

Healthsharing

Spring/Summer 1993

A CANADIAN WOMEN'S HEALTH QUARTERLY

SPIRIT OF THE WEST

Native medicine defies AIDS

Feminist therapists unite

Journey of integration
heals multiple personalities



Healthsharing

Vol 14:1 Spring/Summer, 1993

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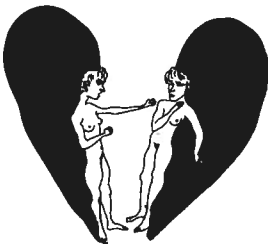
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Financial support for this special report on the Prairie region was provided by Health and Welfare Canada

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Published quarterly by Women Healthsharing Inc. Anyone wishing to make a tax-deductible donation (\$20 or more) please send a cheque payable to Women Healthsharing. Subscription rates are \$15/year, individuals; \$28/year, groups, libraries, institutions. (Prices include GST-Registration No. R119302255)

Outside Canada add \$4 per year. Cheque or money order in Cdn or US funds or international money orders only.

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

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ISSN:0226-1510 Printed in Canada
Publications Mail Registration No. 5327

The Prairie Issue: Stretched to the Limit

The more we discovered about the various elements of women's health issues in Manitoba and Saskatchewan, the clearer it became that time and resources would permit us to cover only a small portion of the immense, women-driven force that is at the heart of the health caring and sharing society. There is a burgeoning list of issues around which concerned women are organizing. We have tried to sketch a picture of what Manitoba and Saskatchewan women are doing to further the mental and physical health of women.

At the outset, we drew up a list of topics: breast implants, abortion, menopause, pregnancy, body image and AIDS. Except in passing, these concerns are not addressed in this issue, because we discovered a plethora of other concerns that we had not considered initially. They came from the women and women's groups we contacted for information and assistance before we gathered the stories.

Without exception, the women whom we asked to write about their organizations responded with a speed and energy that belied the tremendous pressures inherent in their work. Many organizations worry about funding, understaffing, the long hours. Those involved in such organizations spend many hours of their own time working toward a healthier world for Canadian women. I am thinking in particular of groups such as the Women's Health Interaction Manitoba group that has been meeting for years, working behind the scenes on a number of projects. In this issue, we describe their latest—an ambitious, nation-wide health consultation slated for May 1993.

As the information came in, a theme began to emerge: health

is more than the absence of illness—health is wellness, a state of being in which we listen to our bodies, recognizing their signals. Sandi Kirby, who has extensive understanding and training with women and sport, writes of the exhilaration that comes from a body and mind genuinely in synch. The mind-body connection cannot be ignored, and the anguish that can occur in the current mental healthcare system is addressed throughout the issue: our feature on women and mental health; Michelle Laroche's story of Multiple Personality Disorder and its treatment; and the profile of the Womyn's Counseling Services.

Some of the organizations profiled are not specifically directed to women. For instance, the Drug Information Line at the University of Manito-

ba's School of Pharmacy is for seniors, both male and female, but as Ruby Grymonpre points out, the majority of seniors are female. The service is a vital one and of great use to an often neglected segment of society.

An issue that is not directly addressed, but one that is a major health problem for women in the 1990s is overwork. Stress. Women have been socialized to a level of perfection that started with the 50s exhortations to fight waxy buildup on the kitchen floor. Now it includes the added responsibility of a 60 hour work week; raising healthy, happy children; and organizing for a better society. The recurring motif of my organizing meetings was the daily planners stuffed with notes and papers and "to do" lists. The women who fill

Cover artwork by **Lita Fontaine**, a native artist living in Winnipeg. Lita says that the work: "depicts the positive and negative elements that affect all humans and how we, as Aboriginal people, can accept and understand these forces to achieve harmony and balance in our lives.

The central figure is missing, representing those Aboriginal people who have died from AIDS. A spirit looks on asking us to remember those who have been lost to the circle of life. Because, in their passing, they leave us, their courage, strength and knowledge, represented by the medicine bag, the pipe and the medicine wheel. It is with this knowledge that we are able to educate our future generations so that they may remain strong, healthy and alive."

We are grateful to the Manitoba Regional Aids Steering Committee for allowing us to reprint Lita's work, which was originally used on their poster for the Manitoba Aboriginal Aids Conference of November 1992.



these pages hit the deck running every morning, and go to sleep every night knowing that the next day will be busier than the one before. Yet they took the time to offer advice, to suggest other avenues to pursue, and to contribute their writing to this issue of Healthsharing.

JOANNE REID

I have conflicting feelings about this Prairie project, this Prairie issue of Healthsharing. While delighted to have been part of a feminist publishing venture, I am deeply ambivalent about the magazine we've produced. The project could easily have grown to the size of our genuine political commitment to women and women's health issues. However, from the beginning Joanne and I were clear with ourselves about needing to carefully manage the project's timeframe and pay schedule, in order not to jeopardize the delicate balance that is our life as contract-dependent communication consultants (grand title, hard work!). We worked as hard at keeping

the project manageable as we did at reaching out and finding content for the magazine. We didn't want to suffer the irony of diminishing our own health while soliciting stories about women's need to take better care of ourselves!

Personal, emotional health is an issue of growing importance in my life, and I am trying hard to live my politics in the way I organize my work—both paid and unpaid. As feminists, we know society expects women to work twice as hard as men, usually for half the pay and recognition. But as feminists, we often perpetuate this exploitation by seeking funding for projects that have enormous—and enormously important—goals, and then seeing them through even when the funding will realistically support a project only half the size.

The potential of the regional issues of Healthsharing is enormous. And so is the potential of the Canadian Women's Health Network. I want to see all women respected and treated with dignity, but I don't believe we will achieve that goal by overworking and undervaluing

ourselves in the process.

I use this editorial space to urge all of us who are committed to women's health generally, and the CWHN specifically, to keep the long-term goal of the Network in sight throughout the daily grind of organizing. Don't let's expect the Network to be at its beginning what it must become over time: all encompassing, all representative, meeting all women's needs. Let's keep the long-term goal in sight as we struggle with the daily objectives of piecing together a national network of women and women's resources. Let's ensure that our long-term political vision for the Network does not so exceed the short-term political reality of our resources that we set ourselves up to fail. As we build the Network, let's commit to making our short-term resources more congruous with our long-term vision. And for the Goddess' sake, let's take time to rejoice in the birthing of a national network that will, in time, meet the needs of all Canadian women.

AMANDA LE ROUGETEL

Letters

Throwback to the dark ages

I read with interest your recent article "Female Genital Mutilation" (*Healthsharing*, Volume 13 No.4). It was interesting to note, however, that a subheading listed this as a "women's rights issue" and a "human rights issue" but neglected to mention perhaps the most important issue of all: societal!

As a white of European descent, I'll admit that I am repulsed by the fact that such needless "operations" are still taking place. However, as someone not from such a background, are my opinions of any consequence? It seems to me that the real issue here is deeper. The real issue is a lack of equality between the sexes in these

countries, and the battle is for women of that background to fight on the home-front if real change is to take place.

Meanwhile, closer to home, thousands of babies are mutilated right here in Canada each year. The "operation" is called circumcision and is just as much a throwback to the dark ages as FGM. The difference is that a powerful church clings to this ancient tradition, so we accept it. Maybe we should clean up our own mess before we condemn someone else's.

S. Dale,
Ottawa, Ontario

Looking forward

I find that *Healthsharing* is interesting, informative and sup-

portive. My sister and I are looking forward to being regular subscribers.

L. Grout,
Burnaby, BC

Reactions mixed

I received the latest edition of *Healthsharing* (Volume 13 No.4) yesterday, and read C. Clement's letter regarding my article "Sex and Punishment."

My reactions to the letter were mixed. On one hand, I was pleased that C. Clement had read my article, and taken the time to comment on it. On the other hand, I was concerned that she had misrepresented my position in the letter. The statements that I "rejected any role of sexual behaviour in causing cer-

vical cancer," and that I implied "that women shouldn't take part in medical studies" suggested to me a serious misreading of my original text.

As well, I was somewhat annoyed by the implication that I was not aware of the relevant medical literature, and had not done thorough research into the topic. The article arose out of my master's thesis, which involved a comprehensive review of the medical literature on cervical cancer from the last decade.

Clement suggests that my perspective on HPV arises out of an ignorance of the medical research, when in fact I have studied this research in detail, and have simply reached a dif-

ferent conclusion from Clement as to its significance. Nonetheless, I realize that my position on the topic is somewhat controversial, and that, working within the Public Health Department, Clement is more likely to adhere to the dominant medical perspective.

I enjoy reading each edition of *Healthsharing*, and hope to contribute new articles in future.
*J. Darby,
 Downsview, Ontario*

Looking for answers

I would like to share my postpartum experience with other women in the hopes of hearing from others who may have had a similar experience. About two weeks after my daughter's birth

I noticed a little bit of numbness in my right heel. Over the next six months I developed a pain in my right hip which mimics sciatica, and a pins and needles sensation in both my feet. I also have had a pain to the right of my groin.

I have been to many different professionals but no one seems to know exactly what the problem is. I realize that giving birth at 40 may have had something to do with this, but I have never spoken to any other woman who has experienced anything like this. Has anyone ever experienced this before? And did anything help?

*D. Barreca,
 7750 Prince Albert St.,
 Vancouver, BC*

The Women's Health Network: Strength in Diversity

Planning for the Canada-wide Canadian Women's Health Network Consultation meeting, to be held in Winnipeg May 21-24, 1993, is well underway. The Consultation will bring together about 70 women representing different organizations and groups from across Canada. It is hosted by *Healthsharing* Magazine, the Women's Health Clinic in Winnipeg and Women's Health Interaction Manitoba. Funding is provided by Health and Welfare Canada and will cover the airfare, hotel, meals and personal attendant care for the attendees. English, French and ASL will be available.

The Consultation will focus on effective ways for groups to exchange resources and information among groups, strategize for advocacy and action on women's health, use computers and databases in communication, and ultimately build and fund a network. Participants at the Consultation will also share their experiences and insights

into what determines women's health and well being.

Sari Tudiver, the consultation coordinator, says the meeting is for all types of groups and organizations, no matter how informal. "It can be a group that meets around someone's kitchen table or a national organization—so long as they are primarily interested in women's health." The hope is that out of the Consultation will come an empowering network which will help women develop and advocate for better health policies, programs and services: ones based on an understanding of women's specific needs, their diverse cultural traditions, and their feminist visions of health.

The ten women on the Consultation Advisory Committee consulted broadly as they organized the Consultation. They solicited mailing lists and contacts across Canada. Criteria for selecting groups and organizations for the Consultation were drafted and circulated in French

and English to 25 groups across Canada. Feedback was incorporated into the final selection kit that went out in English and French to about 800 groups and individuals.

The criteria for selection try to ensure representation from different types of groups and organizations—small collectives, community health centres, community agencies, etc. Representatives will include women of various ages, races, ethnic backgrounds, abilities/disabilities, socio-economic levels, sexual orientations, training and experiences. Much effort has also been made to reach groups and organizations from all Canadian geographic locations, including northern and rural areas and small towns.

Each group applying is asked to nominate one representative to attend the consultation and then return to her area and share the experience with her own group and with others. Groups represented have some

commitment to further the development of a Canada-wide Women's Health Network.

About 130 applications were received from across Canada. They all reflect wonderful enthusiasm and interest in a Canada-wide, bilingual network. The Advisory Committee and representatives from *Healthsharing* are reviewing the applications and have the difficult task of limiting the attendees to about 70 women.

"The process of the meeting is really important and we are putting a lot of thought into how it can be an effective working meeting that builds trust among

the participants, finds common ground and emerges with an action plan," says Sari. "The meeting is not so much about specific issues—although participants will bring their expertise and experiences working on issues—but about strategies for communicating effectively, sharing information and resources, and lobbying for change. We hope the Consultation will be a model for how the network might function—with sensitivity and respect, building on the strengths of diversity and finding common ground. Hopefully, we will all listen to each other and

learn from our struggles and successes. And we also plan to have a great time."

Groups and organizations not attending the Consultation will be informed of others in their region who can share information with them. A detailed report on the Consultation will be published along with the recommendations and action plan. The Consultation is just one step towards a Canadian Women's Health Network in which many more groups will be involved.

JOANNE REID

Birth Defects Linked to Industrial Pollution

Patterns of birth defects are linked to industrial pollution within the community, according to a study conducted by David McArthur of Conception Research.

McArthur first documented indications of birth anomalies in Pickering in his 1988 report. The report attributes rising infant deaths and fatal birth defects to increased tritium emissions. Greenpeace Canada has provided written support for these findings from Dr. Barry Lambert, a British radiologist at University of London, and Dr. Eric Mintx, a Canadian epidemiologist.

In 1991, based on analysis from the Ontario Birth Defect Registry, McArthur found evi-


dence that patterns of birth defects can be matched with local industrial and chemical pollution. Seven birth defects were detected. The report estimates one-third of birth defects occurring in Pickering were caused by radioactive releases of tritium and carbon-14 from the CANDU nuclear station.

The Atomic Energy Control Board's own studies suggest that a high incidence of central nervous system birth anomalies, such as Down's Syndrome, are linked to radiation releases in Pickering. Child leukemia was reported to increase. Microphaly found in Japan after the 1945 atomic bombing was similarly found in Pickering.

Anomalies are often detected during pregnancy, leading women to choose abortion. McArthur has urged provincial and federal health ministries to conduct a survey of Pickering families to determine whether elective abortions have hidden the reproductive effects of local industrial and chemical pollution. But the ministries have refused to conduct more objective studies, or to release birth defect data to McArthur.

McArthur is now calling for an inquiry. He claims that the Ontario Ministry of Health is concealing a link between birth defects and industrial pollution.

VIRGINIA MAK



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Call for Birth Centre Proposals

The Ontario Ministry of Health plans to licence three out-of-hospital birthing centres by the beginning of 1994, announced health minister Ruth Grier in late March. The ministry has placed ads in newspapers across Ontario asking community groups to make proposals for these birthing centres.

"Birthing centres offer a safe, less clinical alternative to hospitals. By funding birthing centres staffed by midwives, my ministry is acknowledging that most births are uncomplicated, normal deliveries," said Mrs Grier.

Members of the Toronto Birth Centre responded with enthusiasm to the announcement that the ministry has

called for proposals for free standing birth centres.

"The Ministry is encouraging the establishment of facilities that are community based and governed, and this totally reflects the philosophy of the Toronto Birth Centre," said Nancy Levy, chair of the Toronto Birthing Clinic's Proposal Group.

The birthing centres are one of several initiatives that the Ontario government has taken to integrate midwifery into the formal health care system. Midwives are being regulated for the first time in Canada under the Regulated Health Professionals Act, expected to be proclaimed in Ontario by the end of 1993. The 75 midwives cur-

rently in the assessment and upgrading program at the Michener Institute for Applied Health Science in Toronto are expected to be registered with the College of Midwives and offering services by the end of the year.

Midwives will be paid by salary, commensurate with experience and case load, not fee-for-service. A team representing midwives and the ministry will begin in April to work out payment details.

Community health centres, hospitals and independent health facilities will be able to contract with or employ midwives.

JANET CREERY

Living Up To The Myth?

Naomi Wolf celebrated International Women's Day with an appreciative audience of nearly 1,000 at her lecture entitled "Towards a Positive Culture of Female Sexuality" at Winter Garden Theatre in Toronto.

Wolf has been writing and speaking to promote her latest book, *Power Feminism: How to Love the Women's Movement Again*, which is due out from Random House in the fall. The 30-year-old bestselling author of *The Beauty Myth* has been touted as a feminist provocateur, not unlike Germaine Greer and Simone de Beauvoir. She is now writing a third book, on the cultural history of female sexuality.

Her press kit, however, made her knowledge of feminist history seem rather scant. She is quoted as saying: "While there is a long tradition of putting the political and personal together in

lesbian culture, there is also room to look at putting together a new feminist concept of heterosexuality."

Wolf spoke of her own experience with sexual conditioning, telling stories of punishment she received for her adolescent explorations of sexuality. She also criticized mainstream images of sexuality. But her ideas did not add up to the vision of a "radical heterosexuality"

promised in the promotion of the talk. Her only concrete suggestion was for us to turn to our own experience to understand our sexuality.

"We must...create anthologies



Naomi Wolf

of our own erotic cultures that speak to us," Wolf exhorted. Her tone was effusive, but her lecture offered few new answers.

VIRGINIA MAK

Virginia Mak

Mortality Rates for Black Babies Still High

The relative mortality rate for black infants has not improved in the past 100 years, a recent American study found. As in the 1800s, black infants are twice as likely to die before their first birthday as white infants.

Although poverty, poor access to healthcare, lack of education, poor health habits, and early child bearing explains some of the deaths, the leading cause of death was premature delivery, researchers found. Carol Hogue, professor of epidemiology at the Emory University School of Public Health in Atlanta, says racism may be at

the root of the problem.

"Social differences in infant mortality narrow when societies attempt to level wealth among social classes, eliminate discrimination and erase the effects of any remaining social disadvantage through universal healthcare," says Hogue.

Hogue is calling for broad-based racially equitable policies to accelerate improvements in infant mortality, reduce social disparities and reverse the ever-increasing numbers of women and children living in poverty.

"We need to help those living

in poverty to obtain safe housing, adequate nutrition and education, and other basic health requirements," she writes in the February issue of the *American Journal of Public Health*. "As public health professionals, we must not lose sight of the importance of social policies designed to attain social justice, social equality and social equity in healthcare. The policies are the critical points at which we need to intervene in the progression from social disadvantage to an infant's death."

MEGAN WILLIAMS

War Rape in Yugoslavia: Serbian and Croatian Women Unite

In April in Toronto, the Mother Courage II tour featured 10 feminists from around the world to discuss the issue of rape against women during war. Lepa Mladjenovic, a Serbian clinical psychologist and co-founder of the SOS hotline for women and children victims of violence in Belgrade, Serbia, and Vesna Kesic, a Croatian journalist and co-founder of the Zagreb Women's Lobby, spoke of their struggle to help survivors of rape in their war-torn region.

Lepa Mladjenovic:

"Around the new year, our SOS hotline organization formed a special group to try and help all the women who have been raped in this war. We've begun going out to look for these women. As a group, we've found that it's very difficult for us too, because lots of women within the group have

fears about being raped themselves, and fears about being exposed to violence. So we're working at the same time among ourselves. We're also working with women from Bosnia who have been raped either in the Muslim prisons, or by Croat, Muslim and Serbian soldiers.

When women have been raped in war, they are often told they must forget everything and start a new life. Most of the women we have seen have had medical intervention—mostly abortions—and so doctors tell them that everything is good, that they can start a new life, that they're not in the war zone, and that everything's going to be OK. It's a heavy burden on these young women. Everybody's expecting them to start a completely new life. Then some have had the extra violence of having to go on TV.

The women who showed resistance are not alive at all.

One woman told us the story of a young woman who was raped the most often out of a group of six women held in one room, who were there just to be raped by the soldiers in a barrack. She finally couldn't stand it any more, and she broke a bottle of mineral water and hit the guy in the back. She was killed. So they all had to learn that there was no way they could give any resistance at all, which means no sounds, nothing. Those who had a chance at surviving were those who were totally obedient.

One good thing is that there is lots of women's solidarity across national identity although it's not talked about. For example, one young Serbian woman told us she escaped the prison because the Muslim woman who was working in that Muslim barrack as a cook helped her escape. I'm sure that there are lots of these cases in the different war zones."

Vesna Kesic:

"War rapes are certainly not the same as...shall we call them "normal" rapes, that go on in peaceful cultures. When rape is a part of military strategy, and when it happens on such a massive scale as it did in Bosnia and Herzegovina, then there's only one name for it: genocidal rape. This is an attack on the reproductive nucleus of the other group.

"I think every rape which has been committed during the war by soldiers has to be named as a war crime. So when we talk about tribunals and prosecutions, I think we must include everybody who has been using war as a chance to attack women (to show her once again what her place in society is). This is the *manpower* being produced over the women. This is the man's proof of the complete dominance and the victory, and a way for him to humiliate the men from the other group of male warriors. So I think every rape in war must be pronounced a war crime, and all of them have to be punished in an adequate way.

"I'm sure women, if they had any chance to decide about this war, would have tried to avoid it, which cannot be said for our political and national leaders. In that sense, we are now trying to organize more women's activities in Croatia and Zagreb. Groups have very different political, national and even feminist methodologies and approaches. We've been divided, very much—between our nations and into our nations. But I definitely think that all the help that can be given to the women victims of war is necessary, that it's very necessary to help those grass-root, community-based democratic initiatives which involve women working with women. We've tried to establish one in which we try to avoid any nationalism, and in which we say: We are going to help any woman.

Although we know very well which women have been mostly raped and how many, we're not going to focus on that. Because numbers are just one of the ways women have been reduced in this war. How many of them have been raped?

200,000? Then somebody says 14,000, as the Bosnian government says they can prove. Or is it between 30 and 60,000 as somebody else claims, or is it those 20,000 as the European community claims? So when we see how much these numbers are being compared, we see again how much women have been used, manipulated and treated as numbers.

Our small centre for women victims of war is decentralized—meaning that we'll have small centres all around Croatia and Bosnia, where most of the help for women victims of war is needed. We've started to go to the refugee camps, but we don't want to make the women tell their stories. We hate the idea of bringing their stories to the press, which has been done and manipulated and used. We shall be trying to help them self-organize, to give them some political support, some material support, to help them regain any sort of self-confidence, and to help them to bring themselves to life and the society."

MEGAN WILLIAMS

Black Women Often Misdiagnosed with STDs

Black women with endometriosis are frequently told by medical professionals that they have contracted a sexually-transmitted disease, a recent study reports. The culprit? Outdated textbooks and attitudes based on racist stereotypes, says Donald Chatman, a Chicago gynecologist and researcher.

Chatman, an American expert on endometriosis—an often painful disease in which tissue normally found in the uterus is also found on other pelvic organs—found that as many as 40 percent of African American women are misdiagnosed as having a sexually-transmitted pelvic inflammatory disease (PID) when in fact they suffer

from endometriosis.

"Black women often have been erroneously diagnosed as having PID because of racial bias in textbooks that suggest they are more sexually active and promiscuous, and therefore more likely to get a sexually transmitted disease," says Chatman.

Symptoms of endometriosis include painful intercourse, bowel movements, urination and menstruation; chronic fatigue; low resistance to infections; and extensive allergies. The disease can lead to infertility.

"Endometriosis is traditionally thought to affect only white women between ages 24 and 45, but in our research and other studies over the past 15 years,

the disease has been found to equally affect black women and teens in all socioeconomic groups," he says.

Although the cause and cure of endometriosis remain a mystery, the disease can be temporarily treated through medication and surgery. Chatman urges black women—particularly teens and college-age women—to be assertive in getting an early and accurate diagnosis of pelvic pain.

"Since the issues surrounding endometriosis involve important life decisions, women should know for sure if the disease is present," he adds.

MEGAN WILLIAMS

Go-Ahead for Controversial Menopause Drug

A Manitoba company that manufactures estrogen-replacement drugs from the urine of pregnant horses is to receive a \$100 million government expansion grant, despite serious concerns from women's health activists and environmentalists.

Ayerst Organics Limited of Brandon, Manitoba is the only plant of its kind in the world. It manufactures Premarine—a synthetic hormone often prescribed to menopausal women—from pregnant mare's urine.

Brandon city council will only approve the expansion if Ayerst can eliminate the offensive odours which the process produces. The company will have to build a new dumping station with a scrubbing system for the noxious gases. But environmentalists say that may not be enough.

"With the sewage lagoon system that is popular in Western Canada, the ammonia (from the urine) is just sent into the air" says biologist Bill Patton. Since the expansion is expected to double the company's waste water, the local treatment system will be burdened, and trees will die from the airborne ammonia, he explains.

Provincial Environment Critic for the Opposition, MLA Marianne Cerilli, is calling for a federal environmental impact assessment of the project. She says the expansion not only threatens the water quality of the Assiniboine River, but may pose problems for the women who use it.

"We should be asking just what the long-term effects of Ayerst's product will be on the environment of women's bodies," she says.

"Hormone therapy is a lucrative industry. There are some possible non-drug alternatives...but you don't see the Tories putting money into those," says Cerilli.

Nori Korsunsky, who runs the Winnipeg Women's Health Clinic's menopause information sessions, agrees with Cerilli. She says that while hormone-replacement therapy is useful for some menopausal women, particularly those who experience hot flashes or are at risk for osteoporosis, it is prescribed too much.

"A relatively small number of women actually experience such problems, and yet clearly there are lots and lots of women being encouraged to be on hormone therapy" says Korsunsky.

In the 1960s, Premarine was


linked to endometrial cancer. And current therapies, including a combination of Premarine and synthetic progesterone, may increase the risk of breast cancer.

"Women must end this trend of male solutions to women's problems, especially because those solutions usually mean men getting rich and women getting sick," says Cerilli.

Supporters of the deal say the expansion will increase jobs in the province. And they say, since many women from the "baby boom" generation will soon be entering menopause, there will be a guaranteed market for the drug for a long time in the future.

This "guaranteed market" exists because so many medical professionals get their current health information from drug company bulletins and sales representatives, says Cerilli.

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MYRA LARAMEE

Medicine Woman



Prairie Medicine Woman Myra Laramee teaches the way to wellness in defiance of the culture of despair surrounding AIDS

by Joanne Reid

Myra Laramee is well known in Manitoban women's healing circles for her workshops on health and wellness. Her interest in health issues began in the late 1970s when she began to network with other communities and cultures around the issue of wellness. In 1985, she began talking about living with AIDS and the possibility

of AIDS, especially in rural and Native communities. She was the driving force behind the Aboriginal AIDS Task Force, giving workshops throughout the province.

To people living with AIDS and people vulnerable to AIDS, Myra and her adopted brother, Albert MacLeod, brought a message of life. "AIDS focuses people's attention on death, so that they cannot think of doing anything without thinking of death. But all of us are going to die someday. Why bother thinking about it;

"If all four are not tended and understood, the result is disease. I emphasize that all four components must be satisfied if you are to be a well and happy person," she says.

Myra tends to think of things in fours. She explains that the four impediments to wellness are judgement, religion, bureaucracy, and attempts to exert power over any person or thing. Passing judgement on others or accepting their evaluation of us is crippling to our wellness because this outward focus only

was three. Her aboriginal name means 'the woman at the centre of four directions.'

What does she think about cultural appropriation? A glint of laughter shines in her dark eyes: "You mean Indian wannabes?" She shakes her head slowly. "People miss the point of their lives and the lives that lead up to them if they think all the answers are held by another culture. There is a tendency today to look to aboriginals as 'keepers of the laws', to pedestalize aboriginals.

"You don't have to look outside yourself. All you have to do is remember. Just remember. Your own answers will come to you."

When Myra remembers, she remembers the water woman, but she remembers the Celtic side of her background too. She is Cree, Scottish, and French; one of her great-great-grandfathers was a Hudson's Bay Company man at York Factory. She says, "I've looked at maybe 10 faiths, maybe more. I've sat here in Winnipeg and had other cultures flow through me."

Myra believes that living frightens many people, to the point of often being paralyzed with fear. She teaches that we all have four freedoms in our lives: freedom to explore, freedom to grow, freedom to live and freedom to grow old. Once we get past the fear of death we are free to grow old. Aging ceases to be a threat and becomes something to anticipate joyfully.

We are all engaged in a lifetime journey toward health and wellness, says Myra. We are born and then we die: these things we know for sure. It's counterproductive to wellness to worry about the beginning and end of our life. We should concentrate on what happens between those two events. Health begins in the mind, "and health does not come from Shoppers Drug Mart. It comes from us and how we face the failings of our bodies."

During a tobacco teaching in a sweat lodge, she was given the message that she would have to make a commitment to life.

Myra's lifestyle had been destructive in the past. She covered her emotions with alcohol, cocaine, promiscuity, and abusive relation-

"Health does not come from Shoppers Drug Mart"

you should be thinking about the living you got to do before your pass through the western gate," says Myra.

Most of their work was done in response to requests from groups. They did not go out looking for speaking venues, they let people find them. It was a busy schedule of long evenings and weekends.

"There was a time when I couldn't keep up with all the workshops on AIDS that I was being asked to do," she says. "This winter, I haven't been called on as much. I sensed it was time for a change, for a contact with someone from outside Manitoba to help me expand my teaching about AIDS."

She has now contacted a person from Ontario with AIDS and hopes to spread her message nationwide.

That message is wellness teaching. "I use medicine wheels in my teaching. There are seven medicine wheels dealing with seven aspects of life. A lot of people think that these are some sort of mysterious Indian thing...some sort of Indian symbols. They're not. They're just circles. All cultures have circles because life is a circle," she explains.

One of the wheels concerns the four components of wellness: emotional, mental, physical, and spiritual.

serves to draw us away from our inner power. Likewise, organized religion draws us away from the genuine spirituality that is in our hearts. "We must listen to our hearts," says Myra, "if we are to have any personal understanding of our true selves."

Bureaucracy also is "crazy-making" since it has too many loopholes and cannot be trusted, says Myra. She believes that any attempt at "power over," or acceptance of someone else's power over us, is detrimental to our wellness. We cannot control the thoughts and actions of those around us.

Although she rejects the organized church, Myra embraces the spirituality of her own people's traditions.

"In my life, there are ceremonial traditions, sacred items, that have been passed on to me whether I like it or not. I've earned them and now I bear the responsibility of them." That responsibility is to watch and protect people: an obligation she feels quite comfortable with since, with the ceremonial items, came spiritual and healing knowledge.

Her background includes a long line of elite medicine people. Her father's grandmother was a Huron water woman. Her grandfather took her to tribal ceremonies when she

ships. Hers was a classic set up for contracting the AIDS virus. About 15 years ago, she made a choice for life, and has been clean and sober ever since.

Her background helps in her speaking and teaching workshops. When AIDS awareness began to grow in the early 1980s, she knew she should be tested. Then in 1985, waiting for the results of her HIV test, Myra faced the full meaning of her life.

"I knew this was the commitment I had to make. While I was waiting for the results, I made a promise to the Creator. If the test was positive, I would quit my job and devote my life to helping others who are HIV positive. If I was healthy, my commitment would be double, except I wouldn't quit my job." Her test results were negative.

Since then, Myra has helped her son to wait for the results of his HIV test after he was assaulted. It too, was negative. But she has seen eight of her friends die from AIDS and one of her three adopted daughters is HIV positive.

"AIDS puts life into focus. We're all going to die someday but most of us refuse to realize that and live as if we are going to live forever and we have a chance to change our ways sometime later, sometime when it's convenient for us," says Myra.

Her involvement with AIDS education, "has nothing to do with stuff outside me. It all comes from things I know, things I have experienced, things I see, things I believe."

The message she tries to convey in her workshops is one of life and of a personal journey toward wellness. She teaches that the cycle of life is a trip through the eastern gate, through life, through the western gate and then around again. Each time we come back we are given the chance to be a better person. It's a journey toward the pure light that we will eventually become. "The pure light that each of us can be is our part of the spirit of God," she says.

Myra Laramée calls herself a *contraire*. "This is a concept from a forgotten society. A *contraire* sees both sides of all situations and sees things people don't want to see." What she sees now, in the 1990s, is an awaken-

"In my life, there are ceremonial traditions, sacred items, that have been passed on to me whether I like it or not. I've earned them and now I bear the responsibility of them."

ing time on earth. People are looking inward, exploring the inner landscape of their lives, finding their strengths and their purpose in life.

Always the *contraire*, willing to swim upstream and go against the prevailing current, Myra said "No" to government funding for her AIDS work.

"The more we talked and visited and got invited to speak, the more the government wanted us to take money. I refused their money. I have a good job and enough money to afford the freedom to do things without their money. Once you take the money, you've got to do things the way the government wants you to do them."

She does not want to do things their way: "Government funding for AIDS conferences perpetuates the hierarchy in the AIDS movement. I've been at enough gatherings to know that government funded conferences are crocks of shit. If a conference is really a conference, we would talk to each other rather than be talked at by others. You need grassroots people to help grassroots people," she says.

Although Myra has given fewer AIDS-related workshops recently, her adopted brother is carrying on the work. One of her primary commitments currently is the Four Nations

Sharing Circle held at her home every second Saturday. The Sharing Circle is an informal gathering of women who share their lives and experiences.

She is also involved in the group, Women Healing for Change, which focuses on healing from abuse, particularly incest.

"If we could go back to genderless mothers, we could defeat abuse. At one time, the concept of mother had no gender. Mothering was simply giving care to children just as Mother Earth cared for us. Incest cannot exist in such a society, because you cannot harm someone you are committed to protecting. All children were the responsibility of the adults—male and female," she explains.

Myra teaches a holistic approach to life and she lives what she teaches. She has been a cultural counselor and teacher for 15 years and is currently vice-principal of Hugh John MacDonald Junior High School.

What will her future hold? She is serene in the belief that time will tell. She knows she has more messages to give, and when the time comes, she will know where to give them.

"The only thing I know for sure, is if we don't do it right in this lifetime, we're coming back until we get it right."

Health Carelessness



Phillis Wong Kun



AND THE *Plight of Immigrant Women*

by **Johanna Brand**

When Kim San discovered she was pregnant, she and her husband were thrilled. Having spent her first year in Canada isolated, unemployed, and without friends, she wanted more than anything to have a child.

Unlike most immigrants, Kim San, who had fled Cambodia, did not face a language barrier when she came here as a government

sponsored refugee. She had spent three years working as a doctor's assistant in a refugee camp in Thailand, learning English and eventually translating for those who could only speak Cambodian. Her family had been scattered across the globe; her husband's family was exterminated by the Khmer Rouge, a dictatorial regime responsible for the mass murdering of Cambodians in the 70s. And yet it was not bombs or genocide that put an end to their own prospects for children: it was one of the world's best healthcare systems going about its business in an ordinary way.

Kim San, and other immigrant women living in Manitoba, offer their stories as examples of what can happen—and still does—to newcomers who need medical care, yet are still struggling to understand the healthcare system, its culture, and the society that spawned it.

Despite her experiences and language skills, the Canadian medical system was a mystery to Kim San when she first arrived. She did not know where to go to get help with her infertility problem. By the time someone pointed her in the right direction, she realized she was pregnant.

A few weeks later, however, when she went to hospital complaining of severe abdominal pain, her joy was shattered. The doctor who examined her said he was 98 percent certain she had an ectopic pregnancy, and wanted to operate right away.

But Kim San wanted confirmation of this diagnosis. She knew that an operation would end her pregnancy, even if it were not ectopic. She also knew there should be further tests, which she insisted upon having. In the ultrasound room, the technician told her that the fetus had died.

Upset and confused, Kim San returned home. She waited three weeks before finally going to another hospital for surgery. By this time, one Fallopian tube had burst and the other was so badly infected that she is now infertile. It is an experience that pained her so deeply she has spoken of it only once before.

Kim San's experience raises the issue: Do newcomers to Canada

experience the same kind of healthcare in our hospitals and doctors' offices that lifelong residents receive? Assuming they do, can those who bear the scars of all they have left behind—warfare, murders, torture, and disappearances—be expected to respond to it the same way long-time Canadians are?

Sonia Hernandez, a health educa-

and friends in Latin America. Because of Maria's exposure to the frequent kidnappings of children and threats against her husband, she insisted upon keeping her newborn with her after she gave birth in a Winnipeg hospital. The baby was fussy, however, and Maria's room-mate spoke to the nurse, who then tried to send the infant to the nursery. When Maria

It was not bombs or genocide that put an end to Kim San's prospects for children: it was one of the world's best healthcare systems going about its business in an ordinary way.

tor with Planned Parenthood in Manitoba who works with the Spanish-speaking community, thinks not.

"Canadian health staff often have no clue what people have gone through. And the results of insensitivity and lack of cultural understanding can not only traumatize a newcomer, but affect her health and well-being."

Newcomers run into problems when their cultural traditions and practices conflict with those of North America. Nonetheless, the extent to which they change their practices depends not only on how eager they are to adapt to the new culture, but also on family and community support.

In the last five years, Sonia Hernandez and three other health educators at Planned Parenthood Manitoba have helped ease the transition for many. They have also worked hard to educate Canadian health professionals about cultural diversity and its impact on the health of their patients.

Lack of cultural sensitivity can increase healthcare costs. What starts out as a relatively easy-to-cure problem, can grow into a seriously complicated one.

Hernandez cites the plight of Maria (a fictitious name) who, like herself, has experienced death threats and kidnappings of family members

refused, the nurse told her she was a "typical hysterical mother."

Fearful and confused, Maria spent the night in the patients' lounge. The next day she asked for an early discharge, and returned home.

But Maria's story does not end there. Later that day, she phoned Hernandez complaining of pain, and together, they went to a walk-in clinic, and then to a hospital emergency department where Maria was examined by an intern and two more doctors. None could diagnose her problem. It wasn't until eight hours after she had left home—the day after she had given birth—that a specialist determined the cause of her pain, an unusual, but not critical condition. Hernandez points out that "if she had stayed in hospital, the specialist would have diagnosed the problem before she left."

In Maria's case, the misunderstanding was a result of a language barrier. Her hospital room-mate, she later learned, was not in fact upset by her baby crying, but simply worried Maria was not getting enough rest.

But language skills are not always the problem. Angela, a Latin American who speaks good English, believes racism was the central cause of her second-rate treatment.

On admission to hospital for a par-

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tial hysterectomy, Angela informed the staff she was a vegetarian and asked to speak with a nutritionist—a request that was ignored. Because of her various health problems, including diabetes with high blood pressure and liver problems, Angela could not take the usual pain killers. She requested Tylenol with codeine, a medication the hospital said it didn't have. She was instead given only extra-strength Tylenol and told to live with her pain. Meanwhile, her roommate received heating pads and other comforts to relieve her distress.

Because of her diabetes and vegetarianism, Angela did not eat the food she was served. When at last she met with a nutritionist, she discovered no one had even read her chart.

"She was fed sugar and in the course of three or four days, all she ate was two boiled eggs. Her family had to bring medication and food from home," recounts Sonia Hernandez.

Hernandez says in her work as a health educator and medical interpreter, she has witnessed many newcomers receive unnecessarily harsh

treatment from healthcare staff. She recalls one technician, for example, who refused to let her accompany a pregnant woman into the testing room to translate for her, claiming that it would interrupt the ultrasound test.

"Of course, someone who speaks English can ask questions and interrupt at any time," Hernandez points out.

Her services were suddenly required, however, when she was called into the room to explain to the patient that her baby had died.

Often times unexplained procedures, whose simplicity is taken for granted by healthcare workers, can lead to trouble for newcomers.

Tuyet Nguyen, another health educator at Planned Parenthood in Manitoba, explains how one Vietnamese mother accidentally fed her new baby concentrated formula. The woman had received ready to use formula in the hospital, but when she bought cans at the supermarket they looked identical. Not realizing there was a difference, the woman fed her new baby the concentrated formula until he became very sick and was rushed to the hospital.

In other instances, it is Canadian health workers who misinterpret procedures and practices foreign to them. Health educators such as Tuyet Nguyen have intervened on behalf of families who still practice the ancient art of coining. This traditional treatment for flus and colds involves rubbing the back and arms with coins until bruises are left. Vietnamese mothers in Canada who coin their children, however, run the risk of being accused of child abuse if health workers are not taught about the practice.

For newcomers, adapting to a foreign culture can involve many difficulties that are embarrassing, painful or even dangerous. Some experiences can be shrugged off lightly. Others leave lasting scars. With a little cultural sensitivity training, most could be prevented.

Johanna Brand is a Winnipeg writer and television producer who came to Canada with her family when she was a young girl.



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Cracks in the Therapy System



By Joanne Reid

The traditional mental health system is leaving increasing numbers of women feeling angry and victimized. As more feminist therapists offer alternative services, the battle escalates over who has the insight, the proper methods, and the right to treat troubled women. In Saskatchewan, feminist therapists have formed a network to make their voices heard.

Gloria Geller, director of the Social Administration Research Unit at the University of Regina's Faculty of Social Work, is a prime mover in Saskatchewan's Feminist Therapy Network. When therapists gathered at the Women and Mental Health Conference in Saskatoon in 1991, her Research Unit helped form the Women's Mental Health Project, which spawned the Network in November, 1992.

The network is now comprised of about thirty women working in the field of mental health. Geller stresses that the Network is not a service. "It is a facilitation for people interested in a feminist approach to their work."

In the eyes of the therapy establishment, feminist therapists have about as much professional credibility as soothsayers and fortune tellers.

The network faces an uphill battle against the substantial forces working to maintain the status quo in therapy. Geller cites the example

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of a psychiatrist who refused to attend an informal meeting of the network because it was too politically hot for him to even talk to such a group.

Taking a stand against traditional services can mean professional suicide for therapists, says Geller. In one case, a woman working in the field brought information to the group about the treatment of patients with Multiple Personality Disorder (MPD). Initially, the group offered to write letters to the media and government. But shortly thereafter the letter writing campaign was abandoned due to the storm of controversy surrounding MPD. (See the *MyStory* in this issue for further discussion of MPD).

Nonetheless there is a great deal of feminist therapy being offered in various agencies. The catch is that it tends to be done on an individual basis. It's the luck of the draw whether a woman will receive this type of referral or a referral to a traditional doctor. And feminist therapists with the traditional qualifications are torn between the job security of offering traditional treatment, and the greater personal satisfaction of offering feminist therapy.

The network unites women working with feminist approaches. "There are people working in agencies such as transition houses who provide

therapies with empowerment approaches, but they are often isolated. The network brings them together with other front line people such as psychiatric nurses," says Geller. Through collaboration and discussion, these women share information with each other and then with the larger community.

Geller's own consciousness was raised by her studies at the Ontario Institute for Studies in Education. There she encountered the work of Phyllis Chesler whose 1972 book *Women and Madness* argues that women are labelled mentally ill for behaviour that would be applauded in men. Chesler says traditional methods use a "subtle system of reward" to bring women to terms with their male-defined role in society.

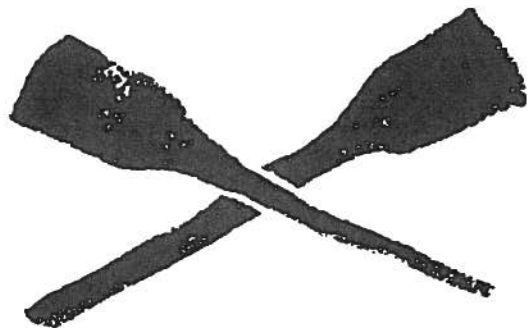
Geller surveyed current therapeutic approaches and concluded that they were, for the most part, antithetical to feminism. "That was when I knew we would have to do our own research and since then, the need to have a feminist approach is a major interest of mine."

What is feminist therapy? At its core is empowerment of the client, says Geller. It grew out of the women's movement's early days when consciousness raising was considered the key to societal change. But in the eyes of the therapy establishment, feminist therapists without traditional qualifications are often considered nothing more than quirky feel-good therapists, with about as much professional credibility as soothsayers and fortune tellers.

Clinics still hire only people with recognized qualifications—psychiatric nurses, psychologists, psychiatrists, social workers. But the Network's activists are working to change that. They see an opportunity in Saskatchewan's revamped health system, which gives each community its own health board. The Network's next plan is to lobby people on the health boards, and so get at the core of the health system.

Joanne Reid is one of the regional coordinators of this issue of Healthsharing. She has been working as a Winnipeg-based freelance writer and researcher for 15 years.

Your Boat Down the RCPsychic Stream



As a coach of a women's team at my local rowing club, I teach women a new way of using both their minds and bodies. I help them to learn from the inside out.

As women, we are socialized to learn from the outside in—to believe that how we appear is more important than what we can do. We tend to be aware of our bodies only when we are ill or injured. Most of us have experienced the chilly climate of male dominated sport, whose highly competitive nature is disabling rather than empowering for us.

The biggest challenge for me is to encourage women to think that they are fully capable of doing the sport, and doing it well. When I hear them

say, "I can't do that," I get them to shift their thinking and focus on what their body can do.

I get women to ask themselves: "How does my body feel? Am I ready for this?" Soon they are saying: "I can do this—by setting my own limits."

It gives me such pleasure when new rowers first recognize they can do it! Their own excitement and energy takes over. Their bodies teach their minds about being capable and well.

The most doubting of participants is surprised when, in a very short time, she can manage the oar, and become part of a team that carries a large boat swiftly over the water.

The new rower begins to talk about the feelings of physical capability she had as a child, feelings she lost as she grew into adulthood. She talks about how good she feels and how clear thinking she is. This is not magic. It is the simple and powerful combination of a body and mind at work together.

Soon, the women start to call

themselves rowers. It is a powerful identification! They feel a sense of team spirit and belonging.

One woman recently talked to me about a nagging feeling she had that she would be more healthy if she could just think better of herself. Through rowing, she was able to make a strong connection between her physical self and her mental and emotional self. She made a journey inward, back to her own power. This woman is not a spectacular rower—her success is in how she feels about herself, not in how fast she rows.

Teaching these new rowers has changed how I think of health. Health means coming to new activities prepared to learn what the body has to teach you about your physical, mental, emotional, and spiritual self. It is about learning to draw continually from a sense of capability rather than learned helplessness. It is a true revolution from within.

SANDI KIRBY

Averting Disaster

The Saskatchewan Institute on Prevention of Handicaps—the only institute of its kind in Canada—is working to ensure that all children have the best possible chance at a healthy life. The Institute strives to help people learn how to prevent disabling conditions in children. Some disabling conditions can be prevented or their effects significantly decreased.

The Prevention Institute offers workshops and presentations to professionals, parents, students, and community groups. Our educational materials are extensive, including a wide variety of fact sheets, resource kits, brochures, videos, and a quarterly newsletter, the *Prevention Post*.

Prevention of disabling conditions in children starts with women before pregnancy, continues during the prenatal period, and extends throughout infancy and childhood. Working mainly in the area of primary prevention, the Institute provides information on prenatal care, healthy lifestyles, safety, genetics, and disabling conditions.

One area in which the Institute does extensive programming is Fetal Alcohol Syndrome. Every year in Saskatchewan, as many as 100 babies may be born with disabling conditions resulting from the effects of alcohol consumed by the mother during pregnancy. Other prenatal programs deal with drug abuse and smoking during pregnancy, whose effects may be equally severe.

Today, injuries have replaced disease as the leading cause of death in children under the age of four. In response, the Prevention Institute has produced two videos on child restraint safety and burn prevention. These videos address the high rates of injury due to incorrect use of child car seats and fires in northern Saskatchewan. The Institute has also been instrumental in coordinating the Provincial Bicycle Safety Coalition, and is represented on the Saskatchewan Interagency Child Restraint Committee.

In order to bring our message to people at their work site, the Institute has developed the Down to Business project offering seminars on pre-conception and prenatal lifestyles, pregnancy concerns in the workplace and

child safety. Employers have shown great interest in this program.

Saskatchewan Institute on Prevention of Handicaps, Box 81, Royal University Hospital, Saskatoon, Saskatchewan, S7N 4J9, (306) 966-2512.

Sharon Chapman

Sexuality and Mental Disability

Sexuality is an important part of life experience and yet there is a noticeable conspiracy of silence around the subject. It should come as no surprise, then, that society still views people with mental disabilities as asexual. This misperception can unnecessarily—and drastically—inhibit their sexual expression. It is particularly damaging to their self-esteem because sexuality is one of the important qualities that makes us uniquely human.

All of us need to feel close to others. Yet many people with mental disabilities have a limited social network, largely due to segregation. While most of us choose with whom we live, work, and spend our leisure time, people with mental disabilities often have little opportunity to make these choices. Parents and support providers may further restrict disabled individuals by imposing arbitrary rules or denying opportunities for privacy.

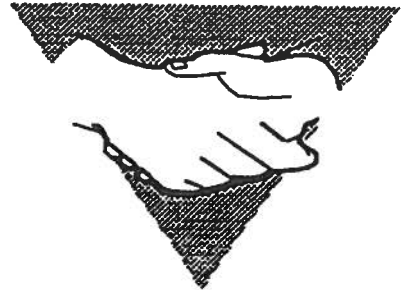
People with mental disabilities need to have accurate information about human sexuality. There are few resources available that contain sexual and relationship information specifically designed to meet their needs. Individualized guidance to promote positive sexuality is also essential.

Violence and abuse is a particular problem for people with mental disabilities. There is substantial evidence that people with disabilities are more likely than others to be victims of sexual abuse. Family members and professionals need to be made aware of the symptoms of abuse and not treat them as behavioral issues or symptoms of the disability.

We believe that with training and support, individuals with mental disabilities can acquire the skills and knowledge necessary to develop a positive sexuality and reduce their risk of sexual abuse.

ACL—Manitoba, 1-90 Market Avenue, Winnipeg, Manitoba, R3B 0P3, (204) 947-1118.

Nadine Rodger, Program Co-ordinator



Gay Pride, Gay Health

A non-profit agency in Saskatoon, Gay & Lesbian Health Services (GLHS), was founded in November 1991 to address health and social issues in the gay and lesbian community. Our community experiences numerous health and social problems brought about by living in a homophobic, heterosexist environment. We experience substance abuse problems as well as suicide and mental illness rates three times those of the general population. Problems of depression, low self-esteem, and paranoia are common.

Obtaining quality services from healthcare and social service professionals and agencies is often a problem for lesbians and gay men. When we seek professional help for problems of day-to-day living, those problems are often ignored, and instead our sexual orientation is seen as the problem. While many professionals are willing to work with gays and lesbians in a non-judgemental way, they are often unfamiliar with the issues we face living in a homophobic society, and are unaware of the diversity of our community. Locating a willing and able professional to help us with a health problem is often difficult—even impossible.

GLHS is working to educate healthcare and social service professionals and agencies about the needs of lesbians and gay men, and to build partnerships with these groups. We provide training and support for professionals and agencies through in-services, educationals (information

packages) and workshops. We've spoken to doctors and social workers about how they can provide quality services to our community.

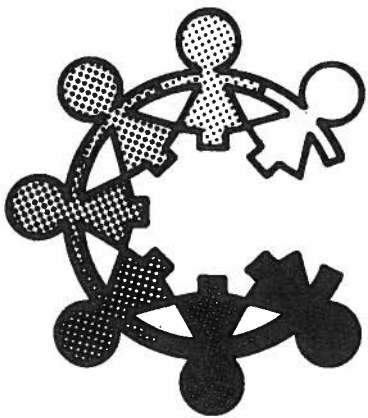
GLHS believes that health is a state of complete physical, mental, and social well-being, not merely the absence of disease. Good health is a basic human right, but to attain health for lesbians and gay men requires action at all levels of society.

We are still developing programs and services that will provide the means for lesbians and gay men to achieve better health. With secured funding from the Health Promotions Directorate of Health & Welfare Canada for the next two years, GLHS will work to promote health and dignity in the community. Support from the local community is vital to the success of the project, since we must raise 20 percent of the funds from them.

To date we have established a telephone support line, a coming out group, and a resource centre. GLHS also operates and is developing groups to deal with issues such as substance abuse (Sober Dykes), child sexual abuse, violence in relationships, and low self-esteem.

Gay & Lesbian Health Services, PO Box 8581, Saskatoon, Saskatchewan, S7K 6K7, (306) 665-1224

Sheri McConnell and Gens Hellquist



Immigrant Women: Promoting Integration

The mandate of the Immigrant Women's Association of Manitoba (IWAM) is to advocate and network on behalf of immigrant women, and to promote activities and services that

facilitate their full integration as equal partners in society.

With social, welfare, and legal agencies, the association addresses the needs of immigrant women throughout the province. Low self-esteem, troubled mental health, abuse, poverty, and racism are components of immigrant women's lives that IWAM would like to see eliminated.

The IWAM's 10th anniversary celebrations in March 1993 focused on a brighter future for immigrant women: more visibility, stronger networks, and more ties with the larger community.

One of IWAM's primary services is cross-cultural counseling for abused immigrant women and their families. If there were time and resources available, the association would like to provide more information on stress management, coping support groups, and networking. But IWAM has faced problems with funding, language barriers, and official recognition.

IWAM, 201 - 323 Portage Avenue, Winnipeg, Manitoba, R3C 2C1, (204) 989-5800.

Beatrice Watson

Looking Out for Women in the Therapy System

The Women and Mental Health Work Group grew out of the Canadian Mental Health Association (CMHA)'s 1987 report, *Women and Mental Health in Canada: Strategies for Change*. The report responded to the national and international concern over the high ratio of women in mental health treatment. Its recommendations provided the mandate for the Work Group.

A Winnipeg-based psychologist, Linda Trigg, chairs the group. Its primary goals are to research and disseminate information on women and mental health; to review existing programs and promote better ones; and to encourage policy-makers to consider social, economic, and occupational factors in the training of future mental health service providers.

In 1989 and 1991, the Work Group brought together people working in the mental health field to consider issues of women and mental health at two conferences in Banff, Alberta.

The Work Group also presented a brief to the National Panel to Address

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Violence Against Women in March 1992, emphasizing the connection between violence and mental health. The group argued that women are too often treated for mental health problems without consideration for their social and economic circumstances.

Aware of the potential for emotional and sexual abuse in counseling situations, the Work Group conducted a survey on abuse by mental health service providers such as doctors, clergy, and other therapists. More than 100 Manitoba women responded, and the group is now compiling the results. A report with recommendations will be released this spring.

Women and Mental Health Work Group, Canadian Mental Health Association, 2nd Floor - 836 Ellice Avenue, Winnipeg, Manitoba, R3G 0C2, (204) 775-8888.

Dr. Linda Trigg

Pluri-elles: la promotion de la santé chez les franco-manitobaines

Pluri-elles, un regroupement de femmes francophones du Manitoba, a fêté son dixième anniversaire en 1992. Ce centre de ressources pour femmes francophones est unique dans l'Ouest canadien et offre divers programmes et services dans le but d'améliorer la condition de vie et de promouvoir l'autonomie des femmes tant au niveau personnel que social et économique. C'est par le biais d'un projet de la Promotion de la santé, financé par Santé et Bien-être Canada, que Pluri-elles a pu se

rendre dans les communautés rurales dispersées dans la province en plus de desservir, au Centre de femmes, la clientèle urbaine.

En 1989, les besoins en matière de santé chez les franco-manitobaines ont été indentifiés lors d'une évaluation effectuée auprès d'environ 500 répondantes. Démarré en février 1991, le projet de la Promotion de la santé répond à ces besoins en offrant de l'information et de l'appui sous forme, principalement, d'un programme de gestion de stress. Les activités organisées dans le cadre de ce projet se déroulent selon les principes d'auto-santé et d'entraide, c'est-à-dire, que chacune est responsable de prendre en charge son bien-être dans un contexte de soutien mutuel entre les membres d'un groupe qui partagent des intérêts communs.

C'est une première pour les femmes franco-manitobaines de pouvoir se réunir de façon structurée et d'échanger dans leur langue maternelle au sujet de leurs préoccupations en matière de santé. Vivant en milieu minoritaire et dispersées dans la cam-

pagne manitobaine, les femmes francophones ont une tâche d'autant plus ardue si elles veulent obtenir des programmes et des services en français. Le besoin de se regrouper et de partager entre amies et voisines est d'autant plus grand vu la pénurie de services et l'isolement vécu par plusieurs d'entre elles. Elles ont grandement apprécié le fait que les programmes soient offerts dans leur langue ainsi que dans leurs communautés au lieu qu'elles aient à "aller en ville."

Au cours du programme de gestion du stress, échelonné sur cinq rencontres, les participantes ont appris différentes techniques de relaxation. Le programme a permis aux participantes, dans une atmosphère de détente et de rire, d'obtenir de l'encouragement et de l'appui pour mieux vivre leurs situations de stress respectives et recevoir ainsi la confirmation que "cela vaut la peine que je m'occupe de moi."

A la fin du programme, des groupes d'entraide ont continué de se rencontrer pour discuter de divers

sujets, par exemple, la préoccupation avec le poids, le syndrome prémenstruel et l'auto-santé. Dans le cadre du projet, des rencontres d'information et des sessions ont été offertes sur les approches corporelles de détente et de guérison, comme le massage shiatsu et l'antigymnastique.

Le projet de promotion de la santé se termine en mars 1993. Les retombées se feront sentir au-delà de cette date: le quête d'un mieux-être au niveau personnel et communautaire se poursuit.

Rédigé par Lisa Brémault (B. Ec. fam.), coordinatrice de développement communautaire du projet de la Promotion de la santé au Centre de femme Pluri-elles.

English Summary: Health in Another Language

Pluri-elles, a non-profit organization founded by and for francophone women of Manitoba, celebrated its 10th anniversary in 1992. It is the only francophone women's resource centre in Western Canada, and offers services and programs that promote women's quality of life and autonomy on a personal, social and economic level.

Pluri-elle's Health Promotion Project, funded by Health and Welfare Canada for a two-year period beginning in 1991, offers a program in stress management. The program helps to establish self-help groups in French rural communities not usually targeted by such programs. The Women and Stress program was developed using a self-help model and holistic approach to health developed by the Cultural Union of Franco-Ontarians and adapted by Pluri-elles.

Given that distance is a major cause of isolation—and that French language health programs are practically non-existent—the stress management program has given rural women a unique opportunity to meet and share their concerns, and get the encouragement and support needed to take charge of their lives and care for themselves. Some groups have continued to meet to discuss topics such as weight preoccupation, PMS, and self-health principles. Other ses-

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sions offered are in relaxing body movements and Shiatsu massage.

The project ends in March, 1993, but the search for greater well-being continues on a personal as well as a community level.

Health Promotion Project, Centre des femmes Pluri-elles, 184 rue Goulet, Saint-Boniface, Manitoba, R2H 0R8, (204) 233-1735, Fax: (204) 233-0277.

*Lise Brémault (B. H. Ec.)
Community Development Co-Ordinator*

Drug Line for the Elderly

Reports indicate that active elderly patients take an average of two to three prescription drugs per person, and that the subgroup of persons aged 75 years and older may take an even greater number of prescription drugs. There is general agreement that women are prescribed more medicines than men and, in particular, a greater proportion of psychotropic drugs such as benzodiazepines (e.g. Valium), antidepressants (e.g. Elavil), and phenothiazines (e.g. Haldol). To add to the poly-medicine, elderly women will often self-medicate with non-prescription drugs. Studies have shown that 70 percent of women take at least one non-prescription drug, compared with 58 percent of men.

The benefits of multiple drug therapy must be weighed against associated risks. Complex drug regimens are confusing, easy to forget, and inconvenient; adherence to such drug regimens is low. The use of multiple medications increases the risk of adverse reactions. Also, the prevalent and chronic use of psychotropic medications may lead to the problem of physiological dependence on these medications.

To make matters worse, the elderly receive insufficient professional advice about their medicines and often rely upon advertising, mass media news items, and word-of-mouth to fill the gaps.

Drug-related events contribute to 23 percent of hospital admissions in older persons. Given the human and financial cost of misedication, strategies to avoid it must be developed.

To this end, the University of Manitoba's faculty of pharmacy estab-

lished its Medication Information Line for the Elderly (MILE) in January 1985. MILE is a telephone-based drug information service. It provides information on medications to the elderly, their care providers, and to health-care professionals. To date, MILE has fielded more than 10,000 enquiries.

The program has now received some \$305,820 from the Manitoba Health Research Council and Apotex, Inc. to develop a pharmacy resource centre for the elderly. The centre will develop programs to educate the elderly about appropriate drug use. It will offer a pharmacy consultation service, a library, and a speakers bureau.

Faculty of Pharmacy, University of Manitoba, Medical Information Line for the Elderly, Faculty of Pharmacy, University of Manitoba, Winnipeg, Manitoba, R3C 3R3, (204) 474-6014.

Dr. Ruby Grymonpre



POWER for Prostitutes

Winnipeg's Prostitutes and Other Women for Equal Rights (POWER) fills an important gap in health care by providing acceptable, accessible and responsible services to women working as prostitutes. Most prostitutes are reluctant or unable to access conventional health services, whose hidden agenda is often to get them off the streets.

POWER was formed in 1985, by prostitutes for prostitutes. With the help of a grant from the Anglican Church, it opened its first drop-in centre in 1986. Church, feminist, and city funding kept the organization going until 1990, when it had to close its doors and seek out a new source of support.

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POWER found it in the "Healthy Public Policy" of the provincial government. Teamed up with the Mount Carmel Clinic, an established community health service, POWER has now received three years' assured funding as a "demonstration project." Five employees and a volunteer pool of 30 now run POWER's two major services: a drop-in centre and an outreach service.

The drop-in house is open five days a week and provides a warm place for women to rest, visit, cook a meal, bathe, do laundry, do nothing, get condoms, or just rant and rave. Services such as counseling, educational and work experience services; advice on alternative fine payment, shelter, and healthcare are also available.

The outreach service involves a team of two workers who provide women on the street with condoms and bad date information; who collect used needles; and who offer referrals and, of course, emergency medical treatment. The workers attempt to make themselves available quietly, so as not to interfere with business.

POWER now has a full-time nurse on staff and all staff are trained to provide information on specific health concerns such as HIV and AIDS, other sexually transmitted diseases, birth control and pregnancy, drug and alcohol abuse, nutrition and other general health-related issues. The nurse, through close working relationships with other healthcare providers, acts as a "portal of entry" to established services.

The primary intent of the centre is to help women consider the broad factors that may impact their health. POWER's philosophy is that prosti-

tutes can and should work without compromising their health.

Much of the real work of health education takes place around the kitchen table. It is loud, confrontational, challenging, and exceedingly healthy. Discussions range from how to feed recalcitrant toddlers to the relative merits of various condom brands.

Prostitutes and Other Women for Equal Rights, 50 Argyle Street, Winnipeg, Manitoba, R3B 0H6, (204) 943-9355

Community-Based Health Services

Community Health Services Association (Regina) Ltd. was founded in July of 1962 by a group of trade unionists, co-op activists, academics, and other medicare supporters. Their immediate goal was to maintain services during the doctors' strike that followed the Saskatchewan government's introduction of medicare. A longer-term goal shared by many

founding members was to create an alternative health service organization that would combine a variety of services in one location, emphasize prevention and education, and allow consumer involvement.

In make-shift quarters, with donated supplies and money and a small dedicated group of physicians who supported medicare, Regina's Community Health Services Association (CHSA) Ltd. was born.

In 1972, CHSA (Regina) Ltd. and other community health associations began negotiations with the provincial government to change their method of funding. They had been receiving fee-for-service payments to clinic physicians and wanted instead a global budget provided directly to each association. They succeeded, and in 1973 CHSA (Regina) Ltd. made the change to budgetary financing. This has allowed the Association to provide for a broad array of support services and programs, and to freely chart its own course. It has also made the organization more publicly accountable.

Today CHSA (Regina) Ltd. has over 11,000 members and the Regina Community Clinic has approximately 25,000 patients on record. It maintains a close liaison with interest groups concerned with health and social services, and speaks out on socio-economic issues that affect health and health services.

Health programs offered through the Regina Community Clinic are structured to meet the needs of the community. They include family medical services, optometry, dermatology, nursing, physiotherapy, radiology, laboratory, nutrition counseling, family and women's counseling, and a non-profit daycare.

CHSA offers childbirth classes that take a modified Lamaze approach which prepares a woman intellectually, psychologically, and physically for childbirth. The Clinic also sponsors a Menopause Support Group that usually meets on a monthly basis. The Group offers women an opportunity to share their experiences and support those in need.

The daycare program employs trained attendants who carefully plan activities for 30 children; the Senior Citizens' Health Check is a general checkup for seniors, and includes

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Nigeria- Health Educators to work with government and village health workers in a guinea worm eradication program.

Ghana- Ophthalmic Nurse/Technician with experience in out-patient care and surgery to work in an eye clinic.

Indonesia- Nurse to work in a community health program aimed at mobilizing local health workers and villagers to improve nutrition, sanitation, organization and disease prevention.

Sierra Leone, Ghana & Indonesia- Medical Doctors to work in a community health program aimed at mobilizing local health workers and villagers to improve nutrition, sanitation, organization and disease prevention.

Nigeria - Physiotherapists and Occupational Therapists to work at a rehabilitation centre and participate in a community outreach program.

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hearing, sight, blood pressure, pulse, vision screening, weight, urinalysis, range of motion, endurance, respiratory, and social assessments; the nursing staff teach women the proper breast self-examination technique through demonstration and use of a video cassette.

The Association has also sponsored programs for women and elders who are victims of abuse.

Regina Community Clinic, Community Health Services Association (Regina) Ltd., 3765 Sherwood Drive, Regina, Saskatchewan, S4R 4A9, (306) 543-7880

Donna Braun



Violence in a Non-Violent Community

Members of the Mennonite Church have had a hard time acknowledging that abuse affects individuals and families within their congregations. The Mennonites are a Christian denomination known as a peace church. They are just now beginning to recognize what workers in the abuse field have been aware of for years: that both abusers and abused can be found in their congregation.

In the late 1980s Isaac Block began studying the incidence of abuse within the Mennonite community in Winnipeg. Concurrently, a group of Mennonite women met to discuss how best to respond to the painful abuse that exists in many homes. The women concluded that a community response was needed to initiate healing. Their discussions led to the formation of *Voices for Non-Violence (VNV): A Preventive and Restorative Response to Domestic Violence and Sexual Abuse*.

In 1991 abuse in the Mennonite community was made public with the release of Isaac Block's study. He found that abuse exists in a significant number of Mennonite homes and that pastors are not equipped to respond in an adequate fashion.

VNV now helps congregational leaders and lay people with the process of intervention in cases of abuse; initiates support services for those who are affected by abuse; co-ordinates educational opportunities for churches; and serves as a liaison between churches, social services, and institutions.

The Mennonite Central Committee provides voluntary service staff and free office space for VNV. The program funds itself on donations. It is overseen by a nine-member board of directors in addition to the Coordinator.

Voices for Non-Violence, 134 Plaza Drive, Winnipeg, Manitoba, R3T 5K9, (204) 269-8555

Heather Block, Coordinator

Beyond Addiction

The problems that bring clients to the Women's Post Treatment Project have not grown over the years, but the number of people seeking help with them has, says Hazel Blennerhasset of the Women's Post Treatment Project. Since 1985 the Project has offered counseling to women recovering from chemical addiction and childhood sexual abuse.

The average treatment lasts eleven months although some clients at the Project have been undergoing counseling for two years. At any given time, the Project has an active client list of 130. Currently, there is a waiting list of 70 women, and the list is closed until July 1993.

Most of our clients come to us from word of mouth although we also get referrals from all the social agencies and other addiction programs," says Blennerhasset. The Project does not offer residential treatment but a combination of individual and group counseling. Some of the clients are unable to work while others are highly functional.

The project was initially funded through the municipal Core Area Initiative program, and located in the

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Salvation Army's Baldwin House because that was the only organization willing to offer virtually free office space and services. It was able to move to Toronto Street with funding from the provincial Department of Health and Department of Family Services, the United Church of Canada and the United Way. The project is now in the process of moving again, to Sherbrooke St.

However, the funding from the United Way, first granted in 1992, is not guaranteed to continue. At this time, the Project is \$50,000 short of its budget need and is in danger of staff cuts.

Women's Post Treatment Project, 62 Sherbrooke St. (after June 1, 1993), Winnipeg, Manitoba, R3C 2B3, (204) 783-5460

Phyllis Mooney, Intake Worker



Preventive Care Through Medicare

The Co-operative Health Centre Prince Albert offers comprehensive healthcare and counseling under

medicare. A multi-disciplinary medical and community service team of 50 (99 percent of whom are women) offers a wide range of services including: physiotherapy; massage therapy; acupuncture; radiology; minor surgery; an evening drop-in clinic; clinic nursing; visiting nursing; social work counseling; palliative care; and prenatal care.

The Centre's services have reduced the use of hospital beds—the family health worker service having allowed many patients to stay in their own homes.

Women with concerns and problems relating to abuse, family violence, aging, menopause, and PMS are the primary users of the centre.

Special projects include the federally funded Enhanced Prenatal Program which provides a supportive environment for pregnancy, and the Saskatchewan Health funded family planning clinic, which informs teens about pregnancy and prevention.

The Centre provides health fact sheets and information kits for pre- and post-natal women, infants, toddlers, pre-schoolers, school age children, and menopausal women.

To become a member, you can purchase a share in the Health Centre for five dollars.

Co-operative Health Centre Prince Albert, 110 8th Street East, Prince Albert, Saskatchewan, S6V 0V7, (306)763-6464.

Eleanor Calder

Winnipeg Women's Health Clinic

Located on the second and third floors of a downtown commercial building, the somewhat drab exterior of the Winnipeg Women's Health Clinic (WHC) belies the spirit and energy that is nurtured inside. Driven by a commitment to feminist healthcare, the staff and volunteers of the clinic provide an alternative approach to health-related problems for many Winnipeg women.

Our clinic integrates health promotion and treatment strategies. By providing many avenues of access to service, we take into account the diverse social and economic conditions of women's lives.

We seek to empower women by



creating opportunities for them to learn self-care strategies. Our services are respectful, informative, compassionate, and non-judgemental. We offer a holistic, multi-faceted approach to health and the treatment of disease and dysfunction.

Another area of our work is advocacy. We lobby the government and other healthcare providers on issues related to women's health. We speak out for community solutions to health and social problems. In the broadest sense, we seek to promote the equal participation of women in the life of the community. We believe that organizations like the WHC lead to the empowerment of women by creating a network of feminist support.

Our management structure is non-hierarchical, participatory, and team-based. All volunteers and staff complete an intensive training program. Core volunteers provide ongoing supervision and training to newer volunteers; they serve as patient advocates, counselors, public educators, and board members. This ensures that both the 20 staff members and the 80 volunteers have a high level of input and commitment to the clinic's goals.

The clinic provides community education as well as medical and counseling services.

We reach out to new mothers experiencing postpartum stress through our Mothers First Help Line. Volunteers who have experienced postpartum stress are available by telephone for new mothers to talk to anonymously and confidentially.

Our Teen Clinic, started by a small group of government-funded students in the mid-1980s, has become a thriving,

weekly event. A team of nurses, physicians, and volunteer counselors provide unplanned pregnancy counseling as well as free and low-cost birth control. Over the years, the issues raised by the teens have become complex and include physical and sexual abuse, weight preoccupation, and date violence.

Many of our services have been developed

in response to a community need. For example, the clinic's endometriosis support group was founded more than five years ago by women who couldn't get answers to their questions or support for their concerns from the mainstream medical community.

Since more than half the women seen in our counseling program identified weight and body image as major concerns, we developed a weight preoccupation support group. In addition, the clinic recognized an urgent need for an alternative approach to the treatment of menopause and PMS, so we added information sessions on these two topics.

The clinic's two physicians and one nurse practitioner form the core of our medical program. Specializing in women's health issues, these three women cannot easily keep up with the demand for their services. Underfunding, understaffing and over-demand mean many of the women who would like to use our services never make it off the waiting list.

Women who want respectful medical advice and information can contact the Women's Health Clinic to make use of its resources and library. The clinic is known as a reliable source of varied medical information. It is also a place where discussion on alternative approaches to healthcare is welcomed and where women are not presumed to need drugs to cope with the stresses of their daily life.

Winnipeg Women's Health Clinic, 3rd Floor - 419 Graham Avenue, Winnipeg, Manitoba, R3C 0M3, (204) 947-1517.

Amanda Le Rougetel

VIOLENCE

IN LESBIAN RELATIONSHIPS

profile

A DOUBLE INVISIBILITY

An Interview with Sally Papsco

Amanda Le Rougetel: How have you come to focus on violence in lesbian relationships?

Sally Papsco: I was first exposed to the issue some seven years ago when I attended a lesbian issues conference workshop on violence. I was in no way prepared for what I heard that day. In a packed room, women told stories about being raped, choked, kicked, smashed with fists, threatened with weapons, run down by cars, robbed...all by their lesbian partners. Before I heard these stories, I had naively believed that this kind of violence only happened in heterosexual relationships. After the workshop, I was no longer so naive, but it was several more years before an ad hoc group of us got together and began to talk about the problem of violence in lesbian relationships.

There's such denial in the community. At a Take Back the Night march in Winnipeg, two very brave lesbians wanted to include the issue of violence in lesbian relationships. Their announcement really rocked the community. Some women were

very angry because they only wanted to address male violence on the march. Others were relieved to have the silence broken, but fearful of what would happen to our community once we acknowledged that violence did in fact exist. The fear was that if you bring up this issue and start talking about it, you'll break up the community—the family, so to speak. This isn't unlike the heterosexual woman's experience—her exposing violence done to her, only to be accused by everyone else of breaking up the family.

After attending another workshop on violence in lesbian relationships held at the Banff conference on women and mental health in May '91, I came back to Winnipeg and made a concerted effort to reach out to the lesbian community, making it known that I was prepared to offer counseling to both survivors and perpetrators of abuse in lesbian relationships. It's a slow, but steady process. I am learning as I go. Like some of my lesbian counseling colleagues, I have gained experience mostly through working

with heterosexual women, and therefore learn with my lesbian clients as I incorporate the issue of violence in lesbian relationships into my practice.

ALR: How can we best understand violence in lesbian relationships?

SP: There are very few resources and even less research, although I believe we can transfer some of our understanding of violence in heterosexual relationships into an analysis of violence in lesbian relationships. Violence is still an issue of power and control. It is a learned behaviour and it is a choice—women who batter are choosing to do it.

We've all grown up with the same kind of conditioning. It's not only males who are capable of internalizing the dominance that is prevalent in our society. It's not only boys and men who want the kind of control over the resources and decisions in a relationship that most of us have grown up seeing our fathers have. Many of us grow up understanding that being violent is a way of gaining control over someone else who—if we're not

strong enough—might threaten us. We are taught that violence is a way of protecting ourselves from harm.

Jealousy and control are big issues and are often confused with love, for both heterosexuals and lesbians. With both kinds of intimate violence, the batterer tends to have unrealistic expectations of the partner. Like the male batterer, the lesbian batterer expects her partner to help rescue her from her own violence, and she blames her partner for that violence. The batterer minimizes, denies, rationalizes, and justifies her behaviour. She refuses to take responsibility for the abuse and tries to place the blame on her partner.

A main difference in lesbian violence, however, is the use of control, based on homophobia. Often, the batterer will threaten to expose her partner as a lesbian to her family, friends, church, work, community, and even the police. She tells her partner that she deserves all she gets because she is a lesbian; that lesbians are just dirty, useless people, and that no one will care because she is nothing but a lesbian.

Sometimes a batterer will claim emotional abuse if her partner shuts down in response to intimidation and control. If the survivor fights back, often the abuser will claim mutual physical abuse. I do a lot of work trying to make a clear distinction between choosing violence and being forced to defend oneself physically.

The survivor has a multitude of issues to deal with, one of which is coming out to family and friends. If it's hard to tell your family you're a lesbian, imagine how hard it is to tell them you're lesbian and your lover is abusive.

Some people who have researched lesbian violence theo-

rize that, just as we understand violence by men against women as misogyny, so can we understand violence between women as a form of internalized misogyny. As women, we're socialized to compete against each other, to pick on each other, make "catty" comments about each other.

We can also understand lesbian violence as a manifestation of institutionalized and internalized homophobia and heterosexism, which keeps us socially isolated. Out of isolation comes self-contempt and contempt for others like us. If lesbians internalize the myths about us that society perpetuates, we come to believe that we *are* all those horrible things. Because we don't like dirty, useless people, we come to hate ourselves and other women like us. Self-contempt can thus lead to violent, ugly behaviour against others like us.

ALR: Where do lesbians go to escape a battering relationship?

SP: Most communities don't have shelters specifically for lesbians. Winnipeg's Osborne House (the shelter for battered women) will accept lesbians, but most of the women who go there are heterosexual. A lesbian might be physically safe, but she'll probably have to deal with being closeted or with coming out to the other women, possibly facing homophobia and confusion.

Many lesbians regard the criminal justice system as hostile and unresponsive. Legal options that are available to heterosexual women aren't realistically available to lesbians. In my experience, judges tend not to issue restraining orders and police tend not to enforce them for lesbians.

ALR: Is there support within the lesbian community for dealing with this kind of violence?

SP: Support within the lesbian community is often limited. Many couples, for instance, share mutual friends. When battering occurs, the victim faces a conflict about who she can turn to. Many victims fear that the mutual friends will take the batterer's side or play down the violence. If the victim fought back, she may feel mutually responsible, ashamed, or guilty, and therefore not want to tell anyone about the abuse. Shame is a big issue. The survivor can spend a lot of time wondering what her friends will think of her for choosing a woman who beats her.

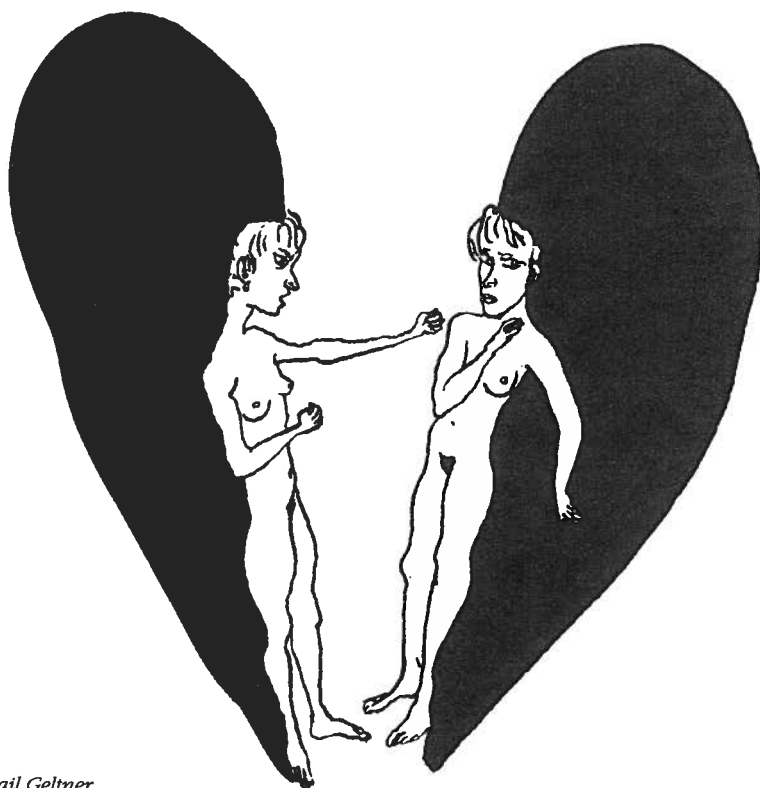
ALR: What is the extent of violence in the lesbian community?

SP: I don't honestly know. I see it in my counseling practice and I know women are hurting out there. We need a community response. The solution is not to isolate the batterers and stick them on an island somewhere. We need to care about all our sisters, and we need to remember that violence is a learned behaviour and can be unlearned. The first step, of course, is for the batterer to acknowledge the violence as *her* problem, and for *her* to want to do something about it. She has to want to change.

I haven't yet had the chance to work through the process with a lesbian batterer, because the ones whom I've identified as batterers haven't come back after the initial session. I think they get really frightened and just stay away. I do see, however, a lot of women who recognize they have *some* abusive behaviour in their lives and who want to take responsibility for it and stop it. This we can work together on.

ALR: How does violence affect a woman's state of health?

SP: A woman who is in an abu-



Gail Geltner

sive relationship is certainly going to suffer mentally and physically. She may be sickly, have trouble sleeping and eating, and perhaps have problems with her periods. She might develop asthmatic conditions and rashes on her body; she may turn to drugs or alcohol as a way of coping. She may try to hurt herself; she may begin to slash. She may experience unending headaches, backaches, stomachaches or stomach problems. But if she seeks medical advice, she might find it very hard to talk about the real cause of her problems. So instead, she is often given prescription drugs to help ease the pain and cope, only to become addicted to them. It's all connected to health, really.

ALR: What can the community do?

SP: We have to educate our community about assault, abuse, and violence in lesbian relation-

ships. We need to do more general workshops, more public speaking. We need to really start talking with each other. And we need to educate the larger community: the social service agencies, the shelters, and the police. I think there's a tremendous need for self-help groups for both the survivors and the batterers. We need to get beyond the myth that violence is all about drinking alcohol. Drinking certainly makes a bad situation worse, but it alone doesn't cause the violence.

We need to build a network of lesbian-positive lawyers who will help women through the legal system. We need to do a whole lot more research so that we can better understand the causes and the cures.

Above all, we need to name the problem for what it is. Planning a group on this issue, I couldn't decide whether I should call it "Difficulties in Lesbian Relationships" or use the "v"

word—violence. In the end, I thought, "No, let's name it what it is." We have to name abusive behaviour as violence, then work to define the term.

We also need to continue combating the homophobia from the straight community, and talk more about internalized homophobia.

ALR: Is it time for a national conference on violence in lesbian relationships?

SP: Yes. There must be many of us working on this issue across the country, all alone in our counseling practices, research, and communities, each trying to get a better sense of the bigger picture. Even if individually we don't think we know enough, we can learn more by sharing our information and resources.

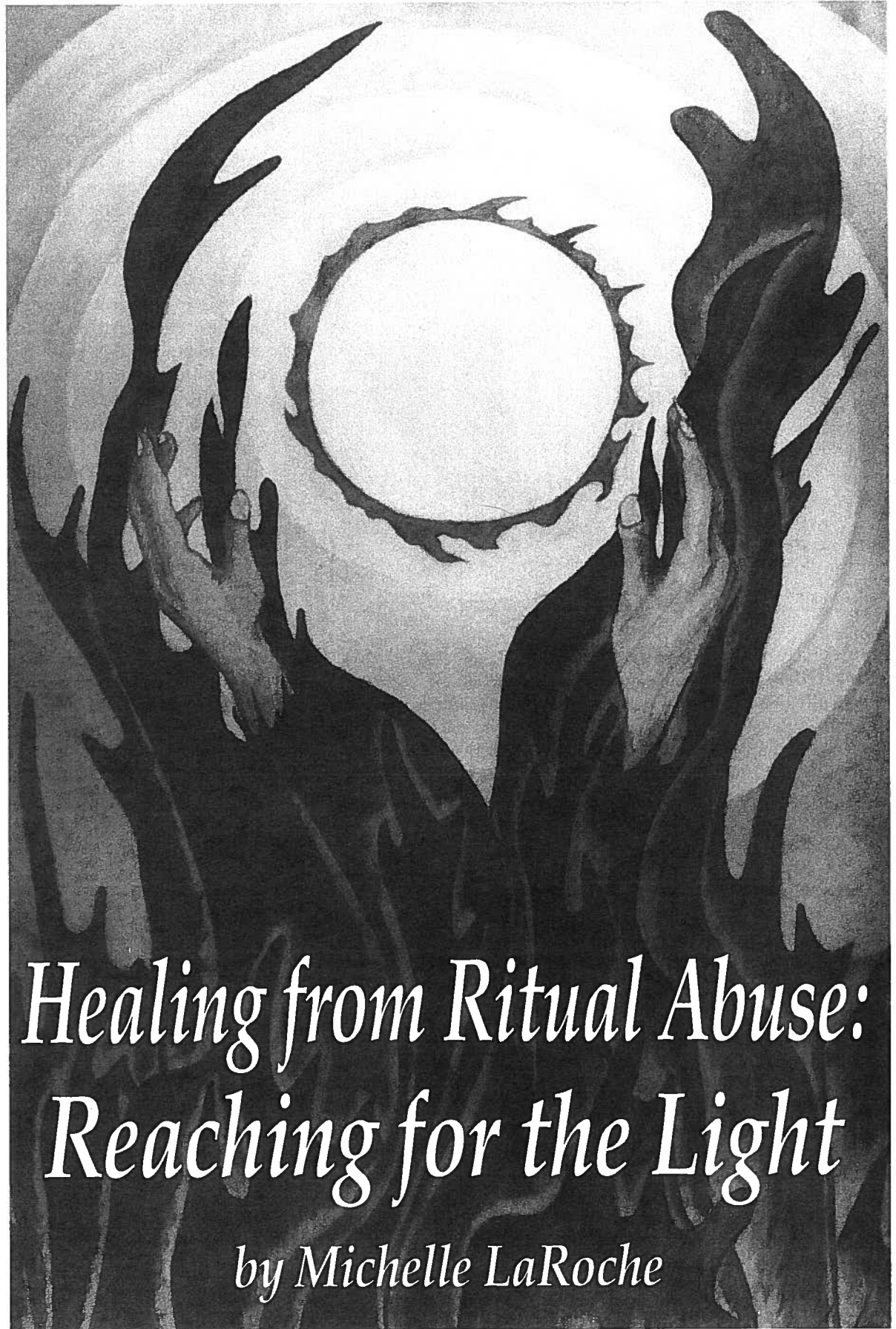
As a counselor, I'm very honest with my clients and make sure they understand that I don't consider myself an expert on this issue. As they provide information, together we learn how to make sense of their experience and how to change their situation.

I'd love to hear from women who are also doing work in this area. As a community that crosses this country, we need to break the silence and shatter the myths.

Sally Papso is a counselor working in Winnipeg. A lesbian herself, Sally is deeply committed to helping individual women address the issue of violence in their lives. She spoke with Amanda Le Rougetel (Co-Regional Coordinator for the Prairie issue of Healthsharing) about her work and her desire to connect with other counselors across Canada on the issue of violence in lesbian relationships.

Sally Papso can be reached through her practice: Womyn's Counseling Services, 73 Arlington, Winnipeg, Manitoba, R3G 1Y3, Phone: (204) 772-2504.

my story, our story



*Healing from Ritual Abuse:
Reaching for the Light*

by Michelle LaRoche

Michelle LaRoche

The pain in healing from severe trauma and ritual abuse is so horrific you think that there will never be an end to it. All the terror you never felt, could not afford to feel, overwhelms you. You are helpless, disoriented, desperate.

I learned to cope with ritual abuse by developing multiple personalities. I split off into 155 different "Personality Fragments"—each with a memory, skill, sex (or sexlessness), age (or agelessness), survival tactic, and set of feelings or lack of feelings. They performed precise and differentiated roles. Some were "magical," non-human; some knew about the others; others knew nothing of each other. Each helped me to survive. Together they formed the exquisitely and intelligently articulated fabric of what my therapist-companion survivor-friend calls my "Magnificent Personality Coping System" (MPCS). My personalities coped with trauma and abuse too extreme to sustain with a unified consciousness.

My multiplicity has been present since early childhood and has manifested itself all throughout my life in ways I could neither understand nor explain. I attempted to disguise every manifestation. The secrecy trapped me, leaving me desperately—and often suicidally—lonely.

My search for help has been full of violence, re-abuse, re-victimization, abandonment and rejection, perpetrated by "professionals" too ignorant, presumptuous, fearful or disbelieving to do anything but compound the original abuse.

I began marriage counseling when I was 28. Blackouts and memories of incest and abuse came up, but my therapist ignored these issues. She laughed when I tried to tell her about the strange voices that by now were plaguing me even in public. When I tried to tell her about the abuse in my childhood (which I did not yet know was ritual abuse) she had me phone home to tell my family I loved them. She ridiculed me when I told her about my damaging re-enactments of abuse.

I quickly learned to bring to therapy only what was rewarded. When my marriage ended in 1980, I continued with this therapist and her quaint goal of "personal growth" for nearly

six years.

During this time, what I did not bring to therapy was spilling over into other aspects of my life. By 1986, I was living dual lives: one by day and one by night. The daytime self only dimly suspected something was wrong. I was becoming more and more self-damaging.

I finally dropped out of therapy,

one of my personalities had managed to call.

I was admitted to hospital the same month its "Dissociatives Clinic" (for treatment of MPD), run by Dr. Colin Ross, was being dismantled. With confirmation of my diagnosis by Dr. Ross, I found myself plunged into a vicious world of psychiatric politics, the strongest proponents of which

I found myself plunged into a vicious world of psychiatric politics, the strongest proponents of which claim Multiple Personality Disorder does not exist

then in 1987 I turned to a new therapist for help with workplace and career issues. I did not intend to work on anything to do with the yell-out voices, the nightwalking, or the peculiar separations that formed my life. But the informed and respectful rapport I had with my new therapist helped to facilitate a process no therapy had ever touched. Abuse I had begun to remember in the marriage counseling sessions began to surface clearly, ravaging me mentally and emotionally. "Personalities" also surfaced more and more clearly.

In mid-1990, the counseling agency where I saw my therapist suffered a funding cutback. Treatment for all incest and abuse survivors was terminated. My therapist, unable to confront me with the truth, instead claimed that despite all the work we had done, she did not have the "requisite psychiatric skills" to work with Multiple Personality Disorder (MPD).

By now, at least 26 personalities had emerged, many of them extremely young and terrified children. I was flooded with memories and overwhelmed with a sense of loss. I had gone into hiding from my family. I was terrified and vulnerable, and the loss of my therapist was unbearable. I was found overdosed on the agency's premises after hours by a friend

claim MPD does not exist. Instead of the relief I should have felt in finally having my condition verified, I found myself instantly labeled a political hot potato—not only MPD, but also a ritual abuse survivor. I was closed out of counseling agencies, outpatient programs, psychiatry, private support groups, and eventually the hospital itself. No one had the "requisite psychiatric skills" to treat me.

I was hospitalized one floor down from where the "Dissociatives Clinic" had been housed. Though the clinic was gone, there were still nurses and social workers on that floor who had been trained in the treatment of MPD. I was refused transfer to that floor or access to the help that I knew was just one flight of stairs away. Dr. Ross had moved into Outpatients, and in the mounting anti-MPD climate that surrounded him, was preparing to leave the country. He helped in whatever ways he could, but the therapy I so urgently needed was not forthcoming.

Throughout the next two years I was hospitalized again and again. In a desperate motion, Dr. Ross and the Canadian Mental Health Association Advocate helped me apply to Manitoba Health for appropriate treatment at an MPD treatment centre in the United States, as no such treatment

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centres exist in Canada. We applied knowing that Manitoba Health had not, and likely never would, send anyone for treatment in the States. As expected, they refused to send me.

Between mid-August 1990, when I was first hospitalized, and mid-November 1991, the brutality of the anti-MPD climate at the hospital kept escalating. MPD-trained or sympathetic staff either resigned or were forced to leave. At the hands of hospital "professionals", I endured trauma after trauma. I was singled out, perhaps because I was highly educated, articulate, and had tried to speak up. In general MPD patients were beaten, ridiculed, refused hospital admission, or forcefully expelled under threat of arrest if they attempted to return to the psychiatric ward. Ultimately, many MPDs were re-diagnosed as schizophrenic and borderline personality cases and deemed untreatable. MPD is the one severe psychiatric condition which is now considered "curable."

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In hospital, I was subjected to nonsupportive therapy techniques designed to "break" me. Utterly ignoring Dr. Ross's recommendations for gentle, respectful treatment approaches to MPD, my first hospital psychiatrists proceeded to go to work on me with a technique called "flooding." In flooding you overwhelm a person's defenses with so much "reality" that the person breaks. The idea is that the person will then surrender her or his former dysfunctioning self and "appropriately" rebuild a newer, "corrected" self.

My psychiatrists used exactly the same psyche-breaking techniques that the cult had used on me as a child. It wildly triggered my long suppressed memories. The hypnosis used to uncover more traumatic memories—not at my own speed, but at the speed demanded by the technique—left me terror-stricken. Too much surfaced too fast. Body pains ravaged me—yet I was refused medication as a requirement of the therapy. I became both desperately attached to and terrified of my psychiatrists—the same way I had been with my captors as a child.

The brutality of the hospital led me to a series of overdoses. I was also propelled towards death by another set of circumstances: cult programming. I had been conditioned to commit suicide, or to believe that I would be killed if I told anyone about my cult/family experiences or tried to escape them permanently. Suicide became a mind-wrenching preoccupation. I grew terrified of my 39th birthday and the year 1991—dates that seemed set for the "Little High Priestess" in me to "go home" to the cult/family.

The fear peaked when on the eve of 1991, Missing Persons called to tell me that my family had reported me missing. They claimed I had been kidnapped by a cult, and identified two of my closest and most supportive friends as the captors.

The hospital psychiatrists and most nursing staff were not helpful. This was during a nurses' strike and only essential services were provided. Talking with patients in the psyche ward was not considered essential. We took our meals and medication in silence punctuated only by the sound

of the Gulf War coverage on television. The ward was, to me, a morgue piled with corpses.

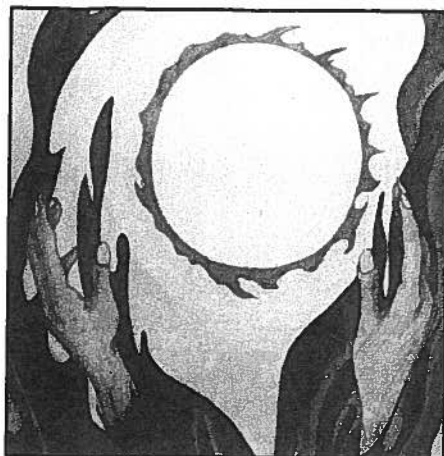
At this point, I became part of a ritual abuse therapy group on the outside. Run by an "expert" on violence and abuse, the group was a place where we could tell our stories, nightmares, fears. Outside the group we had each other, but we were all in the same unresolved, wildly triggered state. The leader did nothing to prevent us from triggering and amplifying each others emotions. She required us all to do individual counselling with her, but wanted only to hear our memories, the gorier the better. When seven of us left the group, the therapist told new members that we had left because we were in denial.

The rest of 1991 was a series of trips in and out of the hospital. I was increasingly sure that I would succeed in committing suicide. Two other MPDs successfully committed suicide, one in December 1990 and the other, her best friend, in July 1991.

Dr. Ross left the country shortly after my birthday on Hallowe'en. Seven nurses and orderlies came to me with orders to dress me and remove me from the hospital. I was terrified, certain that I was being gang-raped. They called the police to remove me from the premises. The police saw the state I was in and were confused about why I was being removed. I was berserk with fear and they took me back to the emergency room where the psychiatrist told them I was just having a temper tantrum, that I'd shut up once they got me home.

I blanked. A very young child in me fled. The next thing I knew I was in Toronto—dazed, confused, frightened, amnesiac and living out of my car. The "Little High Priestess" was going home. Inner Helping Personalities mercifully came forth to keep me from really going home to my family/cult.

I found Gail Fisher-Taylor's business card in my wallet. She is a Toronto-based psychotherapist who works with ritual abuse survivors. A friend had given me the card after attending a conference where Gail spoke. Gail not only saw me, but offered the first substantial help I had ever had in my life.



Gail is both a ritual abuse survivor and an integrated MPD. She understood my experience from the inside out and could follow me into my world as no one had done before. She touched and awakened autistic parts that had been asleep. One, whom we call "the bravest, littlest one of them all" grew and grew until she could speak. It was her knowledge that kept all my parts from returning to my family. Gail became not only my therapist but a testimony of hope for me.

My disability lump sum payment came through, and I was able to buy time and therapy until I could return to my home in Winnipeg. I was hospitalized twice in Toronto. Although there was some scepticism about ritual abuse, it was handled in healthy ways that did not damage me. I made plans to become an Ontario resident, which would allow me to apply for treatment in the United States. Gail and I planned for me to return to Winnipeg to retrieve my belongings and my cat.

What we did not know was that there were parts of me who lived only in Toronto and parts who lived only in Winnipeg. When I returned to conclude my life in Winnipeg, I could not do it. The Winnipeg Parts did not want to leave, the Toronto Parts did not know where they were. My inner worlds went into chaos. I was suicidal, broken-hearted, and frantic. To exacerbate matters, my money was running out.

To my relief and surprise, I found a new psychiatrist who respected me enough not to open me up with another traditional psychiatric assessment. He said he was not trained in

the treatment of MPD, and had never had a ritual abuse client before, but was willing to learn.

Gail agreed to stay with me by phone. We talked for half an hour every week or so. I worked with my new psychiatrist for about six months. The medication stabilized me and I was able to take care of outside things, such as my living arrangements. The psychiatrist, knowing he was not fully able to help me, found another therapist, Mary, who used supporting and validating techniques. With hypnosis and relaxation, she helped me access memories and build inner resources. The Toronto Parts and the Winnipeg Parts finally began joining forces.

The working arrangement with Mary and my doctor is still very new. Together they make an unusual and complementary team. Although I could still benefit from the treatment only available at an MPD treatment centre in the States, I have tried to make the best of it here with the few friends and informal support networks I have. Meditation has helped stabilize me. Supportive therapy that does not push too hard or fast has also helped. Slowly I am succeeding.

I have been out of the hospital for nine months now. My impulse to commit suicide has decreased. But I am still enraged at the brutal treatment I received, beginning with the loss of my therapist in the counseling agency cutback in 1990. Still, I have survived and am now writing from the privileged position of relative safety. We—my fragmented personalities—are building bridges, beginning to share memories, experiences, hopes, and dreams. Someone inside says we are 70 percent of the way to integration. The Wizard can have back his magic; the Dragon, his fire; Starlight, the ability to travel worlds; Ragamuffin, the child's world she never had; and the Bravest Little One of Them All, a chance to rest and to speak. We are integrating and communicating, and writing a book: *The Worlds: Fighting Back*.

Michelle LaRoche is the pseudonym of a researcher, writer, artist, and ritual abuse survivor with multiple personality disorder in active recovery.

Tell The Driver

A Biography of Elinor F.E. Black, M.D.

by Julie Vandervoort

University of Manitoba Press, 1992, 294 pp., \$24.95 ISBN 0-88755-157-2

Reviewed by Amy Zierler

This excellent biography explores the professional and personal worlds of an extraordinary woman. Elinor Black was the first woman in Canada to head a major medical department, and the story of her ascent to the chair of obstetrics and gynecology at the University of Manitoba in 1951 encompasses the story of women's reproductive health care in the 20th century.

Every step of her success, Black won against great odds. Most of her strong-minded Presbyterian family vehemently opposed a woman going to medical school. Her brother, already a doctor, said women were nothing but a nuisance there. The three women in her internship year were not invited to the single lecture on birth control which, being an illegal subject, had to be held surreptitiously.

After graduating, Black gave "facts of life" talks to groups such as Canadian Girls in Training, going further than the groundbreaking Winnipeg Birth Control Society which generally gave information only to married women. She began her practice in Winnipeg in the depths of the Depression, when no one had money for doctors. At the same time, she had to turn down

women who offered \$200 for abortions because to perform them risked professional suicide. In recounting this period, Vandervoort documents the horrible deaths which often awaited poorer women desperate enough to attempt abortion by themselves.

Black's long career saw the advent of hormone therapy and reproductive technology, as well as the increasing use of Caesarian sections. She campaigned vigorously against all of these developments and, for her conservatism, was called unprogressive. By today's thinking her approach to medicine might be called holistic: By the 1960's she was warning that medical students must be taught to "cherish the patient and not the surgical procedure." She lamented the "unconscionable" proliferation of medical journals which denied doctors the time to read anything else. All her life she loved what she called "the art of obstetrics," a craft she saw being lost amid the growth of technical intervention.

As a woman in a man's field, a man's world, Elinor Black paid a great price for her triumphs. Marrying meant abandoning her work, and that was unthinkable. She worked well with her mostly male colleagues, but she had to

build a kind of wall around herself: "Dr. Black," the un-gendered professional, lived on the outside; "Elinor" lived separately within. Her emotional life was with women, and the book celebrates (as Black did) the lifelong friendships which sustained her. These were great, cherished friendships at a time when they could have no other name. They survived time and distance. Nevertheless, in her later years, Black was saddened to discover that the 28 letters she had earned after her name "should prove such poor company in the end."

Elinor Black documented her life in diaries and letters, and she organized and preserved them almost as if she expected that, ten years after her death, someone would decide she had to tell her life story. Julie Vandervoort, a former director of DES Action Canada, has told it vividly, with warmth and intelligence. By the final pages, her subject is a firm acquaintance; the reader can see Elinor's tall, commanding figure move confidently through a room, imagine her quieter moments, mourn her death.

Elinor Black broke important ground for women in medicine and for many women she was a source of inspiration and pride. To accomplish so much, she had to "be one of the boys," yet she was never allowed to forget that she was not a man. The anecdote from which the title is drawn exemplifies this struggle: Sometimes, when she'd called for a taxi, a man would grab her cab because the driver assumed "Dr. Black" was male. She learned to always add, when talking to the dispatcher, "And tell the driver—Dr. Black is a woman."

Looking For Letters...

Stories, poems, et cetera, from women who have been through or are presently going through the menopause experience either surgically or naturally while in their twenties or thirties for a book I would like to publish. Hold nothing back — You are not alone. I hope to bring some understanding and comfort to others. Reply to: Molly, PO Box 215, Great Barrington, MA 01230 USA

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- Infertility Support & Education Program
- Midlife and Older Women Program

We are open evening and Saturday hours by appointment.

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Provincial resources on a wide range of issues important to women, including RU 486 and racism are available from the **Saskatchewan Action Committee on the Status of Women**. Write to the action committee at 2343 Cornwall Street, Regina, Saskatchewan, S4P 2L4, or phone (306) 525-8329.

Breast Cancer Screening

Screening for breast cancer is available for women 50 years of age and over who have no symptoms of breast cancer. This service is provided at a stationary centre in Regina and a mobile centre north of Saskatoon, between Hudson Bay and the Battlefords. There is no charge for this service, no doctor's referral required. Contact *Screening Program for Breast Cancer*, Saskatchewan Cancer Foundation, 952 Albert Street, Regina, Saskatchewan, S4R 2P7, (306) 359-0550 or 1-800-667-0017.

Kali-Shiva provides services to HIV positive women in Winnipeg. A staff of two paid workers and some 72 volunteers, funded by Health and Welfare Canada, provide such services as child care, food preparation, cleaning, transportation and/or companionship. Write to Kali-Shiva, 246 Toronto Street, Winnipeg, Manitoba, R3G 1S2, or phone (204) 788-4477.

The Manitoba Action Committee on the Status of Women

offers access to publications from provincial and federal governments on topics such as health, midwifery, violence against women, and women and disability. Contact one of the following offices: **Winnipeg:** 16 - 222 Osborne Street South, Winnipeg, Manitoba, R3L 1Z3, (204) 453-3879; **Dauphin:** (204) 638-3599; **Thompson:** (204) 778-8549; **Brandon:** (204) 725-2955, Rural co-ordinator: (204) 727-6378.

Women Reaching Out To Women

The *Fort Garry Women's Resource Centre* provides one-on-one counseling, support groups, out-

reach programs, and public education on stress related problems, reproductive health, AIDS, and transitions/menopause/child-birth. For more information contact the centre at Southwood Mall, 1910 Pembina Highway, Winnipeg, Manitoba, R3T 4S5, (204) 269-6836, Fax: (204) 269-0987.

Planned Parenthood Manitoba

Facts of Life Line, (204) 947-9222, is staffed by volunteers who answer questions about sex, sexuality and birth control methods, as well as reproductive health. Booklets are available in Spanish, Vietnamese, Cantonese and Khmer. Volunteers can provide help in many other languages, as well. Write to 206 - 810 Sargent, Winnipeg, Manitoba, R3E 0B9, or phone (204) 982-7800.

The Coalition for Reproductive Choice

of Winnipeg, acting on the premise that reproductive choice is fundamental to good mental and physical health for women, offers literature dealing with their efforts to bring about universal access to medically insured abortions. The coalition takes the stand that they must continue to lobby for these services, since too few physicians currently perform abortions in medicare-funded institutions. If you would like more information, or want to offer support, contact the coalition at Box 51, Station L, Winnipeg, Manitoba, R3H 0Z4, or phone (204) 453-7774.

Keys to Elder Care is a handbook (\$5.50) for anyone who has the responsibility of caring for an elderly person. While it is written specifically for Manitoba and its resources, it offers basic advice and suggestions for dealing with the variety of situations that arise when caring for the elderly. Write: **Keys to Elder Care**, Manitoba Association on Gerontology, Box 1833, Winnipeg, Manitoba, R3C 3R1, (204) 783-5460.

National Meeting of Community Health Centres to look at establishing a national association of Canadian

Community Health Centres, September 30th to October 3rd, 1993, Winnipeg, Manitoba. For more information, write: Patti Sullivan, c/o Clinic Community Clinic, 870 Portage Avenue, Winnipeg, Manitoba, R3G 1W6, (204) 784-4010.

Counseling Services

Non-judgemental and supportive contraceptive and unplanned pregnancy counseling can be accessed through 1-800-563-9923, the Women's Health Centre at the Regina General Hospital in Regina, Saskatchewan. In Moose Jaw, contact Denise at Citizens for Reproductive Rights/CARAL, (306) 693-3107 or 694-1010.

Counseling service is available for women who have experienced childhood sexual abuse and/or are dealing with addiction related issues. For more information contact Women's Post Treatment Centre, 246 Toronto Street, Winnipeg, Manitoba, R3G 1S2, (204) 783-5460.

Prenatal Program and Menopause Support Group

Provided by the Regina Community Clinic, a multi-disciplinary health clinic with a specific emphasis on health education, 3765 Sherwood Drive, Saskatoon, Saskatchewan, S7K 2C2, (306) 652-0300.

Sunrise Health Program

specifically geared to people of Native ancestry, offers a variety of educational programs, counseling, visits to homes, and program coordination in schools. For more information contact: City of Regina Health Department, 1910 McIntyre Street, Regina, Saskatchewan, S4P 2R3, (306) 777-6600.

Saskatoon Community Health Clinic

provides general health services, as well as endometriosis support group, women's mid-life health kit, women's health issues discussion group, prenatal programs, and counseling on birth planning. For more information, write: 455 - 2nd Avenue North, Saskatoon, Saskatchewan, S7K 2C2, (306) 652-0300.