the paper, "Strangers in a Strange World: The Psychological and the Socio-political Situations of Immigrant Women from Eastern and Southern Europe and the Third World" by Eleni Skodra and Eva Szekely (1988). We wanted to include this excerpt along side Judith Pilowsky's article to share with our readers some actual experiences of immigrant women undergoing mental health therapy—their expectations, treatment and disillusion.*

**D**espite their reservations, the immigrant women I spoke to went to see a psychiatrist because they hoped their bodily pain as well as their other difficulties would be alleviated. Most of the women had no knowledge of the kind of treatment a psychiatrist provides. The immigrant women were not told by the person who referred them to a psychiatrist, including the general practitioner, how the treatment would be conducted, how long it would take, etc. The lack of knowledge explains some of the confusion and surprise women feel, particularly during their first set of visits to the psychiatrist's office. Athena talks about her experience:

"When I first went there, (the psychiatrist's office) he asked me about myself. He didn't have to ask me all these questions because he knew the answers from before. Then he asked me about how I was feeling and whether I was still thinking about my family all the time... I told him that they (the pills) were not helping me stop thinking about my family...the pills made me feel sleepy and tired so that some days I didn't even want to get out of bed in the morning at all. So when I was sleeping I wasn't

thinking about my family being so far away but you know, I wasn't really thinking about anything at that point. I was just sleepy. It was hard just getting things done at home when I was taking these pills. I couldn't even do one thing; how would I do all the things I used to do?"

Maria's experience with a psychiatrist was similar to Athena's. Here she describes her initial visit to the psychiatrist and how it differed from the other monthly sessions she attended:

"The first time I saw him he asked me about my life back home, how is my family, are they bad to me, if I like Canada and if I have some family here and how I came.... First I went once a month and then I went once in two months...he questioned me and every time I would tell him my words, when he asked me about something and then he gave me the pills and I go. I think he saw that I am anxious and I not feel comfortable even with him in his office."

Maria's lack of knowledge of the possibility of engaging in some kind of "talk" therapy and of the possibility of discussing her feelings within that context con-

tributes to some extent to the kind of treatment she received. For example, she did not know that the psychiatrist could discuss with her the anxiety she had over being in his office, which she saw as a public place and how that would have been the first step toward alleviating her anxiety in other public places. Instead of dealing with Maria's anxiety and her discomfort with being in the psychiatrist's office, he (the psychiatrist) "just gave me pills. He tell me that there was no problem, that people could not read my mind and that I should go outside and go for walks and do everything. In the end, I told him that I know how I am and that I was afraid and anxious all the time and I couldn't do that. So, he said, "that's fine, just take the pills"... he never told me how I could do what he said, how I could go out and not be afraid and be okay again."

Maria knew what she would like to be able to do, that is, to be able to go and walk outside and not be afraid to be with other people. What she did not know is how to go about reaching this goal. She expected her psychiatrist to give her some direction and tell her how to accomplish this. When I

asked her why she did not tell her psychiatrist what she wanted from him, she told me that she assumed that he knew what was best for her because "he is the doctor." Levine (1982) attributes women's deference to professional expertise to social conditioning. She writes, "conditioned to perceive ourselves as without knowledge in matters relating to our bodies and minds, women characteristically defer to male experts who take over medically "for our own good."

Most of the immigrant women I spoke to saw their psychiatrist a maximum of once a month for a 20- to 30-minute period. To the immigrant women, the number of visits and their duration of 20 minutes "seemed like a lot of time." Angie recalls, "I spent about 20 minutes talking to this man (the psychiatrist). I thought that this was a lot of time." Anna also recalls what her own interaction with her psychiatrist was like; she says, "I spent a lot of time talking about how I felt since the last time I had been there."

Overall, during most of the visits to the psychiatrists, the immigrant women spent the first part of the 20- to 30-minute sessions briefly reviewing how they felt since their last visit. During the final 10 minutes of the session, the psychiatrist renewed the prescription for

medication.

Since I did not speak to the psychiatrists who treated the women I interviewed, I do not know their rationale for not spending more time talking to the women about their fears and concerns. It is possible that in the psychiatrists' opinion they were saving the women a great deal of discomfort and suffering by not discussing their fears and concerns within the context of "talk" therapy. It is possible that the psychiatrists' practice of checking if anything had changed in the women's life situation since their previous visit and the prescription of more medication reflects the practice of "efficient" psychiatry which primarily involves seeing as many patients as possible during the working day, rather than spending "quality time" with the ones seen. If "efficient" psychiatry is practised, then one factor which seems to contribute to it is the lack of what I call "psychological sophistication" on the women's part, that is, the lack of awareness that "talk" therapies exist and a session can be devoted to doing something other than filling out a prescription. The lack of "psychological sophistication" may also contribute to the women's negative reaction when the psychiatrists ask so many personal questions. At the same time the psychi-

atrists may lack "cultural sophistication," that is, the lack of some awareness of the culture and experience of the immigrant women these professionals see.

**T**he literature on cross cultural psychotherapy and counseling suggests that patients need to be educated in the psychotherapy or counseling process. The assumption here being that the client or patient, from a culture different than that of the mental health professional, is offered the option of engaging in psychotherapy and counseling. I agree that explaining to the client what psychotherapy is is important because the client can then decide whether or not psychotherapy may be beneficial. However, it is also important to educate the therapist regarding what the client thinks is beneficial to her and what issues she is willing to discuss. If the therapist is not aware of the multiplicities within which the client lives then the therapist's interventions may do more harm than good. This kind of experience is described by Margarita:

"Half the questions he asked me about I don't remember and half the things I really couldn't see how they were important at all to what was happening to me. When I left his office I felt numb. I was shocked. I didn't know where I was going, where my steps were taking me. I felt like I was floating in air. I was light-headed. It was criminal what this man did to me with his questions...I didn't go back after that..."

With the prescription of psychotropic drugs as the primary mode of treatment, within a very short period of time the immigrant women stopped being functional in every day life settings. Their inability to perform the daily chores at home and their difficulty in working outside the home created additional conflict between the women and their husbands at home.

It is not surprising, therefore, to see that many of the women I spoke to stopped going to see the



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*If the therapist is unaware of the multiplicities of the client's life, then the therapist's interventions may do more harm than good*



psychiatrist and eventually returned to the care of their family physician. In almost all cases, the general practitioner decreased the women's medication (which had been increased by the psychiatrist) but nonetheless, continued the prescription. No attempt was made to engage the women in counseling.

*Eleni Skodra is originally from Greece but has lived most of her adult life in Canada. She has spent*

*the last three years in Greece where she teaches at the University of Patras. Her areas of interest are immigrant women and mental health.*

*Eva Szekely is a staff psychologist at Centenary Hospital in Scarborough. She is an immigrant woman and much of her work over the past few years has centred on immigrant women generally and their experiences in Canada.*

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## Bhooma Bhayana

# HEALTHSHOCK

I am a family physician working with the London Intercommunity Health Centre in Ontario which was created in response to the need for culturally-sensitive health care and programming expressed by various ethnic communities and settlement services.

The centre works with newcomers to Canada, most of whom have left behind political turmoil or war and are mostly from developing nations. For this reason this article will explore "healthshock" as it applies to the immigrant experience in Canada and, in particular, my own experience with immigrants from the developing world as they try to access health care services.

### Defining Healthshock

The *Fontana Dictionary of Modern Thought* defines culture shock as "the trauma or bewilderment and anxiety that is supposedly experienced, most often by those who, whether voluntarily or involuntarily find themselves isolated in an alien culture."

The World Health Organization defines health as "the enabling process by which an individual is empowered to take control of ensuring his or her emotional, physical and spiritual well being."

Healthshock, then, is a term

which describes the interaction that occurs between the health care provider and the health care consumer when each has different cultural backgrounds and experiences. Unlike culture shock the reaction is bilateral and has as great a potential to be positive as well as negative.

The first step in understanding healthshock is to recognize that we all have a culture. The health care provider has a culture, the consumer of health services and even health care systems, in both the "new" and "old" countries, have a culture.

The second step lies in knowing there is also no "correct" culture, although there are more dominant cultures, often due to imperialist history or timing.

### Defining Health

Being healthy does not only mean not being sick. It means being in control of the options you have to fulfill your aspirations.

A sole support mother on social assistance, for example, may not be ill at any given point in time; she may have available to her free visits to the physician, the laboratory and the hospital and she may have free medication. However, on a fixed income, with little power over her future and that of her chil-

dren, she is unable to achieve a sense of being in control of her options.

### Parameters of Healthshock

The parameters of healthshock are quite diverse. First, it rears its head in the meeting of health attitudes, beliefs and practices. Second, it affects the nature of the exchange between the health care provider and consumer. In fact, it impacts on whether or not that exchange is really an exchange at all! Third, healthshock is particularly apparent when it affects certain members of a society such as immigrant women and seniors.

### Health Beliefs

We are all indoctrinated with some system of health beliefs and attitudes. They can be as benign as the belief that going out in the rain may cause pneumonia or as politically charged as the belief that women should experience pain in labour. It does not matter whether or not they are erroneous. The fact that we believe them affects when we seek help, why we seek help, whether we are able to help ourselves and whether we eventually comply with the kind of help that is given.

We all have a belief about what

defines good health. So our tolerance for poor health depends on that definition and our beliefs. In China and India, for example, there exists little tolerance for "abnormalities" or anomalies. Birth defects are less readily accepted in a newborn baby due to the high expectation of what is considered to be "normal." However, in the western developed world, our tolerance for such abnormalities or disabilities is greater because of the availability of technology to correct abnormalities and specialized treatment and care services for people with disabilities.

That is not to say that the threshold for marginalization is lower in the West. The western concept of the nuclear family has a lot to do with the tolerance of the young and healthy and the isolation of the sick and elderly. The point at which the elderly are institutionalized has a lot to do with our cultural beliefs about their

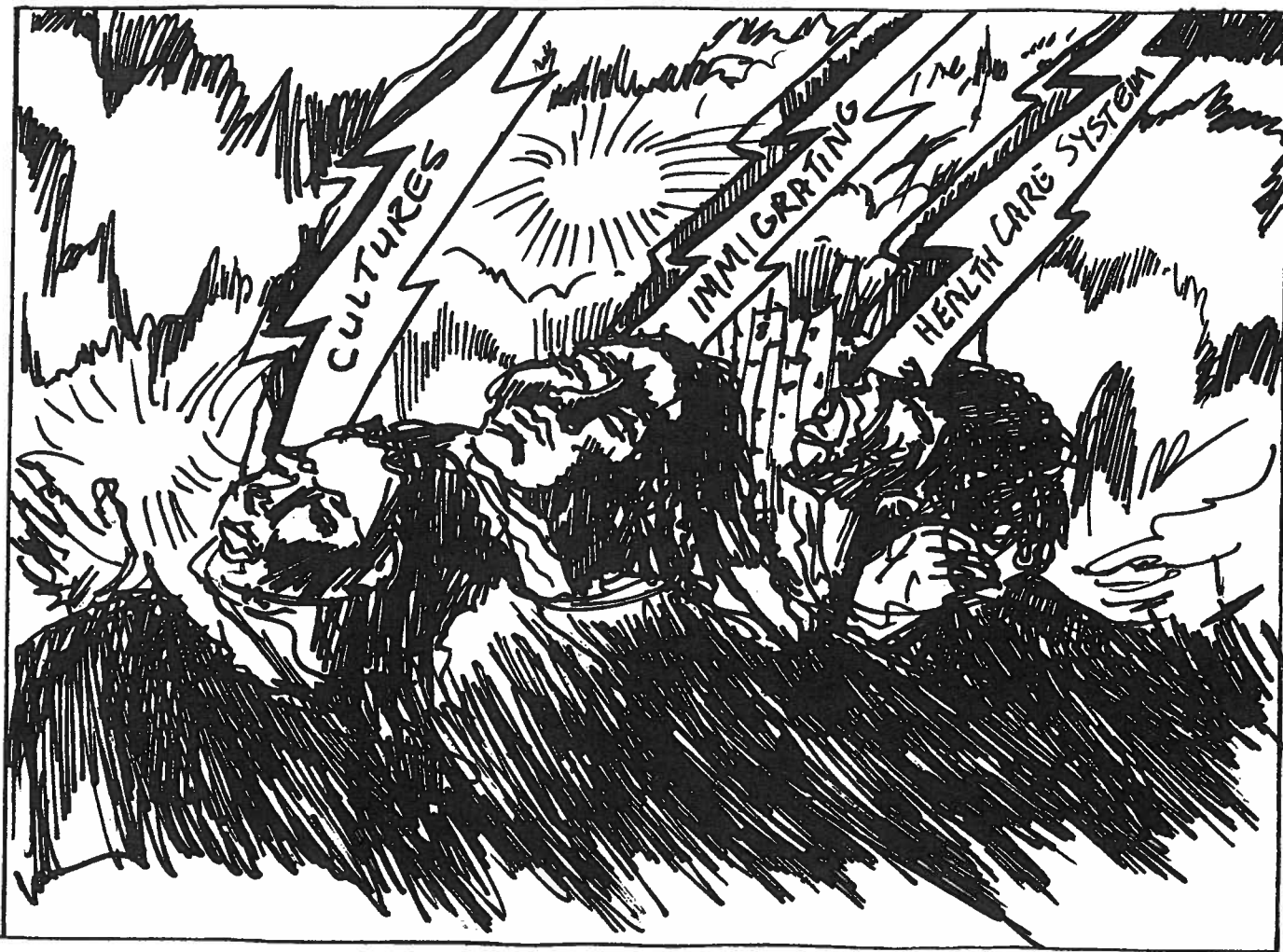
place within the home. Home visiting nurses caring for a dying elderly immigrant whose needs they believe would be better served in an institution can feel frustrated because, despite their pleas, the family refuses to institutionalize. This is an example of healthshock.

**We are encouraged  
to adopt  
western beliefs  
around nutrition**

Many beliefs have a function in a particular time and place and can become antiquated and nonfunctional elsewhere. For example, many women believe that it is imperative to bleed profusely post-

partum. Not bleeding is considered unhealthy. Before the routine use of synthetic syntocinon (a hormone that contracts the uterus after birth preventing hemorrhaging), bleeding was seen as a healthy sign that membranes were being cleaned out of the uterus. A woman who delivered her first baby in a refugee camp on the Thai-Cambodian border delivered her second in London, Ontario. It took several visits during which she insisted something was wrong before we stumbled across her belief that she had not bled enough, to be at the core of her concern.

The belief that a balanced diet is a balance of yin and yang as in Taoist tradition or hot and cold as in Ayurvedic tradition, may make the Western belief in a balanced diet based on four food groups, as recommended in the Canada Food Guide, seem ill-conceived. I find this latter belief the most difficult



to deal with and perhaps the only one I would call erroneous. The fact that we are encouraged to adapt Western beliefs around nutrition because they are considered to be more "advanced" is uncomfortable to accept, especially when we know that such adaptation leads to a higher incidence of heart disease in new immigrants even within the first generation of migration.

Beliefs about the course and purpose of life can impact on health practices as well. The quiet acceptance of one's fate, so pervasive in Eastern philosophy, is difficult to reconcile with a commitment to preventive methods. Heroic measures to salvage life are difficult to accept when there exists a deep-rooted belief in reincarnation for example.

Additionally, in Canada there are strong beliefs about the patient's "right to know" which argue that the individual should be allowed to grieve and settle her material, emotional and spiritual concerns if her condition is terminal. However, it is widely believed in Latin America and parts of Asia that to inform a family member that they have a terminal illness is to make them lose hope. The family conspires to keep the patient in the dark about his or her illness. This situation could prove to be challenging for the health care workers in Canada, caught between a sense of duty to an individual patient and a level of respect for the beliefs of the family members. On the other hand, the family may experience considerable stress in being in conflict with the health care professional, a situation that would have likely been avoided if they were still in their home country.

The clash of health belief systems becomes much more apparent in the area of mental health. I am told by people from rural areas of Northern Africa that, in their villages, people were not institutionalized for mental illness. Every village had its "town fool" who was cared for by all. That "town fool" might

## ***Suppressing health beliefs can lead to cultural genocide***



## ***Health care providers must open their minds to the beliefs of other cultures***

even be considered shamanistic. In the absence of urbanization, the stresses that associate schizophrenia with drug abuse or antisocial behaviour, do not exist. The presence of the extended family and inherent social support networks also make provisions for a quieter reprieve from existing stresses. There is certainly not the marginalization, isolation or identification of

mental illness in the same way as in our health care system.

In some countries, particularly those in Latin America, psychiatric facilities are often commissioned by the state, legitimizing abuse of human rights, with political prisoners incarcerated in psychiatric facilities for so-called "treatment."

Urbanization, westernization, the removal of the inherent support systems, intergenerational stresses and the effect of migration itself, subjects the family unit to a higher degree of danger in terms of health and mental health. This is particularly true for refugees leaving situations where they had been incarcerated or tortured. By the same token, beliefs or stigma about the mental health care system may make access difficult.

Furthermore, beliefs about the treatment of mental illness can be at odds. Today's western psychological approach to catharsis, be it in a supportive, insight-oriented or psychoanalytic vein, is often at odds with the South East Asian belief in denying or attempting to channel feelings into other outlets. Beyond being simply a difference in methods of treatment, this also shows a strong sense of denial of mental illness or dysfunction.

Health practices also cause healthshock. The use of traditional health practices for a period of time before seeking medical attention can alienate the health care provider. Expressing such alienation can, in turn, disempower the patient. People generally need to be validated for what they do. However, the more foreign or unusual the practice, the more unlikely it is to receive validation. For example, feeding one's child honey and lemon for three days before seeing the doctor for a cold is more likely to be met with approval than the Cambodian practice of "coining," in which a coin is rubbed over the skin to produce marks in an attempt to alleviate pain and other symptoms.

But to suppress or eradicate health beliefs and practices would in some ways result in a form of cultural genocide. We have only to look as far as Canada's own native peoples and their need to revitalize native healing to see this.

### **Dynamics of the Exchange**

There are different models of interaction between the health care provider and the consumer. They range from the view of the provider as a patriarch, technocrat or partner in achieving health goals.

For many people who have been told what to do without informed consent or without partnership in the decision making process, there is a kind of learned helplessness. They have been used to being told that they are going to have surgery rather than being told the risks and benefits involved and being allowed to choose for themselves.

For providers who like to be partners, healthshock is experienced in the frustration felt at hearing the statement, "Well you're the doctor, you decide."

In many refugee camps, the Intergovernmental Committee on Migration has developed a system of mandatory immunization whereby a family's food rations are tied to their compliance with immunization for the children. In Canada, though immunization is mandatory, save for a handful of religious dissenters, the same watchdog approach does not exist. Only a form needs be completed at school entry. On the one hand it is a wonderful libertarian approach to partnership, but on the other hand, as the recent rise in measles in North America attests, there is room for improvement.

I encountered an interesting case while visiting the All India Institute of Medical Sciences in 1984, which illustrates well the advantage of the patriarchal model. A woman from an outlying village went to a gynecology clinic complaining of infertility. She and her husband had tried for a year for her to become pregnant without success. Examination revealed that her vagina ended in a blind

pouch and that she had no uterus and no ovaries. In fact two testicles could be felt in either groin. She was actually a male. In the context of the kind of exchanges the gynecologist was accustomed to, he made the unilateral ethical decision not to tell her and simply to decree irreversible infertility. I have often thought that if she had been given the full information of her condition, it might have resulted in some psychological trauma and subsequently more difficult choices.

### **Immigrant Women**

In Ontario, 25 per cent of women are immigrant, refugee and racial minority women. This group accesses health care services far less than the other 75 per cent. Recently the Women's Health Bureau of the Ministry of Health conducted community consultations in the six health regions of the province to identify the health care needs of immigrant women. The results may show what many of us already know. Linguistic barriers keep immigrant women in isolation and keep them dependent on their spouses, family members and friends to communicate for them. Furthermore, remaining dependent can make immigrant women feel powerless in a range of cases whether communicating with an immigration officer, dealing

with their family physician or seeking help if they are in an abusive or violent family situation.

Given the many factors which confront immigrant women, it is not surprising that they experience healthshock more than other groups in our society. Providing health information and services in languages other than English is part of the solution in decreasing the effects of healthshock; having community and public health care providers who are culturally-sensitive and aware is another. However, health care providers must also validate immigrant women's experiences by becoming aware of the existence of healthshock and opening their minds to the beliefs of other cultures. In this way, we can begin to break down some of the barriers to access and equality that exist in our health care system between the health care worker and the consumer of those services.

*Bhooma Bhayana is a family physician working with the London Intercommunity Health Centre which primarily provides services to immigrant women. A second-generation South Asian woman, Bhooma is a former board member of the Riverdale Immigrant Women's Centre and has also worked with the South Riverdale Community Health Centre.*

## **COMING TOGETHER**

### **Support Groups for Immigrant Women**



The kit raises and answers the question that's often asked: "Why special groups for immigrant women?" It includes a User's Guide; 12 Session Plans, hand-outs for group members, and a Resources Section. The hand-outs are in Portuguese and Cantonese, as well as English. Sessions cover issues like: **Bringing up Children in Canada; Conflicts with your Teenager; Dealing with Anger; Stress and Relaxation; Wife Assault; Assertiveness Training; Dreams and Action Plans.** The simple language and attractive format make the kit easy reading.

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# WOMEN IN HEALTH

## Profiles of four women's health organizations that are making a difference for immigrant women

### The Regina Immigrant Women's Centre: Primary Health Care Project

When Pas Alejandria, a native of the Philippines, discovered she needed surgery to remove an ovarian cyst, she was afraid to tell her supervisor at work. "Because it was a woman's disease I thought it was related to sex, and it wasn't something I could talk about to other people," she says.

In the Filipino culture, women don't talk openly about serious problems to people they don't know personally. As a result, Alejandria ended up in trouble at work because she had not given her supervisor enough notice of her need to take sick leave.

Dealing with the medical system can be a frustrating and frightening experience for anyone. But for immigrants who have to cope with cultural differences—from language barriers to conflicting social customs—the experience is even more confusing and stressful.

Alejandria was taken aback by the barrage of seemingly personal questions she was asked by any number of medical personnel. "Did my mother or father ever have this health problem or that disease? I was afraid to answer. It seemed so unusual and I had never even heard of some of these diseases." In the Philippines, people don't have much contact with doctors because they don't seek out medical treatment unless they're extremely ill, says Alejandria.

Immigrant women and their families face innumerable obstacles as they attempt to maintain their health in Canada. Often they have left behind the healers and community supports that helped them deal with health concerns in their own countries.

Some of the health problems immigrant women have are directly related to the fact that they are in a

different, strange environment. Isolation is a common problem, but it is usually not addressed until it becomes a full-blown crisis, according to Erika Cancino, coordinator of the Regina Immigrant Women's Centre. "Then the doctor will call it mental illness and prescribe pills."

"We need to make immigrant women more aware of the health services available in the community. We have to help them overcome cultural difficulties," says Cancino. "Many immigrant women do not even want a doctor to see them nude," she adds.

To help overcome these barriers to good health, the Regina Immigrant Women's Centre has launched a Primary Health Care project. The goals are to help immigrant women work together to learn about healthy ways of living in their new communities; to learn about common diseases and treatments; to explore existing health services and to work out ways of relieving stress.

Popular education techniques, which include role playing and other forms of non-verbal communication and focus on action-oriented problem solving, are an integral part of the project. Project participants are encouraged to act out their problems with other members of a drama group. "Our problems become a lot less stressful when we can laugh at them," says Cathy Ellis, the group leader and coordinator of the health care project.

Because many of the participants have a limited knowledge of English, Ellis has developed materials with a visual focus as opposed to materials with a language orientation.

Ellis, a registered nurse with a background in midwifery, has 10 years experience in the health care field





The classes and the drama group are designed to give immigrant women a support system, a group of friends to help them look at the issues in their lives that affect their health

in Central America and Mexico. She leads informal sessions and brings in guest speakers to talk about a wide range of issues. Classes are offered once a week during the day and in the evening to accommodate everyone's schedule. A popular theatre group has been formed to help participants work on problems and solutions in a creative and enjoyable atmosphere.

"The classes and the drama group are designed to give immigrant women a support system, a group of friends to help them look at the issues in their lives that affect their health," says Ellis.

The project emphasizes primary and preventive health care. One of the first educational sessions dealt with home health issues, including how to set up a first aid kit and what to do in an emergency. The session also looked at how to deal with the harsh Saskatchewan climate. Immigrants may not know how to winterize their home, how to avoid frostbite or where to get economical winter clothing.

Mental health is also a theme highlighted in the program. "Many immigrant women face an overwhelming amount of stress," says Ellis. There are immigrant women, for example, who are well-educated, qualified professionals in their own countries who cannot pass language requirements or whose credentials are not recognized in Canada. "When you don't deal with that stress positively, you're going to get sick," says Ellis.

The program looks at ways of coping with stress, such as yoga and tai chi, dealing with alcohol and drug abuse, as well as the pitfalls of cigarette smoking.

Reproductive issues, from how conception takes place to birthing and breast feeding, are discussed as part of the health care project. The focus is on child-

birth customs in Canada and includes visits to the hospitals. There are discussions on prenatal and postnatal care, family planning and menopause.

Raising children in a new culture can be a confusing experience. One of the sessions considers cultural differences in child rearing, as well as practical answers to questions about accessing day care, getting the necessary vaccinations and common Canadian childhood diseases.

The project, which received funding earlier this year from Secretary of State, Women's Program and Multiculturalism for its first 10 months, has received additional funding from the same source to continue. Evaluations are ongoing to ensure the real needs of the participants are being met. The program is being advertised in several different languages to attract as wide a group of women as possible. Free day care and transportation are available to those who need it.

Additionally, the project hopes to produce a practical handbook aimed at immigrant women's need for information on health matters.

Since women are the primary health care givers in every society, the project is bound to help immigrant families understand and cope with new customs and cultural differences. Helping people maintain good health is the first step to ensuring they become active and productive members of their communities.

This article by Susan Dusel has been reprinted, in part, from *Network of Saskatchewan Women* (Winter 1991)

## Planned Parenthood Manitoba

Planned Parenthood Manitoba (PPM) is a non-profit, community-based organization established to provide education, advocacy and information on human sexuality, reproductive health and family planning.

Focusing on the needs of all Manitobans, PPM has developed an Immigrant/Refugee Health Program. Through this program, linguistically and culturally appropriate education services are provided in the areas of reproductive health and maternal/child health to four communities: Vietnamese, Chinese, Cambodian and Spanish. This program is based on four years of developmental work which also included a one-year demonstration project funded by the MHSC. Through our initial work, we began to identify barriers to mainstream health education and health services. It was found that these barriers render many existing services inappropriate, ineffectual or inaccessible to many non-English speaking residents of Manitoba.

It is important to note that, in many cases, prevention and early identification of health problems does not take place because most immigrant women do not have access to traditional health services. This

by the cultural beliefs and values of each community. Additionally, it is affected by the class and privilege context of a family.

Our team of trained health educators, through an understanding of the issues involved, attempts to address the problems of access to a range of existing services and to provide culturally-appropriate education services.

The four health educators in the team come from a variety of professional and educational backgrounds and were selected in terms of their interpersonal skills and acceptability within their communities. Later, each completed a two-year program in specialized training and practical experience in the areas of reproductive and maternal/child health.

Services provided by the health educators include:

- interpretation facility for medical appointments and other health-related issues;
- client advocacy and support;
- orientation to Manitoba health, health education and hospital services;
- referral, appointment setting and patient follow-up;

### Through our initial work, the barriers to accessing mainstream health education and services were identified

is of particular concern to women working at PPM in the area of reproductive and maternal/child health.

The Immigrant/Refugee Health Program demonstrates the effectiveness of a community-based health education model where health educators are women from the same community and cultural/linguistic background as the client group they serve.

The program model is unique in several aspects:

- it encourages a variety of program responses based on the actual characteristics and concerns of each community;
- it utilizes the skills of workers coming from the communities to serve the newcomers to that community in all stages of assessment, planning and implementation;
- the health workers provide both "link" services between mainstream health services and their communities and direct education services and programs;
- it places equal emphasis on educating health care providers to the needs of immigrant clients and to the cultural assumptions in the health care system, as it engages in an ongoing community education program.

Reproductive and maternal/child health is a crucial and sensitive area in the provision of health and health education services, as it is heavily influenced

- cultural interpretation for clients and for health professionals;
- direct client education services in the areas of reproductive and maternal/child health and safety, STD's and AIDS;
- resource evaluation, translation and development;
- consultation services and workshops on cross-cultural issues for health professionals.

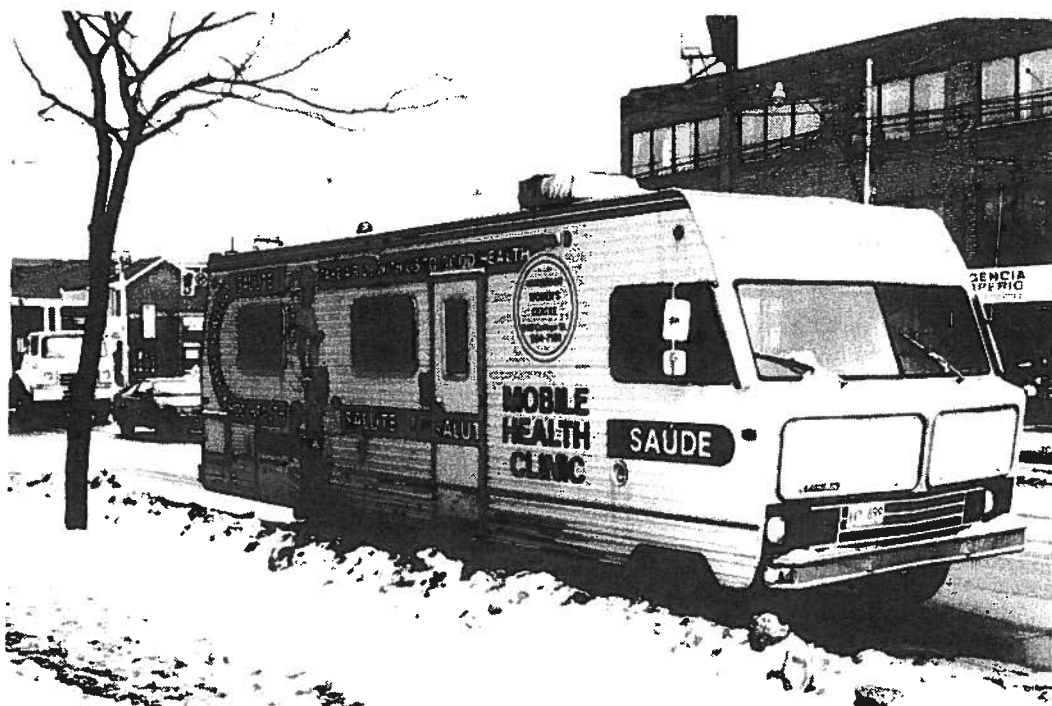
As well, each of the Health Educators has, in different areas, initiated various creative health promotion activities. For example, the team has developed teaching videos on infant feeding; initiated information and referral lines in languages other than English; sponsored larger community education programs designed to facilitate the development of community resource persons on specific health topics.

The program offered a facilitator training program in contraception. This intensive, 70-hour training course in childbirth education attracted 15 participants from nine countries. Program staff were also instrumental in the design and delivery of an AIDS education program.

Our program coordinator developed a manual which documents the issues and recommends strategies in establishing similar programs to serve the needs of communities in different areas. Moreover, as the settlement patterns change rapidly, we need to

look at alternatives for addressing needs within other smaller, newly-formed immigrant communities. Therefore, we are beginning to look at developing program responses to needs that other ethnocultural communities have in the areas of reproductive and maternal/child health.

This program has received an extremely positive response from both the client population and generic health services. We anticipate that our program will continue to illustrate many health care issues pertinent to immigrant/refugee health care while providing a model of response for health services across Canada.



The mobile health unit is a 28-foot, traveling health care system. It allows women to see a doctor at their workplaces, ESL classes, community centres, or refugee centres

## The Immigrant Women's Health Centre

The Immigrant Women's Health Centre (IWHC) was formed in 1972 as Centro Donne, an outreach program of the Birth Control and the Venereal Disease Information Centre of North York. In 1975, Centro Donne became autonomous and was able to serve women from Italian, West Indian, Portuguese and Hispanic communities. By 1979, the program was able to serve the Chinese community and in 1983 the Vietnamese community. In 1981, with the backing of the City of Toronto's Public Health Department, a Mobile Health Unit was added to this service.

The Immigrant Women's Health Centre was formed as an "alternative" to the existing health care system. There has, in fact, been an increase in demand for our services not only from our clients but from other organizations, including government services, universities, colleges, community services and hospitals.

The group of women we serve face difficulties in accessing mainstream services because of language barriers, racism, sexism and other concerns around settlement and adaptation issues. The unique concept of the Immigrant Women's Health Centre focuses on making health services equally accessible.

An integral part of our work is reaching women in

the workplace, community centres, malls, housing projects, schools, ESL classes, refugee centres, hostels and community events. This is greatly facilitated by the use of the Immigrant Women's Health Handbook, a handbook we produced (and continue to update) to provide information on birth control, family planning, sexually-transmitted diseases and the reproductive system; it is published in Chinese, Vietnamese, Italian, Portuguese, Spanish and English. The handbook has proven to be a useful education tool for the women using our services.

The main thrust of our work done is preventive health care with a major concentration on family planning and cancer prevention. The importance of Pap smears, birth control and breast self-examinations, which we teach women to do monthly, is emphasized. Many family doctors do not provide this service. They conduct "physical examinations," but exclude breast examinations and Pap smears. In an effort to provide our services in a medical setting and to empower our clients with information such as patient's rights, we operate a clinic with a woman doctor.

The clinic was only allotted funds to be open for three hours in our first year of operation, however

since then it has been increased to six hours. The clinic operates twice per week and we see an average of 1,000 women per year.

Before a woman sees the doctor, she receives culturally-sensitive counseling from a counselor who speaks her language and is from the same community. Information is provided about her area of concern which may relate to birth control, abortion, sexually transmitted diseases, prenatal care, cancer prevention, etc. She then sees the doctor. If she requires the counselor to interpret, the counselor will accompany her to the examining room.

Another important aspect of our services is the Mobile Health Unit (MHU). The MHU is a 28-foot, "trav-

### Our concern, first and foremost, is the empowerment of immigrant women in accessing health services

eling" health care system. It was first started in 1981 as a three-year pilot project and has since become an integral component of the services we provide.

The MHU provides direct counseling and an opportunity to see a doctor women at their workplaces, schools, ESL classes, community centres, malls, refugee centres, etc. The unit travels with counselors and a woman doctor. The MHU Coordinator contacts prospective locations and describes the program to the employer or administrator. Dates are then scheduled for the counselors to go to the workplace to conduct specific information sessions with women based on their needs.

The last stage of the program involves the participation of the doctor who is available to any woman who would like to see her.

For many women this is a lifesaver. The MHU staff is only allowed to make contact at specific times, such as lunch time or class time, but this may be the only time a woman might get to see a doctor or to speak to a health counselor. For women, health is a low priority - long working hours, racist/sexist environments and unhealthy working conditions perpetuate some of the more serious health problems and attitudes.

Although the Mobile Health Unit has seen approximately 2,000 women in the last two years, it is a service for which we have had to constantly lobby and advocate. The City of Toronto, knowing the value of the program, has continued to provide "emergency" funding to keep it going. However, the Ministry of Health has so far not taken responsibility for a project that is working, is well-administered and is reaching a group of women that they profess to want to serve.

We may not be the only group serving immigrant women but we are the only group that reaches them at their workplaces and provides services sensitive to their needs. Furthermore, we provide a bridge between the women we serve and other

agencies/organizations who wish to access them.

The Centre is currently examining its role within the health care system and assessing how it can maximize its service to the communities it serves.

The Immigrant Women's Health Centre is now being placed in the role of "consultants without pay" for many institutions including universities, hospitals and other "mainstream" agencies. In many cases, the problem experienced by these organizations is simply that of lack of acknowledgement of immigrant women as having special needs based on their experiences and concerns and a lack of respect for their input into a system that is sorely suffering from misinformation about the needs of immigrant women.

These institutions are governed by boards that operate from a totally mainstream perspective. There is little tolerance for a health care perspective that does not conform to that model. There are qualified individuals from these communities that can make valuable contributions at the board level, but there is little effort or desire to involve them. Consequently, these boards do not reflect the communities they serve.

Many of these mainstream groups now invite us to make submissions about their services, yet nothing changes. We have concerns around such consultations in terms of how the information we provide is received and used by mainstream organizations since there is always the risk of stereotyping.

Our dilemma regarding consultations is that we do not want to refuse consultation fearing a new program purporting to serve all women may overlook the special needs of immigrant women. But our consultation still cannot ensure that the service will incorporate a perspective to serve immigrant women in accordance to the needs specified. The Immigrant Women's Health Centre then, is forced into a role of brokerage for centres that profess to serve immigrant women but has no control over their policies, procedures, mandate and philosophy.

Additionally, we suffer when a case for increased funding for our own service is weakened because funders believe there are many health centres serving women and so automatically believe that the needs of immigrant women are being met.

The collective of the Immigrant Women's Health Centre has pledged unwavering support for immigrant women and their needs. We will continue to lobby and advocate for services to be available to immigrant women within the context of their cultural heritage. We will work with other groups with the same goals and aspirations. Our concern, first and foremost, is the empowerment of immigrant women in accessing health services.



The immigrant/refugee health program trains women from various immigrant communities not just as translators, but as health educators

## The Women's Health Clinic

In 1981, the Women's Health Clinic Inc. opened its doors to the women of Winnipeg in about 700 square feet of office space with three paid staff. The clinic was founded by Pregnancy Information Services, an entirely volunteer organization made up of women, offering information and counseling concerning birth control, unplanned pregnancy and sexuality issues.

The women of "PIS", as the organization was affectionately known, had been doing this work since the early 1970s and were acutely aware that these health concerns were most often not understood nor addressed adequately in the traditional medical care system. They felt that there was a definite need for a broader focus in working with women around reproductive issues. Central to this need was a commitment to offer the women of Manitoba a feminist health care alternative. The PIS board developed the idea of a non-profit health clinic for women based on a feminist model, to meet these needs.

Since 1981, the Women's Health Clinic has moved twice and has grown into a community health clinic which employs 25 paid staff, 75 trained volunteers and is governed by an 18-member board of directors. All staff, volunteers and board members are women and actively reflect the community they serve. The clinic has maintained its commitment to a pro-choice feminist model of health care in the services it offers to hundreds of Manitoba women of all ages and cultural backgrounds each year. These include medical services, counseling, information sessions, support groups, confidential counseling and testing for AIDS. Additionally, we provide speakers to the community and a resource room is available for public use.

It is the philosophy of the Women's Health Clinic that a woman's health is intrinsically related to her life experience and her position in society. Consequently our services offer a holistic and multi-faceted approach to health. Integral as well to our approach is our commitment to provide services in an atmosphere that is respectful, informative, compassionate and non-judgemental. We hope to empower women not only in their own lives, but in their communities as well.

Acknowledging that women's health needs are still not well addressed in the general medical community, the Women's Health Clinic continues to expand its services to respond to these needs. We have taken an active role in promoting prevention and appropriate women-centred care in such health issues as birth control and unplanned pregnancy, premenstrual syndrome, menopause, weight preoccupation, DES exposure, postpartum stress and smoking cessation.

Recently, we have obtained funding to do public education around midwifery, established a support group for women suffering from endometriosis and have just published a resource on women's chemical dependency for caregivers and consumers. The resource is entitled "Women Recovering: A Handbook for Care Providers," and can be ordered from the clinic.

As well, the Women's Health Clinic continues to take a leading role in advocating for women. In the past, these issues have included compensation for Canadian women injured by the Dalkon Shield and the prevention of the licensing of Depo-Provera for con-

traceptive use. Presently the clinic is involved in a highly successful pro-choice campaign to promote the range of choices available to young women. The clinic has also recently spoken out about the dangerous possibilities of the Norplant birth control implant.

Since its inception, the Women's Health Clinic has sought to improve health services available to immigrant women. We have worked to make our services more accessible and we support and use the expertise of groups which already exist in the community to work with immigrant women. We are aware that immigrant women seeking appropriate health care may have special needs that others may not be sensitive to, such as language barriers and different cultural expectations. Consequently, the Women's Health Clinic has sought to sensitize all staff and volunteers to enable them as client service workers, volunteer counselors and health care providers to assist immigrant women in obtaining the health care they need.

With the diversity of the immigrant women's community in Manitoba and the reality that it is growing all the time, the Women's Health Clinic cannot realistically expect to provide the range of programming needed to adequately serve all the women we see.

Therefore services such as the Immigrant/Refugee Health Program of Planned Parenthood have been essential in assisting us to provide the best possible health care for immigrant women.

The clinic was involved with this program from its outset, providing training to its staff in the area of birth control, sexually-transmitted diseases and unplanned pregnancy. We have continued through the years to work closely with this service, providing ongoing health care to many of their clients.

The Immigrant/Refugee Health Program is a unique and integral service for immigrant and refugee women because it trains women from various immigrant communities not just as translators who accompany their clients to medical appointments, but as health educators. These educators are familiar with medical language and the system and can assist their client through what can be an intimidating and confusing experience to find the health care they need. Also, the staff provides consultation to health care workers and offers professional workshops on multi-cultural health issues.

Earlier this year this program fell victim to the fickle policy of restraint of our provincial government. It was only after a loud and angry protest on the part of Manitoba's immigrant community that the program was temporarily reinstated pending a review of provincial resources. The program remains on shaky ground and the Women's Health Clinic has joined other community groups in protesting the provincial government's insensitivity to the health care needs of immigrant women.

As well as providing direct health care to the

immigrant women's community, the Women's Health Clinic is represented by staff at various meetings of community boards and on advisory groups such as the AIDS Awareness Coimmittee for Immigrants and Refugees. The clinic maintains an openness to serving the needs of Manitoba's immigrant women's community in terms of the services we offer, the women who come to work at the clinic as staff, volunteers and board members, and by participation in and active support of community groups and agencies dedicated to providing and improving social and health care services to immigrant women.

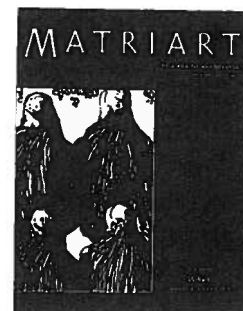
In the near future we are looking at working with women around sexuality and AIDS, reproductive technology and setting up more counseling services for women around the issues of weight preoccupation, self-esteem and sexual abuse. We also see a great need for more services available in the area of wife assault and would like to expand into the area specifically to work with teens in abusive relationships.

As women from a variety of social, cultural and life experiences, we, at the Women's Health Clinic, realize the necessity to develop in all our programming a capacity for validating each woman's life experience and remain dedicated to providing the support and appropriate resources to enable each woman to make informed choices towards her own best health care.

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# IMMIGRANT WOMEN'S HEALTH RESOURCES

## ***Counselling Immigrant Women: A Feminist Critique of Traditional Therapeutic Approaches and Re-evaluation of the Role of the Therapist***

Eleni E. Skodra in *Counselling Psychology Quarterly*, Vol. 2 No. 2, pp. 185 - 204, 1989.

This article stresses the importance of understanding the socio-political and economic conditions under which immigrant women live. Skodra describes the somatic and psychological difficulties immigrant women face and presents a feminist approach to therapy as an alternative to traditional counselling practices.

## ***Cross Cultural Health Education Project: A Health Promotion Project***

Malton Community Council, October 1985.

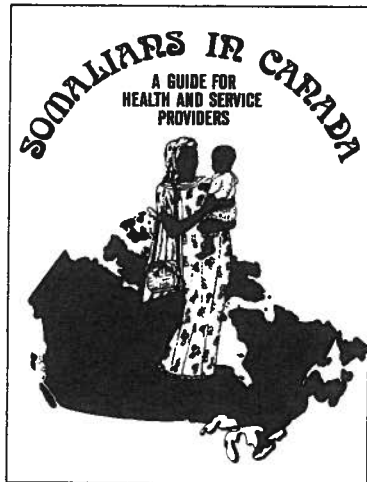
This is the final report of the Cross Cultural Health Education Project. It identifies the health education needs of the "multicultural" community, but especially those of South Asian women. The report identifies existing resources, explores the possibilities of cooperative planning, delivers health education services and makes recommendations on cross-cultural education.

## ***Somalians in Canada: A Guide for Health and Service Providers***

Sandy Hill Community Health Centre, Vanier, August 1991.

The Somali Women's Health Project evolved in response to the increasing numbers of Somali women seeking health care services at the Sandy Hill Community Health

Centre in Vanier, Ontario. A dialogue was initiated between centre staff and a group of Somali women to explore cultural beliefs and health practices. The result of this collaboration is this guide which outlines the Somali women's views on numerous health and social issues, including prenatal and postnatal care, sexuality, difficulties in Canada, childbearing and client provider relationships.



## ***Health Education for Immigrant Women: A Manual and Resource Guide***

Pamela Thompson with Harminder Sanghera and Mohinder Mroke, Orientation Adjustment Services for Immigrants Society (OASIS), Vancouver, 1986.

This manual is designed for service workers attempting to implement programs based on the Indo-Canadian Women's Health Project coordinated by OASIS in Vancouver.

The organization has also produced a 80-page, self-help handbook, *Your Own Health Handbook: A Guide for Immigrant Women*

which is available in Punjabi (\$7) and English (\$3). This handbook aims at increasing immigrant women's knowledge of their bodies, improving their understanding of health services in Canada and helping them to become responsible health care consumers.

## ***Health Promotion with Immigrant Women: A Model for Success***

Pamela Thompson in *Canadian Nurse*, pp. 20 - 24, December 1987.

The need for preventative health care programs for new Canadians to link social support and health care prompted the creation of the Indo-Canadian Women's Health Project. An 8-week course, covering orientation to health services, self-responsibility for health, exercise, nutrition, body awareness and stress, was begun and proved so successful that two additional sessions were held at the participants' request. The author provides suggestions and guidelines for others considering similar projects.

## ***Multiculturalism and Canadian Psychiatry: Opportunities and Challenges***

Lin Tsung-Yi, in *Canadian Psychiatric Association Annals*, Royal College of Physicians and Surgeons of Canada, Vol. 19, November 1986.

The common assumption of medical universality across cultures is questioned. Cultural relativism as a principle for future research and clinical pursuits is advocated. The advantageous position of Canadian psychiatry to develop culturally-relevant psychiatry because of the government's com-

mitment to multiculturalism is discussed, particularly since Canada's universal medical insurance system would facilitate its creation.

### **Immigrant Women and Mental Health**

Leti Larosa, in *Common Ground*, Vol.6 No. 4, July 1987.

The fears, anxiety and stress, loneliness, isolation and despair of new immigrant women can be physically destructive, leading to such health disorders as ulcers, insomnia, weight loss or gain, depression and breakdown.

### **Multicultural Health Education: Responding to the Challenge**

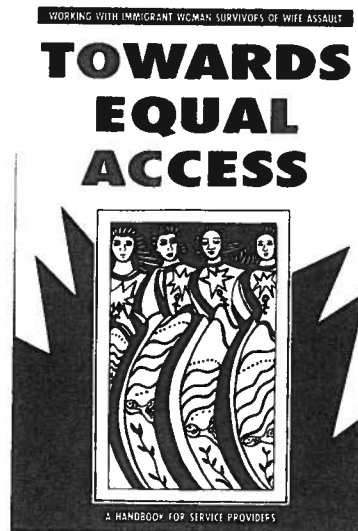
Pamela Thompson and Jane L. MacDonald in *Health Promotion*, pp. 8 - 11, Fall 1989.

This report was written for health care workers and multicultural groups interested in developing culturally-appropriate health education within the Canadian context.

### **Mental Health Needs of Immigrant Women**

Juliet Cueno and Alma Estable, *Partnerships in Health in a Multicultural Society, Symposium Proceedings*, November 1986.

Immigrant women face special mental stresses due to differences in cultural background and expectations, prejudice and discrimination, arduous working conditions and language barriers which isolate them.



### **Immigrant Women's Health Handbook**

Immigrant Women's Health Centre, Toronto, 1991.

This handbook discusses the reproductive system, contraception, abortion, sexually-transmitted diseases, cancer prevention and nutrition, among others. It is a popular resource and has been recent-

ly updated. Available in Portuguese, Italian, Spanish, Chinese, Vietnamese and English.

### **Towards Equal Access**

Fauzia Rafiq, Editor, *Immigrant and Visible Minority Women Against Abuse*, Ottawa, August 1991.

This book is a compilation of various perspectives of women (and men) working with immigrant and racial minority assault victims. Its content is designed to fill some of the gaps in counseling victims of assault that outreach workers and counselors have identified. It aims to increase their knowledge of cross-cultural counseling skills and Ontario's multicultural/multi-racial/multilingual communities. It is primarily intended for service providers working with immigrant women survivors of assault. (Cost:\$15)

### **Wife Assault: The Chinese Family Life Services Experience**

Sui-Lin Lisa Chan, Chinese Family Life Services of Metro Toronto, 1989.

This study was undertaken to examine the work of the Chinese Family Life Services with the abused and abusers of Chinese descent. The results showed a rise in the number of wife assault referrals and self-referrals to the agency during the 35-month study period. The data dispels the myth that wife assault does not exist within the Chinese-Canadian community.

Recommendations to ensure linguistic and culturally-sensitive clinical counseling services in the Chinese community are provided.

### **Working with Assaulted Immigrant Women: A Handbook for Lay Counselors**

Monica Riutort and Shirley Endicott Small, *Education Wife Assault*, Toronto, Revised 1985.

This manual is directed at counselors working with immigrant women and examines specific problems of wife battering. It offers an approach to providing help. (Cost: \$2.50)



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# REVIEWS

## The Black Women's Health Book: Speaking for Ourselves

Edited by Evelyn C. White, (Seal Press) 1990 290 pp.

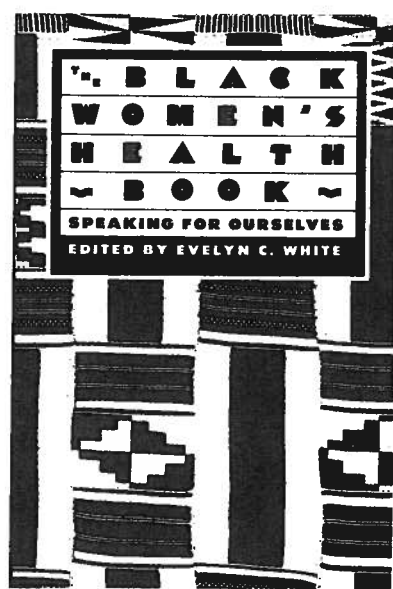
Reviewed by Kecia Brown

African-American women suffer a high rate of death from curable cancers, high rates of such chronic diseases as lupus, diabetes and hypertension, and the highest rate of infant mortality in the country. African-American women excessively bear the brunt of the healthcare politics of this culture, having to negotiate a healthcare system that is tailored to service wealthy white men.

African-American women have had to turn to predominantly white feminist publications for support around social issues that are inherently female. *The Black Women's Health Book: Speaking for Ourselves* integrates their needs for the first time, addressing the health of African-American women as no other book has before.

Evelyn C. White has done a fine job of covering a myriad of topics with an appropriate touch. Each article or piece is preceded by a small introduction to explain the background or context in which a given article was written. Often grim statistics are reported; then one reads a personal account, political analysis or narrative. These essays bring the statistics to life, unlike what you read in the newspaper or hear on the radio.

This is a glorious book filled with medicine of the heart by many Black women, famous and unknown. There are herstories of the abuse—physical, sexual and



chemical—in these women's lives, and their personal battles to overcome them. As a Black woman, I was glad that all of these issues were being addressed together in one book and I was glad that women were standing up and speaking of issues that are rarely spoken about. Black women often have to be about survival—survival of our children, survival of spouses or lovers—but rarely are we about our personal survival. This book is about Black women sharing experiences and that deep inner hurt that “you don't tell nobody, 'cause there is no use in the tellin'.” But there is use in the telling and the sharing; it strengthens our survival.

In reading this book, I was reminded time and time again of the need for a nationalized healthcare system that gives all persons equal access to adequate health care. In listening to the stories of African-American women, it is obvious that being healthy is a lux-

ury in our lives.

The anthology includes a talk given by Byllye C. Avery about the circumstances that led to her founding of the National Black Women's Health Project. It tells of Avery's “falling into” health care, with her involvement around abortion issues in the early 1970s. While in Florida, Avery was giving advice to women as to where they could get abortions. Most of her clients were white. Upon giving this advice to a Black woman, the woman responded that she couldn't get there. “We realized we needed a different plan of action, so in May 1974 we opened up the Gainesville Women's Health Center,” says Avery. Later Avery opened another facility named “Birthplace,” and out of those experiences came more ideas and the founding of the Black Women's Health Project.

An important piece in the anthology, written by Angela Y. Davis, gives a political analysis of the healthcare system, as part of the continuum of oppression faced by women, poor people and people of color. “While our health is undeniably assaulted by natural forces frequently beyond our control, all too often the enemies of our physical and emotional well-being are social and political. That is why we must strive to understand the complex politics of Black women's health.”

Davis recounts in detail the story of Sharon Ford, a welfare mother whose child died during birth due to prejudice at two hospitals that refused to admit her because of her welfare status. Ford was finally admitted to a third hospital, the reputed “poor people's medical warehouse.” According to Davis, Ford had taken many precautions because of serious circumstances surrounding her pregnancy, of which she was well aware. She had subscribed to a health plan but was not believed when she reported this information. In addition, the insurance company's tardiness in processing her application exacerbated the situation. Davis writes, “Standing at the intersection of racism, sexism and economic injustice, Black women have been compelled to



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bear the brunt of this complex oppressive process.”

In excerpts from her book *A Burst of Light*, Audre Lorde describes her personal experiences with combatting cancer, including her feelings, her battle over others' decisions about her body and encounters with the health care system. She writes about the reaction she gets from a white male doctor upon her questioning of the need for a biopsy: “He saw my X-rays, he proceeded to infantilize me with an obviously well-practiced technique...Racism and sexism joined hands across his table as he saw I taught at a university. “Well, you look like an intelligent girl,” he said, staring at my one breast all the time he was speaking.”

The debate as to the causes of high pregnancy rates among African-American teenage females is critical. Faye Wattleton gives a commentary relating the resistance to sex education and contraceptive access and the perception of young women that a better future is not available to them. In an interview conducted by Marsha R. Leslie, a teenager named Mikeil shares her experiences as a young mother. Mikeil's reasons for becoming a young mother are probably the major reason for high pregnancy rates among teens: “I became sexual because of peer pressure—to satisfy the guy and because so many girls were talking about it.” Mikeil says of her baby, “I have something to live for.”

Jewelle Gomez and Barbara Smith discuss the dynamics of being lesbian and Black, and the subsequent effect this has on the health of both homosexual and heterosexual Black people. “I think that in addition to affecting lesbians' emotional health, homophobia affects the mental health of heterosexual people. In other words, being homophobic is not a healthy state for people to be in,” says Smith. Gomez and Smith also discuss the ingrained sexism and homophobia that are not only tolerated but supported in the Black community.

Child sexual abuse and incest, drug addiction, AIDS, and women dealing with debilitating illness are

other areas in which personal herstories are given. White includes the narratives of various health care workers—two doctors, a traditional midwife, a nurse and a dentist. While their individual perspectives are unique, all speak of the obstacles faced by Black women working and dealing with the health care system. In an interview Smith says, “There is no question that Black women have some of the worst health problems of any group. Two words came to mind when you asked that question...freedom ...and safety... The reason that Black women don't have good health in this country is because we are so oppressed. It's just that simple.”

Interspersed with the political pieces and narratives are poems by Lucille Clifton, Pat Parkers and Kate Rushin. The book finishes with a short herstory by Alice Walker, about the loss of the use of her right eye in a childhood accident and a second poem by Lucille Clifton. This literacy touch provides an uplifting and hopeful ending, while adding richness and continuity to the book. My only complaint with this book is its cost of \$14.95 (\$19.95 in Canada), which prices it out of the range of so many women who desperately need to read it.

*The Black Women's Health Book: Speaking for Ourselves* speaks not only to Black women but to all women and all Blacks. It is directed toward Black women, but must not be kept to them solely. Not only does it speak on health, it speaks to the heart; it is a fine piece of literature for the soul. The experiences it contains speak to all of humanity.

*Kecia Brown is a feminist who has a long-term interest in traditional and non-traditional healing techniques. She hopes to see the day when the [American] health care system offers equal access to all.*

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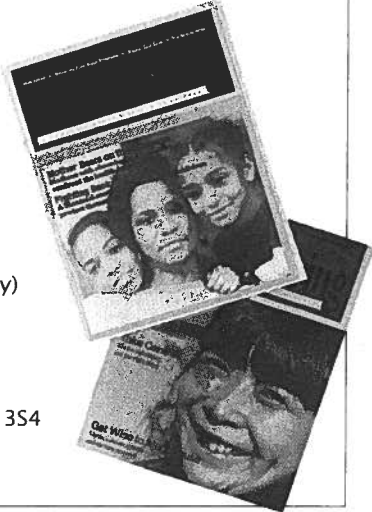
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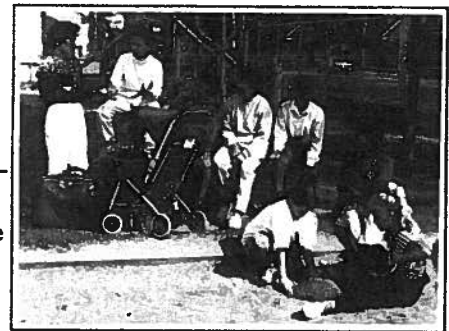
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