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HERizons

the manitoba women's newspaper

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SEPTEMBER 15, 1981

A Win for Tan Jay Women

by M. Lamb

The 18-day strike of the Tan Jay garment workers, at the Notre Dame plant, ended victoriously on August 18. Most of these workers — 105 of the 120 — are immigrant women. The contract sought illuminates some key feminist issues.

It called for more time than the legislated maternity leave allows, enforcement of the overtime clause basing overtime pay on daily overtime and the piecework average rather than the 38½ hour week, and notification of impending lay-offs and work-day recalls.

As well, the union demanded an improved delay-time clause for time lost because of machinery breakdown, based on the piece-work average rather than the lower guaranteed wage, and the provision of all necessary tools and equipment. Previously, for instance, women had to buy their own scissors for the job.

The wage increases over three years would be 10%, 10% and 12% compounded. And the "bridging of service" clause applies to workers in all three Tan Jay factories in Winnipeg who find it necessary to leave the job for an extended period. When they return to work, they no longer lose their previous seniority gains in wages, vacation time, and other benefits.

Management refused a sexual harassment clause essential in the garment industry with its immigrant women workers especially vulnerable to victimization. And in the place of the previously won right of the union to follow any plant a former shareholder might establish, the compromise stipulated that if the Notre Dame plant moved to another location, the union would move with it.

Nevertheless, the achievement of this contract through strike action demonstrates that the Tan Jay women are ready to stand up to management, and get action from their U.S. led union, the International Ladies Garment Workers (ILGW).

The previous contract had expired March 31, 1981, and the ILGW Western District Council realized inaction would result in raiding by other unions. They sent in Terry Hanley, an able organizer, and hired another young woman, Leslie Spillett, and these two made an excellent team, who worked well with the Tan Jay workers through the negotiation process and the strike.

Negotiations, which began in February, had been prolonged by owner, Peter Nygard. He was using the usual delaying tactics in the hope of demoralizing the workers. His approach — prolonged negotiations, loss of confidence in the union, a lost strike.

In the meantime Nygard could enjoy his jet set life-style according to an article in the Vancouver Sun (May 9, 1981), this included his six $35,000 cars, the sunken "love pit" in his luxurious and well-publicized mansion adjoining the Tan Jay factory whose workers sweated to make it all possible.

These same workers had waited since April for four months' back pay. He had handled this time and a half overtime pay very adroitly for his own good and welfare, paying them time at the piece-work average — half-time at the smaller guaranteed wage.

Negotiations dragged on. Conciliation failed to move management. Nor did the 85% strike vote. The Canadian director of ILGW came to Winnipeg from Montreal. Finally on June 7, the company agreed to the wage increases and other demands. In view of inflation it was "a steal of a deal". But Nygard sat on it for seven weeks, refusing to answer calls or meet with the union.

Then Nygard insisted on a number of changes. The union security clause must go. And lest Tan Jay "go broke", pay increases in the minimum wage

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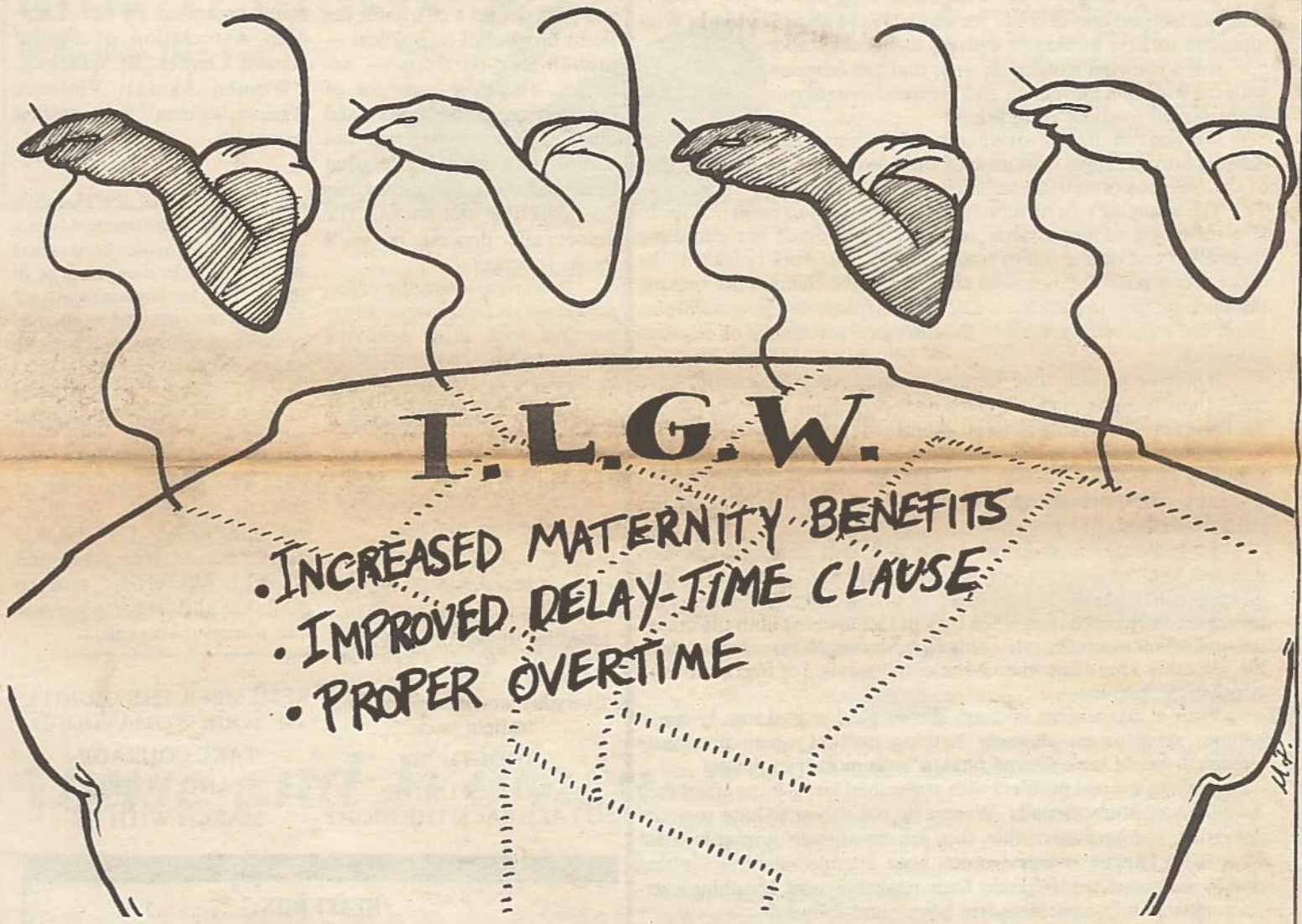

Inside :

Editorial —

by Debbie Schwartz

Returning childbirth back into the hands of women has been a vital issue for feminists. It is not surprising therefore that one of the most controversial topics concerning women's health care is that of the increasing numbers of cesarean deliveries.

Not only has this subject been the cause of accusations of medical incompetence and unprofessional motives (financial gain and convenience) between physicians, it has initiated heated debate amongst women, leaving those women who delivered by cesarean section with feelings of inadequacy and confusion.

As a mother of three children delivered by cesarean section, I can remember vividly my thoughts following the birth of my first child. I felt that I had missed out on a very special process.

I felt cheated that after the many hours of arduous labour and coming so near to delivering vaginally that my baby would be brought into this world through an incision in my abdomen.

Nobody congratulates you on a job well done when the birth of your baby occurs in an operating room. Needless to say, I reacted angrily to those who would say "Oh, you took the easy way out" or "Do you really think a surgical delivery was necessary?".

My experience parallels that of numerous other women and has led me to research the legitimacy of cesarean births with peaked interest.

In the 50s, only 5% of births occured by this method. Today, cesarean sections may account for up to 25% of all deliveries. In Winnipeg, 18 to 20% of women delivery their babies abdominally.

It is somewhat ironical as well, that this increase has coincided with the women's movement and the trend toward more natural, less sophisticated methods of birthing.

Women no longer obediently place their legs in awkward delivery table stirrups, relinquishing their own common sense for that of the onimous obstetrical technicians.

The changing role of women from passive to active in childbirth is a reflection of her general role change. Women are educating themselves and opting out of traditional roles to work outside of the home. As a result women who choose to have children are making this decision later in their lives. The complications that may occur as a result are a definite variable in the increased percentage of cesarean deliveries.

It is true as well that women, through their education, have sought out better medical advice during pregnancy which has led to the detection of possible birthing problems.

Fertility drugs, toxemia and other phenomenons are other contributing factors. People may argue that all of these conditions were present years before cesareans were prevalent, and that none the less babies were born.

To boast that women previously delivered numerous children unaided, without pointing out that many died during childbirth or at an early age thereafter is equivalent to saying cesarean deliveries are an unnecessary procedure, when they in fact lowered both the maternal and infant mortality rate. Although Mother Nature seems infallible, she takes a hard line when it comes to "survival of the fittest" and population control.

With improvements in drugs and surgical procedures, cesarean sections serve as an alternate birthing method where previously childbirth would have proved fatal to both mother and baby.

Perhaps the real problem with abdominal births is the effect they have on women emotionally. Women do not choose to have cesarean deliveries, and because of this, they are emotionally unprepared for what is to happen. Many women have attended natural birthing classes and practised diligently their relaxation and breathing exercises, anticipating a problem-free labour and delivery.

Women may feel that they have failed at a "fundamental" function and blame themselves for the difficulties they experienced. Often doctors do not explain why and how a surgical delivery is to take place contributing even further to the intimidation and confusion mothers feel.

Often women are under a general anesthetic during the delivery and miss out on the joy of hearing their baby's first cry.

Most hospitals still do not allow fathers or friends into the operating room and the disappointment of not having shared such an important moment is more than upsetting.

Support rather than criticism is a must. Education and exchange of information between parents and doctors will not only remove the suspicion from this delivery but effect positive changes to improve the birthing experience. Women must demand inclusion into the reasons and procedures of their cesarean deliveries, to remove any doubt that it is a necessary step.

I will not say that cesarean delivery is without abuse. There is evidence that in the U.S.A. some may be performed unnecessarily perhaps for monetary gain but more likely to avoid any risk of a malpractice suit. American doctors have become rather paranoic and employ drastic measures to avoid injury or death.

In Brazil, cesarean deliveries are fashionable and account for up to 60% of private deliveries. But in Canada, where financial gain is not large enough for a doctor to compromise professional integrity and abdominal scars are not in style, the number of cesarean births can be medically substantiated.

For those of us who comprise the 20%, removing the fear and cynicism and replacing it with a celebration of a new life is a long awaited change.

Bulletins

by Brigitte Sutherland

The Manitoba Action Committee on the Status of Women feels that the right of a woman to housing or to a job is far more important to legally protect than the right of a landlord or employer to discriminate against her.

Yet Renaissance International would have it reversed and is using — perhaps illegally — its charitable tax status and wealthy secret backers to sway provincial politicians to endorse their view.

MACSW has applied for and been denied a charitable tax status because of its political — though non-partisan — activities. Therefore, our side of the abortion, sex education, and other feminist issues will not receive the same publicity that Renaissance can buy through its tax-deductible donations. The democratic process is, as a result, endangered.

In recognition of the unfair advantage of Renaissance International over other lobbying groups, politicians should refuse to particpate in its survey and the federal courts should move quickly to remove Renaissance's tax-exempt status.

★★★★★

In Canada a woman is raped every 17 minutes.

In the U.S.A. a woman is raped every 3 minutes.

1 woman in 4 will be sexually assaulted sometime in her life.

BUT

Everyday women are learning to fight back.

TOGETHER.

WOMEN UNITE
TO TAKE BACK THE NIGHT

TAKE BACK THE NIGHT MARCH:
Friday, September 18th, 1981
Meet at 9:00 p.m. in front of the Legislature. Bring flashlights and all your women friends. Celebration at Women's Building after the march. Phone ahead to register for free childcare — 783-8501 or 783-7889. For information or childcare, leave messages for Susan, Marsha, or Cathy of the W.A.V.A.W.

The "Take Back the Night March" is an international event. In Canada, the march is being organized by the Canadian Association of Sexual Assault Centres. In Winnipeg, "Women Against Violence Against Women" is organizing the march.

The purpose of the march is to bring women together in action against violence against women, be it in the streets or in the home. Our hope is to attract as many unorganized women as possible to share with them one experience of STANDING TOGETHER AS WOMEN and to introduce them to organized groups which might enlist their labour for the coming years. We must work together in order to end our oppression. We invite you to SPREAD THE WORD to members of your group and to ALL WOMEN, and to publicize this event wherever and whenever you can.

REMEMBER THE DIGNITY
OF YOUR WOMANHOOD

TAKE COURAGE
STAND WITH US
MARCH WITH US

TUES. SEPTEMBER 15, 7:30 p.m. Place: YWCA, 2nd floor. Panel discussion on "Women and Development." This is part of the YW's Open House. Participants are Susan White, Manitoba Coordinator, OXFAM Canada; Anu Bose, Development Education Officer, Canadian Council for International Cooperation, Ottawa; Sari Tudiver, Project Officer for Women and Development, Manitoba Council for International Cooperation; and Doreen Orman, Board Member, National YWCA and past chairperson of the YW's Cooperation for Development Committee.

WED. SEPTEMBER 16 7:30 p.m. Place: YWCA 2nd Floor Lounge. "The New Technology: An International Perspective." A talk by Anu Bose, Development Education Officer, Canadian Council for International Cooperation, Ottawa. Anu will provide particular emphasis on how microprocessors are affecting women's paid work in Canada and the Third World.

TUES. OCTOBER 13 7:30 p.m. Place: YWCA 2nd Floor Lounge. "Women as a Force in Development: Experiences from Nicaragua." Audrey Silvius, Marquis Project, Brandon, Manitoba, recently returned from a trip to Nicaragua and will discuss how and why women are in the forefront of social change in that country.

These latter two events are the first two in a six part education series sponsored by the Manitoba Council for International Cooperation. For more information, call 475-4169.

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HERizons — The Manitoba Women's Newspaper may be purchased at the following locations:

Brigit's Books — The Women's Building.; Clothes Encounters; Co-op Books; Harvest Food Co-op; Liberation Books; Manitoba Action Committee on the Status of Women; Mary Scorer Books; Red River Bookstore; University of Manitoba — U of M Bookstore, the Info Desk and Medusa Hair Stylists.
In The Pas, at Deters' Confectionary and in other areas across the province.

If you'd like to distribute the paper or know someone who would be willing to distribute the paper, especially in Brandon, the North or rural Manitoba, please contact us by writing to Box 551, Winnipeg, Manitoba, R3C 2J3.

"Herizons" conceived by Gerri Thorsteinson
MWN's flag designed by Mary Catherine Figurel

TYPOGRAPHICAL UNION LABEL WINNIPEG 3

The aim of this newspaper is to provide an alternative means of communications with a feminist perspective in order to stimulate, to inform, to effect change and to unify women's strengths. It also serves as a public forum of discussion for the women of Manitoba.

The Manitoba Women's Newspaper is currently operating out of Box 551, Winnipeg, Manitoba, for further information call Debbie Holmberg at 772-8170. Views expressed in this publication are those of the writer and does not necessarily reflect The Manitoba Women's Newspaper policy. Submissions are welcome. Editing rights are reserved and submission does not guarantee publication. A self-addressed stamped envelope will ensure that submissions will be returned to the writer. We have applied for a 2nd class mailing permit.
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Charles and Di

by M. Lamb

We were all happy, weren't we, along with television viewers everywhere to settle for the Royal Wedding rather than such trivial concerns as the realities of unemployment, the ever-rising costs of food, housing and heating, and the threat of nuclear holocaust. As for the status of women, equal pay for work of equal value, child care, how can these issues compare with the status accorded to Lady Di, a simple country girl, who shared a flat with three other girl-friends, and worked in a London kindergarten, but nevertheless became the bride of the heir to the British throne.

The name of the game is vicarious gratification, just one of the important functions served by the Royal Family. No doubt the three million unemployed in Great Britain, mostly women, are properly gratified.

Are there still malcontents out there carping about bread and butter realities and the unlikely probability of their children's survival as Reagan shoots toward the target of a limited nuclear war? Then they weren't paying attention to the inspired solution propounded by the Archbishop of Canterbury during the Royal Wedding service. He said, "Much of the world is in the grip of hopelessness. Many people seem to have surrendered to fatalism about the so-called inevitabilities of life: cruelty, injustice, poverty, bigotry and war. Some have accepted a cynical view of marriage itself."

And what could be more cynical than to suppose that injustice, poverty, and war can adversely affect a marriage? So what if you can't find a job, can't afford milk or oranges for the kids, or get blown up in World War III?

The Archbishop sounded this consolatory note: "If we solved all our economic problems and failed to build loving families, it would profit us nothing, because the family is the place where the future is created good and full of love — or deformed."

So if you're deluded enough to believe that a good future for the family and a world full of love require working to change economic conditions by abolishing discrimination, unemployment, weapons of mass destruction, and war itself, you've lost your marbles.

"The real adventure" the Archbishop exhorted the royal couple and us, is not joining our sisters and brothers in righting economic and social wrongs. It is "the royal task of creating each other and creating a more loving world." A world obviously on cloud nine impervious to such inconsequential problems as starvation and war which have nothing to do with happy family life.

And isn't it reassuring to know that if our families are impoverished, radiated or pulverized, the Royal Family will go on?

As the Queen's biographer pointed out, the Family has put pressure on Charles to find a girl with no past, and there aren't that many nineteen year old virgins available. Consequently, two earlier girl friends were dropped as not unblemished. Thanks to the double standard, we don't have to worry about the blue blooded paternity of the royal lineage.

Queen Victoria may have had her ghillie, her son his score of mistresses and her royal uncle may have locked his wife out of his coronation, but what has any of that to do with the example the Royal Family has always set of building "loving families".

And there's no need to take "a cynical view" of royal marriage as the choice of a suitable partner to provide legitimate heirs. True, Lady Di was given a medical examination to ensure she is capable of mothering future kings. But as the Queen explained, "After all, that is what we are for."

However, Prince Charles has made it clear that the choice of Lady Di was not based on the workings of her fallopian tubes. "I'd want to marry someone who had interests which I understood and could share," he said.

Fortunately for him, Lady Di's interests are few. She is "unassuming, has no academic pretentions, enjoys quiet, country life, is a traditionalist". She wants to be "a helpmate and companion". Her first priority is "being a good wife". And she admires Prince Charles as her "tower of strength".

During a TV interview, he joked to her, "You're the one with the domestic responsibilities," which certainly indicates his determination to understand and share her interests.

Lest we fear a plebeian strain in the royal line because of the sordid details of Lady Di's pre-marital existence, such as sharing a flat and working in day care, it's comforting to know that the flat cost her father, Earl Spencer, the equivalent of $237,500 and the kindergarten where she worked part-time serviced the children of the best families, among them the great-granddaughter of Sir Winston Churchill. "Di is rich. Charles is richer still and will inherit one of the richest monarchies still flourishing in a democratic age."

And there's no doubt that Charles is democratic. As he puts it, "I enjoy shooting; therefore I see a lot of people who shoot." So any prole who happens to play polo, ride to hounds, or fly an airplane could join the charmed circle of his friends. This doesn't mean he shirks his responsibilities. Members of the Royal Family "care deeply who stands where on the steps when they arrive some place". Fortunately, Lady Di doesn't have to worry about her place on the steps from now on.

Nelliegrams

Every time we say "lesbian" out loud we challenge the assumption that heterosexuality is the only option for women; we assert women's right to choice, the self-determination, to autonomy. *Stepping out of Line,* A Workshop Manual and Resource Guide on Lesbianism/Feminism published by a collective will be useful to women who are interested in finding ways of talking with other people about lesbianism and feminism. It will be most useful to women who identify as lesbian/feminists and are looking for ways of sharing this perspective with other women. We imagine that the Manual will be interesting reading for almost anyone. Available from Women's Press at $6.00 plus 75¢ handling.

★ ★ ★ ★

Calcium build-up may be responsible for causing pelvic inflammatory disease in IUD users, according to research at the University of Texas Medical Center. Calcium, a favorable environment for bacteria to grow layers itself on the IUD. The researchers advise women to replace their IUD every 2 to 3 years to guard against infection. Incidentally, about 50 million women now use the IUD worldwide.

★ ★ ★

Status, the new Irish women's magazine, held a conference recently in Dublin to bring together women from all over Ireland. They discussed a Charter of seven demands concerning education, health, rural women, women in the home, family law, employment and social welfare. There were some late inclusions, such as a motion on abortion: "The decriminalisation of abortion as the first step to free legal access to abortion on demand". It was passed by 283 votes to 147 with 88 absentions, to whoops of delight from Irish feminists. Sister Stanilaus Kennedy, who was one of the platform speakers, concluded, "While many of us might not agree with all the issues on the Charter, today's conference showed the great potential (of women) that is here." ★ ★

Womanwise, a Denver women's health care clinic is testing a new disposable barrier-type birth control device. The new product is a round, pliant, spermicide soaked sponge 2" x 1½" thick which is inserted like a diaphragm, but does not need to be specially fitted. Once inserted it can be left in for 48 hours. Preliminary studies show it to be about as effective in preventing pregnancy as the diaphragm (85-97%). Cost is expected to be 50-60¢ per sponge.

HERizons ON HEALTH

A Patient Participation Group

by Gerri Thorsteinson

Old stereotypes die hard, as feminists well know.

The doctor-patient relationship traditionally showed the patient in a passive role, presenting herself for assessment while the physician in a fatherly role used his technical skill and knowledge to take care of the patient.

As part of an overall social trend, some patients are seeking a more active role in their own health care, but few clinics offer the opportunity for patient input on a regular, organized basis.

. . . to be well again people must regain control over their own health and patients must be retrained in self-help and self-care.

Winnipeg's Family Medical Centre (FMC) initiated such a group four years ago after the centre's social worker, a second year resident and a staff physician heard about a Wisconsin clinic's patient participation group at a conference.

The FMC is a teaching program, training residents in family practice as well as providing primary medical services.

The original committee was composed of a staff physician, social worker, two resident physicians, a nurse, a secretary and nine laypeople recruited by staff physicians' invitation. Later, others were invited to join by a waiting room notice and by word of mouth.

Lynn Ryan became a patient, a member and eventually chairperson of the patient advisory group.

She said that although attempts were made to keep the lay-membership of the group representative only "middle class professionals" were willing or able to commit time to such an endeavor.

Looking back, the group's accomplishments have varied from such practical suggestions as a potty-seat for the patient's washroom to writing a brochure detailing the clinic's services. A document of patients' and physicians' rights and responsibilities was drawn up; a waiting room bulletin board with current literature was set up, a patient representative elected and membership attained on the selection committee for resident applicants.

There is a rich theoretical background that such a group can draw on. Ivan Illich advocates a deprofessionalization of medicine because it has been responsible for iatrogenisis (physician caused disease or disability) at a social, clinical and cultural level.

Some of Illich's proponents argue that to be well again people must regain control over their own health and that patients must be retrained in self-help and self-care. The influence of the feminist Boston Health Collective (Our Bodies, Ourselves), is acknowledged by S. Sagov in "An Active Patient's Guide to Better Medical Care".

Many of today's major health problems such as heart disease, cancer and stroke can be affected by individual lifestyle changes. Ryan agreed that some disease and illness are brought about by excessive behaviors, both personal and societal. But she says it is too simplistic to blame the patient for their illness.

She sees patient participation as a political movement which would assert individual autonomy and responsibility as well as addressing the larger causative agents of environmental pollution, stress and an inflationary economy.

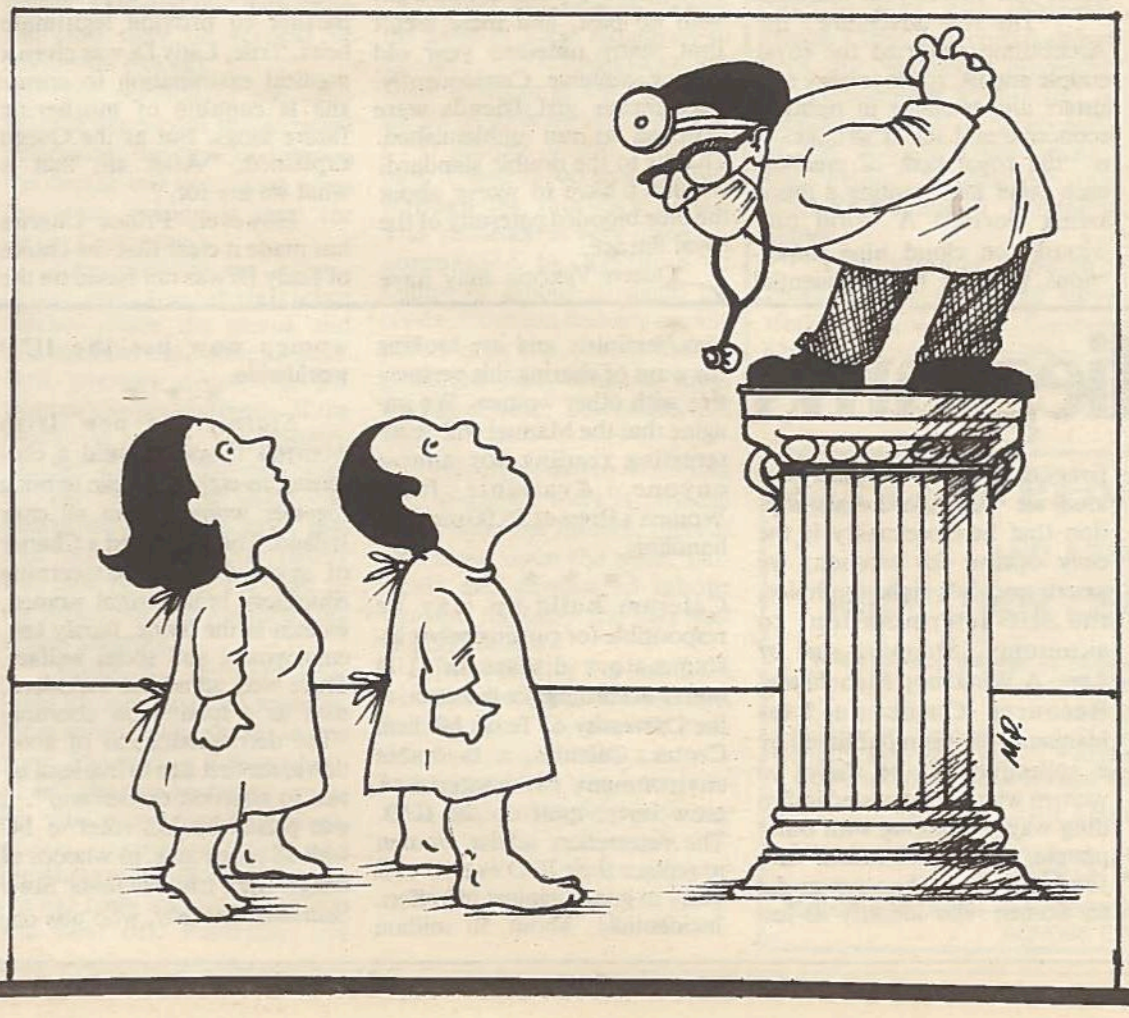
Applying the theory to medical practice is a slow and, at times, frustrating process. Ryan said medicine still appears a mystical process to many, the language incomprehensible, tests invasive and technology complicated.

Traditional attitudes of physician infallibility are deeply imbedded. One group member, a former nurse felt too uncomfortable talking to incoming residents about the groups' role and eventually dropped out.

Ryan feels that the relationship between physician and patient should be one of partnership," of two adults, trusting, sharing and respecting differences." The physicians at the clinic are open to patients' concerns; for example they will not perform home deliveries but they have acted to create a birthing room, making the hospital more homelike.

Presently the only place to learn about theory behind the patient-physician relationship is through one's own reading, Ryan said. Patients must be re-educated to integrate the "partnership" concept and more professional guidance is necessary.

Ryan is writing a paper on the group's experiences to record the innovative efforts of the FMC staff and to add to the existing knowledge for other groups' reference.



HERizons ON EDUCATION

Women's Studies

by Leslie Campbell

In the last decade the mix of courses, conferences, organizations, films and literature that compose women's studies has blossomed and stimulated people to such a degree, it is difficult to imagine how so many have escaped its influence and inspiration. Unfortunately, those of us involved with women's studies must still contend with poor funding and accusations — based on ignorance and prejudice — that women's studies is biased, trendy, narrow ("it only deals with half the human race"), and uses unscholarly methods. The ultimate complaint, however, that women's studies is subversive, indicates a much clearer comprehension of its nature; and I'll make no attempt to disprove it.

The text chosen to use this year in the women's studies course, taught at the University of Winnipeg, describes women's studies as "research and learning in a feminist context". (Sheila Ruth, *Issues in Feminism*) It's a good definition because it indicates that anyone can — and most feminists are — engaging in women's studies in any setting, not only the structured, institutional ones. As well, the definition recognizes the necessity of a feminist perspective to the unbiased study of women. Contrary to what many believe, feminism is not a bias — it is rather an attempt to remove bias and to restore balance.

Women's studies grew naturally out of the women's movement and women's desire to understand our experiences, our history, and our world. Traditional approaches were quickly discovered to be inadequate as they were (and still are, though perhaps to a lesser degree thanks to the pressure of feminists) riddled with androcentric assumptions: only men and their activities and perceptions really mattered. In fact, even when women have been deemed worthy subject, it has been men and who have made the pronouncements on the basis of their observations (and hang-ups), instead of allowing women to report on their own feelings, experiences, and opinions. Most of the 'great' philosophers, historians, scientists and theologians are guilty of this (eg. Aristotle, Augustine, Aquinas, Rousseau, Freud, Sartre . . .). Thus it's not surprising that we start sputtering when a man objects that "women's studies deals with only half the human race."

Traditional forms of inquiry also failed feminists in their search for knowledge because of their narrow, 'disciplined' framework. The usual disciplines — history, psychology, economics, etc. — cannot provide an integrated, holistic account of woman's experience and position. Reality and women themselves do not divide up into neat disciplines; thus women's studies is necessarily inter- or multidisciplinary (even undisciplined by patriarchal standards). Though university courses are often categorized and labelled in traditional ways, they will generally incorporate much information from other disciplines — of course, then they're accused of too much overlap.

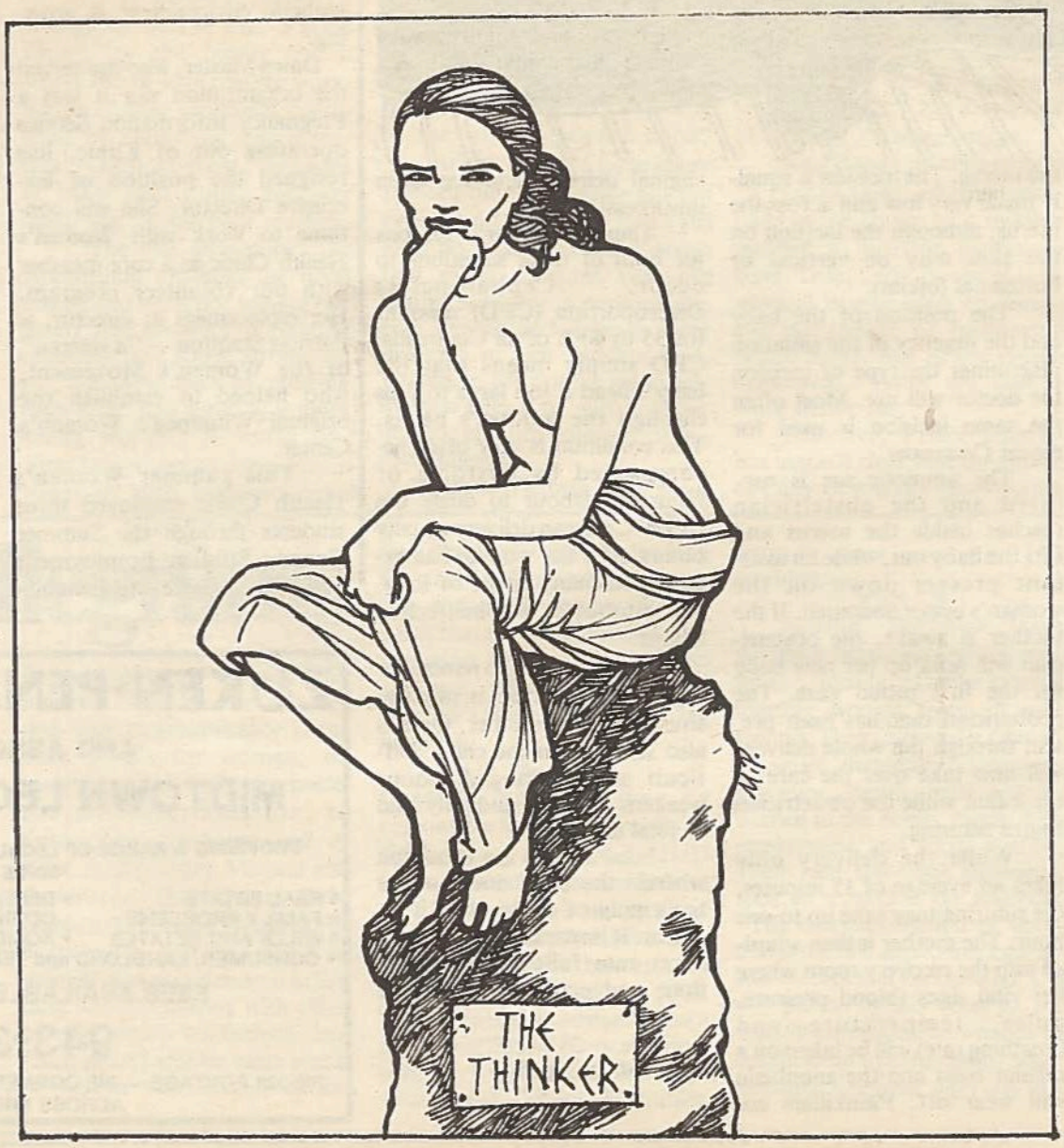
The unwillingness of those engaged in women's studies to stay within the boundaries of traditional intellectual territories is one of the factors behind the unscholarly charge (and probably behind the trendiness charge as well). Perhaps more importantly, it is the unorthodox acceptance of the personal or affective aspects of learning that result in this accusation.

Women's studies classes have a unique atmosphere: warm, personal relationships develop among class members, virtually all participate in class discussions and listen solicitously to one another, and feminist teachers are not concerned about maintaining the all-mighty authority image. Everyone is there out of genuine interest and everyone is viewed as an authority on 'life as a woman' — or as a man, but rarely do men cross the threshold (eg. out of a total of 70 students in the four classes I've taught only one was a man).

. . . feminism is not a bias — it is rather an attempt to remove bias and to restore balance.

Assignments too differ, usually through being more innovative and student-directed. Because women's studies is a radical and relatively recent phenomenon, we have, as Sheila Ruth points out, "no models after which to style our activities. The criterion for our methods is productivity."

Obviously then, women's studies is subversive. In fact, it aims at subverting the patriarchal order of our society by increasing our awareness of it and its effects on our lives. The attempt to dismiss women's studies as a fad rests on ignorance of this very serious purpose and the powerful role it plays on the lives of those involved.



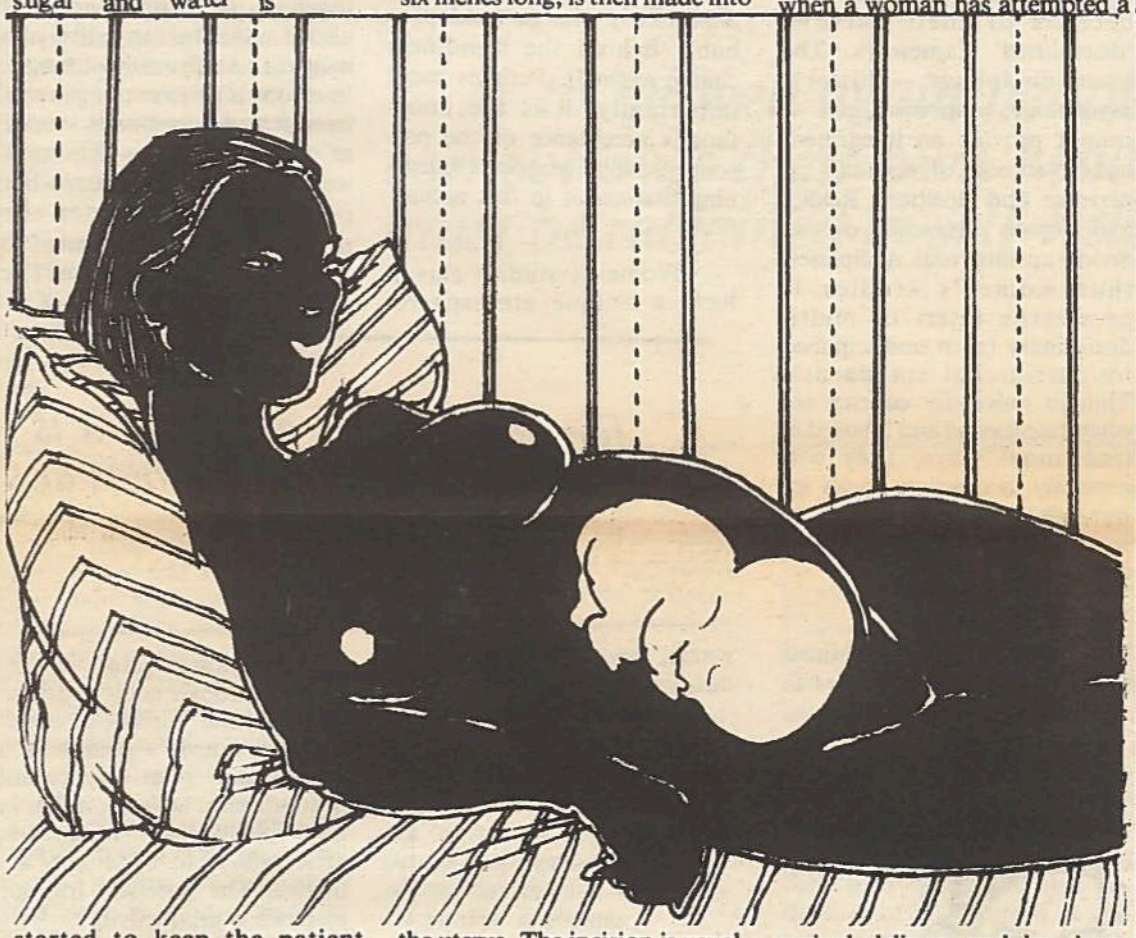
Medical

Cesarean Sections

by Debbie Schwartz

Cesarean or abdominal delivery is a birth through an incision made in the abdominal and uterine walls. It is major abdominal surgery.

In an elective (planned) Cesarean delivery, the course of events are as follows. The woman is usually admitted to the hospital the day before she is scheduled for surgery. The usual blood tests and preparations for surgery are administered. An intravenous or I.V. drip usually of sugar and water is started to keep the patient hydrated since she may not drink or eat anything 12 hours prior to surgery. The abdominal and vaginal areas are shaved.



The following morning a catheter (thin rubber tube) is inserted through the urethra into the patient's bladder. This will ensure that the bladder is empty so that it will not interfere with the surgical procedure.

Women are now given the choice between a general or epidural anesthetic. The epidural, although slightly uncomfortable, is preferable to the general anesthetic because it allows the woman to remain awake during the delivery of her baby.

For an epidural, after local anesthetic (freezing), a very fine plastic tube is placed, through a needle, into the space around the spinal cord. More freezing can be injected, to numb the lower half of the body.

The anesthetic is administered in the operating room. At the same time, the area that is to be operated on is washed with antiseptic and the woman is draped with sterile blankets. The woman is also given oxygen to ensure that the baby receives an adequate supply during delivery.

Whether the patient is now asleep or still awake, the surgical delivery is exactly the same. The incisions are through the skin, the subcutaneous fat, and the fibrous layers that cover the muscles of the lower abdominal wall and through the peritoneum (the thin lining of the abdominal cavity).

An incision, approximately six inches long, is then made into the uterus. The incision is usually made very low and across the uterus, although the incision on the skin may be vertical or horizontal (bikini).

The position of the baby and the urgency of the situation determines the type of incision the doctor will use. Most often the same incision is used for repeat Cesareans.

The amniotic sac is ruptured and the obstetrician reaches inside the uterus and lifts the baby out, while an assistant presses down on the woman's upper abdomen. If the mother is awake, the obstetrician will hold up her new baby for the first proud gaze. The pediatrician that has been present through the whole delivery will now take over the care of the infant while the obstetrician begins suturing.

While the delivery only takes an average of 15 minutes, the suturing may take up to one hour. The mother is then wheeled into the recovery room where her vital signs (blood pressure, pulse, temperature and breathing rate) will be taken on a regular basis and the anesthetic will wear off. Painkillers are usually administered to ease the discomfort that the woman will now begin to feel.

The catheter and I.V. will probably be removed later the same day. Total recovery will take up to three months, but the woman will usually be up walking the next day.

Cesarean deliveries are performed as a precautionary step when awaiting a vaginal delivery is felt to be difficult or dangerous or as a last resort when a woman has attempted a vaginal delivery and has been unsuccessful.

There are several reasons for both of these situations to occur. Cephalopelvic Disproportion (CPD) account for 35 to 40% of all Cesareans. CPD simply means that the baby's head is too large to pass through the mother's pelvis. This condition is very often accompanied by dystocia or failure of labour to dilate the cervix. Cesarean delivery usually occurs after the woman has experienced many hours of long, uncomfortable, but ineffectual labour.

It is important to remember that whenever there is physical stress upon the mother, there is also stress upon the child. Difficult and prolonged labour weakens the baby and may lead to fetal distress.

Fetal distress is a condition wherein the baby does not get the supply of oxygen that it requires. It is marked by a drop in heart rate following contractions and continuing with the

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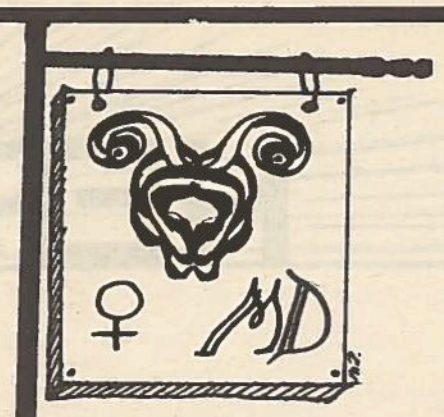


Women's Health Clinic

by Pat Stainton

Women's Health Clinic has undergone a rapid and gratifying period of growth since we opened in May of this year. The response from Manitoba women has exceeded even our expectations and, we now have over six hundred clients. There is already clearly a need for more space for our examining rooms, volunteer counselling program and our support staff.

We are presently using the services of four part-time physicians, all of whom are good, caring people, and fine physicians. To provide more stable and comprehensive service and to cover all the time the clinic is open, we need full-time doctors and we are conducting interviews, to engage a full-time physician. Ultimately we hope to be working with at least three doctors. The demand for good health care for women in a sympathetic environment is growing.

Dawn Master, who has served the organization sice it was a Pregnancy Information Service operating out of Klinic, has resigned the position of Executive Director. She will continue to work with Women's Health Clinic as a core member with our volunteer program. Her replacement as director, is Patricia Stainton — "a veteran" of the Women's Movement, who helped to establish the original Winnipeg's Woman's Center.

This summer Women's Health Clinic employed three students through the Summer Canada Student Employment Program. These students — Kim Bailey, Pam Craig, and Debbie Whitney, had already worked with Pregnancy Information Service as volunteer counsellors.

They have organized and updated our information. They supervise new volunteers and function as counsellors themselves. With the help of this program our counselling facility has progressed considerably. Also, Pam has developed a new program to deal with post partum depression. The counselling and the post partum depression services are both going to continue operating with Women's Health Clinic.

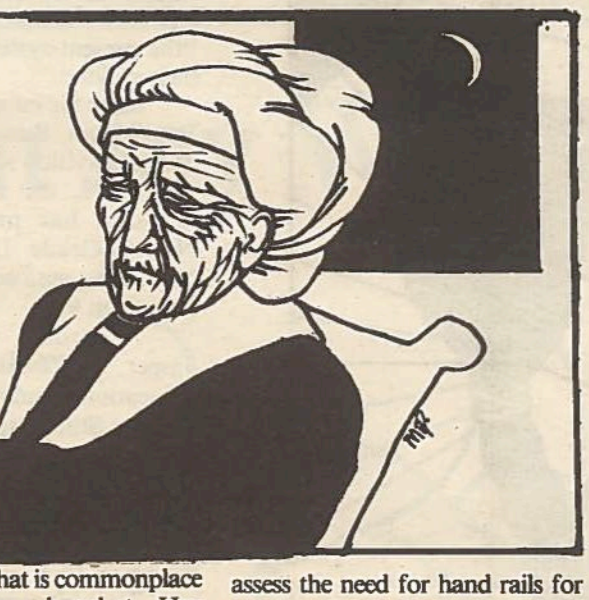
In the volunteer counselling program, we currently have twenty women. All counsellors undergo a thorough training. They commit themselves to a minimum of one — three hour shifts per week, for a sixth month period and attend a monthly coordinating meeting. If anyone is interested in joining the group, she will be more than welcome. The next session begins September 18, 1981.

On the whole, the Women's Health Clinic is running smoothly and effectively. At the same time, there are admittedly problems. Our facility is limited in terms of space and the examining rooms are particularly small. We need full-time physicians to provide comprehensive on-going treatment. We must have better facilities for them to work on, and until we do, it will be difficult to attract even the most dedicated doctors. However, at the present, we can't afford to move. If you support our efforts, your donations can be made out to: Women's Health Clinic, 555 Broadway Ave., Winnipeg, Manitoba, R3C 0W4. Please include your address.

We want to thank all the women who have supported us, both financially and morally. Your interest and enthusiasm makes all our efforts worthwhile. Sisterhood is still blossoming and powerful!

Geriatric Care and Women

by Susan Price, Darcy York



In an era in which the main thrust of medical science appears to be the prolongation of human life, it is contradictory that there is not an equal emphasis placed on the maintenance of the elderly. At present, those over 65 years of age comprise approximately 10% of the Manitoba population and the majority of these are women.

One of the greatest problems facing the elderly is the decision of whether or not to remain in their own homes as they age, especially once they are widowed. Various services are available to the elderly to help them to meet basic needs such as food preparation, bathing, shopping, etc., but these services can be costly to those on a low fixed income. Government subsidies may ease this financial burden somewhat; they are not plentiful enough to make a significant difference in the problem of poverty among the elderly.

The following ficticious case is used here to describe the typical response of a family faced with the decision of where to maintain an aged parent following the death of her spouse. It will also attempt to illustrate the alternatives to nursing home placement.

Mr. and Mrs. B. have been married for 57 years. They have lived in the same home for 50 years, managing well on their own. Mrs. B. has a minor hearing impairment in her left ear which requires the use of a hearing aid. She is slightly overweight and often complains of her ankles swelling. Mr. B. is a healthy individual with no underlying medical problems. He is very supportive of his wife and they enjoy many community activities together.

Upon returning from an afternoon visit one day, Mrs. B. finds her husband unconscious on the floor. He dies before reaching the hospital.

One month after the funeral, Mrs. B. arrives at the hospital emergency ward accompanied by her daughter. Upon examination, Mrs. B. is found to be dehydrated with grossly swollen ankles and acute confusion. From the daughter, it is gathered that following the death of her husband, Mrs. B. became acutely depressed and withdrawn. She refused to eat and lost her usual interest in taking meticulous care of herself.

Mrs. B. is admitted under the geriatric service of the hospital for assessment. After the results of her routine physical exam, Mrs. B. is found to have a urinary tract infection (U.T.I. — a common occurance among women and also a common underlying cause of acute confusion in the elderly) and mild congestive heart failure (C.H.F.). She responds well to antibiotics and diuretic therapy.

Despite interactions with the nursing staff and other patients, Mrs. B. remains depressed and withdrawn. She is reluctant to discuss her future plans with the staff, even though they feel she is able to return to her own home and encourage her to do so. When confronted with inquiries concerning her discharge home, Mrs. B. becomes quite anxious and says she doesn't know what she will do — that her daughter is making those decisions for her.

The nursing staff then decides that a family conference is necessary in order to arrange Mrs. B.'s discharge. In attendance at this conference are a social worker, medical staff, a pharmacist, a home-care coordinator and nursing staff.

Prior to the conference, Mrs. B.'s confusion has markedly improved. She is still occasionally forgetful but that is commonplace within her age bracket. Her depression has lightened through increased socialization with ward staff and fellow patients. She has become involved in ward activities, taking particular interesting in calling Bingo and ushering at teas.

At the family conference, it becomes apparent that Mrs. B.'s daughter is intent on having Mrs. B. placed in a nursing home. It is her contention that Mrs. B. would be unable to cope with affairs previously handled by her husband. Mrs. B.'s daughter also states that she is not prepared to assume the responsibility for her mother's upkeep. Mrs. B. is reluctant to express her feelings for fear of upsetting her daughter, but all clearly see that she wishes to return home.

During the course of the family conference, it is brought to the daughter's attention that a complete assessment will be done prior to discharge. This will include assessment to determine her ability to function in safety at home and to maintain adequate nutrition. Also included will be a visit to the home by a specialist to assess the need for hand rails for toilet, grab rails for tub, etc.

Another conference of the geriatric health team is then planned to determine and arrange specific support services that are necessary to maintain Mrs. B. in her own home. These services can include weekly visits by the V.O.N. to aid with bathing and by a homemaker to assist with housekeeping.

Mrs. B. is then discharged for a one-week trial period to determine how well she can cope. In this case, the patient is financially independent and therefore, with her support services, able to deal with the physical aspects of her life. Her emotional needs, however, are not so easily met.

The emotional needs of the elderly are basically still left wanting. Age and opportunity centers exist that try to deal with these needs but all too often the elderly are not aware of such facilities or do not have the transportation to visit them. It is here that society has a special responsibility to the aged, particulary where women are concerned. More often than not, women who are widowed are encouraged to remain in the community on the assumption that they can cope, while women must be "looked after" and frequently are relegated to the often inappropriate or inadequate care of nursing homes.

Mrs. B. was fortunate to have been referred to the geriatric staff of her hospital. A likely alternative course would have been for her to receive treatment on a medical floor and then be released. In that case, Mrs. B. would have been left on her own, most likely to deteriorate rapidly, both medically and physically, requiring repeat hospitalization and eventual nursing home placement.

To prolong human life, in itself, is a major medical accomplishment. However, it is not enough. There is also a responsibility to maintain quality of life.

The realization that an increase in availability of care services (and public awareness of these services) is vital to the future well being of the elderly. Perhaps then the fear of growing old and being at the mercy of the decisions of relatives will become a thing of the past, and feelings of self worth and usefulness will be restured within the elderly in society.

Alcohol Abuse and Women

by Terry Marchessault

Alcoholism is not unique to women, but the disease has different ramifications for women than for men.

W. Fraser, author of *The Alcoholic Women: Attitudes and Perspectives* says most alcohol-dependent women fit into one of three broad classifications: "Women Behind Lace Curtains; Single, Professional and Career Women; and Skid Row Women".

"Women behind lace curtains" manage to maintain a front of respectibility. They hide their drinking from neighbors and friends, and often even from their families.

These women are typically between 35 and 45 years of age, and are housewives who have decreasing feelings of self-worth as their lives progress and their children become increasingly independent. If their husbands are gaining success in their careers, this further aggravates the problem by widening the gap between the womens' perceived self-worth and that of their husbands.

The changing role of women also serves to worsen the situation of traditional housewives because although at one time they may have been considered "successful", they may now feel they have forfeited their own identity by becoming a wife and mother. They may be identified by others as Mr. So and So's wife or So and So's mother.

Feelings of low self-esteem and worthlessness may develop, among such women, which can lead to alcohol dependence.

Although their drinking behavior may remain a secret for some time, these women will likely reach the point where the problem can no longer be hidden from those around them.

Although single, professional and career women may have interesting and fulfilling jobs, other aspects of their lives may seem empty and they fill the void by drinking.

This situation of loneliness may arise because the women funnel their energies into their careers, neglecting to build social networks. Added to the loneliness may be the pressure of trying to maintain a career, often in a male dominated profession and in a very competitive atmosphere.

Although many companies have policies intended to assist male employees with alcohol related problems, these services are not usually extended to female employees who may need them just as much. This may, in itself, force these women to conceal their alcoholism even more than their male colleagues. This attaches greater stigma to the female alcoholic than to the male alcoholic.

"Skid row women", on the other hand, are outcasts from the mainstream of society. They may be physically, emotionally, or educationally disadvantaged. These women are products of a social and economic situation which often includes alcohol as a daily part of their lives. Lack of social mobility, status and prestige may lead to alcohol dependence as a source of relief from the disparaging aspects of their lifestyles.

Skid row women depend on missions, flophouses, emergency departments of hospitals, etc. for bare survival. These women may also turn to prostitution in order to obtain the alcohol they depend on. The skid row women alcoholics have often hit "rock bottom" before they find someone who can help them with their alcohol dependency and related, underlying social and economic problems.

Having identified some of the factors which precipitate alcoholism, it is necessary to consider ways in which to deal with the problem. Intervention could involve the use of groups such as Alcoholics Anonymous or other group therapy; it could include individual counselling, detoxification centres, community-support systems, or company-based programs.

Ideas for prevention of alcoholism can parallel modes of intervention. By considering each of these main classifications, one can pinpoint the precipitating factors and attempt to alleviate them. Intervention must be initiated where an apparent risk of alcoholism exists rather than after the disease has developed.

Prevention could be assisted by community education programs and control of the contributing factors. If women drink because they are lonely, then one logical course of action is to alleviate that loneliness. If women drink because of the pressures of families or careers, then we need to establish community-based drop-in centres or train company social workers to afford these women the opportunity to discuss these pressures and obtain the help necessary to cope.

a first step toward solving the problems presented by alcoholism would be to destigmatize it.

A first step toward solving the problems presented by alcoholism would be to destigmatize it, to encourage women to seek help where needed, and to explore more fully the possibilities of intervention and treatment.

Alternatives in The Pas

A new way to learn

by Patricia Rawson

The Integrated Learning Centre is a new alternative school in The Pas and the first of its kind in Manitoba.

The private school, funded by The Pas Indian Band, was started to try to overcome a high drop-out rate (over 90%) of their students attending schools in The Pas. Elsie LaJambe, a teacher at the school, says an alternative was initiated because "the present system was failing their children".

Since the integration of The Pas Indian Band and Kelsey School Division schools in 1966 until 1978, the Kelsey School Division has produced five Native Grade 12 graduates. Most drop-outs occur in Grades 7 through 9.

According to Brian G. Jasper, in *Tánáke (Why?)* — Education Study of The Pas Reserve Students, "The present public school system is totally inadequate for meeting the needs of Native people who wish to retrain the cultural strength of their past."

The Integrated Learning Centre opened in October, 1980, and teaches Grades 7, 8 and 9. There was an enrollment of 42 students, with this initial year being devoted to drop-outs. Ages ranged from 14 to 21.

In accordance with the provincial curriculum, emphasis is placed on native content. The students are taught to understand their cultural background by attempting to eliminate the negative aspects of native heritage, as incorrectly depicted in textbooks. Elders of the community eagerly participate in the program, passing on their knowledge, experiences and traditions.

Excursions during the first year included a science trip to nearby Clearwater Lake, visits to a local farm and tour of Keewatin Community College. In February, the students participated in a camping and trapping expedition where they rented a secluded cabin for 10 days, living off the wild.

During April, of 1980, staff and students visited the Plains Indian Cultural Survival School in Calgary, Alberta, a very successful alternative school dedicated to retaining Native culture. This trip was a source of inspiration for the participants.

Mrs. LaJambe feels that "through cultural activities, I am learning with the students and, therefore, am able to generate even more enthusiasm".

The school's atmosphere is informal and very flexible; students and teachers are on a first name basis. Open discussions are encouraged, creating self-confidence. Mrs. LaJambe explains, "once the students achieve self-confidence, learning becomes easy". Individual counselling plays an important part in the curriculum.

Attendance is not overly stressed since many students have to miss school during trapping season. At that time, the pupils are urged to take their school books and to keep a diary to relate their experiences to classmates upon their return.

In the future, mornings will be devoted to academics, with cultural activities in the afternoons. At least two camping trips are planned for the coming year. Other projects include preparing a history of The Pas Reserve by interviewing community elders and a native studies unit.

The first-year students are enthusiastic about this new concept in education. The 1980-81 school year produced three graduates, all of whom are continuing their education. Mrs. LaJambe feels the school is successful because "most students are now motivated to carry on their education".

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Tan Jay

would be counted as part of the hard-won wage scale increases. Since the company failed to honor its agreement, the only recourse was strike.

In spite of threats, coercion and intimidation, the workers stood solid. Divide and rule did not work or break the solidarity between the Chinese, Vietnamese, Portuguese, Filipino, Italian and East Indian workers, nor between the male cutters, and the much lower rated women sewing machine operators.

There were charges of communist influence, and police and company harassment. Supervisors tried to remove picket signs, phoned workers at home, threatened firings and blacklisting. A Filipino supervisor, who wouldn't go along with these tactics, was fired. Pressure was brought to bear on the Filipino community to get the women back to work, to no avail.

Scabs were few. One of the most effective solidarity actions was the picket line set up by the workers of the Tan Jay factory in Montreal, which no one crossed. Quebec has anti-scab legislation, a tremendous help in the struggle for a decent standard of living for the most exploited and victimized group of Canadian workers, the unskilled and semi-skilled immigrant women.

Fourteen percent of these are in the garment industry; in Manitoba, the percentage is even higher. They need positive action from the U.S. led union bureaucracy. They need the provincial legislature to improve and enforce its labour standards legislation.

The courts, quick to penalize employees for illegal strikes, must fine or jail employers who violate minimum wage, overtime and other labour laws. And we must urge the federal government to change the 1978 Immigration Act which can be used to intimidate the deport immigrant women who organize and struggle for better wages and working conditions.

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Cesareans

resting stages between contractions. If this occurs, a quick delivery is important and Cesarean section may be chosen. Only 10 to 15% of Cesareans are performed for this reason.

With the widespread use of fetal monitors during labour, changes in the fetal heart rate are detected more readily and therefore, this early detection has contributed to the number of Cesareans performed because of fetal distress. This technique may be causing some "false alarms" and newer techniques may help confirm the need for a "section".

Hemorrhaging from the uterus is responsible for another 10% of Cesarean deliveries. Hemorrhaging occurs as a result of placenta abnormalities and is a very critical condition where immediate delivery is crucial to both mother and child.

Another 20% of abdominal births occur because of unusual position of the baby. Babies who are in a transverse position (lying across the abdomen) must be delivered by Cesarean section. Thirty to forty percent of breach (buttocks first) babies are delivered abdominally.

The remaining 20% of Cesarean deliveries are planned in anticipation of an unsafe vaginal delivery. In these cases the woman does not go into labour but undergoes tests to ensure that her baby is as close to term as necessary for its survival. The woman is then scheduled for an elective Cesarean section.

Advanced maternal age, maternal diseases such as diabetes, hypertension, heart disease, herpes infection, multiple births and extensive abdominal surgery may be reasons to avoid vaginal delivery.

For a more detailed review of pregnancy problems, there are many informative books on the market.

Thanks to our financial contributors: Grace Ivey and T. Nestor.