

Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

A LEAP TO THE

Healthcare in Crisis

Is universal medicare in danger under NAFTA?

Breaking with Tradition

Lesbians talk about parenting

Midwifery in Transition



Healthsharing

Vol 14:2 Summer/Fall, 1993

Editorial Board

Susan Elliott, Colleen Ferguson, Amy Gottlieb (Acting Managing Editor), Lisa Huncar, Virginia Mak, Hazelle Palmer, Megan Williams

Regional Coordinator

Candia Alexander

Advertising and Circulation

Lisa Huncar

Design/Production

Susan Elliott

Printing

The Delta Group

Cover Art

Katie Pellizzari

Healthsharing Office

14 Skey Lane, Toronto, ON, M6J 3S4
Telephone (416) 532-0812
Fax (416) 588-6638

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.

Authors and artists retain copyright, 1993. No part of this magazine may be reprinted without prior permission. Unsolicited manuscripts or artwork please include a self-addressed envelope. Writing guidelines available upon request. Indexed in the Canadian Magazine Index and available on-loan in the Canadian Business and Current Affairs Database.

FEATURES

10 Healthcare in Crisis

How the North American Free Trade Agreement will affect Canadian healthcare.

Janet Maher

14 Midwifery in Transition

The regulation of midwifery is a chance to work for the inclusion of the diverse experiences of women.

Anne Rochon Ford

18 Breaking with Tradition

More and more lesbian couples are choosing to become parents—here some of them discuss their experiences.

Rachel Epstein

23 In Our Own Words

Organizations and issues are profiled in three areas: Woman Abuse, Workplace Hazards and Environmental Health and Challenging the Medical System.

ALWAYS IN HEALTHSHARING

4 Healthlines

5 Letters

6 Update

37 My Story, Our Story

A journey from alcoholism to life.

Virginia Ross

39 Reviews

"You're in Charge: A Teenage Girl's Guide to Sex and Her Body"

Fayola K. Lawrence

40 Resources & Events

inside



Our Radical Roots

When *Healthsharing* started 15 years ago, getting a feminist vision and analysis of health issues out across Canada was a novel idea. Now, in 1993, we face a somewhat different situation. Years of hard work by feminist health activists and educators and the feminist movement in general, has had an impact. We're not taking about a revolution, but at least an acknowledgment in more mainstream organizations, publications and at some levels of government, that there are serious health concerns that are specific to women and that women's voices should be heard. But while this change in consciousness doesn't mean there has been a fundamental shift in how health care is delivered or what research is done, it means that we have made some gains. While it is important that there is now some reflection of women's health issues at a broader level, that reflection is still unfortunately, "whitewashed" and middle class with the radical message of feminist analysis mostly buried.

As the move to integrate and co-opt the feminist health movement has developed, we at *Healthsharing* have attempted to reflect the radical roots of feminist health activism, broaden the concept of health and include a more global representation of women's voices. Women's health issues are not just reproductive issues, though we certainly have cause for anger with the unnecessary hysterectomies that are performed, the largely uncritical approach to hormone replacement therapy and the lack of research into the causes of endometriosis. Women's health issues are not just about diseases which affect women more than men, though we are angry at the incredibly slow response to the breast cancer epidemic. Feminist health activism is about looking at women's lives as a whole, about the impact of women's oppression, poverty, racism, class bias, abilism, ageism on

our lives - it's about making fundamental changes to our medical system.

Healthsharing's future is unclear, not because there isn't a place for the radical, holistic, self-help message of the publication, but because we are once again scraping the bottom of the barrel—a barrel emptied by Tory deficit-cutting policies. Now, more than ever, with the building of the Canadian Women's Health Network, *Healthsharing* has an important role to play in putting our voices into print and sharing them across the country.

Let's take solace in the recent electoral defeat of the Tories, but not slip into complacency. It is possible that with the election of the Liberal government our chances for survival may be better. But we are not holding our breath. If anything is to change, including funding to women's organizations, it will only come about, as it always has, through our mobilization. At the same time, we once again are appealing to our readers for help.

AMY GOTTLIEB

In working on this issue, I have often envisioned a world where the traditional wisdom and knowledge derived from women's experience together with the commitment of women's health activists, would provide new directions for the health care system. The cost of health care would be drastically reduced and the health and well-being of the people would be enhanced. However, in this non-ideal world many organizations and individuals continue to struggle for fundamental changes in the medical system.

Another issue of the Canadian Women's Health Network series is complete. We attempted to reflect the great diversity of Ontario - in ethnicity, race, culture, language, sexuality and geography. We wanted to bring

you the voice of energetic and committed women working to create better conditions for us and our families.

Perhaps the most striking problem which emerged as I attempted to find out about groups in Ontario, was the lack of time to respond to the questionnaire I sent out, and to write articles for this report. This was largely because women's organizations are understaffed and overworked. The most common concern was the limited funding available to essential projects and programs. It is frightening that lack of government funding threatens this good work.

I want to thank the women who responded to the questionnaire, wrote articles and were interviewed. We did not have space in the magazine for all your submissions but the resource bank will store a record of your work and resources which will be used by the Canadian Women's Health Network.

CANDIA ALEXANDER

Our Cover



"The cover concept represents the barriers Canadians will face to quality healthcare under NAFTA and any other government assaults on universal medicare," says Katie Pellizzari, a former *Healthsharing* collective member. She has illustrated many articles for *Healthsharing* in the past. A visual artist and illustrator, Katie has recently opened her own graphic design studio and can be reached at (416) 652-2694.

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

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

Defining Choice

In "Selective Abortion", (*Healthsharing*, Winter/Spring, 1993), abortion rights activists are criticized for: "contributing to the mindset that disabled fetuses should be aborted ...[and painting] the birth of a disabled child as a disaster."

Choice means the option to say yes or no to abortion, or to any medical procedure. CARAL does not promote abortion for fetuses which have tested positive for a disability. What CARAL promotes is the freedom of each individual woman to make her own choice.

As pro-choice advocates, we do not paint the birth of a disabled child as a disaster. What is a disaster to us is a woman who finds herself pregnant and can not get an abortion but is unwilling to carry the pregnancy to term, *for whatever reason*. Pro-choice means that the woman herself makes the decision. There is never a case where a fetus *should* be aborted or *should* be carried to term.

We agree that choice is not a real choice when society does not help women who are disabled or women who are poor and without social support. We believe equally in fighting for the rights of disabled women to make the choice to have a child, and we agree that society and the medical establishment do not facilitate disabled women's right to choice.

But surely what we have struggled for all these years in the pro-choice movement is to have women recognized as moral, conscientious human beings, capable of making difficult decisions on their own. Why would we step back from that principle?

How can we say that it *is* OK to have an abortion because the woman is unable to continue the

pregnancy for financial or emotional reasons, but it *is not* OK to have an abortion because the woman is carrying a fetus which tests positive for a disability? If we can accept these other reasons, we must also accept the reason of disability. In fact, there are usually many factors which come into play in a woman's decision. No one has the right to judge any woman's reasons, or apply anyone else's standards to her reasoning.

Choosing abortion because a genetic anomaly has been detected is not a form of prejudice against disabled people. This line of reasoning is spurious, unnecessary and dangerous. Our attitude towards people who are already here - in fact, most disabled people became disabled through accident, not genetic disorders - has nothing to do with our freedom to choose whether or not to have an abortion when the fetus tests positive for a disability.

Comparisons of abortions to the Holocaust and eugenics are illogical and historically inaccurate. Individual women's choices cannot be compared to government policies to "purify" and "improve" the race. These comparisons are unworthy of feminist discourse. "Disabled fetuses" are not like victims of the Holocaust; to compare the abortion of fetuses with the extermination of a race is simply fallacious. This is precisely what the anti-choice movement does in its attempt to deny abortion to women.

Women have the right in any and every case to have abortions. There are no circumstances under which forcing a woman into unwilling motherhood is right. Unplanned, unintended, unwanted pregnancies are never acceptable. Proponents of choice must not lose sight of this principle. Disabled children, too, deserve the right to be wanted. Arguments like many of the ones presented in this article seem to purposefully make women feel guilty about choosing abortion when the fetus tests positive for a disability.

We do not believe that the medical profession is a monolith of coercion for abortion in cases of

fetal abnormality. Prenatal tests may be overused in some centres, but in many others there is a lack of access to these tests. Some doctors are biased in favour of abortion when an anomaly has been detected, but are opposed if a woman wants an abortion for any other reason. This we deplore. But persuading a woman to have a child who will be disabled is also coercive. Likewise, denying women information in case they might choose abortion is paternalistic and meddling. Informed consent, which includes non-directive and unbiased counseling, has been the battle cry of the women's health movement for many years. As women coming from diverse perspectives, we must discuss these issues more fully, but we can not compromise on the most basic principle of feminism: control of our bodies and our lives.

K. Holmwood,
President, Canadian Abortion
Rights Action League (CARAL)
Toronto, ON

Concerned

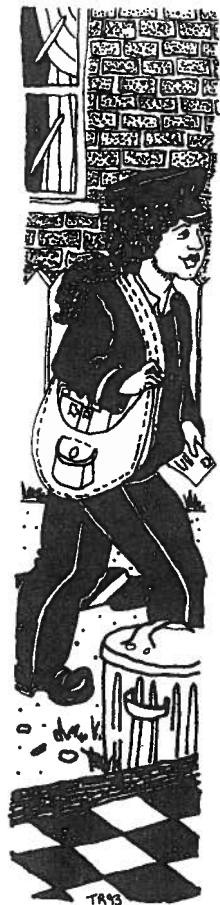
I always enjoy your magazine and really appreciate your political and social awareness. However, I was concerned about an item "Toxic pollutants: the key to endometriosis?" (*Healthsharing*, Winter/Spring 1993). In an age when we are dealing with environmental and people abuse let us not forget the animals. By quoting results of an experiment done on animals you legitimize this method of acquiring information. We can only imagine the suffering forced on these victims. Experiments on animals can often be misleading and are very often cruel. Animals were not put on earth for us to work out our problems.

J. Kirk
Denman Island, BC

Not Alone

Thanks and continued success! I look forward to every issue - makes me know I'm not alone in "Rural Ontario."

M. Barton
Brighton, ON



Canadian Women's Health Network is happening!

After a year of planning and over a decade of dreams, the Canadian Women's Health Network is underway. Women representing 80 organizations involved in various aspects of women's health met May 21-24, 1993 in Winnipeg. The meeting was hosted by the Women's Health Clinic, Women's Health Interaction Manitoba and Healthsharing and was funded by Health and Welfare Canada.

Participants came from every province, the Northwest Territories and the Yukon, and from urban and rural communities. Diverse groups such as the Women's Resource Centre in Chetwynd, B.C., the Toronto Women's Health Network, the Nurses' Union of Newfoundland, the Immigrant Women's Association of Saskatchewan, the Federation des Centres de Santé de femmes from Montreal and Breast Implant Information Association of Alberta were all represented. The planning committee tried to ensure strong representation from aboriginal women, women with disabilities, Francophone women and lesbian women.

The inclusiveness of the meeting, and its welcom-

ing and comfortable atmosphere seemed to be one strength that participants especially noted and appreciated. This was later reflected in the emphasis on "unity with diversity and support without interference" when participants addressed what they meant by solidarity within a network.

The consultation began with an opening panel on "The Agonies and Ecstasies of Working in Women's Health." Sunera Thobani, the president of the National Action Committee on the Status of Women, and former co-chair of their Health Committee, Justine Kiwanuka, from Disabled People's International, Lucie Thibodeau from Centre des femmes Inter-

femmes, and Carla Marcelis from Women's Health Interaction talked briefly about their struggles and what empowers them and gives them hope. They served as "catalysts" for the small group discussions that followed. Participants met to develop a mission statement; discuss common values and principles, models of information exchange, solidarity and action, membership issues, accountability and the process of sharing tasks and responsibilities; and possible sources of funding. We also spent time talking with others from around the country about issues of concern, renewing old friendships and making new ones. There were energizing exercises, activities to help us get to know one another and have fun, and wonderful songs.

By Monday morning, despite our diversities and an intense, sometimes difficult process, we had found common ground. In the climate of harsh cutbacks to necessary services across Canada, the need for networking among women's

health groups and organizations was clear.

Participants agreed to establish a Coordinating Committee that includes regional representatives and women representing the interests of specific sectors—women with disabilities, immigrant women, women of colour, aboriginal women, lesbian women, older women and young women. The Committee includes Francophone and Anglophone women and will operate bilingually. As part of a two-year mandate, the tasks of the Coordinating Committee are: to finalize the mission statement; explore sources of funding; finalize an action plan; work on a model for long term networking; link with other groups and regional contacts; and monitor health policies so that we know which issues need to be put forward for action. As well, "focus groups" were established to develop specific strategies for communication (including computer linkages), membership and funding.

The meeting ended on a high note. Women stood together in a circle, passed sweetgrass from one to the next and spoke about their experiences and appreciation of the meeting.

A report about the Consultation and the next phase of building the network will be ready in October, 1993 in English and French. For more information contact the Women's Health Clinic, 3rd flr, 419 Graham Ave., Winnipeg, MB, R3C 0M3, Tel:(204) 947-1517, Fax:(204) 943-3844

SARI TUDIVER



INTERNATIONAL GUIDE TO PERIODICALS OF INTEREST TO FEMINISTS, LESBIANS, AND GAY MEN. OVER 400 LISTED!
\$9 (US FUNDS) PPD TO TSUNAMI RECORDS,
P.O. BOX 42282, TUCSON, AZ, 85733, USA

Ontario enforces Human Rights Code for disabled people

Restaurant owners, theatre owners and landlords were told by the Ontario Human Rights Commissioner to take note of its recent decision that ordered a plaza owner to provide adequate access for disabled people and pay \$1000 in compensation to a woman who was denied access because of her

disability. Marjorie Elliot of St. Catharines, Ontario, launched a complaint to the commission after she was turned away by a maintenance worker at the Village Green Plaza outside of Virgil, Ontario for parking near the mall's entrance driveway. Ms. Elliot said she was forced to park near the

entrance because the mall did not provide parking spots wide enough for her specially equipped van or a ramp for wheelchairs.

Elliot, who had stopped at the plaza to have lunch with a friend was outraged at being turned away. "I'm not a second-class citizen. It's not a privilege to go to

that plaza. It's a right," she told the *Globe and Mail*.

The decision is seen by the Canadian Human Rights Commission as a great victory for disabled people, and is expected to set a precedent for similar cases elsewhere in Canada.

WHS

Montreal Health Press celebrates 25th anniversary!

In 1968, a group of left-wing McGill University students created a stir when, as part of their student council election platform, they published the *Birth Control Handbook*. Not only did this ground-breaking booklet deal with controversial topics like birth control, sexuality and abortion at a time when giving information on these subjects was illegal, but it was written from a strong feminist perspective.

While it was an instant hit on campuses and in clinics across North America, not everyone received the book with enthusiasm. In one Montana town, it was burned, and in another incident, U.S. officials decided it wasn't fit to cross the border and dumped it into Lake Erie. Despite the opposition, demand grew and the reprints continued.

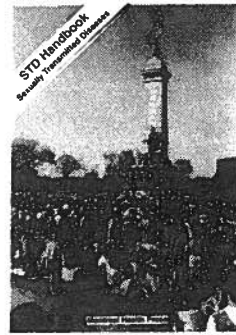
The history of the press unfolded in close connection with Canadian feminists' struggle for

reproductive rights and sexual freedom, concern with sexual violence, and outspokenness on menopause. In the early days, just after the publication of the first *Birth Control Handbook*, women with unwanted pregnancies began calling for information, and the Health Press responded by setting up informal abortion counseling services. This responsibility then shifted to the Montreal Women's Centre, which became the Health Press' first home. By the early 70s, it had evolved into a feminist collective and was officially founded in 1972.

Shortly after, the *VD Handbook* was published in an effort to reduce widespread ignorance and confusion about venereal diseases. Written by two medical students, it aimed to compensate for the inadequate and moralistic response to STDs (sexually transmitted diseases) by the government and

medical professionals. Almost three million copies were distributed worldwide by 1977. Since then the *Birth Control Handbook*, *A Book About Sexual Assault*, and most recently, *A Book About Menopause* were published with great success. Updated editions of the former two are now available.

The Montreal Health Press is delighted to celebrate its twenty-fifth anniversary this year. Having weathered several periods of economic and political difficulties, it continues to fulfill its original mandate to provide comprehensive, non-judgmental and easy-to-read information on health and sexuality and sells thousands of books to clinics, hospitals, high schools, universities, women's groups and individuals all over North America. The Press' survival is a testament to the continued relevance of its books. As Anne Rochon



Ford writes in her preface to *Menopause: A Well Woman Book*, "For those of us who have been involved in the women's health movement in Canada, the work of the Montreal Health Press has been like a wise older sister—there when you need her and always with the information you've been looking for."

Montreal Health Press books can be obtained by sending \$4 per copy to the Montreal Health Press, C.P. 1000, Station Place du Parc, Montreal, H2W 2N1. For bulk orders (as low as \$0.85 per copy), please call (514)282-1171 or fax (514)282-0262.

ANITA MALHOTRA

Menstrual products stop supporting big business

The idea of a reusable menstrual product is not absurd to those of us who have followed the 'Stop the Whitewash' campaign for the past year. Not only have hundreds of women switched to cloth pads in funky designs and colours, many have begun using The Keeper, a natural rubber menstrual cup that will never see you investing your hard earned money in single use tampons (and GST!) again.

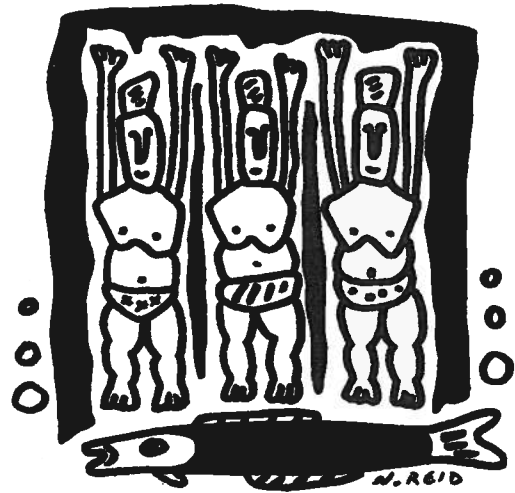
The most obvious reason for switching to reusables is that the 'sanitary' products now on the market create enormous waste. Each woman uses over 10,000 pads or tampons in her lifetime that do not easily break down in landfill sites. Tampons and applicators create major headaches for sewage treatment workers and, along with other plastic waste, account for the death of thousands of marine mammals each year, who choke on the plastic. In areas around Victoria and Halifax, for example, millions of the applicators are discharged directly into the ocean because sewage treatment facilities do not exist.

The less obvious reason

for switching to cloth alternatives is that 'mainstream' pads and tampons are bleached with chlorine and chlorine dioxide for that 'whiter-than-white' look. Unfortunately, these chlorinated compounds have implications for both the environment and women's health. (See *Healthsharing* Summer/Fall, 1992)

Since March 1992, a Toronto-based environment group has been conducting a campaign to bring environmentally safer and healthier products to our shelves. Using the arguments of *Whitewash* authors Liz Armstrong and Adrienne Scott, the campaign encourages women to use their consumer power (women do 80% of the shopping of goods and services) to demand better products.

'Stop the Whitewash' has conducted dozens of workshops across Canada explaining the dangers of chlorine and the waste from these products. For over one year, women have been writing to the companies and calling the 1-800 numbers on pad and tampon boxes, for cleaner, safer products that are not bleached



and excessively packaged. Despite the efforts, the companies' responses have been evasive at best. Women have heard impersonal recorded messages and received dismissive, curt responses in the mail.

Last May, 'Stop the Whitewash' tried yet again to solicit 'real' responses from the companies in order to complete its report card on their environmental progress. Procter & Gamble's response? They were "not interested in engaging in further correspondence" with the environmental group.


Although none of the major sanitary product companies have responded to women's health and environmental concerns, 'Stop the Whitewash' is most frustrated by P&G's blatant indifference to those who buy its prod-

ucts. In response to their disregard, the group has announced plans of a boycott of P&G products including Always pads, Attends incontinence products, and Luvs and Pampers diapers. To launch the boycott, 'Stop the Whitewash' will be holding a rally in Toronto where it will announce the results of the report card in October. The rally will also mark the launch of the book *Soap Opera: The Inside Story of Procter & Gamble* by Wall Street Journal writer Alecia Swasy.

If you would like to endorse the boycott or attend the rally, contact the 'Stop the Whitewash' office in Toronto at (416) 516-2600 or write The WEED Foundation, 736 Bathurst St., Toronto, ON, M5S 2R4.

LINDA NORHEIM

Nancy Reid



ANN DRAKE
Counselling & Consulting
160 Garfield Street South
Winnipeg, Manitoba
R3G 2L8
Telephone: (204) 786-1971

Stephanie Irwin
Counselling Service for
Childbearing Difficulties

- miscarriage • infertility • infant loss
- traumatic deliveries

Group and Individual Sessions
(613) 729-3220

Sources for chlorine-free menstrual products

Re-usable Products

• **Anna's Choice:** 25 Fisherville Rd. Suite 110, Willowdale, Ontario, M2R 3B7, (416) 736-7821. Day-time and overnight pads with absorbent terry layers, nylon moisture barrier.

• **We Care:** 28 Fairleigh Avenue South, Hamilton, Ont., L8M 2K2, (416) 545-0165. Menstrual pads & "Waddles in White" diapers.

• **Moonwit Menstrual Pads:** RR#4 Maliview C-25, Ganges, BC, V0S 1E0, (604) 537-4683 or Fax 537-5115. Flannel and terry pads in 3 sizes in flannel and terry.

• **Harmony Naturwear:** 8-190 Allen Street East, Waterloo, Ontario, N2J 1K1, (519) 576-1623. 100% cotton menstrual (and incontinence) pads

available in four sizes and unbleached fabrics for allergies.

• **The Keeper:** Silver Mountain, 308 Memorial Ave., Thunder Bay, Ont., P7B 3Y2, (807) 345-2300 or Fax 344-7908. A reusable menstrual cup made of 100% rubber, worn internally to collect menstrual flow.

• **Many Moons:** 14-130 Dallas Road, Victoria, BC, V8V 1A3, (604) 382-1588 or Fax (604) 382-7688. Pads made of 100% flannelette with three styles and three colour schemes: wild, soft pastel and plain.

• **Women's Choice:** PO Box 245, Gabriola, British Columbia, V0R 1X0, (604) 247-8433. 100% unbleached cotton menstrual and incontinence pads available in five sizes. Purse carriers,

panties and utility bags also available.

Disposable Products

• **Bio Business International:** 152 Lambertlodge Avenue, Toronto, Ont., M6G 3X3, (416) 651-0939, Fax 651-0939. Terra femme tampons are 100% firstgrade cotton, chlorine-free and applicator free. No chemicals added to deodorize or 'enhance' absorbancy.

• **Ecofem:** 6872 Barrisdale Dr., Mississauga, Ont., L5N 2H4, (416) 542-0505. 100% cotton, sterile, chlorine-free, biodegradable tampons. Also distribute Many Moons menstrual pads in Eastern Canada and Manitoba.

• **Natracare:** c/o INNOVITE, 196 Wildcat Rd., Downsview, Ont., M3J 2N5, (416) 661-8272, Fax

(416) 661-5992. Chlorine-free menstrual pads, pantyliners and tampons. Available in health food stores.

• **The Natural Order:** PO Box 850, Station P, Toronto, Ont., M5S 2Z2. Cotton & disposable menstrual products.

• **Seventh Generation:** Dept. GM, Colchester, VT 05446-1672; (800) 456-1177. Chlorine-free panty shields & pads made with CTMP (mechanically ground) pulp. (same as "President's Choice" 'chlorine-free' pads.)

• **Sisterly Works:** R.R. #3, Box 107, Port Lavaca, Texas, 77979, (512) 893-5252. Sea sponges and 100% cotton menstrual pads in three sizes.

update

Lesbian couple denied access to sperm bank

Two British Columbian women have been denied access to the only sperm bank in the province because of their sexual orientation. Tracey Potter and Sandra Benson were told by the College of Physicians and Surgeons of B.C., the governing body for the province's doctors, that the sperm bank has the right to deny them service.

Gerald Korn, the sperm bank operator, is the only physician in B.C. who can provide insemination with frozen sperm. Frozen sperm mean fewer health and legal risks for the woman

who is impregnated, as donors are fully tested for infectious diseases and anonymity is ensured.

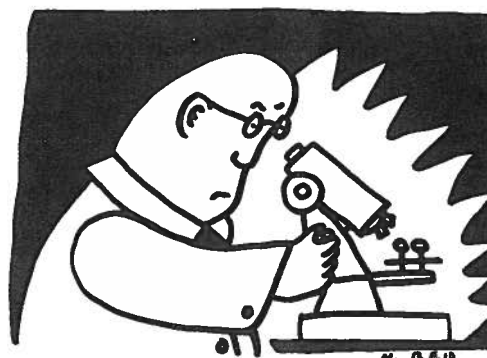
Although Korn has inseminated lesbians in the past, he now routinely asks patients to identify their sexual orientation and refuses those who identify themselves as lesbians. When the couple complained to the B.C. College of Physicians and Surgeons, whose functions include protecting patients from abuses of power by doctors, they were told Korn had a right to deny them access to sperm as it was

not deemed a medical emergency. There is currently no appeal process from this decision of the College. Under the present physicians' code, B.C. doctors therefore have the right to refuse gays and lesbians treatment because of their sexual orientation.

Potter and Benson contend that this violates the Human Rights Act of British Columbia and have secured the B.C. Council of Human Rights to proceed with the case against Korn. He is charged with refusing to provide a service because of discrimination

based on sexual orientation and family status. The hearing will most likely be held in the fall of 1994.

MEGAN WILLIAMS



Healthcare *in Crisis*

NAFTA threatens not only Medicare, but all the social programs
Canadians have fought for years to receive and maintain

Is universal medicare in danger in Canada, as suggested by many of our politicians and news media? How will the North American Free Trade Agreement affect medicare in Canada, if at all?

The short answer is that the funding of healthcare in Canada has really been at risk ever since the passage of the Federal Hospital and Medical Insurance Acts in the early 1960s, which marked the beginning of public health insurance, or medicare in Canada. The Acts worked by providing federal funds for provinces to pay for physician and hospital services. The North American Free Trade Agreement (NAFTA for short), threatens not only medicare, but all the social programs Canadians have fought for years to receive and maintain.

Medicare and Its Original Promise

medicare, the sacred trust of Canadians, is in fact a very limited program, and has been eroded significantly over the past decade—so much so that it is unlikely to survive the current round of deficit reduction and all too likely to undergo further attacks from NAFTA.

The original vision of medicare had two components. The first addressed the elimination of barriers to access—through a public insurance system—to all services considered medically necessary. It was anticipated that the process of eliminating the barriers would be gradual, and would eventually extend from essentially acute care services (those given by physicians, primarily in hospitals) to services such as dental work, eye care and nutritional counseling—first for children and seniors, and then to the rest of the population.

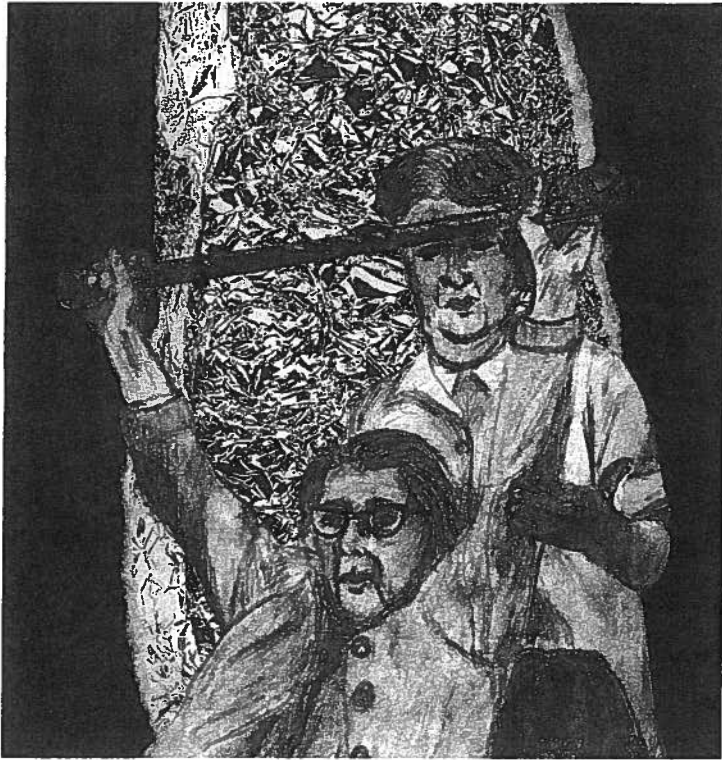
The second component involved the implementation of a comprehensive public and preventive healthcare strategy. This includes programs like seat belts and child restraint seats in cars effective anti-smoking, anti-drug and

anti-alcohol campaigns, pre-natal nutrition, population programs, and better occupational health and safety. All these programs have shown a greater impact on improving the health status of Canadians and the citizens of other countries in the world.

The past three decades have witnessed some expansion in the range of services covered for some or all of the population, in one or more provinces. These include ambulance services, enhanced dental services for school children, and drug benefits for seniors and welfare recipients.

For preventive healthcare, however, progress has been extremely slow. While some small preventive and public health measures have been implemented in recent years (such as non-smoking areas in public places and helmet laws for motorcyclists) they are generally quite limited, not very seriously enforced, and have rarely been accompanied by the kind of public education which might lead to changes in behaviour. Although each provincial and territorial health budget reserves some funds for public and/or preventive initiatives, the amount generally accounts for a fraction of the total. In other words, what we spend health money on is illness care, not healthcare.

In the climate of economic growth and liberal social and political ideology of the 60s and 70s, governments were relatively content to spend on health infrastructure (modern hospitals, research facilities, labs, and clinics) and health services. Until the late 70s few politicians or citizens were seriously concerned whether the responsibility for funding healthcare or other social programs was federal or provincial. Established Programs Financing, the original federal-provincial cost-sharing mechanism, ensured relatively open-ended funding to provinces. It was the Canada Health Act, passed after several years of funding erosions at the federal level, that attempted to ensure that provinces spent federal healthcare funds for healthcare



“What has Canada come to, when someone who has spent her life caring for others is told by our politicians that now she is too old to count.”

—Mary Anne Oger, small business woman in Thunder Bay, talking about her mother who does her own kidney dialysis at home to save the medicare system about \$15,000 a year.

alone. Passed in 1984, the Canada Health Act allowed the federal government to reduce transfer payments to any provinces that increased access barriers to a number of specified areas—generally acute care in hospitals.

The Canada Health Act is largely considered the bible on medicare in Canada, because it enshrines five principles for continued federal funding:

- **Universality** Healthcare must be available to all residents of Canada, on uniform terms and conditions.
- **Accessibility** Healthcare must be reasonably available to all residents of Canada close to where they live and work and without direct or indirect charges or other impediments.
- **Comprehensiveness** Every province insures a full range of services for all residents as required.
- **Portability** Coverage of health-care services extends across Canada.
- **Public Administration** Our health-care system is administered and operated on a non-profit basis.

Although the Act was not perfect, it did lead fairly quickly to the elimination of balance billing or extra billing by physicians. Seniors' and social benefits recipients' access to drug benefit programs increased, and home care and long term care services were extended, making community care

cost-effective. But a working-poor adult with a bad toothache could expect little relief until an abscess or major dental crisis landed her in hospital. Incentives to corporations to be more respectful of the environment or occupational health and safety remained low. For many Canadians, especially Native people, people of colour, the poor and immigrants, the system has been less than universal and accessible. And a further decade of restraint budgets at the federal level have resulted in a chipping away at social programs which are even less able to meet the needs of Canadians already marginalized by the system, to say nothing of ensuring equity of access to all Canadians in 1993.

This erosion coincides with the aging of post-war baby boomers. By the year 2000 nearly a quarter of our population will be over the age of 60. While the majority can anticipate several good years after that age, advances in technology have raised our expectations of good health in our later years. If those expectations are to be fulfilled, we will need to have the resources for costly technology. The “cost-cutting” alternative will be increasing limitations on accessibility to those who are poorer, older, sicker, or otherwise marginalized.

As federal politicians hasten to

insist, direct federal healthcare spending has so far not been cut—only the rate of increase in spending has been reduced or frozen. To assist provinces in paring down their budgets, Federal Health and Welfare Minister Benoit Bouchard hosted a meeting of Federal-Provincial Ministers of Health, in June 1991. The provinces have responded in various ways, from de-insuring some services and procedures, placing caps on others, and introducing deductibles, co-payment fees, or user contributions.

Restructuring has already resulted in job loss, primarily of support workers: predominantly lower-paid female nursing assistants and ward aides. It has also meant a shift to more part-time and casual work in home care and attendant care services. Bed closures, particularly in smaller prairie and northern towns, threaten whole communities.

The new-found interest of many provinces in community-based care options for seniors, people with disabilities and chronic psychiatric patients is ironic. Given the cost containment objectives of health administrators, many current and potential patients and their traditional caregivers, namely mothers, daughters and sisters, have reason for distrust. As acute and chronic care institutions

“The Tories have been attacking medicare by stealth for a decade. Now they’re doing it openly with talk of user fees and the delisting of insured procedures...”

—Sunera Thobani,
President, National
Action Committee on
the Status of Women



reduce the number of beds or close down altogether, more and more of the burden will fall on women—many of whom are already caring for children to whom our child care system is woefully inadequate.

Furthermore, the declining role of the federal government in financing, regulating and supporting innovative

new programs burdens poor and other marginal Canadians and makes it easier for middle and higher income earners to lose interest in how universal health care is. Those with secure finances will be less and less likely to imagine themselves ever being recipients of government financed healthcare.

Universal family allowances have

disappeared, to be replaced by a ‘targeted’ children’s benefit. Unemployment insurance coverage has been reduced and will be unavailable to the increasing numbers of contract workers. Not only has the federal government withdrawn funding for unemployment insurance, its commitment to training now comes from unemployment insurance funds—funds reserved for those eligible for or in receipt of unemployment insurance benefits.

Moreover, in spite of the rhetoric about the need for a more educated populace, cuts to student aid in the post-secondary sector have effectively shut the door to many promising young people. Those students who can come up with the money to support themselves are faced with overcrowded classrooms where it can be a challenge even to find a space to sit.

Two other disturbing developments deserve notice. The first is a substantial expansion of the use of private healthcare insurance to make up for service gaps. Particularly in the decade of AIDS, and other chronic conditions requiring costly intervention, there have been few incentives or sanctions for private insurers who disqualify potential users on the basis of certain risk behaviours. At the same time, much of the middle class, or at least those still in relatively secure employment,

What Can be Done

A big part of the solution to the erosion of Medicare is to get the subject back on the public agenda and to debate alternatives based on factual information.

If you need information, or want to work with others to maintain and enhance publicly funded healthcare, contact one of the following groups, or their provincial or regional affiliates:

The **National Action Committee on the Status of Women** is running a cross-country campaign focusing on national social programs, with the theme “We Can Afford Equality”. Contact: NAC, 57 Mobile Drive, Toronto M4A 1H5, Tel. (416) 759-5252 or toll-free 1-800-665-5124, Fax (416) 759-5370.

The **Action Canada Network** is a pan-Canadian coalition of popular sector organizations including women, trade unions, anti-poverty activists, peoples of the First Nations, immigrants and visible minorities, people with disabilities, seniors, farmers, environmentalists, and faith groups. Their agenda is to cancel the 1989 Free Trade Agreement, oppose NAFTA and democratically

develop a comprehensive alternative program of jobs and social justice. ACN can be reached at 804-251 Laurier Avenue West, Ottawa K1P 5J6, Tel. (613) 233-1764, Fax (613) 233-1458.

Under the Canadian Constitution, the delivery of healthcare is a provincial responsibility. It is at this level that many of the detailed spending decisions are made, and hence at this level that citizens can have an impact. Two important strategies are on the agenda of provincial and regional social justice organizations and deserve to be more broadly supported. One is to maintain vigilance on the effects of the delisting of drugs and medical procedures and the introduction of deterrent fees, user contributions, co-payments, or deductibles for services which have previously been available without payment. The second, proposed by several witnesses to the recent public hearings on NAFTA, is to press provincial governments to procure supplies—linen, hospital equipment, food and drugs—from Canadian suppliers whenever possible.

Katie Pelizzari

are turning to private insurance as a back up to the deteriorating services, hoping that private insurance will cover them if they should need costly hospital technology.

The second distressing change has been the opening and expansion of a range of commercial services outside the publicly insured system. Some of these are licensed and regulated. Others include a growing number of unregulated and largely unevaluated counseling therapies related to such issues as eating behaviours or violence and incest survivor therapy, which are available only to those prepared to pay.

What About Free Trade?

The Canada-U.S. Free Trade Agreement, implemented following the November 1988 federal election, was significantly more comprehensive than any previous trade arrangement. Although medicare was formally exempt under the Agreement, Chapter 14 on Commercial Services outlined a number of exceptions to the exemption. These exceptions included a broad range of hospital and healthcare management services such as general, rehabilitation, and extended care hospitals, nursing homes, drug and alcohol treatment facilities, homes for physically and mentally disabled and children in need of care and protection, ambulance services, home care, public health clinics, medical and radiology labs and blood banks.

The basic provision of the 1989 Agreement allows U.S. firms the same access to the commercialized or privatized market as Canadian firms. While there has not been a great increase in commercialization since the agreement, the seeds have been sown for the takeover of hospital laundry and housekeeping, dietary, and security services by large U.S.-based multinationals.

As Colleen Fuller of the BC Health Sciences Association noted in her presentation to the Commons hearings last fall on NAFTA, "private laboratories, walk-in medical clinics and various kinds of treatment facilities have sprung up like weeds in major cities across the country."

She goes on to suggest that the only reason U.S. corporations have not moved in to the Canadian health

system on a massive scale is that the Canada Health Act has acted as an effective barrier. However, as federal funding declines—at the current rate, Quebec will no longer receive federal cash transfers after 1996, Ontario will lose federal funds in 1998 and no province will be entitled by 2005—the incentive to uphold the principles of medicare will disappear.

Since the Free Trade Agreement came into effect, pharmaceutical and medical devices industries have grown enormously. Encouraged by the first federal extension of drug patents and interest-free government loans and grants, a number of drug and biotechnology firms have put big money into new plant capacity in Canada.

What about NAFTA?

While we are led by supporters to believe that the North American Free Trade Agreement is simply an extension of the Canada-U.S. Agreement to include Mexico, the reality is much more troublesome. Whereas the Canada-U.S. Agreement addressed issues within the jurisdictions of the two national governments, NAFTA will eventually bind provincial and municipal levels of government to its rules.

NAFTA sets up a process to review public services that, because of existing laws, are excluded from the agreement. By the end of 1998 all exclusions in the areas of community, social and professional services, as well as health and education, will be examined to determine the extent to which they constitute indirect subsidies to Canadian traders. This whole examination will take place, not in our national, provincial or state legislatures, but in a closed tribunal with representatives appointed by the three governments. It is also worrisome to note that the deadline corresponds to a time when provinces will be struggling to cope with the final withdrawal of federal funds. The most likely result will be the further stripping of provincial health plans. The need for any review at all may well be preempted by the provinces themselves.

And if the Bill C-22 extension of drug patents from four to ten years were not enough to boost drug manufacturers profits, the Mulroney government's Bill C-91, which further

Continued on page 36

THE CANADIAN RESEARCH INSTITUTE FOR THE ADVANCEMENT OF WOMEN

A national, bilingual non-governmental organization which promotes, disseminates and coordinates research on women.

Activities include:

- an annual conference
- a quarterly newsletter
- networking through a computerized Bank of Researchers
- research reports
- a small research grant program

Recent publications on:

- Feminist Literary Criticism
- Women's Autobiography in Canada
- Stereotyping of Feminists
- Women in Politics
- Midwifery
- New Reproductive Technologies
- Strategies for Effecting Change in Public Policy
- The Women's Movement

To obtain a copy of our publications catalogue and information on becoming a member of CRIAW **Contact:**
CRIAW, 408-151 Slater St.,
Ottawa, Ont. K1P 5H3.
Tel. 613 563-0681
Fax 613 563-0682
TDD. 613 563-1921

We offer a discount of 20% when you order 10 or more of the same title.

Midwifery in Transition



by Anne Rochon Ford

Adapted from a presentation to the National Workshop on Midwifery Research and Evaluation, McMaster University, Hamilton, November 13, 1992

In the summer of 1989, the Interim Regulatory Council on Midwifery (IRCM) got together for our first meeting in Toronto. It was an exciting time. We all had a sense that we were living an important piece of history—the first meeting of the first provincial regulatory body of midwifery in Canada. The Ontario Minister of Health Elinor Caplan met with us and told us how wonderful it was that this was finally underway. We were feeling pretty self-congratulatory.

One of our members, Jesse Russell, a Métis woman from the Thunder Bay area, later told me that she found our self-congratulating a bit offensive. In this sea of white faces, she wondered how this group was ever going to address the needs of women not represented at the table. She asked the group how we were going to address the issue of Aboriginal midwifery and the fact that Aboriginal people in this country have a long tradition of midwifery which is quickly being eroded from their culture. Others at the meeting raised the issues faced by immigrant women who come to this country with a variety of birth customs—would our rules and regulations prevent them from giving birth the way they were most comfortable? And how would we address the province's

recently-introduced French Language Services bill, which is intended to insure that francophones in this province receive health and social services in their mother tongue?

It became clear that it would not be sufficient to look at areas like standards of midwifery practice and qualifications for entry without also examining the birthing cultures and needs of women not represented on the Council. With one exception, council members are all white women in our thirties and forties, all able-bodied and each with at least one university degree. With a few exceptions we come from urban centres and English is our mother tongue.

But if we look at the development of this wave of midwifery in Ontario—in Canada for that matter—we see a movement which has been led primarily by women who share these same traits. For they are the traits of advantage in our society, with the one exception of our gender. The resurgence of midwifery has been a social movement in Canada—a movement which has challenged the status quo. Like most social movements, it has been spearheaded by those with the greatest degree of comfort in speaking out and taking chances,

those with the least to lose. This in no way diminishes the efforts made by all of us to make midwifery a recognized profession in Canada. But it does mean we need to change our composition and how we look at the issues. In all of our efforts to promote midwifery across Canada we must work for the inclusion of those who have not been a part of that movement; women who feel excluded because they can't read or understand our literature, women who see only white faces and assume they aren't welcome, women who use a wheelchair and can't get into our inaccessible buildings for meetings, teen mothers who assume this is only for women their mother's age.

The Equity Committee of the IRCM was formed three and a half years ago to address the imbalance which has long existed in the midwifery movement. Early on we realized that even though we have learned a lot from reading previous research on the issues, nothing can replace the act of actually going out and meeting people on their own ground. We had to drop our assumptions and we had to do what every good midwife learns to do best—to listen. We learned what it felt like to sit in a room full of people who had an implicit mistrust of

Terri Robertson

white people from the south and be grilled by them before we could be trusted with their stories.

Over the past three years the Equity Committee has traveled to, and consulted with, Aboriginal communities in Sioux Lookout, Thunder Bay, Timmins, Moose Factory, Moosonee, Attawapiskat, Walpole Island, Manitoulin Island, Akwesasne and Six Nations. Ironically, as one group of women in Ontario began making tremendous gains in the past two decades with respect to more choices in childbirth, another group, Aboriginal women, has seen their choices minimized.

As is the case in other parts of Canada, Aboriginal women living in remote areas in the north of Ontario are obliged to leave their communities prior to their due date and fly to a larger community where they often know no one. They arrive there in their advanced pregnant state, live in a hostel or ward of a hospital until they go into labour or are induced, deliver their baby usually amongst strangers and remain in the hospital or hostel until it is determined that they can return home. Women are often away from their family and community for a minimum of three weeks and as long as several months where there are complications or a woman is considered high risk.

Depending on the community the woman has come from, her English skills may be limited but she will be obliged to speak it with her caregivers and hospital staff. The hospitals usually offer only minimal attention to any Native birthing customs and traditional foods.

Aboriginal women who live in the south and are pregnant may consider themselves somewhat luckier since they at least do not have to be flown out of their communities for lengthy periods of time. Most do have to displace themselves from their communities to deliver their babies, as do most women living in rural and remote parts of the provinces. In some cases, such as the Walpole Island First Nation in Lake St. Clair in southwestern Ontario, women do not have to go very far, possibly just across the bridge which takes people off the island to the hospital in Walpoleburg. While women may not

have to be away from their families for long and can bring their husband or partner in with them, I heard women report negative experiences with hospital staff, many of which were a result of racism.

We also heard fear and trepidation expressed by some community members when another one of them suggested that women should have the choice to stay back home in their communities to give birth. Some feared that midwifery care would be second class care. In this area of provincial jurisdiction there was fear that too much involvement from the province would make it easy for the federal government to renege on their promises to Native peoples. One woman said: "They made treaties with us and we want them to honour them."

But with the exception of the predominantly white medical, nursing and administrative staff who we met in the zone hospitals, the process of evacuation and the virtual disappearance of midwifery in Aboriginal communities was viewed as a huge loss to Aboriginal culture. Many communities are losing the skills and knowledge of the traditional Aboriginal midwife. No longer able to pass their trade on to younger women as they have done for centuries, the women who once practiced are now getting old and dying. Some equated the negative effects the loss has had on their communities to the effects of residential schools. Others worry that violence in the home has escalated as a result of the protracted periods of time women are away. One participant at a community meeting in Sioux Lookout commented, "At a time when there is so much sadness in Native communities, one of the few joys we had—a baby being born in the community—has been taken away from us."

We also met many men and women born in the 1940s and 50s who maintain a strong connection to the midwife who assisted their mother in childbirth. One woman said "I was born in the bush and that made me strong." We also heard stories of women in some communities who are trying to revive the tradition of midwifery. At Akwesasne First Nation on the St. Lawrence River we met a remarkable woman, Katsi Cook, who has been practicing as a midwife for over a decade. The practice had been

passed on to her by her grandmother who had learned it from her mother. One of her clients told us that being able to have her baby at home in the Mohawk tradition had "contributed strongly to her sense of self and her role in the community." When the baby was born, Katsi passed it to its grandmother who wrapped it in deer-skin and whispered to the baby in her mother tongue, welcoming the baby into the world. She told us that the birth had brought her family closer together and had helped at healing some of the wounds felt so strongly in her community.

Our committee also consulted with groups of immigrant and refugee women and women who work with them in Toronto, Ottawa and Kingston. We spoke with women about the childbirth customs of their countries of origin and about the role of midwives, about their experiences with the health care system in Canada, and about what needs to change or improve to make things better for women immigrating to or taking refuge in Canada.

Their responses varied greatly according to their origins and experiences: how long they had been in Canada and how well they knew the system, their ability to communicate in English, whether they were women of colour, what their status had been in their home country, whether they have papers and are covered for health insurance, whether they came from countries where female circumcision is practiced, and what the status of women is in their country of origin. Refugee women also come to this country under quite different circumstances than those who emigrate by choice, an experience often characterized by a high degree of fear and instability where women are more likely to have a past history of traumatic experiences.

The women we spoke with were very dissatisfied with the way they or others they know have been treated by the health care system, particularly in hospitals. One woman who had been a physician in Guatemala and had given birth to her last child in a Toronto hospital summarized the experience this way:

"Because we do not speak English, we are forced to be silent—to accept

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

Women spoke of the cultural bias in prenatal classes and in the written information distributed to them during their pregnancies. The issue is not just language, we were told over and over again; it is cultural appropriateness. For example, when the importance of exercise is stressed in a prenatal class, this may mean completely different things to the woman recently immigrated from Vietnam—where exercise is considered an essential part of a healthy pregnancy right up to the time of delivery—and the woman from Iran—where women are taught to eat copious amounts of food and favour rest over activity. Examples of such differences in approaches to pregnancy and childbirth are endless, but this underscores the importance of consulting with the groups of women you are working with to determine what is culturally appropriate. We were told that, of course, the ideal is when a prenatal class can be taught to a group of women by a person from that culture who speaks their language. This is happening increasingly in large urban centres.

In Ontario over the past ten years, large numbers of people have emigrated from countries where the practice of female circumcision is still prevalent. We spoke with a woman from Somalia who told us that in her country, a woman often weeps when she gives birth to a daughter because she knows that pain her daughter will have to go through with circumcision, usually performed at between 5 and 8 years old. She told us "There are certain things you don't even have words to express." The woman who comes to Canada from one of these countries often goes through even more pain when she faces unbelieving and judgmental health care workers. Women go from doctor to doctor until they find one who has some understanding of how to work with her in pregnancy, one who will not make her feel like a freak.

For women who come from countries where midwifery is the norm, the answer to better care for immigrant childbearing women in Canada is simple: credential the midwives who have come here from other countries so that they can work with the women of their language and culture who have settled here. It is estimated that there are thousands of women in Ontario who have midwifery training and experience from other countries; the IRCM is in the process of determining how these women's training and experience will be assessed, and how to integrate them into the system.



In the past year, the Equity Committee has met with two groups of women with disabilities in Toronto, and although their disabilities varied considerably—from polio to spina bifida to deafness to a rare form of muscular dystrophy—their experiences with the health care system are very similar. Those who have had their disability since birth have had more experience with the health care system in their first ten years of life than those of us who are non-disabled would have in a lifetime. The more unusual their disability, the more they have been paraded around in front of doctors and interns, made to feel abnormal. Many know more about their own condition than the average health care worker is taught in school.

We heard many stories of disabled women's experiences with insensitive caregivers in pregnancy and childbirth. One woman with polio was told in the same visit where her pregnancy was confirmed that the doctor had already booked her for an abortion. Another woman with a muscular disorder reported that with the delivery of both

of her children, "I had to wait a while before someone said "Congratulations". There is a widespread belief in our society that disabled women first of all are not sexual beings, secondly, shouldn't reproduce if they are even capable of getting pregnant and thirdly, cannot be fit parents. This is the environment in which a disabled woman must deal with her pregnancy and childbirth. Many are disturbed to learn how difficult it is to find a specialist in childbirth who knows anything about her disability.

We learned that because some women with disabilities have spent their lifetimes being told and feeling that they are not normal, and because midwifery practice stresses working with normal pregnancies, many have never considered working with midwives in their pregnancy. We learned that women with disabilities are a group who would definitely benefit from the help of a midwife in pregnancy and childbirth.

Another group of women we spoke with were lesbian clients of midwives in the Toronto area. Their experiences of feeling marginalized and discriminated against in the childbirth system had led a number of them to seek out the care of midwives. They face societal prejudice about their choice of partner and about their ability to parent. Hospital staff are often extremely uncomfortable about the presence of a woman's partner in the labour and delivery rooms. One woman noted that a midwife had been helpful for her in the hospital setting not only as an advocate but as a cultural interpreter—interpreting her lesbian culture to the hospital staff.

In Ottawa and Sudbury, we spoke with childbearing francophone women, another minority in this province who have struggled to obtain culturally and linguistically appropriate health services. As with francophone minorities in most other provinces in Canada, it is assumed that because most can speak and understand English to some degree it is sufficient to provide services only in English. Women spoke of the hardship of not being able to communicate in their mother tongue at a time when one is often feeling so vulnera-

ble. It is difficult to find a French-speaking midwife even in areas where there is a large percentage of francophones. In recognition of this gap, the IRCM has strongly recommended that the university which will house the midwifery baccalaureate program be prepared to offer the program in French, and that a certain number of spaces be designated for francophone students.

Teen mothers spoke to us about their experiences with pregnancy and childbirth and the role of midwives. Often seen by society as irresponsible for getting pregnant, teens reported that they felt they were being punished by the people who were supposed to be helping them. One woman spoke of how anxious she was to get out of the hospital as soon as the baby was born for fear that Children's Aid would come in and snatch the baby from the nursery. Teen culture often doesn't have a lot of room in it for those who are pregnant and is unable to provide the support a woman needs to prepare her for what is coming. Young women report feeling marginalized and as if they didn't fit in, particularly in prenatal classes and on obstetrics wards.

As the result of a programme between the Midwives Collective of Toronto and the Hospital for Sick Children, a number of teen mothers have been able to use the services of midwives in the past few years. They told us that this made a big difference in their experience of the health care system during pregnancy and childbirth. Midwives not only can help allay fears and guide young women through the health care maze, they can also act as role models for a group who may have a hard time finding them elsewhere.

Our consultations also brought us to the Prison for Women in Kingston, the only federal prison for women in this country. We felt it was important to hear what incarcerated women who are pregnant or considering pregnancy had to say about midwives. Although the number of pregnancies the prison deals with are minimal, the inmates we spoke to felt there was a strong role for midwives. We heard

what it feels like to be brought into hospital in labour in handcuffs and with shackles around the ankles, the policy of the Kingston General Hospital in relation to incarcerated women. The shackles are removed in order to allow the woman to deliver her baby, but often the handcuffs are not unless she is unconscious. We found it hard to believe this was 1992 and we were sitting in a room in Kingston, Ontario.

Finally, we met with people in the Mennonite community of St. Jacob's in southwestern Ontario. Mennonites in this part of Canada have had a long tradition of delivering their babies at home with midwives playing an important role in the community. This was a group who needed no convincing about the benefits of midwifery care and have already opened a midwife-staffed Family Birthing Home in town. Their adherence to simplicity and reliance on things natural versus technological makes the Mennonites link to midwifery an obvious one. We sat in the kitchen of an Old Order Mennonite family who had had their four children at home with the help of a local midwife talking to them about birth and children. A mere hour's drive from the hustle and bustle of downtown Toronto, we were struck by the resourcefulness of people for whom running water, electricity and telephones were only recent acquisitions.

If midwifery is to be truly inclusive these voices must be listened to and integrated into its development...I'd like to leave you with the words of contemporary American author Louise Bogan. She has written: "In a time lacking in truth and certainty and filled with anguish and despair, no woman should be shamefaced in attempting to give back to the world, through her work, a portion of its lost heart."

Anne Rochon Ford is a writer and policy adviser on women's health and equity issues in Toronto, and a former member of the Healthsharing collective. In January, she was appointed to the Transitional Council of the College of Midwives.

Update

Since this talk was delivered, the Interim Regulatory Council on Midwifery completed its mandate and the Transitional Council of the College of Midwives was appointed in January of 1993. Due to intense lobbying by the IRCM and its Equity Committee, the government appointed a much more diverse Council, including two Aboriginal women (one of them Katsi Cook, referred to above), a disabled woman and two immigrant and visible minority women.

The transitional council will soon have the authority to officially register and regulate midwives when proclamation of the regulated Health Profession Act takes place in the provincial legislature at the end of 1993. In the new year, registered midwives will be paid on a salary basis by the provincial government. The biggest task which lies ahead for the Transitional Council is working out a process for registering the many foreign credentialed midwives who would like to practise in Ontario. Midwives from a variety of training and practice backgrounds will need to integrate into a model of practice which is woman-centred and offers a woman a choice of birthplace.

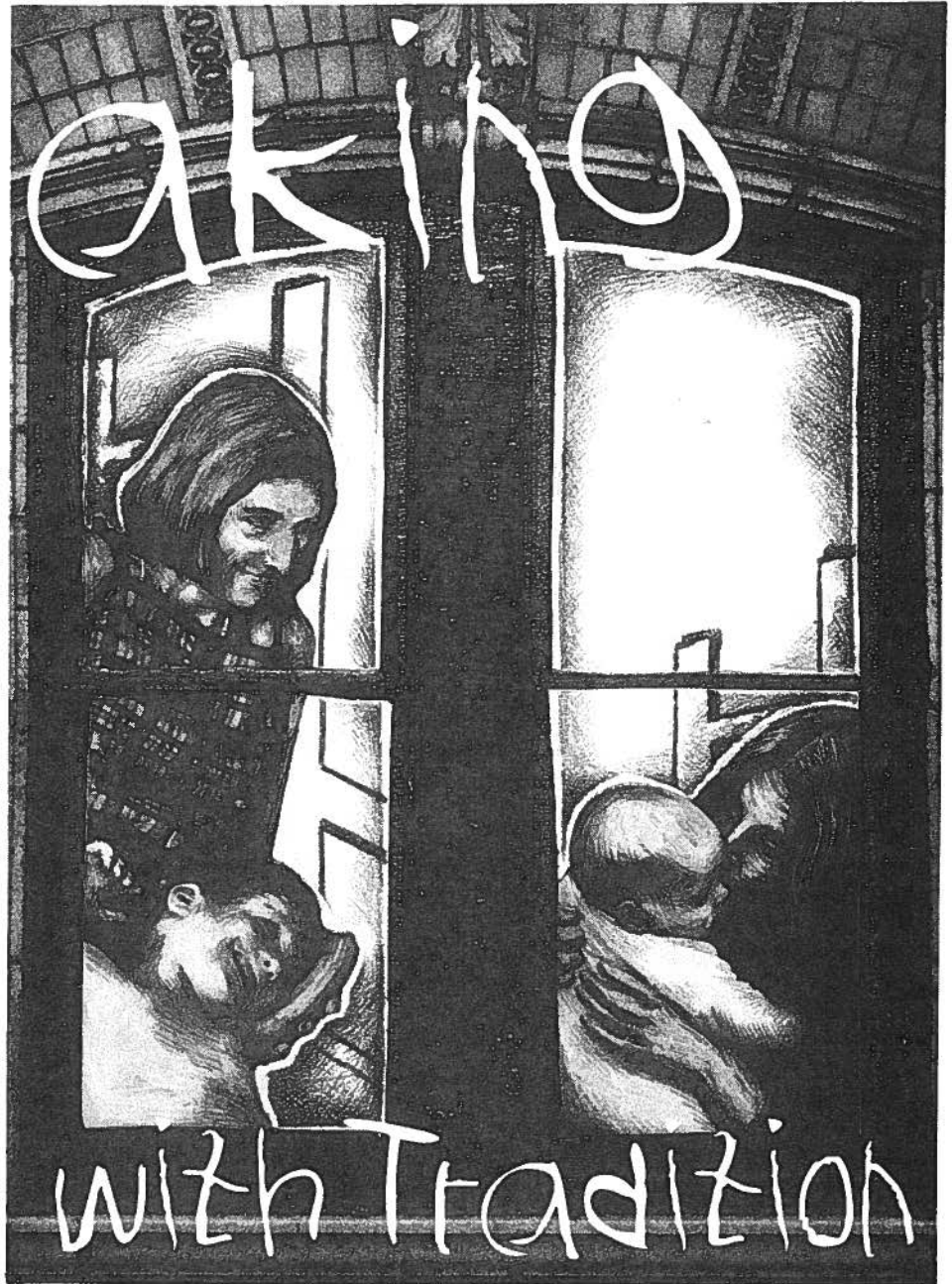
The first group of midwives to be registered in the province will be a group of currently practising midwives from around the province who recently graduated from a one-year intensive program at the Michener Institute of Applied Health Sciences in Toronto. A four-year Bachelor of Health Sciences in Midwifery program began this September at McMaster University in Hamilton, Ryerson Polytechnic University in Toronto and Laurentian University in Sudbury. In Sudbury, designated placements have been set aside for francophone students and at all three schools, placements are held for a number of Native students. Part-time students are accommodated at Ryerson.

A full set of reports of the Equity Committee of the IRCM are available at cost from the Transitional Council of the College of Midwives, P.O. Box 2213, Station P, Suite 285, Toronto, ON, M5S 2T2, as are a wide range of Council policy documents.

Breaking

by Rachel Epstein

North America is experiencing a baby boom among lesbians. Lesbian parenting in itself is not a new phenomenon; lesbians have always parented children who were often the result of heterosexual relationships or marriages. What is new, however, is lesbians choosing, as lesbians, to bear and raise children.



While lesbians choosing to get pregnant and parent a child face a myriad of issues, including whether to single parent, co-parent or develop an alternative parenting model, this article focuses specifically on how lesbians who are choosing to co-parent in couples are defining and living out their parenting roles. It explores the ways that lesbian families pose a serious challenge to the typical mother-father parenting roles in the dominant model of the nuclear family. While posing this challenge, these new family forms are also undermined by the homophobia (fear of homosexuals) and heterosexism (assumption that everyone is heterosexual) encountered by lesbian parents generally and particularly by the lack of societal recognition of the

non-biological lesbian parent.

When I refer to the traditional model of the nuclear family I am referring to a model which consists of a heterosexual married couple with one or more children who are genetically related to the parents. The woman and children are economically dependent on the man; he is the primary breadwinner, she the primary caretaker of physical and emotional needs. The children are the property of the parents and the parents have authority over the children. All of these roles are considered "natural". This is the ideological model upon which most social policy related to the family is based; it does not necessarily describe what North American families actually look like.

I come to this research with much personal interest and involvement. I am a 37-year-old white, Jewish, middle class, lesbian mother. I am co-parenting a baby girl

Lori Dell

with my partner of six years. I am the biological parent; she the non-biological. As we raise our daughter we engage in an on-going process of defining our different roles in relationship to our child. There are few models for a family with two female parents; we develop them ourselves through experience and by observing and sharing information with other lesbian families.

I conducted the interviews for this project when I was six months pregnant. The baby felt imminent and I wanted to learn from people who had done this before me about the parenting models they had developed. I wanted to know how lesbian parents are defining their parenting roles. What does it mean to have two mothers? Are their roles the same and equal? If not, what are the different roles? What is the impact of the lack of societal recognition of the non-biological mother? How do family, friends and the larger society support or not support the choices that lesbians make regarding parenting roles? Are lesbians challenging and/or recreating the structure of the traditional nuclear family in the parenting roles they are developing?

The women I interviewed were "ordinary" lesbians like myself. I found their words a reminder of the courage it takes to lead one's life in contradiction to the dominant society; I was also inspired by their thoughtfulness, self-awareness and determination. While parenting small children can sometimes result in a withdrawal from active political life, the issues raised by lesbian parenting puts us right in the middle of current theoretical and strategic debates within the lesbian and gay movement and in the larger political arena.

A feminist approach

My approach to this research was primarily a feminist one. I acknowledge the importance of using women's lived day-to-day experience as a starting point, while also recognizing that women's experience is not monolithic. There are many realities to women's lives and to the oppression we experience as women, some of the differences being based on race, class, culture, ethnicity, ability, age and sexual orientation. Lesbians

experience the world differently because we are lesbians.

Of course our experience as lesbians is also not monolithic. We too differ in significant ways from each other. My recognition of this means that I attempted to interview lesbians who are diverse in terms of race, class and age.

The women I interviewed were all from within a particular subsection (feminist, activist) of the broader "lesbian community" of which I am a part. I interviewed three lesbian couples who have had one or more children as a couple. They are:

Couple 1: A—35 years old, lesbian for 17 years, middle class, Scottish Protestant (WASP), biological mother to girl, age 5, non-biological mother to boy, age 7. B—31 years old, lesbian for 10 years, working class, white, assimilated Francophone, biological mother to boy, age 7, non-biological mother to girl, age 5.

Couple 2: C—38 years old, lesbian for 15 years, middle class, white, (WASP), biological mother to girl, age 5. D—50 years old, lesbian for 15 years, middle class, African/English/French/Portuguese Jew, grew up in Jamaica until age 19, non-biological mother to girl, age 5.

Couple 3: E—29 years old, lesbian for 15 years, working class, culturally Canadian, racially African, grew up in Barbados, biological mother to girl, age 1, non-biological mother to girl, age 2. F—31 years old, lesbian for 11 years, working class, South Asian/Black, grew up in Jamaica, biological mother to girl, age 2, non-biological mother to girl, age 1.

Challenging the nuclear family

The division of labour within lesbian households (i.e. who stays home with children, who goes to work) is not based on the presumed economic dependence of a woman on a man, but rather on which partner can get work, who can make more money, and on the desires of each partner. All the women I interviewed described a similar negotiation process leading to decisions about who would work at home and who would go out to work. These decisions are not always easy to make and each location brings with it different fears, feelings and resentments.

"I won't sit here and say there's no resentment, of course there is. I mean you've [she indicates her partner] talked to real grown up people all day, that actually have opinions and feelings. And then she turns around and says to me, 'but you watched Y. walk first and you listened to Y.'s first whatever'. so trying to not get the 'grass is greener' syndrome, realizing there are many flaws being out there and there are many flaws being in here." E.

What differs for these couples from what might be the common experience of heterosexual couples is that there is flexibility in terms of who does what. If one partner expresses distress about the work she is doing, there is room for negotiation and change.

"I clearly remember the day when I said to B. 'The flags are starting to fly, B., I gotta get out of here. I've talked baby babble for a year and a half now, I don't know what it's like to socialize with adults, my brain is atrophying in places, I've got to get out.' So that was the end of that phase." A. (emphasis mine)

What the child(ren) would call each of its parents was an issue for each couple. Most wanted names that implied some form of equality between the parents, and some definitely wanted to be called some form of "mommyism."

"We figured whatever it was it would be something that was equal, so when she first started talking she'd call us Mama C. and Mama D., and then she just dropped the Mama at some point and she uses our first names now. She's always referred to both of us as her mom, or 'my moms'." D.

"We both wanted some form of mommyism, and not first names. I ended up believing in the theory that the kids would pick for themselves. And now they do. And they have different names for different situations. It's like 'Moomm' does a certain job, and 'Where's A.' does another, but mostly it's Mommy A. and Mama B." A.

Parenting roles

Contrary to the gender-prescribed roles explicit in the traditional model, lesbian parenting roles are based on each woman's personality, likes and dislikes, and style. One parent may be the "funny" parent, the other more serious; one might do sports with the kids, while the other pushes academics; one

is more easy going, the other more hard line. The challenge to gender-defined roles is profound. As one woman said, "We're not modelling male-female power dynamics, we're modelling women doing everything that needs to be done in order to maintain life. So I think it's very different."

Significant in the discussions about roles was women talking about the feelings associated with being the non-biological parent. The non-bio-

...tied to her. This caused conflict between A. and I because I could not comfort W. (daughter). I wanted to feed her. It caused conflict too between me and W. at times because I'd think 'does she love me?'" B.

The feeling of being left out of breastfeeding seems to be compensated for if the non-biological mother becomes the "at home" parent and spends more time with the kid(s).

"At four months she stopped breast-

evened out, but fairly recently." D.

Some biological mothers spoke about their desire to have their partner bond with the baby in order to share the emotional responsibility.

"I didn't want any sort of ownership. Yes, you are my birth child, but I want you to bond with whoever you want to bond with because otherwise it becomes a lot of emotional responsibility on me and me alone. The reality is there will come a point when you have your life

Schools
are a
major
institution
that
lesbian
mothers
have to
confront



logical lesbian mother can feel excluded even before the baby is born. A non-biological lesbian mother, unlike a father in a heterosexual relationship, doesn't have a defined role in helping her partner get pregnant.

All of the women I interviewed acknowledged that the period of breastfeeding was the period where the difference between the biological and non-biological parent was most marked. A breastfeeding infant is much more dependent on and tied to its biological mother than on anyone else. Nobody else can meet its physiological or nurturing needs as fully. This almost always results in some feelings of jealousy and being left out on the part of the non-biological parent.

"From the day she was born she (daughter) hated the bottle. So A. was

feeding and went to her new job and I was full-time at-home mom. So whatever bonding stuff around breastfeeding I might have been worried about was obviously easily compensated for by the fact that I was doing hours and hours with them." A.

In the case where the couple had only one child it seemed to take longer for the relationships to equalize, even when the non-biological mother spent lots of time as the primary caretaker.

"I knew she would be more attached to C. because of breastfeeding. It didn't matter when she was a little baby, it mattered later on when she was able to clearly show a preference, which she did. If she got hurt and we were both there she'd go to C. first, or she'd want C. at night. Now [child is five] that has

and I have my life and if I haven't learned to let go it becomes harder the older I get. So it was important for me for the two of them to establish how they will operate with each other." F.

One choice the lesbian non-biological parent has that fathers share but rarely exercise, is the option to actually suckle the babies they didn't give birth to. While it can take a great deal of effort to actually produce milk, suckling for comfort is easy to do.

"I suckled my first born for the first month and a half. Comfort suckling they call it. Instead of using a pacifier she would do that." E.

Non-biological parents also spoke about the insecurity of their parenting role and, indirectly, about the power of the biological parent. Because non-biological lesbian parents are not legally

Lori Dell

recognized or socially sanctioned their "right" to mother can be "granted" or taken away by the birth mother.

"I remember when Y.[son] was about 24 hours old, me saying to B. 'you better be absolutely sure that you agree with what we said all along, cause I'm hooked... If you don't see me quite the same as a mother, you tell me right away because if you tell me that a week from now we have a large battle on our hands, cause you'll be fighting with his mom, not just with your lover, but with his mom.'" A.

The parenting role of the non-biological mother is not based on biology or on legal ownership. It is this role in particular that challenges the traditional model's emphasis on biology and children as property and which points the direction for new definitions of "parent" and "family."

Undermining the challenge

The challenge lesbian parents pose to the traditional model of the nuclear family is undermined by the institutionalized homophobia and heterosexism embedded in the society and encountered in the behaviours of family, friends and institutions.

All the women I interviewed spoke about on-going struggles with family members, particularly parents, to get them to recognize the legitimacy of the non-biological parent and to consider themselves grandparents to the children their daughters' partners gave birth to. This struggle for recognition can have a history in the family's refusal to recognize or accept the initial lesbian relationship, let alone the children that become a part of it. "My daughter's friend's daughter" is how one lesbian's mother described the child her daughter is parenting but didn't give birth to. This description sums up her refusal to legitimate her daughter's primary relationship and role as a parent. Another woman described being referred to in a joking manner by her partner's family as the "aunt" or "live-in nanny."

The homophobic behaviours of family members range from extreme acts of exclusion, almost akin to "disowning", to much more subtle forms of showing preference for biological links—taking one kid out but not the other, forgetting a birthday, writing to one but not the other, refusing to recognize a non-

biological grandchild in public.

Lack of legal protection for non-biological lesbian parents means that negative reactions from their parents can lead to fears about claims grandparents might make on grandchildren if anything happens to the children's parents, particularly to the biological parent. Women talked about the need to get parents to sign a written statement agreeing not to make such a claim because "you know when people die, people get weird. So really we should do it." A.

Rejection by biological family is a contributing factor in the establishment by many lesbians of what might be called an "extended family by choice"—a supportive network of people who act as family to one another. By establishing family ties that are not based in biology, lesbians once again challenge traditional notions of family.

"I'm not a nuclear family because I have many extensions in my family. I know that our children will be able to turn to many people in our community because we have established the bonds for them." E.

Although it is less frequent and less threatening, lesbian parents also run into confusion and homophobia from peers who do not understand or accept the family forms they are creating. Sometimes friends just can't get their head around the concept of two women parenting together and will only confer true "mother" status on the biological parent.

"When I talk about Y. being my daughter my straight friends say 'but no, she's F.'s daughter.' They have to make it very clear that she's F.'s biological daughter." E.

Lesbian parents, like all parents, have to deal with institutions such as hospitals, daycares and schools. This means having to make choices about how and with whom to be "out" and when to intervene on behalf of your kids.

All the women I interviewed had chosen to be very "out" in dealing with institutions in order to instill confidence, not fear, in their children. But being "out" means encountering and dealing with homophobic responses which can vary in their intensity, from extremely serious to mildly annoying. Non-biological parents are sometimes refused admission

to parent-teacher interviews or are denied permission to make important medical decisions for their children if the biological parent is not present. And then there is the day-to-day unpleasantness of people's reactions to a lesbian family.

"You can tell a doctor three times 'talk to me like I'm his mother, so is she', and they don't get it. Sometimes they really say 'I don't know what you're talking about.' 'We're two lesbians, we're both the mother.' 'Hub. No, I'll talk to the one with the dress, that's safe.'" A.

Schools are a major institution that lesbian mothers have to confront. Many of the women I interviewed had positive experiences with individual teachers, although they also talked about their parenting status being tolerated but not made visible in the classroom.

The kids of lesbians too have to learn to deal with homophobic reactions from classmates, teachers, etc. One couple's strategy is to encourage their kids to do well academically so that at least they can't be 'gotten' in that area.

"Even though the kids tell him he's going to burn in hell because he believes in Nature instead of God and that his mothers are faggots...in that environment he's still strong because they still have to come to him for the answers, because they don't know and he does." A.

The homophobia and heterosexism encountered by lesbian parents, and particularly the powerful lack of validation of the non-biological parent can lead to doubts on the part of lesbian parents and their children about the legitimacy of their families. The pressure of always having to defend your right to parent can undermine your confidence in your role.

"When we were dealing with family pressures that's when we would notice our biological role with the kids and it would cause us conflict because then we might get fearful that I'm seeing V. more as my child and she's seeing W. more as her child." B.

Children too are vulnerable to external pressures.

"Sometimes someone will say in front of the kids, 'so you're V.'s mom and you're W.'s mom.' That's really the hardest because you have to watch them go through learning peo-

ple's rather heartbreaking confusion, and maybe it makes them a little bit doubtful. 'Are...are... aren't you my mom? What do you mean I'm yours, she's hers?'" A.

New definitions

Although lesbian families might resemble traditional male-female nuclear families in some aspects of outer appearance there are enormous differences which pose a fundamental challenge to this model. By their simple insistence on their right to parent, as well as through the parenting roles they are developing, lesbian parents profoundly challenge the patriarchal model which defines roles through biology. In particular, the non-biological lesbian mother defies traditional notions of parenthood in that she has neither biological connection nor legal status as a parent. She is forging new ground and her existence calls for new definitions of "family" and "parenting."

Jo Van Every, in a 1991 presentation on British social policy and the family, proposes that "family" could be defined as "an emotionally supportive network of adults and children, some of whom live together or have lived together." Brian Mossop, a Toronto gay activist who recently fought a case to get bereavement leave to attend his lover's father's funeral, argues that "family" has to be

defined in terms of how members of a household act (sharing finances, housework, emotional support, etc.), and not in terms of legal status like "spouse."

In terms of parenting, both these definitions imply that people would be defined as parents *based on the act of parenting*. These redefinitions raise other important questions, starting with how lesbians define their parenting roles. All the women I interviewed consider themselves "two mothers" and want their children to refer to them using some form of "mommyism." Is our desire to be "two mothers" buying into the traditional model and an example of consciously opposing the nuclear family form while upholding it in practice? Are we using the term "mother" because that is all we know? Is there another term that would more usefully describe the act of parenting children? Or, on the other hand, is our insistence on the use of the term "mother" to describe a non-biological lesbian parent a radical redefining of the term and a challenge to the notion that everybody only has one mother? Is a suggestion that we call ourselves "parents" instead, a subtle rejection of the legitimacy of the non-biological "mother"? Lesbians are faced with the choice of redefining and reclaiming or redefining and renaming.

This question of reclaiming or renaming is linked to the debate currently being waged in the lesbian and

gay community about spousal rights. If we fight for state-sanctioned lesbian and gay marriage and the rights and privileges that go along with it, are we embracing the nuclear family—an institution that has historically oppressed us? Are we forsaking the rich and varied alternative relationship structures lesbians and gays have created? Or is a struggle for spousal rights a way to obtain immediate gains for coupled lesbians and gays while continuing to struggle for more radical change that would guarantee equal income support and other benefits to everyone in society, regardless of marital status? How do we secure rights for lesbian parents without recreating relationships of economic dependence? The lesbian non-biological parent is not a "husband." Her experience defies conventional definitions of family and points the way to new forms of familial relationships, and possibly, as one woman I interviewed said, a new kind of love.

"It's a different love, but it's as big a love, or as love a love. W. (biological child) and I are forced on each other in a physical way. Conversely with V. (non-biological child) there's a different deep, sort of philosophical part of the love." A.

More research needs to be done focusing on the experience of the non-biological lesbian parent, including the emotional aspects of her experience as well as looking at what happens when lesbian couples break up in terms of custody and visitation rights. Lesbian couples who adopt might provide an important contrast even though in Canada to date only one woman can be the legal parent.

My hope is that this research will be useful in several ways. First, that it will offer an alternative vision to the seemingly unchanging model of the nuclear family; second, that it will be a vehicle for the previously unheard voices of lesbian parents; and finally that it will provide a useful and thought-provoking reflection of our on-going struggles to create families.

Rachel Epstein has been in the "mother zone" for the past 18 months. A revised version of this article will be published next year in a textbook on Canadian families, edited by Marion Lynn.

The Regional Women's Health Centre

The centre offers a range of health services designed to meet the special needs of women of various ages. Our aim is to encourage women to participate actively in the enhancement of their reproductive health.

There are no service fees and referrals are not necessary.

Current programs include

- Bay Centre for Birth Control—Family Planning Program
- STD/HIV Prevention Program
- Provision of contraceptive devices
- Midlife and Older Women Program
- Social Work Program—Incest Survivors Group
- Women's Health Centre Resource Library
- Infertility Support & Education Program
- Life Skills & PMS Education & Support Groups

We are open evening and Saturday hours by appointment.

- For more information, contact us at: 586-0211
 - **Bay Centre for Birth Control** 351-3700
 - **Women's Health Resource Centre** 351-3716
- 790 Bay Street, 8th Floor,
Toronto, Ontario, M5G 1N9



WOMEN'S
COLLEGE
HOSPITAL

Woman Abuse: A National Crisis, A National Responsibility

Male violence against women will continue to be a national epidemic as long as state authorities maintain the attitude that it is not a societal problem but just a 'domestic argument gotten out of hand.'

Woman abuse has no class, colour, creed, economic or educational background. We all know someone, or we ourselves have experienced some form of abuse by brothers, fathers, stepfathers, other male relatives or friends. Women who are political refugees have experienced forms of unspeakable abuse because of their particularly vulnerable situation. Male violence against women can result in severe mental or psychological injury, physical harm or death.

Women are reluctant to admit that abuse is happening to them. This is even more problematic because of the tradition of handling health and domestic problems privately; these issues are considered the domain of family or a very close friend whom one can trust. As one woman pointed out, "This forces the women of my community to turn to the same man who is her abuser, for solace and understanding, which she will never get from him."

In order to develop effective programs to eradicate woman abuse, the issue has to be understood in all its complexities: the reasons it occurs, and the impact on the victims, the children who experience it happening to their mothers, the young girls experiencing it in secret, and the men responsible.

Many groups throughout Ontario are working to stop woman abuse, providing much needed services including research, education and training to professionals and counselors, group and individual counseling and shelter.

The experience of Women's Outreach in Sault Ste. Marie, is that abused women are left feeling isolated, powerless and guilty; they experience mixed feelings of anger, fear and shame. Responding to this situation, Women's Outreach provides short-term and long-term counseling for women who have experienced abuse of any form at any point in

their lives. They provide both individual counseling and group sharing programs, and produce materials adapted to specific needs.

One of the major barriers faced by the Women's Outreach in Algoma District is the response of the police, the justice system, and city government to woman abuse. According to Women's Outreach, these political and legal institutions "treat women as if they are to blame, treating violence and assault against women lightly. This kind of attitude denies the prevalence of violence against women and therefore it is difficult to get tax dollars apportioned for services for women."

"Anduhyau", a women's shelter that deals with the specific needs of First Nations women, runs a program called "Nimisuk". They found it necessary to develop a culturally-based program which blends traditional Native medicine and western psychotherapy. The women who started this program recognized that the western approaches were not working for many of their people. One of the major reasons for this failure was the absence of an understanding of Aboriginal culture and identity and the impact racism has on aboriginal women who are abused.

Education Wife Assault (EWA), a non-profit community organization providing education and training on the issue of woman abuse, believes that education and training are among the first steps which must be taken to stop abuse. They work towards this end by encouraging public awareness and supportive intervention. One of the particularly effective projects of EWA is their partnership program where they work with women in different communities to develop their own resources and workshops in their language.

EWA offers a framework for eliminating woman abuse: freedom from assault is every person's basic right, wife-beating should no longer be defined as a woman's private dilemma, it is assault, not interaction gone wrong. It is not a sickness, it's a crime.

Perhaps the least understood aspect of woman abuse is sexual abuse in a

IN OUR OWN WORDS

Many groups and organizations throughout Ontario are working to eliminate woman abuse, reduce workplace & environmental health hazards and improve the health of women. This section profiles some of these groups and the issues involved.

dating relationship. The woman is invariably blamed as being responsible because she put herself in a situation to be raped, either by the way she dressed or what she did. Women's Habitat, in partnership with EWA and MediaCom, are running a pilot "Poster Contest on Violence and Sexual Assault in Dating Relationships," in six to eight high schools. The objective is to educate teenage women and men about the issue.

These groups along with thousands of others are working towards zero tolerance: a time when women can walk down the street, live with their families and friends, and carry on a full life, without fear of abuse of any kind.

Women's Outreach in Northern Ontario

Women's Outreach began in 1985 in response to a strong community need. They provide short and long term counseling for women ages 16 and older who have experienced any form of abuse at any point in their lives. This includes sexual abuse, assault, physical, emotional, verbal and psychological abuse.

Women's Outreach focuses on helping women to understand the source of the varied emotions they experience as a result of abuse and how society contributes to maintaining the abuse. They work with each woman to try to help her develop new coping mechanisms, teaching her how to listen to her inner wisdom. They also encourage women to share with each other to help reduce the feeling of isolation.

When their sense of isolation dissipates, the guilt and shame lessen. Many realize that the medical and psychiatric labels which are used to control them, serve to reinforce the societal denial of abuse. This awareness empowers women within their personal/familial relationships and affects the wider society.

Women's Outreach faces a high demand for their services in the large community they serve. (The Algoma District spans north from Sault Ste. Marie by approximately 320 miles and east by about 150 miles. Populations are clustered in small communities of between 50 and 6,000 people). They have a waiting list of approximately a year for their individual counseling services. And as is typical in rural communities, there is a lack of child care and transportation to allow women to attend individual and group counseling. Women must travel lengthy distances to get together. Many women who are in an abusive relationship may have to walk 20 miles, and usually more to escape or obtain services. Even when transportation and childcare are available, women often can't afford to pay.

If a woman lives in the city and cannot get care from a public agency due to a long waiting list, she may not be able to afford private therapy. In any case there are few private therapists who are feminist and there



Woman abuse has no class, colour, creed, economic or educational background

are very few female physicians, not to mention physicians who understand the dynamics of woman abuse.

It is in these difficult conditions, that Women's Outreach works. There is a clear need for expansion of services and resources in this area.

Women's Outreach can be reached at 898 Queen St. East, Sault Ste. Marie, ON, P6A 2B4.

Dating Can be Dangerous: Teenage Woman Abuse

When we think of woman abuse, we think first of men assaulting women they know or live with, and then of rape by strangers. More recently the silence surrounding the issue of rape and physical violence in teenage relationships has been broken. Date rape

and teenage woman abuse are researched and talked about more openly now.

Women's Habitat, a women's shelter in Etobicoke, in partnership with Education Wife Assault and MediaCom, are running a pilot "Poster Contest on Violence and Sexual Assault in Dating Relationships", in six to eight high schools in Etobicoke in the fall of 1993. The objective of the project is to educate teenage women and men about the issue through their participation in the poster contest.

Women's Habitat became aware of teen dating violence as a result of speaking in schools on the issue of violence against women. They were asked questions by students such as "what can I do if my boyfriend has abused me?" The increased demand for education on the issue of dating violence led to the development of

Phyllis Wong Kun

he pilot poster contest.

According to Health and Welfare Canada, dating violence "is the sexual, physical or emotional abuse of one partner by the other in a dating relationship where the couple is not living together. While incidents of violence against men do occur, violence against women is more pervasive, more systematic, and usually more severe."

It is difficult to determine the actual prevalence of dating violence, since it is rarely reported by the teenage victims. A study of 304 secondary students in Toronto showed that one in every five women has experienced at least one form of abuse in a dating relationship; sixty percent indicated that they had been exposed to dating violence. Date rape however has the lowest reporting rate of all forms of rape; it is estimated that only 1% of date rapes are reported to the authorities.

Young women face the problems of shame and guilt more acutely than older women. Teenagers have difficulty talking about their relationships, particularly when they are experiencing physical and/or sexual violence. There is fear of being blamed by parents and others in authority. Limited knowledge about sexuality, contraceptives, relationships, and life as a whole makes the experience even more confusing.

What about the young men, the perpetrators of the violence? They too are going through a very confusing period of their lives. They are expected to prove their "manhood," using the prevalent role models. Their acts of violence are an expression of their need to be in control, to dominate a woman in the way that they have seen their father dominate their mother or other men control women.

There is a great need for the schools to develop policies and procedures for dealing with woman abuse in the school system. Often young men who assault young women remain in the same class with no disciplinary measures taken or attempts to deal with the impact on the girl. Some schools do not even acknowledge that there is a problem. When there is some movement on the issue, support must be provided in a culturally sensitive

manner, challenging racist attitudes of staff and students.

The poster contest is an attempt to get broad participation of students and staff in discussing this issue. If this project is successful it will be extended to other schools.

For more information contact either Gayle Janes at (416)968-3422 or Janet Walker at Women's Habitat (416) 252-1785.

For help call the following:
Assaulted Women's Help Line, (416) 863-0511; Youthline, (416) 922-1700; Kid's Help Line, 1-800-668-6868; Distress Centre, (416) 486-1456.

Fayola Lawrence

Building Connections in Eliminating Woman Abuse

Education Wife Assault (EWA), a non-profit organization founded in 1978, believes violence against women must stop, and that education and training are among the first steps which must be taken to reach this goal. They work towards this end by encouraging public awareness and supportive intervention.

Like other groups in the city of Toronto in particular, and in Ontario as a whole, one of their major challenges is to meet the needs of an increasing range of cultures, languages and expectations. To meet this need EWA works in partnership with other groups to develop resource materials for education and training in the language and culture of the groups concerned. "We have focused on projects, materials and programs that reflect the true spirit of working together, in terms of power, control and trust, as these essential elements impact on our relationships with each other - personally and at work." EWA's most recent partnership projects involved the development of materials in Vietnamese and Urdu.

EWA's partnership program is unique. One of the biggest challenges facing the Vietnamese women in producing materials on woman abuse is the lack of a vocabulary in Vietnamese to describe the issue, because of the fact that wife assault is treated in their country as a private



family matter. According to Chi Dang, one of the Vietnamese participants, "as women together, we managed to overcome this linguistic denial. We searched for, and recreated words that best described us... We dug deep into our soul and deeper into our his/herstory in an attempt to understand and acknowledge what has caused violence against us."

The work of EWA is guided by an understanding of the complexities of systemic racism in our society, which add other dimensions to the methods of solving problems of woman abuse among women of colour. A woman may be more reluctant to call the police because of the potentially racist treatment she and her partner could receive, even though he has hurt her. The fear of children being taken away and put under the care of the state also stops many women from reporting abuse.

The work of these two partnerships is only a small part of the tremendous demand out there for the services of groups such as EWA.

EWA also provides education and training to a wide range of people. Legal and health care professionals, students, community groups, social service workers, counselors, men who are violent, and women who have been assaulted use their services.

The wealth of clear, concise, quality information available at a very low cost makes their message very accessible. All the basic information on woman abuse is published by them on 13 single page information sheets at only \$0.50 per sheet. EWA continues to have an impact at various levels, with different communities of women, social services workers and educators.

For further information on Education Wife Assault, call (416) 968-3422 or write 427 Bloor St. West, Toronto, ON, M4M 1T4.

Anduhyaun House

As a board member of Anduhyaun, a women's shelter that deals with the specific needs of First Nations women, I am aware that eight out of every ten Aboriginal women in Canada has been a victim of violence. I cannot think of one Native woman who has not suffered some sort of violence. At the same time, Aboriginal women also face racism and the legacy of colonialism, which have a constant impact on our lives. Therefore it should not surprise health practitioners that culturally-based programs are required. This is particularly true for women who have survived child sexual abuse. Although there are similar issues with all women who have survived sexual abuse, for First Nations women, the prescriptions for healing should take a different form.

Most of my experience around sexual abuse and what the Native community is doing to help incest survivors, I have gained from my involvement with Anduhyaun and my relationships with women in my community.

Anduhyaun runs a program called Nimisuk, a Cree word meaning "my sisters." Nimisuk was started by two women at Anduhyaun, Catherine Brooks a former board member and now executive director and Pauline Smith, the assistant director of the shelter. Pauline noticed that 60 per cent of the women who went through Anduhyaun had been victims of sexual abuse; and forty per cent of the women who stayed at the shelter returned again and again over a period of years before a level of self-confidence and independence

was achieved. The women were returning to the shelter despite being referred to a program at the Barbara Schlifer Commemorative Clinic. It was apparent that there were important elements missing in the program and it was not meeting the needs of Aboriginal women.

For Pauline and Catherine the solution was to develop a culturally-based program for Native women who are survivors of incest. They consulted with First Nation elders and traditional healers on possible approaches for the program. It was decided that it should blend traditional Native medicine and western psychotherapy. Nimisuk was born.

Traditional Native medicine in the program consists of purification lodges, women's healing circles and full moon ceremonies. These traditional healing ceremonies are used to bring about wholeness to the individual and connect them with the community and the earth. The full moon ceremony is a special ceremony to honour the moon who represents our grandmother.

Issues of identity and the impact of racism were immediately identified as central to the program. These are issues that all Aboriginal women must face in their healing process. In order for a program to be helpful, it has to address not only the physical abuse women have suffered but also the systemic racism that they confront. These cannot be separated.

Nimisuk is run as a self-help support group with facilitation from two counselors. There are three levels that the women can go through and as they progress through these levels, they make more decisions as a col-



lective about what to work on.

Nimisuk is not the only program in the Toronto area for incest survivors. Native Family and Child Services has a program called Mooka-am, which means breaking through the surface in Ojibway. Like the Nimisuk program, Mooka-am blends traditional and Western therapies.

Aboriginal women who have been through these programs have a lot more confidence and hope in their future. Through the Nimisuk and Mooka-am programs First Nations communities in and around Toronto are beginning to face the tremendous challenge of healing the suffering inflicted by incest and sexual abuse. For more information about these programs please contact: Catherine Brooks, Anduhyaun House at 106 Spadina Road, Toronto, ON, M5R 2T8, Tel: 920-1492 or Native Child & Family Services of Toronto, 464 Yonge St., Suite 201, Toronto, ON, M4y 1W9, Tel: 969-8510.

Carole Couchie

Dr. Phyllis Marie Jensen RN, PhD.
Healing the body, mind, heart and spirit

Psychotherapy and Art Therapy
Jungian Dream Analysis
Smokefee for Women

(416) 465-1323

KINESIS

News About Women That's Not In The Dailies

KINESIS is Canada's foremost feminist newspaper. For wide-ranging national and international coverage of women's issues and culture, send \$1 for a sample issue, or \$21.40 (Outside Canada \$25) for a year's subscription (10 issues).

KINESIS: #301-1720 Grant St, Vancouver, BC Canada V5L 2Y6

Phyllis Wong Kun

Workplace Hazards and Environmental Health

"I have the right to decide what happens to my own body, not because I know more than anybody else, but simply because it is my body. And I have a right to acquire the information that can help me make those crucial decisions."
Audre Lorde, "A Burst of Light"
(Ms magazine, Vol.III, No.6)

As we end the 20th century, environmental hazards have become one of the biggest health concerns across North America. Dealing with the many environmental concerns and their impact on our health brings us smack up against the political and economic power of the financial and manufacturing giants of the industrial countries. It is no surprise that a growing number of scientists, health workers and environmentalists have identified environmental contaminants as playing a large role in our deteriorating immune systems and general increase in ill-health. More specifically, it is now becoming clear that environmental pollutants play an important role in the current breast cancer epidemic.

The increase in the prevalence of breast cancer since 1950, from one in twenty to today's rate of one in eight was the topic of a 1992 Greenpeace Report entitled *Breast Cancer and the Environment: The Chlorine Connection*. The report concludes that this increase is largely due to the increase in chlorine-based compounds—the basis of some plastics, pesticides and paper bleaching. Megan Williams, in an article in *The Rag Times*, Feb/March 1993, a newsletter of the Women and Environments Education and Development Foundation, (WEED), discusses the reaction of the Canadian Cancer establishment to this new evidence. WEED's "Stop the Whitewash" campaign advocates for the elimination of chlorine based compounds to bleach women's sanitary napkins and tampons.

The "Stop the Whitewash" campaign began in 1990, following the brilliant example set by the Women's Environmental Network (WEN) in Great Britain. Focusing on women's

sanitary products and diapers, British women wrote letters, telephoned politicians and pressured manufacturers to abandon chlorine gas bleaching of these products. They succeeded...in just six weeks!

Another environmental concern related to breast cancer is the startling evidence that mammogram screening for women under 50 has very low detection rates and at worst can even be a culprit by inducing breast cancer due to overexposure to radiation. Dr. Rosalie Bertell, president of the Toronto based International Institute of Concern for Public Health discusses mammography and suggests that the less expensive breast self-examination may continue to be the best form of early detection.

The Ontario Nurses Association, (ONA), the union representing more

than 50,000 Ontario registered and graduate nurses has made health and safety issues in the workplace a major concern. Nurses are exposed on a daily basis to both physical and chemical hazards in their workplace.

"Nursing is often dangerous to those who practice it. It does not have to be that way—improvements can be and have been made, although not without pain, struggle, patience and compromise." says Lisa McCaskell, research officer at the ONA.



As we end the 20th century, environmental hazards have become one of the biggest health concerns across North America



Workplace Hazards in Nursing

Every working day, nurses face numerous threats to their safety and health. They risk back injuries as they assist heavy or uncooperative patients; they may be exposed to a number of infectious diseases or to radiation as they assist patients being x-rayed. Dangerous cleaning and sterilizing chemicals are found throughout most healthcare facilities; nurses who work in the operating room, recovery room, or in obstetrics

may be exposed to anesthetic gases, and many nurses have to handle medications such as cancer-fighting drugs that may damage their own cells. They are also at risk of violence from patients or their visitors as well as sexual harassment from many sources including physicians. Furthermore, nurses work in an environment often made stressful by the high emotional and physical demands of ill people and their families. All this is handled with too few staff and too little rest for those who work shiftwork.

The Ontario Nurses' Association (ONA) is the union representing more than 50,000 registered and graduate nurses who work in hospitals, homes for the aged, nursing homes, the community, and industry in Ontario. ONA's work, like that of other unions, focuses on collective bargaining, grievances and arbitration, union education, and improvements to government legislation. Although much of this activity focuses on the bread-and-butter issues of wages and benefits, health and safety is also an important component.

Back injuries are the single most important health and safety problem faced by ONA members. Numerous studies have demonstrated that nurses suffer from one of the highest incidences of back injury compared to other groups of workers. A recent U.S. study showed that only one-third of those nurses who said they had episodes of occupation-related back problems actually filed an incident report. Workers' Compensation statistics show that in Ontario, approximately 1200 nurses per year suffer a back injury for which they receive compensation. These injuries represent between 50 and 60 per cent of all compensable injuries to nurses yearly, and result in compensation payments of over \$8-million—not to mention the anguish and despair of those previously able-bodied nurses who may be incapable of nursing again.

In recent years, ONA has sought to reduce the number of back injuries by lobbying for legislative changes that would offer nurses and other healthcare workers greater protection. In 1993, the provincial government made into law a regulation under the Occupational Health and Safety Act, specifically targeted at workers in health care facilities. The new regulation was to have obliged employers in the health care sector to provide mechanical lifts and other devices to assist in moving patients. However, at the last moment, the government withdrew these provisions because of the financial burden on employers who would have had to invest in new equipment. ONA continues to lobby to have these provisions reinserted into the regulation.

Another health and safety issue of great importance to ONA members is

Health Professionals needed overseas!

Nigeria - Nurse/Midwives to facilitate the delivery of primary health care activities in a hospital and a community health extension program.

Nigeria-Child-to-Child Coordinator to train teachers and health workers in the Child-to-Child approach to primary health care.

Ghana- Public Health Nurse with experience in maternal and child health for a community outreach program.

Ghana- Registered Nurses with surgery and pediatric skills to work in a hospital ward.

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.

Salaries are modest but cover overseas living costs. To apply, send your resume to: CUSO GH-1, 135 Rideau Street, Ottawa, Ontario K1N 9K7.



abusive and violent patients. Numerous Canadian studies have pointed to the magnitude of the problem: a 1992 report by the Nurses Assault Project Team, which surveyed over 800 Ontario nurses, found that 59 per cent of nurses reported being physically assaulted at some time in their nursing career and 92 per cent had experienced harsh or insulting language on the job; a survey of 350 Saskatchewan nurses found that, in the preceding year, 81 per cent had been subjected to verbal abuse—75 percent of it from patients—and 53 per cent had experienced physical abuse at work. A 1989 study from Manitoba found that one-half of Manitoba nurses are physically assaulted by their patients at some point in their career.

ONA has sought to address this problem in a number of ways. In 1991, a booklet, "Violence in the Workplace," was produced and distributed to the entire membership. The booklet defines the problem of violence and gives practical advice on how to improve safety conditions and develop policies and procedures. ONA also worked to have the issue addressed in the recent health care regulation, in sections on staffing and the employers' obligation to warn staff of potentially violent patients. However, as with provisions on patient handling, it was dropped because of "cost implications." The union has also attempted, with limited success, to include the issue of abuse by patients in collective agreements so that nurses have some way to deal with the situation when it arises. Other nurses' unions in British Columbia and Manitoba have been more successful in winning effective clauses in union contracts.

Nurses, as well as other healthcare workers, are also exposed to dangerous chemicals and substances: disinfecting and sterilizing solutions such as glutaraldehyde and ethylene oxide; anesthetic gases such as nitrous oxide; and recently even latex gloves designed to protect workers from infectious diseases have proved to be hazardous to nurses' health. Glutaraldehyde, used to disinfect instruments, can cause skin problems and severe respiratory sensitivity. Exposure to anesthetic

gases has been linked to increased rates of miscarriage, and very recently nurses have begun to develop severe respiratory symptoms and dermatitis from latex exposure.

Locally, ONA advises members of ways to reduce or avoid exposure to dangerous substances and helps them develop strategies to work effectively within health and safety committees in their workplaces. Those nurses, for example, who have developed sensitivities to substances often need assistance from ONA to negotiate their return to a work area which does not endanger their health.



**Every working day,
nurses face
numerous threats
to their
safety and health**

Shift work is another threat to nurses' health. The majority of hospital nurses continue to work rotating shifts. Typically, nurses who work 12-hour shifts rotate from day to night shift every two weeks, year round. Eight-hour shift workers may work a combination of days and evenings, or days and nights, although some nurses still rotate through all three shifts. Studies on shift workers consistently point to ill effects on health, mood, productivity, safe work practices, and social and



family life.

Winning improvements in nurses' schedules has been a top priority of ONA members, and gradually improvements have been made. Most hospital nurses now get at least one in every three weekends off. Many have every other weekend off. Eight-hour shift workers, who for years rotated through all three shifts now work only two. Collective agreements now set out the number of hours that a nurse must have off as she changes from one shift to the next. However, when compared to much of the workforce in Canada, nursing shifts remain grueling. Many eight-hour nurses have to work seven consecutive shifts with only one weekend off every three or four weeks; many remain on-call at night for specialty areas and still have to work the next day. To make matters worse, many "weekends off" follow a night shift ending on Saturday morning which often means the first part of their weekend is spent sleeping.

Sadly, it seems that nursing and other healthcare groups have lagged far behind other workers, in the battle to improve working conditions. Nurses have often been reluctant to demand safer healthier working conditions, perhaps in part because of nursing's history as a female-dominated, caring profession. For years, many nurses have accepted back injuries, violence, fatigue, and exposure to dangerous diseases and chemicals as "just part of the job." Gradually however, this acceptance is disappearing, and nurses are demanding their health and safety on the job be treated seriously. The Ontario Nurses' Association is fully behind nurses in their struggle.

Lisa McCaskell



Parentbooks

201 Harbord St. Toronto, Ont. M5S 1H6
 Mon. — Sat. 10:30 — 6:00
 Phone (416) 537-8334

December 6th Rose Buttons

December 6th is Canada's National Day of Remembrance and Action to End Violence Against Women. To honour this day, and as part of the 16 Days of Global Activism Against Gender Violence (November 25–December 10), the YWCA of/du Canada is again producing Rose Buttons with an accompanying bookmark. The December 6th button, which bears a large red rose, reads:

"In Commemoration of the 14 women killed in Montreal, December 6, 1989, and all women who have suffered from violence."

Groups working to end violence against women can sell the buttons for fund-raising and public education. Available in bags of 100 for \$50.00. English or French text.



To order, contact:
 YWCA Canada, 80
 Gerrard St E., Toronto,
 ON, M5B 1G6, Tel:(416)
 593-9886, Fax:(416)971-
 8084, Att:Rose Button

Breast Cancer: The Chlorine Connection

A growing body of scientists, health workers and environmentalists are pointing to environmental contaminants as playing a large role in the breast cancer epidemic. A recent study released by Greenpeace comes to the striking conclusion that chlorine-based compounds make a significant contribution to breast cancer.

Current statistics estimate that an alarming one in eight women in North America will contract breast cancer at some point in her life. This makes it the most prevalent type of cancer in women and the leading cause of death in women between ages 40 and 55. These rates have risen from one in twenty in 1950 to today's rate of one in eight. "The worldwide increase in breast cancer rates has occurred during the same period in which the global environment has become contaminated with industrial synthetic chemicals, including the toxic and persistent organochlorines," the Greenpeace report entitled "Breast Cancer and the Environment: The Chlorine Connection" states.

Organochlorines, first produced in the early 1900s, have been made on a large scale since World War II when they were used as chemical weapons. They include DDT, PCBs, dioxin, Agent Orange and thousands of lesser known chemical products and by-products. Each year in North America 13 tons of chlorine are produced, Greenpeace reports. Only one per cent is used to chlorinate drinking water—the rest is employed in the production of plastics, to bleach paper and for a myriad of other industrial and agricultural uses.

A recent study carried out in Hartford, Connecticut—the first of its kind in North America—found that women with breast cancer have 50 to 60 per cent higher levels of organochlorines, including PCBs in their breast tissue than in the breast tissue of women without breast cancer. Experts say these toxic compounds are attracted to fatty tissue.

Mary Wolff, an epidemiologist at Mount Sinai Medical Center in New York, who led the study, says the results surprised even her. "This is the first new evidence that could be a clue about the rising breast cancer

rates. I've personally been a skeptic all along about the environmental connections to breast cancer, but I keep being proven wrong."

Similar findings to Wolff's study surfaced in a recent Finnish study. A group of 44 women with breast cancer were found to have significantly higher concentrations of the pesticide bHCH in their breast fat than a set of 33 women without breast cancer. The findings of these two studies confirm similar results by Israeli researchers.

The report also cites Israel's decline in breast cancer rates over the last decade as the probable result of an aggressive program to phase out pesticides made from organochlorines. From 1951 to 1976, Israeli levels of chlorine-based pesticides in cow's milk, human milk and human tissues were among the highest in the world, and 5 to 800 times higher than US levels. When the phase out program began, breast cancer rates in Israel dropped by 8 per cent over the first ten years—a stark contrast to the rising rates in other industrialized nations.

Despite this evidence, no Canadian studies have been done exploring the link between breast cancer and environmental contaminants. Indeed, most North American cancer researchers believe this is simply not a worthwhile area of pursuit. Howard Morrison, a scientist at the Laboratory for Disease Control at Health and Welfare Canada, however, was spurred on by this evidence and, along with several other American and Israeli scientists, is currently planning a study that will look at toxins and breast cancer.

Jay Palter, a chlorine issues campaigner at Greenpeace Toronto says Greenpeace would like to see organochlorines phased out or "sun-set" as a class. "This class of toxins behave in an extremely dangerous way," he says. "Research has found that individual compounds can't be singled out as the sole cause of cancers, that in fact it's a combination of these toxins that's so dangerous. That's why it's essential to target them as a class, rather than regulating individual chemicals."

Megan Williams, reprinted with permission from The Rag Times, Feb/March 1993.

Breast Cancer and Mammography

The use of mammography, in conjunction with other diagnostic methods, is not controversial. It is universally recommended. However, mammography performed yearly on asymptomatic women, or undertaken for screening purposes on large numbers of women, raises medical and ethical questions.

One problem is accuracy. Mammography provides five to 10 false reports of tumors to every correct report. Many false-positive results lead to reexamination, exposing women to additional X-rays and further stress. Some lead to unnecessary surgery.

Mammography also fails to detect advanced tumors measuring more than two centimeters in diameter. Failure to detect a cancer can encourage a false sense of well-being and lead ultimately to extensive surgery and chemotherapy.

A second problem with mammography is efficiency. Proponents of mammograms hope to reduce breast cancer deaths through early detection; at the same time, they admit that in the process of reducing deaths, mammography programs may increase breast cancer rates through cumulative X-ray exposures.

Advocates say each breast cancer cure attributed to mammography is worth it. Critics argue that the resulting number of breast cancers and unnecessary surgeries is too great a trade-off. Critics also note that physicians intent on "preventing death" often fail to inform women of the known and suspected risks of mammography screening.

The public relations effort behind mammography conveys a false sense of benefit, security and control, and it does so by glibly overlooking the core question: How much X-ray exposure is too much? Part of the answer can be found in the epidemiological studies, which reveal that breast tissue becomes cancerous over a wide range of doses.

While the most up-to-date mammographic equipment delivers only 0.14 rads to breast tissue, the total dose measurement of such exposures may not be the critical factor. Indeed, once a breast tumor overrides the

body's defense system and becomes established, any further dose of radiation is not cancer inducing. What counts, according to an updated report on the Hiroshima and Nagasaki data, is a percentage increase per exposure over a person's base risk.

A 1991 report on a Canadian study investigating the risks and benefits of mammography analyzed the study group of 50,000 women. Of those between the ages of 40 and 49 who received mammograms, 44 developed breast cancer; of those in a comparable control group not receiving mammograms, 29 developed the disease. The entire report has not yet been released; however, the findings have been verified and the outcomes are statistically significant.

How much is too much? Quite simply, no level of mammography exposure can be presumed safe, particularly for females under 55 years of age.

One last question overlooked by many of mammography's ardent champions: What might lie at the root of today's breast cancer epidemic? Percent increases in breast cancer throughout North America began appearing in the mid-1980s among women approaching 60-plus years of age. These women were just over 20 years old at the time the first nuclear bomb was set off in Alamogordo, New Mexico, in July 1945. Then, after the second and third nuclear bombs were dropped on Hiroshima and Nagasaki, this group of women was exposed to repeated fallout from nuclear weapons testing, the debris of which was deposited from west to east throughout the entire North Temperate Zone.

Between 1946 and 1958 about 109 nuclear weapons were detonated over the Pacific Islands; and between 1951 and 1963 about 214 were detonated over Nevada. Radioactive debris from these more than 300 above-ground tests drifted eastward over the continent—so much so that measurable amounts of radioactive particles were found in

IN OUR
OWN
WORDS

milk, vegetables, meat, and fish throughout the United States and Canada. Women who were in their 20s at the time comprise the largest group of today's breast cancer victims.

If the root of today's breast cancer epidemic lies in above-ground nuclear testing, mammography—a source of further exposure to radiation—may only intensify the problem. Certainly, since babies born in the 1940s and 1950s have become a generation of men and women at risk for many diseases such as AIDS, toxic shock syndrome, and chronic fatigue, the password ought to be caution. And caution in terms of breast cancer prevention means special protection against mammography and sound information on self-care.

Rosalie Bertell, excerpted with permission from Mothering, Summer, 1992.

No level of mammography exposure can be presumed safe, particularly for females under 55 years of age



Challenging the Medical System

"A detailed review of the literature demonstrated how little reliable research has in fact been carried out in this area..."

This is a quote from a Society of Obstetricians and Gynecologists of Canada (SOGC) report on endometriosis from April 1993. The same could probably be said of many health and medical conditions that mainly affect women.

Women with endometriosis, breast cancer, stress-related symptoms, chronic fatigue and reproductive health problems are constantly searching for answers from the medical system, but with very little satisfaction. Diseases which primarily affect women are often less researched and therefore prevention and treatment lag behind. But some of this is beginning to change through the efforts of feminist health activists, patients' rights advocates and health educators over the past twenty years.

The Endometriosis Network of Toronto (TENT), a non-profit organization run almost entirely by volunteers is attempting to respond to a significant gap in medical knowledge about the illness. It provides public education, family support services and coordinates medical care and social services for persons suffering from endometriosis. They encourage medical and scientific research into the causes of the disease, with a view to developing preventive measures and treatment. TENT also promotes early diagnosis and use of existing technology for treatment.

On another front, lesbians, gay men and bisexuals are continuing to fight for equity within health care. Project Affirmation is a three-year project sponsored by the Coalition for Lesbian and Gay Rights in Ontario and funded by Health and Welfare Canada, which is addressing the discrimination and ignorance that many lesbians and gay men experience within the medical system.

The project will conduct a province-wide assessment of needs, host a province-wide conference, publish a resource guide and recommend responsive programs.

Despite campaigning for years to



We must understand the issues and be passionate and committed to changing the system

promote breastfeeding over the use of infant formula, Infact Canada continues to struggle against the infant formula manufacturers. These manufacturers are as strong as ever and still have the power to influence the medical establishment. Through their deals with hospitals, whom they pay to be the sole supplier of infant formula and are therefore compelled to distribute it free, the manufacturers have a tremendous impact. Women are inundated with information and advertising which encourages bottlefeeding over breastfeeding. The dominant view of a woman's body as a sexual object discourages women from baring their breasts for the purpose of breastfeeding, despite the overwhelming evidence that breast milk is healthier. The challenge for Infact and others promoting breastfeeding is to deal with both the pro-formula propaganda and the free cans of baby formula which women often receive in hospital.

There are many women seeking doctors who can help them find solutions to their reproductive health concerns. This includes teenagers, women in their menopausal years, lesbians and women with disabilities. This search sometimes leads them to organizations which are practicing and researching holistic approaches to health care. The Justisse Group is

one of these. They promote a method of fertility awareness which puts control back in the hands of women. One of Justisse's primary goals is to inform women of their choices in birth control methods and to act as a resource centre. They are also hoping to teach teenage girls about fertility through the school system and to increase public knowledge of birth control issues and new reproductive technologies.

These are some of the organizations struggling for change within the health care system. Women are in the leadership of this struggle. But it is not enough just to be a woman. We must understand the issues and be passionate and committed to changing the system.

Project Affirmation: Service Equity for Lesbians and Gay Men

Lesbians, gay and bisexuals are mobilizing for equal access to health and social services in Ontario. Project Affirmation, an organization formed to coordinate these efforts, will need your input for their needs assessment process this fall.

Early in 1993, Project Affirmation brought together many people across the province who are committed to fighting for equity for sexual minorities.

Overseen by the Coalition of Lesbians and Gay Rights of Ontario, Project Affirmation, has received a three-year project grant of \$275,000 from Health and Welfare Canada.

Lesbians, gay men and bisexuals often find health and social services unsafe and unaffirming. Admission forms often request information about a heterosexual partner, but leave no space to identify a same sex partner. A same sex partner often does not have access to information and decision making about their sick partner.

This lack of recognition often discourages people from "coming out" and declaring their sexuality. When lesbians, gay men and bisexuals can't be honest about their real lives this silence results in service inequities and ill-health. Lesbians who have sex

Phyllis Wong Kun

only with other women are given unnecessary pregnancy tests.

Assumptions by health practitioners about their clients' sexual practices can often delay diagnosis of HIV.

People who do disclose their sexual preference face other risks. Many encounter discomfort, ignorance and outright discrimination. They may feel unwelcome in programs where heterosexuality is the assumed norm. Their lovers may be excluded in situations where heterosexual lovers are welcome. They may battle homophobic stereotypes about their life choices. They may be given inferior treatment or refused service.

Living in a homophobic world creates tremendous pain and struggle. As many as 30 per cent of completed youth suicides are committed by lesbian and gay youth. Some of the youths who attempted suicide frequently cite negative responses to their sexual orientation as motivating factors. Programs that address survivors of violence or people coping with addictions must acknowledge the distinct pressures that sexual minorities face.

Project Affirmation plans to conduct a needs assessment survey, host a province-wide conference in 1994, recommend new and responsive programs, implement plans of action and publish a resource guide.

The project will visit nine cities in Ontario: Thunder Bay, Sudbury, London, Kitchener, Ottawa, Oshawa, Peterborough and Toronto.

For more information or to get involved, contact Project Affirmation at 552 Church Street, Box 90, Toronto, Ontario, M4Y 2E3. 1-800-363-5530 or in Toronto 593-9229. TTY 416-974-9450.

Endometriosis

As many as one in five women suffer from endometriosis. Endometriosis occurs when tissue similar to the endometrial lining of the uterus exists elsewhere in the body, usually in the pelvic cavity. The disease can cause internal bleeding, scarring, and cyst formation. Symptoms tend to worsen at time of menstruation.

In April of this year, the Society of Obstetricians and Gynecologists of Canada (SOGC) published a report on the recent Canadian Consensus Conference on Endometriosis. One of the SOGC's most welcome statements is that research into the cause of endometriosis should have priority over research into existing treatments for the disease. Today's improved technology for treatment is based on unproven theories of causation that date as far back as the 1920's. Women with advanced endometriosis can endure repeated regimens of powerful hormonal drugs, multiple surgeries, and possible hysterectomy, only to have the disease recur.

The Endometriosis Network of Toronto (TENT) frequently hears from women who have run the gamut of medical intervention and are still desperate for relief from their pain. TENT offers these women, and all women with endometriosis, a community in which to share their experience and pool their knowledge. TENT helps women with endometriosis to be sophisticated consumers in the medical market.

Lorri, a member of TENT, was relieved to be told after surgery that she had only "mild" endometriosis. She has since learned that the standard classification system for

endometriosis describes the disease's potential effect on fertility, not the extent of the disease itself.

Traditionally, research has concentrated on improving fertility, not on reducing pain.

Lorri was twenty-five years old when she underwent her first surgery for endometriosis. The doctor performed open-and-close diagnostic surgery; he did not remove any of the disease. After surgery, Lorri was back in pain. Her doctor prescribed Danazol, a hormonal drug which induces menopause for the duration of treatment. Lorri at first refused, knowing that the drug could have powerful, sometimes permanent, side effects. But, desperate for intervention, she at last agreed to try it. Lorri was on the drug for two years.

Toward the end of this period Lorri agreed to a second operation. Her doctor removed much endometriosis but left "powder burn lesions." She assured Lorri that this remaining endometriosis would be eliminated by a post-surgical round of Danazol. Lorri went back on Danazol. At the end of treatment, her pain returned.

Clinical studies show that Danazol reduces symptoms for the duration of treatment, but that in many women the disease later recurs. Sterling-Winthorp, Danazol's manufacturer, recommends that women undergo no more than one treatment of Danazol, over a period no longer than nine months. Some women, like Lorri, have come to TENT after spending years on Danazol. The long term effects of the drug are still unknown. Lorri learned more: "The doctor informed me that two years of being in a menopausal state, the effect of Danazol, could have already seriously affected my chances of child-bearing."

Another gynecologist suggested pregnancy, which is thought to provide the same relief as drug therapy

IN OUR
OWN
WORDS



MAH ACUPUNCTURE CLINIC

established in Toronto for over 25yrs.



ENJOY GOOD HEALTH THROUGH ACUPUNCTURE

• SPECIALIZING IN PAIN RELIEF •

Headaches	Arthritis	Allergies
Whiplash	Sports Injuries	Digestive Disorders
Backache	Depression	Menstrual Problems
Sciatica	Stress & Tension	Stop Smoking

ANGELA MAH M.Sc., D.Ac. Acupuncturist

Graduate of The University of Toronto &
The Academy of Traditional Chinese Medicine, Beijing, China

464 Yonge Street, Suite 206, (at College Street)
Toronto, Ontario, M4Y 1W9 (416) 920-3806

without the side effects. But TENT knows of women who became swamped when their new responsibilities of motherhood were complicated by a recurrence of the disease that pregnancy was to have "cured".

Lorri instead agreed to try a new GnRH hormonal drug, Lupron. Like Danazol, Lupron induces temporary menopause to control the endometriosis. Clinical studies invariably measure the effectiveness of GnRH drugs against the effectiveness of Danazol, not against long term health improvements in women taking the drug. For this reason, researchers funded by the drug manufacturers can promote GnRH drugs as being equally as effective as Danazol, with fewer side effects.

Four weeks into Lupron therapy, the familiar pain returned. At her absolute limit with pain, at the age of twenty-seven, Lorri agreed to undergo the definitive treatment for endometriosis—hysterectomy. A recent clinical study conducted for the Endometriosis Association based in Milwaukee concludes that nearly half of women who have a hysterectomy for endometriosis afterward suffer recurrence of symptoms.

Eight weeks after surgery, Lorri's pain returned: "Both of us [she and her husband] were visibly upset when my doctor suggested psychiatric help. I told her that I would take my business elsewhere."

Lorri accepted a prescription of Synarel, another menopause-inducing GnRH drug, to see her through the pain while she looked for a replacement doctor.

Through research, Lorri located a gynecologist in Toronto who has a

high reputation for his surgical treatment of women with endometriosis. At laparoscopy he discovered a spot of endometriosis. More importantly, he saw that scarring from previous surgeries had caused Lorri's bowels to twist around and adhere to her abdominal wall. In the next year, he operated twice more on Lorri for these bowel complications.

Within a month after the last surgery, Lorri found herself bedridden, hospitalized, and drugged with morphine for pain relief. Her only recourse was to travel, gravely ill, to a clinic in the United States for emergency surgery. She almost didn't make it.

A malpractice suit has been suggested to Lorri, but she will not sue the gynecological surgeon for performing endometriosis-related bowel surgery, out of regard for other women like herself.

Lorri's is just one story. The SOGC reports that "The Consensus Conference was in many ways a chastening experience...Women with endometriosis associated symptoms currently must seek medical care which may or [may] not be helpful."

It is TENT's hope that, until a cause and a cure for endometriosis are found, greater public awareness and greater physician awareness can contribute toward improving healthcare for women with this disease. TENT can be contacted at (416) 591-3963, or by letter to The Regional Women's Health Centre, 8th Floor, 790 Bay Street, Toronto, Ontario, M5G 1N9.

Arllys Poncbuk

In the tenth grade we studied artificial methods of birth control, and I scored a perfect mark on the exam. A year later I was in the hospital giving birth to my son. Somehow I had learned all that information in my head without ever knowing it in my own body. I had no idea what my own cycles were, or what they could tell me.

An I.U.D. I had caused Pelvic Inflammatory Disease and being on the Pill for years seemed foolish, with all the studies warning of its dangers. When I heard that natural methods existed, I didn't realize that learning them would benefit me in many ways.

The advantages of Justisse are numerous: a woman can avoid or achieve pregnancy as she chooses, when she chooses; it is inexpensive to learn; and there are no harmful side effects. Fertility charts provide an important diagnostic tool if and when problems do arise, and the knowledge a woman can gain about her body will benefit her through all her reproductive years and menopause.

One of the main arguments against Justisse is that it takes patience to learn. It takes a few minutes a day of observing and noting symptoms at first, but the motions quickly become second nature. Have you ever noticed that pregnant women go to great lengths to learn about their bodies and hormonal changes, but the rest of us take no time at all?

It is a practice that has coloured my whole way of life, because as I have become aware of my fertility cycles, I have also become more and more sensitive to the needs of my body. Cyclical changes, like menstruation and premenstrual tension become easier to accept when seen as valuable signals and not simply inconveniences to be dispensed with as quickly as possible.

The effectiveness of The Justisse Method increases with diligence. Justisse bases its 99.6% effectiveness rate on careful charting and following instructions. Justisse practitioners are trained to teach women how to determine their own personal fertility cycles and they know that no two women are alike. They won't tell you when you are fertile; instead, they teach you how to judge for yourself. Charting your cycles will determine your fertility every hour of every day

Justisse: The Feminine of Justice

The Justisse Method of Fertility Awareness is putting the knowledge of women's bodies back into the hands of the women. Besides promoting reproductive health, fertility awareness is extremely empowering. When I learned to chart my cycles and found I could avoid or achieve pregnancy without the aid of the medical and pharmaceutical industry, I felt incredibly empowered. I also felt ripped off that I hadn't been given this information years earlier.

EXPERIENCE THE SAFETY AND EFFECTIVENESS OF

HOMEOPATHIC MEDICINE

FOR

KIDS

- OTITIS • ECZEMA
- ALLERGY • ASTHMA
- COLIC • TEETHINGS
- ENDO • MIGRAINES
- ADD • NIGHTMARES

Protect your child from needless suffering

NATUROPATHIC PAIN CLINIC

State of the art and centuries-old treatments for acute and chronic pain.

Dr. H. COHEN, B.Eng., N.D.
Naturopathic DOCTOR and Assoc. (416) 538-7839

of your cycle.

Many women reject fertility awareness as contraception because they don't wish to be abstinent for the few days every month that they are fertile. Conversely, many women who chart their cycles find their fertile days an exciting challenge to explore sexuality in new ways.

The Justisse Group has practitioners in Edmonton, Toronto, Vancouver, Kitchener, Mississauga, and Halifax. We communicate through our newsletter "The Justisse" with Fertility Awareness Educators all over North America and are currently modifying our teacher-training course so that it can be taught by correspondence. Although we are privately-owned and a profitable company (in theory, anyway), we see clients on a sliding scale basis and have been known to barter for services. We publish *The Justisse Method of Fertility Management: A User's Guide*, available by mail order and through retail outlets.

In a culture so inundated with quick and potentially harmful technological fixes, we believe that fertility awareness should be an essential part of the education of women and health professionals.

Justisse can be reached at 21 Badgerow Avenue, Toronto, ON, M4M 1T4.

Connie Littlefield

The Big Business of Feeding our Babies

Many Canadian hospitals accept huge sums of money—up to a million—from infant-formula companies in exchange for being the sole supplier to the hospital. Often these contracts compell hospitals to distribute free samples to new mothers. Infact Canada is campaigning to stop this.

Infact Canada (Infact Feeding Action Coalition) is part of the International Babyfood Action Network works to "protect, promote and support breastfeeding". It actively promotes the implementation of the World Health Organization (WHO) code on Marketing of Breast Milk Substitutes.

According to WHO studies, infants up to two months old who are not breast-fed are twice as likely to have

diarrhea—the cause of one-third of all infant deaths in the world—and their chances of dying from it are 25 times greater than those children who are breast-fed. The International Lactation Consultant Association, (ILCA), based in the U.S.A., in their Summary of The Hazards of Infant Formula, compiled by Marsha Walker, points out that while there has been "increased awareness of the risks which a failure to breastfeed holds for infants, young children, mothers and families" in developing countries, in many developed countries "...replacement of breastfeeding by commercially prepared breastmilk

breastfeeding must be encouraged & supported



substitutes has become the norm, if not at birth then shortly thereafter. In these resource-rich areas, the decision of what to feed infants is becoming an increasingly emotional issue." She cites some of the cultural pressures such as: the commercialization of infancy and childhood, non disrupting parental lifestyle, marketing strategies of bottlefeeding, and health workers' fear of creating guilt in mothers who choose not to breast feed.

UNICEF and the WHO have launched a 'Baby Friendly Hospital Initiative' campaign to stop infant-formula companies from influencing hospitals.

The initiative started in Pakistan and 11 other developing countries in 1991 and since then more than 760 hospitals in developing countries have been 'certified' as baby-friendly, including 100 in the Philippines. In Canada, this initiative has been slow to catch on, thanks to the contracts signed between hospitals and infant



formula companies.

In Ontario, the Women's College Hospital accepted \$1 million from Mead-Johnson for exclusive rights to provide free formula for the next ten years. A split in their board and opposition from staff could not prevent the contract. Other Ontario hospitals such as the Doctors' Hospital and the Toronto General also have contracts with infant formula companies. Many of these companies are located south of the border.

"Unfortunately, there is no legal means to enforce the WHO marketing code. We're trying to seek support from the Liberal Party and the NDP to legislate some restrictions on these companies. Meanwhile, we're writing letters and doing advocacy work", said Betty Sterken, National Coordinator of Infact Canada, "Corporate influence is hard to crack".

On April 1, 1993, Barbara Sparrow, Parliamentary Secretary to the Minister of Health and Welfare told the House of Commons that Canada has realized the aims and principles of the International Code of Marketing Breastfeeding Substitutes - first by encouraging all hospitals to adopt policies and practices in support of breastfeeding and secondly by endorsing the Canadian Infant Formula Association's Code of practices which she claims supports the International code. But as Jim Karpoff, former NDP health critic, points out "...the infant formula companies...totally disregard their own code, let alone the much more strenuous WHO code." Breastfeeding protection will be achieved through grass roots action and education with the support of organizations like Infact.

For information on Infact Feeding Action Coalition, write or phone: Infact, 10 Trinity Square, Toronto, Canada, M5G 1B1 (416) 595-9819.

Virginia Mak

"Who is looking at the cumulative effect of all these cuts—in social assistance, the drug program and medicare?...With NAFTA there will be no turning back..."

—Josephine Grey, anti-poverty activist in Metro Toronto

Continued from page 13

extends patents for up to 20 years should have brand name manufacturers laughing all the way to the bank.

What the patent laws really do is give the brand name producer a full 20 years before the 'recipe' for the drug becomes public property and can be used by a generic manufacturer even if it is only marginally different from another. It is hard to see how this will not mean astronomical drug prices—and the end of drug benefit plans delivered by most provinces.

Under the implementation procedure, all three federal governments must pass and proclaim the NAFTA legislation before it comes into effect on January 1, 1994. In Canada, the

legislation has already passed both the House of Commons and the Senate. As of July 15, 1993, proclamation is still required for Canada to be bound by the terms of the Agreement. It is anticipated that passage in Mexico will not be a problem, but the situation in the United States is less and less certain. President Bill Clinton has indicated that accompanying its passage in the U.S. Congress will be side agreements on labour and environmental standards. Even with those agreements, it is by no means clear that the deal will get congressional assent. In late June 1993, environmental activists secured a U.S. court decision requiring an environmental impact assessment before the legisla-

tion passes the House of Representatives. If this court ruling stands it is unlikely that the assessment will be completed within the required time frame.

Can We Save Medicare?

Medicare, presumably the most sacred of the sacred trusts of social programs, has been eroded in such a piecemeal way that it is now difficult to restore as a national program. It has become even more challenging to move to the second phase of public and preventive strategies that hold so much promise for reducing our overall costs of maintaining a healthy population.

There is probably no question that women, as the lower income earners and those still socially responsible for the care of children and elders, have benefited from government policy initiatives like pay equity and affirmative action, and from transfer payments which make possible the expenditures on social programs. And so, it is no surprise that women have the largest stake in supporting medicare and the allied range of social programs.

Although the situation looks bleak, we still have superior healthcare provision for virtually the whole Canadian population while spending less than 10 per cent of our Gross Domestic Product (GDP). According to the General Accounting Office of the United States, it takes 14 per cent of U.S. GDP to provide very uneven levels of service to some 30 million Americans.

The reform of healthcare in Canada is long past due. But what we should be defending is not simply a system of illness care against "deficit fighters" and commercial interests. Community-based care need not be undertaken as a cost-containment measure, but as a legitimate option with adequate support systems and professional, well paid staff, in safe and comfortable working conditions. Investment in preventive and public health measures is every bit as important to the health status of Canadians as investment in new drugs and high-technology medical devices.

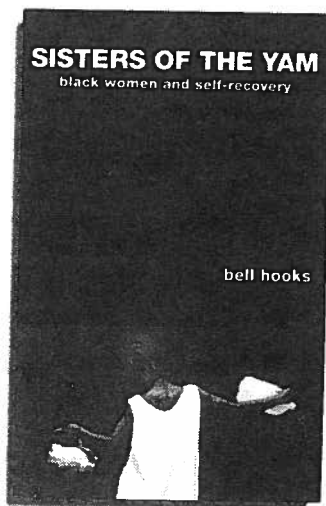
Janet Maher has been active in the women's movement for 20 years. Her interests are primarily in the areas of social policy, social planning and healthcare.

Sisters of the Yam

black women and self-recovery

bell hooks

Tackling such issues as addiction, violence, truth-telling, spirituality, work, grieving, erotic experience, reconciliation, community activism, and estrangement from nature, hooks shares numerous strategies for self-recovery that can heal individuals and empower effective struggle against racism, patriarchy, and capitalism.



ISBN 0921284 75 6 \$16.95

between the lines
394 Euclid Ave. Toronto, Ont. M6G 2S9

Finding My Voice, Finding Our Voices: A journey from alcoholism to life

by Virginia Ross

“Hi. My name is Virginia. I am an alcoholic.” Before reading further, reflect for a moment on this statement. What images and labels come to mind? What images and labels do you think others typically assign alcoholic women?

I do not fit the stereotype, and, more importantly, virtually no woman does. Yet, we all believe we do—women I know in recovery internalize the messages given us by society—sometimes with tragic consequences.

I remember a very courageous, beautiful woman with two young children. She could not escape the awful stigma of the label, the myths, and the stereotyping because her family, too, were ashamed of her. She was a responsible caring mother, an obedient wife to an abusive husband, and a well respected employee. Finally, unable to cope, this woman with so much to give took her own life.

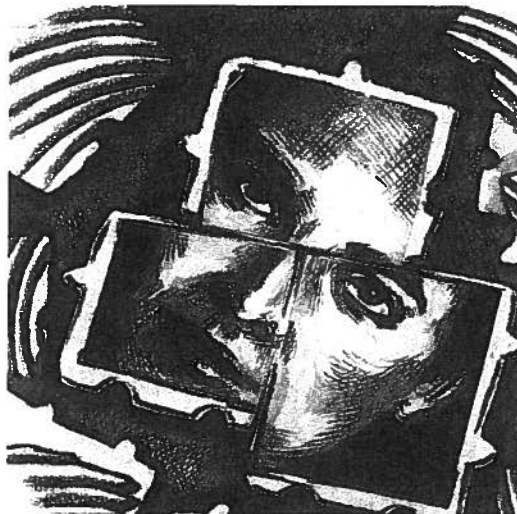
Journal Entry: June, 1987

“I can't figure out why I am a mental mess...struggling more and more. God, I hate myself. Why do I need to drink...to take valium? Why do I have such strong feelings of failure? I have failed all my life...need to find the common decency to disappear...suicide. God, I am so afraid, so full of fear. What causes alcoholism? How, at age 46, can I put my life together so I can become someone worth liking? I am so ashamed, I have let everyone down...so worthless. This world, and especially those I love, would be better off if I really never were here...how can I disappear? No matter how hard I try, there is an obsessive voice inside me saying, you can't do it—you will fail again. Whose voice is it?”

Six years have passed since those dark journal days, and I have “put my life together and

become someone worth liking.” Words that filled my world, like *denial, despair, fear, failure, shame, suicide, bad, hatred, guilt, anger, blame*, have been replaced with *acceptance, hope, courage, success, pride, living, good, love, innocence, joy, forgiveness*.

In my journey I have discovered many things. None, though, more important than the discovery that the “obsessive voice inside me” was mine, but it was also more than mine. It was society's voice—the voice



that labels an alcoholic woman as “the lowest of the low.” This is not to deny my share of the responsibility, but it is vital that alcoholic women, indeed all women, become more aware of the role society plays in perpetuating women's addictions.

My Addiction

My story begins in 1974. I was two different people. In “society's” eyes, I was bright, hard working and successful. I obtained many of the rewards most valued in our culture, such as a satisfying career, money, “perks” (the corner office, club membership, company car), a house with a pool, friends and social activities. Yet, I carried a huge secret: I was useless,

worthless, and no good. I was an alcoholic! Yes, despite having a negative view of alcohol, and especially a negative view of women who drank, I was an alcoholic. Alcohol removed those deeply imbedded feelings of worthlessness and fear. I finally belonged! As I advanced up the career ladder, I also fell deeper and deeper into that pit called alcoholism. Finally at age 34, it all caught up with me. Being bright, smart, and “altogether”, I decided to seek medical help. This was 1974—if negative stereotypes exist today, imagine 1974! Fraught with insecurity, I labeled myself with all the negatives. Over a period of some months my experience

with the medical profession went something like this:

Virginia: Doctor, I'm an alcoholic, I can't stop drinking.

Family physician: Nonsense. If you drink too much, stop. You are not an alcoholic.

Virginia: Doctor, I can't stop drinking. If I'm not an alcoholic, then something else is wrong with me.

Family physician: I will send you to a psychiatrist.

Psychiatrist: Here, take these pills, and if you decide to drink, stop taking them.

Virginia: I have started drinking again.

Psychiatrist: If you decide to stop, come back and see me.

Virginia: I have collapsed. I can't drink. I cannot go to work. I cannot cope.

Family physician: I will refer you to the Clarke Institute (a psychiatric centre in Toronto).

And so began my first recovery, one that now carried two stigmatizing labels: alcoholic and psychiatric patient. For the next twelve years I refrained from using alcohol. I became more driven to succeed, more driven to prove that those labels were not me. Despite my exter-

my story, our story

College Street Women's Centre

for Health Education and Counselling

College Street Women's Centre for Health Education and Counselling provides therapeutic and consultative services.

As women and as therapists we are sensitive to the socio-cultural context in which we live. We believe that education is essential to restoring the power and control women need to make informed choices. We are committed to providing an atmosphere where a woman can learn to nurture and strengthen herself.

Services Provided
Individual counselling
Couple counselling
Consultation and education

Groups
Body Image
Menopause
Early menopause
Sexual abuse/incest
Guilt, anger and shame

Areas of Specialization

Life transitions
Relationships
Personal growth
Sexual abuse
Sexual assault
Incest

Eating disorders

Body image

Sexuality

Reproductive cycle

- abortion
- PMS
- menopause
- infertility
- pregnancy
- gynecological health

Head injury

We are a fee for service.
A sliding scale is available.

College Street Women's Centre

for Health Education and Counselling

489 College Street, Suite 201

Toronto, Ont. M6G 5A1

Tel. (416) 929-1816



nal success, I remained emotionally unequipped to handle any crisis. When that crisis came in 1984—my only brother was diagnosed with AIDS—I encountered stress I simply did not have the skills to handle. Finally, in January 1987, I began to drink again...the voice in my head that had been imploring me to kill its pain won out. At that time I had been using valium over two years. Ironic that when I wrote my journal entries, the world saw me as a success, but I knew it was only on the outside. My insides, as reflected by those journal entries, knew the truth: I had reached the breaking point.

My Recovery

It was at The Donwood Institute (an addiction treatment centre in Toronto) that true recovery began. The last 12 years of abstinence were not recovery, they were simply abstinence. Cross-addicted to alcohol and valium, the pain of the first few months of recovery was incredible. I had to throw off my armour of independence, carefully acquired and nurtured all my life. Strangely, as I began to let others into my world of pain and fears, change began and a flicker of hope returned. I learned that good health encompasses all our being: physical, mental, emotional, and spiritual.

Exactly how did I recover? First, let me say that recovery is hard work. It is more, much more, than a three or four week stay in a treatment centre, although that is an excellent beginning. I attribute a large part of my recovery to my participation in a self-help program. I continue that program, but have also extended it. A group of 10 women joined together four years ago to support a terminally ill friend. We remain a group today, and strengthen each other with regular meetings and frank talk. I am also undergoing therapy to uncover the real reasons for my addiction. Finally, three years ago, I began night classes at York University. Next month I begin my social work practicum at The Donwood Institute where six years ago my recovery began. I plan to work with addicted women and to advocate for the structural and attitudinal changes that are crucial for the good health of all women.

The details are mine, but this story

belongs to many women. The need is great, collective action critical. I end with the statement that opened my story, with one slight difference: Hi. My name is Virginia. I am an alcoholic, and much, much more, I have found my voice.

Virginia Ross will complete her Social Work degree next Spring. Her goal is to work with addicted women, advocate for change and pursue related studies in the addiction field.

Resources & Further Reading

- Call a self-help group and/or a treatment centre in your community. Alcoholics Anonymous (AA) is listed in your telephone directory. It has, in larger centres, some "women only" groups. In Toronto and Kingston, Women for Sobriety meetings are available. There are about 25 "women only" treatment centres in Ontario, plus numerous mixed centres. Most, if not all, centres are covered by OHIP. In Toronto, the Jean Tweed Treatment Centre for Women is especially recommended. The Donwood Institute also has a program for women.
- Understand that a treatment centre is only the beginning. Family members often expect you to leave "cured". In fact, the first few months are often harder on everyone, including you, because you are beginning to experience the emotions and deal with the events that caused you to self-medicate in the first place.
- Continue to build a support network, such as a self-help group.
- Consider therapy, preferably with a professional familiar with addiction problems of women.
- Learn more about addiction from a woman's perspective. Suggested Reading: *Turnabout* by Jean Kirkpatrick, founder of Women for Sobriety and *Many Roads, One Journey* by Charlotte Davis Kasl.
- For women not addicted, I encourage you to learn more about the problems of addicted women. For example, do you know that recent research suggests that 60% - 80% of women who become addicted have previously experienced incest, physical abuse, or other forms of sexual assault? An excellent book on this topic is *Trauma and Recovery* by Judith Lewis Herman, M.D.

**You're in Charge:
A Teenage Girl's Guide
to Sex and Her Body**

Niels H. Lauersen, M.D., Ph.D.,
and Eileen Stukane, (Fawcett
Columbine), New York, 1993,
\$11.00, 345 pp.

Reviewed by **Fayola K. Lawrence**

You're *In Charge* is a book that every teenage girl should pick up, written for all growing girls, from puberty to older teens, who are wondering what is happening to their bodies and have questions about their sexuality. *You're In Charge* covers subjects that seem uncomfortable to talk about with our parents or any adult, the things we whisper about with our peers during sleep-overs.

For the very first time here is a book that teens can relate to. The authors have written it in a way that makes the reader feel that she is being spoken to directly, in a language and style that is matter-of-fact, conversational and easy to read. By the fourth page you actually say "Yes, I know how this feels," and you keep on saying it throughout the book.

As a teenager I know exactly how it feels to think we know everything, to think we're in control of certain situations and to think we're all grown up. But this is not so at all. We have so much to learn, so much to experience, so much growing up to do. Reading *You're In Charge* is one of the first steps a teenage girl can take to know more about herself and her body, and one of the first steps a boy can take in understanding girls better.

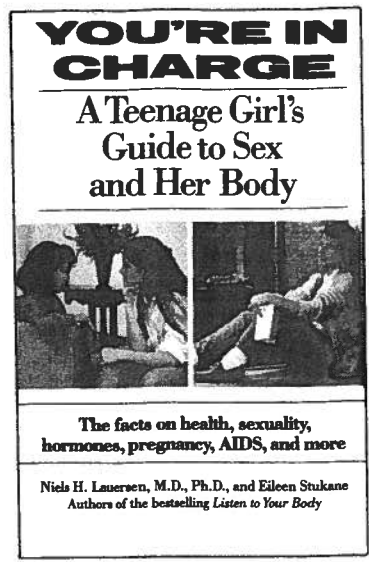
Chapters Two and Three talk about the first things that are really important to young girls; how our bodies are changing and how to be happy with our bodies.

Chapter Two, "How Your Body and Looks are Changing; What They Didn't Tell You in Health Class" explains the power of hormones, how they control the body, the body's glands (the home of the hormones), and

how each hormone affects our growth. On the menstrual cycle, the first and second half is explained, giving the reader a clear understanding of what goes on in our bodies throughout the month. Some amazing facts about the nature of our reproductive organs and how they work is described. Did you know for example that a girl is born with two million follicles, or eggs in her ovaries, and that she uses about four hundred in her lifetime?

Chapter Three, "How to Be Happy with Your Body" tells about the process by which our figures change, how our hair grows, how our skin reflects what we eat, the bad and good sun, acne; the list goes on. Throughout this chapter and the book, questions are asked by teens wanting to know more about themselves and their bodies, and they are answered by both Lauersen and Stukane.

The authors see the importance of letting the girls learn a bit about the development of the opposite sex. We have to understand the boys to get along with them better in relationships of any kind. Birth control methods, sexually transmitted diseases, what it means to be pregnant and have a baby, ending a pregnancy before childbirth, how you eat and what it reveals about how you feel about yourself and making healthy choices, are topics all covered in *You're In Charge*.



This book made me more confident in myself because I came to realize that the things I have gone through, every other teenager has gone through too. I learned in Chapter Four "What Boys are Going Through", that the feelings boys have and the cycles they go through are very similar to what we girls experience.

The parent of every teenage girl should buy her this book. It will be a good guide and friend to her at every opportunity. The price is reasonable. Your life and that of others could be changed through this book. As Lauersen and Stukane conclude, "You are the master of your own destiny because you're in charge."

Fayola Lawrence is a Grade 13 student interested in a journalism career.

WHAT YOU SEE



DRAWINGS BY GAIL GELTNER
INTRODUCTION BY LINDA HUTCHEON

**Second Story Press,
1992**

**\$12.95
Paper**

Finally, here is a book that celebrates the twenty-year career of social commentator Gail Geltner. A sharp-witted talent, Geltner and her pen and ink illustrations have confronted and challenged readers in hundreds of magazines, books and newspapers. Since the 1970s, she has been a strong graphic voice for the women's movement. This beautifully designed collection contains dozens of reproductions and provides an entertaining and incisive window on contemporary society.

"Community Action for Health"

Community educators and health activists produced this special issue of *The Moment*, (Vol 6 No.3 1993), to be used by community organizers, health care workers and anyone who wants to do something to transform the system of treating illnesses to a system that promotes all round well-being, reduces illness and respects health as a fundamental human right.

Copies are \$3 from *The Moment*, 947 Queen St. E., Toronto, ON, M4M 1J9, Tel: (416) 469-1123, Fax: (416) 469-3579.

Black Coalition for AIDS Prevention

This is a coalition of organizations and individuals representing diverse Black communities which provides training, workshops, community forums, support and counseling to people living with AIDS, as well as developing culturally-specific educational material.

To become involved, contact the coalition at 597 Parliament St., Suite 103, Toronto, ON, M4X 1W3, Tel: (416) 971-7588, Fax: (416) 599-0759.

Peterborough Area Handbook

Who Can I Ask? A Handbook for Women in the Peterborough Area is a resource produced by the Women's Health Care Centre of Peterborough Civic Hospital. They offer individual counseling on sexual abuse, eating disorders and unplanned pregnancy, a resource library, and sponsor a "Facts of Life Line" at 749-9111.

The Centre can be contacted at 876-5031.

Toronto Health Network

The Toronto Women's Health Network is a 125-member organization of women who are involved in or interested in women's health issues. They produce a monthly newsletter which contains current information about women's health resources and upcoming events, meet on a monthly basis in a wheelchair accessible location, and are open to women of dif-

fering backgrounds.

For more information contact the Toronto Women's Health Network, 1884 Davenport Rd., Toronto, ON, M4V 1W3, Tel: (416) 392-0898, Fax: (416) 392-0645

Women's Health Interaction

Women's Health Interaction is an Ottawa collective of volunteers, supported by Inter Pares, working with groups across Canada and in the Third World. They focus on women's health as it relates to reproduction, population control, new reproductive technologies, medical violence against women and pharmaceuticals.

Women Creating Reproductive Freedom, Challenges and Dilemmas: A Critique of Population Control, as well as other pamphlets and resources are available from WHI, 58 Arthur St., Ottawa, ON, K1R 7B9, Tel: (613) 563-4801, Fax: (613) 594-4704.

HIV/AIDS Newsletter

VOICES is a newsletter of Voices of Positive Women, an organization directed by and for women living with HIV/AIDS. VOPW was formed to empower women regardless of race, creed, colour, ethnic origin, age or sexual orientation, through education, information and support.

VOICES, and other resources can be ordered from VOPW, P.O. Box 471, Station C, Toronto, ON, M6J 3P5, Tel: (416) 324-8703, Fax: (416) 324-9701.

Women's Health Office

The Women's Health Office of the McMaster University Faculty of Health Sciences works to increase awareness of, and responsiveness to women's health issues. Their network includes members and students from Medicine, Nursing, Occupational and Physiotherapy, the Women's Studies program, local doctors and nurses, representatives from the Women's Centre of Hamilton-Wentworth and interested members of the community.

For more information about involvement in a committee or project, or to add your name to the mailing list, contact the

Women's Health Office, McMaster University Faculty of Health Sciences, Room 3N45A, 1200 Main St. W., Hamilton, ON, L8N 3Z5, (416) 525-9140 ext.2210.

Women's Health Conference

"Reproductive Health and Justice: International Women's Conference for the International Conference on Population and Development 1994", will be held in Rio de Janeiro, Brazil, January 24-28, 1994.

Information and eligibility requirements can be obtained from the International Women's Health Coalition, 24 East 21st street, New York, NY 10010 USA, Tel: (212) 979-8500, Fax: (212) 979-9009.

Electronic Mail Network

The Centre for Women's Health Research in the US is starting an electronic newsletter (*Women's Health News Line Newsletter*) and discussion group for anyone interested in women's health who can access E-mail on internet or bitnet. The newslines will provide networking opportunities by connecting subscribers to one another.

To subscribe, send the following E-mail message to: `LISTSERV@UWAVM.U.WASHINGTON.EDU` (for internet users) or `LISTSERV@UWAVM` (for bitnet users). Make the body of your message one line that says: `Subscribe WMN-HLTH firstname lastname`. For example: `Subscribe WMN-HLTH Jane Doe`.

Women Against Violence Kit

MATCH International has developed a resource kit "Linking Women's Global Struggles To End Violence" in which women from developing countries and Canada share their experiences. *MATCH* also works to broaden the network of women organizing for change by trying to bridge North and South, contributing to the growth of a feminist perspective of development.

The resource kit is available from *MATCH International Centre*, 1102-200 Elgin St., Ottawa, ON, K2P 1L5.

FROM THE NATIONAL FILM BOARD OF CANADA



FROM THE NATIONAL FILM BOARD OF CANADA



FROM THE NATIONAL FILM BOARD OF CANADA



FROM THE NATIONAL FILM BOARD OF CANADA

