

Canadian Women's Health the network

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and refugees with HIV/AIDS

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editor's note:

In the spirit of spring, this issue of *Network* “plants a seed” for our next special issue on women’s health and the environment with an introductory article on climate change and its impacts on women’s health. We have also included information about the growing movement to involve more women in decision making around climate change mitigation and adaptation.

Women’s health and the environment is one of two primary focus areas at the Canadian Women’s Health Network this year. The other is mental health as we continue to work as part of the Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addiction established by the CWHN in 2006. The Group is working to ensure that sex- and gender-based analysis (SGBA) is included as the newly formed federal Mental Health Commission begins to implement recommendations from the Senate report *Out of the Shadows at Last*. Following a focus on mental health in recent issues of *Network*, this issue doesn’t address the topic; instead, it reflects the diversity of other women’s health issues that have come to our attention lately, either through the work of the Centres of Excellence for Women’s Health or other CWHN partners.

Women’s health and the environment is one of two primary focus areas at the Canadian Women’s Health Network this year.

This includes a summary of the research from Women and Health Protection (WHP) on women’s use of the highly prescribed cholesterol-lowering class of drugs called statins. Also from WHP, we have a follow-up on the Charter challenge on direct-to-consumer advertising, which will be in the Ontario Superior Court this June.

A commentary from CWHN provides an update on the Human Papillomavirus (HPV) vaccine one year after the federal government announced its contribution of \$300 million toward a mass vaccination program in Canada. An article from the *Fédération du Québec pour le planning des naissances* looks at the HPV vaccine specifically in Quebec and the joint call for a moratorium on the vaccine in that province.

Researchers at the Prairie Women’s Health Centre of Excellence write about how the long shadow of history continues to affect access to health care for First Nations and Métis women in the Prairies. And a summary of the *Cherchez la femme* workshop by one of the event’s speakers examines the challenges faced by women in minority francophone communities in their roles as health-care consumers, workers and volunteers.

In a tribute to American health activist Barbara Seaman, who died at the end of February, three Canadian women’s health advocates describe some of Seaman’s groundbreaking and inspiring work, which undoubtedly saved ▶

The opinions expressed by contributors are their own and do not necessarily represent the views of the Canadian Women’s Health Network, its funders or its members. Articles are intended to provide helpful information and are not meant to replace the advice of your personal health practitioner.

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thousands of women's lives, and the legacy she has left for the women's health movement throughout North America.

We take a look at the issues facing women immigrants and refugees with HIV/AIDS in Canada by profiling three community-based projects in Vancouver, Montreal and Ottawa. And Fern Charlie, a peer interviewer for the Vancouver Area Drug Users women's group shares her experiences as part of the project Women CARE in Vancouver's Downtown Eastside.

Finally, before presenting our regular section of Recommended Readings, we've included an excerpt from the book *Highs & Lows: Canadian Perspectives on Women and Substance Use* and an interview with one of the editors, Nancy Poole, from the BC Centre of Excellence for Women's Health.

As this was my first issue as editor of *Network* (replacing Kathleen O'Grady who is on maternity leave), I relied heavily on members of CWHN staff and the Expert Review and Advisory Committee who provided feedback on the articles during the editing and review process. Thank you all. Special thanks to Susan White, Assistant Executive Director, whose analysis and eye for detail have been invaluable.

Your input is always welcome. You are also welcome to join us at the Canadian Women's Health Network by submitting article ideas, serving on a committee or sending your women's health resources to be included in the CWHN on-line database. To stay up-to-date on CWHN activities and women's health topics, bookmark our website (www.cwhn.ca), visit our MySpace and Facebook pages, join our list-serve and subscribe to our monthly e-newsletter, *Brigit's Notes*. In the meantime, relish the warming days of spring and even the dog days of summer. Winter will be back before we know it.

Sincerely,

Ellen Reynolds

Director of Communications

Curel® Supports CWHN

CWHN is most appreciative of the recent generous financial contribution made by Curel® to support our women's health information database. Curel® is also currently informing the public about CWHN's services through their marketing activities. For more information, please go to: www.curelwomen.ca/cwhn/en/



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FEELING THE HEAT

WOMEN'S HEALTH IN A CHANGING CLIMATE

BY KIRSTY DUNCAN

FOR THE FIRST 20 YEARS THAT CLIMATE CHANGE GARNERED INTERNATIONAL ATTENTION, GENDER ISSUES WERE NOT EVEN ON THE AGENDA—EVEN THOUGH WOMEN AND GIRLS REPRESENT HALF OF THE WORLD'S POPULATION AND ARE LIKELY TO EXPERIENCE VERY DIFFERENT HEALTH IMPACTS COMPARED TO MEN AND BOYS. WOMEN ARE GENERALLY POORER THAN MEN AND MORE DEPENDENT THAN MEN ON PRIMARY RESOURCES THAT ARE THREATENED BY CHANGES IN CLIMATE.

When it comes to decision making about climate change, women in most parts of the world have remained almost invisible until just recently. At the Eighth Conference of the Parties to the United Nations Framework Convention on Climate Change in 2002, participants finally acknowledged that women *are* vulnerable to climate change, and that they may even bear a disproportionate share of the adaptation burden. More recently, the United Nations Commission on the Status of Women addressed “Gender Perspectives on Climate Change” at the 52nd session of the Commission in New York in February 2008. And at the UN climate change conference in Bali, Indonesia in December 2007, the global network of activists and scholars, Gender CC—Women for Climate Justice, was established and issued a statement demanding more women's participation in climate change decision making (see sidebar on page 6).

Future global climate and health

Humanity is currently undertaking a global scientific experiment by injecting enormous amounts of greenhouse gases (GHGs), such as carbon dioxide and methane, into Earth's atmosphere. The Intergovernmental Panel on Climate

Change (IPCC) predicts that carbon dioxide (CO₂) levels will double, or even triple, over pre-industrial levels by 2100. Canada is one of the largest producers and consumers of fossil fuels, and one of the largest per capita emitters of GHGs in the world.

Global mean temperature is projected to increase from 1° to over 6° C over the coming century relative to 1990 temperatures. This projected warming is greater than any experienced by humans in the past 10,000 years. At the Poles, warming will be much greater than for the Earth as a whole; northern Canada's average winter temperature is expected to increase by 8° to 10° C over the same period. Inuit communities are already experiencing temperature increases that lead to decreasing sea-ice cover, which affects the ability to hunt and fish for traditional food. Also, the melting sea ice may open the Northwest Passage to international commercial shipping; increased traffic may result in more pollution, affecting the Arctic fisheries and the general health of people and wildlife living in the region.

Dr. Margaret Chan, Director-General of the World Health Organization, characterizes climate change as “the fifth horseman,” and when she declared climate change as the theme for this year's World Health Day, she referred to it as “the defining



issue for public health during this century.” It is therefore imperative to address the impacts of climate change on human health, and to invest in future resilience. Gender-based analysis that examines how climate changes affect women and men differently must also be part of the process, including consideration of the role of poverty as a significant health determinant.

Statistics Canada’s most recent data (2003) show that almost 1.5 million adult women are living in poverty in Canada. Thirty-six per cent of Aboriginal women live in poverty, compared with 17% of non-Aboriginal women; and the poverty levels for lone-parent families led by women (51%), women of colour (29%), women with disabilities (26%) and senior women (41%) are also of great concern. An examination of some of the direct and indirect health impacts of climate change indicates that women who experience the highest levels of poverty in Canada are also among the most vulnerable to climate change impacts.

Direct health impacts

Thermal extremes

In a warmer world, heat waves are expected to become more frequent and severe. Particularly vulnerable are infants, elderly people and people living in poverty.

In 1936, Canadians suffered under

...women who experience the highest levels of poverty in Canada are also among the most vulnerable to climate change impacts.

temperatures of 38° to 41° C in Hamilton, Niagara Falls and Toronto. Some residents reversed the flow of their vacuums to try to keep cool, while others fled to the beaches where men flouted decency laws by brazenly sporting topless bathing suits. At night, thousands of citizens abandoned their homes to sleep in cool cemeteries and parks on blankets or mattresses, or in parked cars along the waterfront; Toronto’s *Daily Star* reported that the Canadian National Exhibition ground looked like a “vast dressing room.”

Almost 1,200 Canadians died during the crisis (compared with 42 people the previous year), with Toronto experiencing 225 deaths. Heat exacerbated many underlying health conditions, such as cardiovascular and respiratory disease,

which subsequently killed. More recently, heat waves in Europe killed 35,000 in 2003; in France, female mortality was 15 to 20% higher than male mortality for all age groups.

Men and women differ in their response to extreme heat. Women sweat less, have a higher metabolic rate and thicker subcutaneous fat that prevents them from cooling themselves as efficiently as men. Women are therefore less tolerant of an imposed heat stress.

Heat-related health impacts can be reduced through individual behaviour adaptations, such as drinking more fluids and the use of air conditioners—as long as people have access to these resources. Poverty among elderly women, for example, limits their access to resources and contributes to the higher risk of heat-associated death. On a structural or societal level, adaptation may include the development of community-wide heat emergency plans and improved heat warning systems; however, as with individuals, it cannot be assumed that the necessary resources are available.

Extreme events

With increased temperatures, extreme weather events, such as floods, hail, ice storms, and tornadoes, are also likely to increase. Gender significantly affects the daily lives of women and men, before, during and after an extreme event. ►

FEELING THE HEAT

Those likely to suffer most from a disaster include women living in poverty, those in violent relationships and others with limited access to resources.

Women generally endure more mental stress than men as the primary caregivers during and after extreme events. Women also suffer increased violence at these times. Police reports of domestic violence following the 1980 Mt. St. Helen's volcanic eruption increased by 46%, and in 1998, a Montreal police chief reported that 25% of calls received during the 1997 ice storm were from women experiencing abuse. During the chaotic days and weeks following Hurricane Katrina in 2005, the National Sexual Violence Resource Center in the US recorded 47 sexual assaults, which according to the Center represents only a "small percentage of the informal anecdotal reports and accounts."

Women must be included in disaster prevention, mitigation and recovery strategies. Specifically, women must be engaged in: family, household and

workplace preparation for extreme weather events; response and recovery; emergency-site organization; physical and emotional care for children; and organizing support networks.

Indirect health impacts

Indirect risks of climate change include increased air pollution, decreased food production, reduced water quality and quantity, and increased vector-borne disease (disease usually transmitted to humans by an insect) such as malaria and Lyme disease.

Mosquito-borne transmission of malaria in Canada is dependent on the interactions among the mosquito vector, human host, malaria parasite and environmental conditions—particularly climate conditions. Malaria may also be contracted by Canadians travelling to countries where the disease is present, but not known to be endemic.

The potential for the re-introduction of malaria into Canada and the United States has been demonstrated by recent

outbreaks of the disease in densely populated areas of New Jersey and New York in the 1990s. However, continued and increased application of control measures—such as water management, disease surveillance and prompt treatment of cases—probably would counteract any increase.

A warmer climate and longer frost-free seasons in Canada may permit the spread of Lyme disease, a bacterium transmitted to humans by ticks. Lyme disease can usually be treated effectively with antibiotics, but if left untreated, it may lead to arthritis or neurological problems. In Canada, the disease is mainly found in southeastern parts of Ontario, Manitoba and Nova Scotia, and in southern British Columbia, but as temperatures rise, scientists are concerned that the ticks may move further north, carrying the disease with them.

Climate change is likely to increase acidic precipitation ("acid rain") and smog. The sulphur dioxide in acidic precipitation is created mainly from the

WOMEN PUT GENDER ON THE CLIMATE CHANGE AGENDA

"When women's rights are not protected, more women than men will die from disasters. The issue of climate change is too important to ignore the voice of half the world's population."

— Lorena Aguilar, Senior Adviser to the World Conservation Union at the UN Commission on the Status of Women meeting in New York, February 2008.

AT THE 52ND SESSION of the UN Commission on the Status of Women in New York in February 2008, a panel discussion addressing "gender perspectives on climate change" brought together experts from around the world calling for women's participation in all aspects of the climate change debate, including mitigation and adaptation. The panel, which was moderated by Commission Vice-Chairperson, Ara Margarian, also included Anastasia Pinto, adviser to the Centre for Organization, Research and Education and Woro B. Harijono,

Director-General of the Meteorological and Geophysical Agency of Indonesia. Citing numerous studies, panelists showed that climate change is a gender issue and that when natural disasters strike or severe weather events occur, the different impacts on women and men must be considered.

Women, they said, are underrepresented in decision making about climate change and panelists called on governments—and the members of the Commission—to ensure women's participation in planning and decision making, especially towards the development and implementation of gender-sensitive policies and programs. They called for broader support for the development of a gender strategy or plan of action within the United Nations Framework Convention on Climate Change (UNFCCC), and the establishment of "a system for governments to use gender-sensitive indicators and criteria" for reporting to the Convention's Secretariat.

burning of sulphur-containing fuels, such as coal and oil; important sources include power plants, pulp and paper mills, refineries and smelters. Nitrogen dioxide, another component of acidic precipitation, comes from motor vehicle

6,000 hospital admissions in Toronto each year. Studies have found that women have a greater deposition of inhaled particles in their lungs than men—an indication that women may be more affected by air pollution.

health impacts of climate change for women and men, gender-based analysis is a necessity, and women must be involved in adaptation and mitigation strategies to meet the changing climatic conditions. In the words of Nobel laureate, Amartya Sen, “The voice of women is critically important for the world’s future—not just for women’s future.” ❧

Kirsty Duncan is an Associate Professor, Health Studies, University of Toronto (Scarborough), and was recognized as one of the Nobel Prize winning Canadians on the Intergovernmental Panel on Climate Change.

For more information, visit:
Gender and Climate Change
www.gencc.interconnection.org/index.html

World Health Organization (WHO)
World Health Day 2008: Protecting Health from Climate Change
www.who.int/world-health-day/en

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To effectively address the health impacts of climate change for women and men, gender-based analysis is a necessity, and women must be involved in adaptation and mitigation strategies.

exhaust, electric utilities and industrial boilers, and is also associated with smog. Canada’s love affair with the automobile certainly contributes to the problem. In the past 20 years, while Canada’s population has increased 16%, the number of passenger cars on the roads has increased by over 60%.

Health effects of increased air pollution are likely to range from mild illness (e.g. eye, nose and throat irritation) to severe illness and even death. Air pollution is thought to be responsible for 1,700 premature deaths and

Females also have fewer red blood cells than males, and thus may be more sensitive to the toxicological influences of air pollutants.

Voice of women critical

Even if greenhouse gas emissions were stopped immediately, the effects of human activities would still influence Earth’s climate for many years to come. People with limited access to resources, have the least capacity to adapt to climate change and are more vulnerable to its impacts. To effectively address the

As countries around the world prepare to draft the post-Kyoto Protocol strategy by the end of 2009, ensuring women’s voices are included in the process is of the utmost urgency, according to Minu Hemmati, from the global network, Gender CC–Women for Climate Justice. “This process will need a lot of awareness-building,” said Hemmati, citing the fact that neither the Framework Convention nor the Kyoto Protocol mentions women or gender. “Even though it appeared that attitudes were changing and gender equality is now considered by some as an important factor in mitigating climate change and adapting to its impacts, women’s participation in relevant negotiations must be consistent and continuous.”

In a letter to the plenary of the UNFCCC in Bali, Indonesia in December 2007, Gender CC stated: “We would like to express our grave concern at the marginalization of women’s views, voices and rights during this conference and the future climate change regime. We are here to help govern-

ments to recognize the vital urgency of gender equality in their policies and program at the growing climate crisis... We ask you to ensure that adaptation and mitigation strategies uphold basic human security and the right to sustainable development, and do not exacerbate the injustice, inequalities and inequities between women and men. Women have a strong body of traditional knowledge that can be used in climate change mitigation, disaster reduction and adaptation. Proper acknowledgement, protection and financial support should be available to sustain this knowledge... We look forward to a climate regime that is gender sensitive, respects nature as well as human rights.” ❧

For more information, visit:
UN Commission on the Status of Women:
www.un.org/womenwatch/daw/csw/52sess.htm

Gender CC–Women for Climate Justice: www.gendercc.net/

EVIDENCE for CAUTION *Women and statin use*

BY HARRIET G. ROSENBERG AND DANIELLE ALLARD

From Women and Health Protection

STATINS are a class of prescription drugs designed to lower cholesterol. The leading statin drugs are Lipitor (generic name atorvastatin), Crestor (rosuvastatin), Mevacor (lovastatin), Pravacol (pravastatin), Zocor (simvastatin) and Lescol (fluvastatin).

The rationale for prescribing these drugs is based on the *cholesterol hypothesis* which argues that drugs that can lower total cholesterol (TC) or LDL cholesterol (often called “bad” cholesterol) or raise HDL (“good” cholesterol) will prevent heart disease. The measurement of cholesterol lowering is called a surrogate endpoint, which is different from the measurement of the hard endpoints of decreased heart disease or death. Having cholesterol is often thought of as a virtual disease state. However, cholesterol performs many vital functions in the body: it maintains cell wall structure, is crucial for hormone and Vitamin D synthesis, bile salt production and digestion, brain and neuron function. It is critical in fetal development and is an essential component of breast milk.

IN THE LAST 20 YEARS, A CLASS OF CHOLESTEROL-LOWERING DRUGS CALLED STATINS HAVE ACHIEVED THE STATUS OF BEING THE MOST WIDELY PRESCRIBED PHARMACEUTICALS IN THE WORLD. IN CANADA, WOMEN ACCOUNT FOR HALF OF THE THREE MILLION PEOPLE WHO TAKE STATINS DAILY.

Researchers Harriet Rosenberg and Danielle Allard at Women and Health Protection recently reviewed the effectiveness and safety of statin medications for women in Canada. They were looking for the evidence base for use of this widely prescribed class of drugs. What they found was evidence for caution.

In 2006, 23.6 million prescriptions for statins were dispensed in Canada at a cost of \$2 billion (CAN). Statin sales were predicted to increase, with projected earnings of \$30 to \$33 billion (US) worldwide in 2007. Lipitor is the top selling pharmaceutical in Canada. Worldwide sales reached \$12.9 billion (US) in 2005.

In their report, *Evidence for Caution: Women and Statin Use*, Rosenberg and Allard look closely at the available evidence about statin use and discuss research information that challenges the cholesterol hypothesis (see box), in particular for women.

There are significant differences in the way heart disease manifests in men and women. Women have different symptoms; their symptoms are less likely to be recognized and, as a result, women may not receive timely emergency treatment and usually have a higher risk of death after a heart attack. This is especially true for younger women. Heart disease is often described as the leading cause of death for women. This is true only for women in their 80s: women between the ages of 30 and 79 are most likely to die of cancer. For men, on the other hand, heart disease and stroke are much more likely to occur at a younger age. The death rate due to heart disease among women is currently only about half that for men.

In the recent past, these differences were explained by theories of hormonal differences between men and women—theories that led to the widespread prescription of hormone therapy (HT) for menopausal women to protect against

heart disease. However, in 2002, the groundbreaking Women's Health Initiative tested this hypothesis and found the opposite to be true; and, most recently, additional evidence has linked HT with an increased risk of developing breast cancer.

There are many risk factors associated with heart disease, including smoking, diet, poverty and exposure to environmental pollutants which are modifiable, but cholesterol has become the most prominent and feared risk, perhaps because it is the only one that can conveniently be addressed by taking a pill.

The first statin was Mevacor, manufactured by Merck and officially approved for cholesterol lowering in individuals with the rare condition of Familial Hypercholesterolemia (FH) in 1987. Since then statin use has been substantially expanded to larger populations as the cholesterol targets have been lowered. Six additional statins have been approved for sale in Canada, one of which, Baycol, was voluntarily withdrawn from the market in 2001 after it was linked to at least 50 deaths worldwide caused by a serious and potentially fatal muscle disorder.

One of the most in-depth reviews of women and statin trials was undertaken in 2004 by researchers Walsh and Pignone. They evaluated data from every significant clinical trial about cholesterol-lowering drugs (both statins and non-statin drugs) and women. After reviewing over 1,500 articles, they concluded that for women without heart disease, lowering cholesterol does not reduce the death rate from heart disease or the overall death rate. They also noted that there is not enough evidence to know if events such as non-fatal heart attacks or strokes are reduced.

Analysis by researchers at the

Therapeutics Initiative at the University of British Columbia, which looked at a total of 10,990 women, also found no evidence that statin therapy reduced coronary events in women without heart disease.

In addition, a recent overview in the medical journal *The Lancet* (2007) (and cited in *Our Bodies Ourselves: Menopause*) also emphasized that there has never been a single clinical trial showing that statin therapy is beneficial for women who don't already have heart disease or diabetes. They question the evidence base for guidelines promoting statin use for this large population of women (75% of women statin users do not have heart disease) which is based on research which even the guideline authors say is "generally lacking" for women and extrapolated from men.

For women with pre-existing heart problems, statin use according to the survey by Walsh and Pignone, has been shown to reduce coronary events and coronary death, but not the overall death rate. This is of concern because a decline in coronary deaths appears to have been negated by an equal number of deaths or even an increase in deaths from other causes. These researchers were unable to fully explore this issue because many of the trials only release data on deaths caused by heart disease, and not other causes of death, making a more detailed analysis impossible.

A different review, looking at three trials where women with pre-existing heart disease are represented found that for women, cardiac events were reduced by only 0.8% per year for a five-year period and there was no decline in overall death rates.

Over the last two decades, guidelines in the United States and Canada have recommended statin therapy for ever

larger populations, but researchers have questioned the science behind the "lower is better" hypothesis. Critics have pointed out that guidelines for statin drug use in women are weak and they express concern about possible conflict of interest which may bias the recommendations by guideline writers, the majority of whom have financial ties to the companies manufacturing statins.

Safety concerns

Statin have been described as "so safe they should be in the drinking water." Yet, evaluating the safety of statin therapy for women is exceptionally difficult due to a lack of gender-based analysis in research. Also, only two of 14 key statin drug trials have released all of their serious adverse events data despite repeated requests by researchers. Access to these unreleased data is urgently needed to thoroughly evaluate the risks as well as the benefits of statins.

There are many on-line groups of former statin users, and their partners, who describe experiences with cognitive and memory impairments, including amnesia, episodes of depression, mood problems, especially extreme irritability, peripheral neuropathy, muscle pain and exercise intolerance, weakness and fatigue, blood sugar problems, and the unmasking of underlying genetic conditions (e.g., Parkinson's disease, ALS) that are disabling or life-altering.

Since 2004, Dr. Beatrice Golomb and colleagues at the University of California (San Diego) have been compiling information on statin-related problems, including memory loss, mood and violent or aggressive behaviour. Their work has found associations between aggressive behaviour and statin use not seen in clinical trials. This research found that some statin users who had mood and ►

EVIDENCE FOR CAUTION

memory problems also had muscle problems and weakness, which would affect their ability to undertake proven heart-protective exercise programs. Their research has estimated that, while clinical trials may report 1 to 7% of patients experience adverse drug reactions, the number of adverse reactions with statin use may be closer to 15%.

Research indicates that statin exposure in younger women is associated with higher risks of miscarriage, and children born with rare and profound birth defects. Furthermore, there is no significant research on the health implications for women taking statins and birth control drugs at the same time.

Also of concern to women is the inadequate research on the troubling association between statin exposure and breast cancer. In addition to a history of association between cholesterol-lowering drugs and cancer, two statin trials saw a statistically significant increase in breast cancer and an overview of five trials that examined breast cancer risk found a non-statistically significant 33% higher rate in women taking statins than in the placebos. Further research is needed to assess the long-term impact of statin use and its relation to breast and other cancers. Of special concern, is targeted research on the dual exposure of menopausal women to statins and hormone therapy (HT). The small amount of research

that currently exists on the combination of statins and hormone therapy found an elevated risk of breast cancer.

In *Evidence for Caution*, Rosenberg and Allard assessed the impact of statin use on women starting from the assumption that if a woman is put on a drug to prevent heart disease, the reasons for doing so must be based on the highest quality, most credible data possible. There must be solid evidence of advantage over harm and careful analysis of any serious adverse outcomes that may arise immediately or with years or decades of use or when used in combination with other drugs commonly prescribed for women.

In other words, a woman in Canada should be able to take a pill, safe in the knowledge that its benefits and safety were tested on women like her and that

she is highly likely to derive a clear advantage in terms of health and longevity.

The authors state that, in terms of statin use, these expectations have not been met. Instead they found a pattern of overestimation of benefit and underestimation of harm—in short, evidence for caution. ❧

Harriet G. Rosenberg, PhD is an Associate Professor in the Health and Society Program at York University doing research on women and health. Danielle Allard is a PhD candidate at the Faculty of Information Studies at the University of Toronto. She works as a research assistant at Women and Health Protection.

The full report, *Evidence for Caution* can be found at the Women and Health Protection website at www.whp-apsf.ca

For more information, see:

- “Are lipid-lowering guidelines evidence based?” by James Wright and John Abramson, *The Lancet*, January 20, 2007.
- “Exploring statins: What does the evidence say?” by E. Kaczorowski, *Women’s Health Activist* May/June 2007, published by the National Women’s Health Network www.womenshealthnetwork.org
- *Our Bodies Ourselves: Menopause*, Boston Women’s Health Book Collective. See also “Women and heart disease: Selling statins.” www.ourbodiesourselves.org/publications/menopause/default.asp
- Maryann Napoli Center for Medical Consumers www.medicalconsumers.org

New from *Brigit’s Notes*

CWHN takes pride in our monthly electronic newsletter *Brigit’s Notes* and we are pleased to announce that we are using a new service to deliver the bilingual bulletin to your in-box. Subscribers now have the option of receiving *Brigit’s Notes* in either HTML or text format. *Brigit’s Notes* provides women’s health information you can trust and will keep you informed about what’s new on the Canadian Women’s Health Network website, including new policy initiatives, research, calls for submissions, events and conferences, new resources and updates on women’s health issues and activism.

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From the Canadian Women's Health Network

The HPV vaccine, one year later

IN JUNE 2007, THE CANADIAN WOMEN'S HEALTH NETWORK PUBLISHED THE POLICY PAPER, "HPV, VACCINES, AND GENDER: POLICY CONSIDERATIONS," TO RAISE QUESTIONS AND CONCERNS ABOUT PLANS TO BEGIN MASS VACCINATION PROGRAMS AGAINST INFECTIONS WITH SOME TYPES OF THE HUMAN PAPILLOMA VIRUS (HPV) AMONG SCHOOLGIRLS IN CANADA. THE LAST SENTENCE OF THE PAPER READS: "AT THIS POINT IN TIME, THERE ARE MORE QUESTIONS THAN ANSWERS."

One year later, there are perhaps even more questions than answers. Nevertheless, provinces and territories have either started school-based vaccination programs, or plan to begin them in the fall of 2008. Thus, parents across the country will be faced with the difficult decision of whether or not to allow their daughters to be vaccinated. And there remain concerns that they will too often lack the full information needed to give authentic informed consent.

We continue to ask: What's the rush when cervical cancer rates are low and have already decreased substantially through the provision of Pap screening programs? Why was the vaccine campaign launched by the Minister of Finance in a budget speech even before the group set up to harmonize immunization policies in Canada issued its recommendations—a report that we still await? Why spend \$300 million for a vaccine when the funding could be applied to effective, holistic sexual and reproductive health programs? In fact, we are concerned that the vaccine may actually divert resources from improving Pap screening so that all provinces might have an organized program.

Research has shown that most sexually active people will experience an HPV infection, but that 80 to 90% of these will clear spontaneously within two years. Only four types of the virus are covered by the vaccine—two of which are associated with the development of cervical cancer—and we still don't know how long protection lasts. So, even those vaccinated will continue to need Pap tests as they get older.

The criticism that has been hurled at those raising questions about the vaccination program, including those speaking on behalf of the CWHN, has been quite surprising. This is espe-

cially true for the CWHN authors of the commentary "Human papillomavirus, vaccines and women's health: questions and cautions," published in the *Canadian Medical Association Journal* in August 2007. We are certainly not the only ones asking questions. In fact, the 56 experts on vaccines and sexual health convened by Health Canada in 2005 to review the vaccine approval process also wanted answers to these questions before they recommended approval of a vaccination program. Unfortunately, they have been fairly silent since then.

For voicing our concerns at CWHN, we have been called irresponsible and even lumped in with fundamentalist groups opposed to the vaccine for moral reasons (worried that the vaccine will promote promiscuous behaviour) and with others who are opposed to vaccines in general. For the record, we at the CWHN are not opposed to the HPV vaccine in itself. Rather, we are opposed to a mass vaccination program at this time in the absence of sufficient long-term evidence of its effectiveness, and in the absence of public debate and full, unbiased information.

A major source of public information on the HPV vaccine has been the media. But, with a few exceptions, media coverage has not provided the full story and, in many cases, has instead misinformed the public. Gardasil is not a "vaccine against cancer," and we do not now know if it will "prevent 70% of cervical cancers" as has been published in the national media. Yet, this misinformation, which is based more on clever marketing by the manufacturer, Merck Frosst, than on good journalism, continues to appear. The exceptions, for example in the *Globe and Mail* and the CBC, are investigative reports ►

HPV VACCINE

about the lobbying by Merck Frosst that took place prior to the federal government's \$300 million announcement, and articles that go into detail about the available scientific evidence, as well as articles critical of the government process to approve the vaccine and its failure to provide adequate public information.

In PEI, Nova Scotia and Newfoundland, uptake of the vaccination programs which began last September has been high (around 80%), but in Ontario only 50% of girls eligible for the vaccine have actually received it so far. School-based vaccination programs usually have very high uptake rates, and the low rate in Ontario, where most of the investigative media reports were published, may be

because parents have decided to wait until further evidence is known.

The governments of Quebec, British Columbia and Manitoba all recently announced they will be unrolling vaccination programs in the fall of 2008. Without the usual National Immunization Strategy to guide provinces in the implementation of a vaccination program (the Strategy was not used in this case), the authorities in Quebec have decided to provide only two doses of the vaccine to Grade 4 girls, then a third shot when the girls reach Grade 9. The vaccine is approved for use in three doses within six months, so Quebec's plan would be an "off-label" (unapproved) use of the vaccine. A clinical trial is currently underway to evalu-

ate this method, which may or may not prove to be effective in the long term, but it has not yet concluded.

HPV testing is another area of study. The BC Cancer Agency is conducting the HPV FOCAL Study to determine if a test for HPV in women can replace the usual Pap test, allowing women to be screened less frequently. The study is expected to last from two to four years. There are also studies examining whether or not boys should be vaccinated. While it may be shown that vaccinating boys is not an effective method of HPV prevention, the evidence is not yet available. In the meantime, women and girls are being vaccinated and are certainly bearing a disproportionate burden in the prevention of HPV infection.

Quebec groups call for a moratorium on HPV vaccination campaign

BY NATHALIE PARENT *From the Fédération du Québec pour le planning des naissances*

IN SEPTEMBER 2007, the Quebec government announced that it would launch a human papillomavirus (HPV) vaccination campaign for girls to begin in the 2008 school year, joining other Canadian provinces that have announced similar vaccination programs. The details of the campaign, with an estimated cost of \$70 million over three years, were announced in April by the Quebec government stating that the vaccine will be administered to nine-year-old girls in Grade 4 and 14-year-old girls in Grade 9.

The campaign was criticized as soon as it was announced in September, in particular by the *Réseau québécois d'action pour la santé des femmes* (RQASF) [Quebec women's health network], which called for a moratorium, a position supported by the *Regroupement des maisons de jeunes du Québec* [Organization of Quebec youth centres], Women and Health Protection and the Canadian Women's Health Network. The groups urged that the millions of dollars earmarked for the campaign be directed toward prevention and toward improving access to health care for women, in particular for adolescent girls.

In November, the call for a moratorium was taken up by

more than 30 groups and individuals representing a variety of interests at an all-day event, "*Journée d'étude sur le vaccin contre le VPH*," organized by the *Fédération du Québec pour le planning des naissances* (FQPN) to examine and discuss the vaccination program. Even after discussions with the public health officials attending the meeting, participants were not convinced of the need to launch such an extensive vaccination campaign so quickly. They felt that the data required to support such a decision were still insufficient, in particular with respect to the duration of vaccine-induced immunity, the need for repeat doses, the vaccine's long-term effects, etc. They also questioned the approach favoured by public health officials, which is based on expensive new technologies, instead of promoting awareness, prevention and sex education.

Disappointed with discussions with public health officials, the FQPN addressed its call for a moratorium directly in a letter to the Minister of Health and Social Services. The Federation demanded concrete steps aimed at countering the influence of the manufacturer of the proposed vaccine, Gardasil, through increased public education and awareness.

Some groups are encouraging governments to put vaccination programs on hold through calls for moratoria, such as in Quebec where plans are in place to begin vaccinations this fall (see sidebar). Beyond our borders, a similar campaign for a moratorium on the HPV vaccine is underway in Spain. And the government of Minnesota in the United States did put its HPV vaccine program on hold to take the time to adequately prepare for implementation, including properly educating the public and determining the sustainability of funding in the long term. In the meantime, the Minnesota government has stated it will continue to depend on its effective Pap screening program for the prevention of cervical cancer.

In Canada, it's not too late for governments to review the decision to

implement mass vaccination programs—to wait until more questions are answered, or at the very least until they have provided a comprehensive public education program. Provincial and territorial governments also need to plan for when the federal government's contribution of \$300 million runs out two years from now, how they will sustain such a costly program. In the meantime, governments could focus on improving Pap screening and sex education—for both girls and boys. Research may later show that the HPV vaccine does help prevent cervical cancer, but for now the data do not merit a mass vaccination program.

As we've said from the beginning of this story, the CWHN is not anti-vaccine—not even anti HPV vaccine. But we are critical of how this vaccine was introduced and will continue to keep our

eyes on this ball. We encourage others to keep asking questions too and to demand the public education on the HPV vaccine necessary for parents and girls to make informed decisions before the next round of vaccinations takes place. ❧

For more information:

“HPV, Vaccines, and Gender: Policy Considerations,” Canadian Women's Health Network, June 25, 2007
www.cwhn.ca/resources/cwhn/hpv-brief.html (soon to be available in French)

“Human papillomavirus, vaccines and women's health: Questions and cautions,” by Abby Lippman et al.,
Canadian Medical Association Journal, August 28, 2007
www.cmaj.ca/cgi/content/full/177/5/484

The letter also calls attention to the following concerns:

- That the planned vaccination program is not in keeping with a comprehensive view of health or with an essential prevention approach.
- The need to adopt concrete measures to increase access to and improve monitoring of Pap test screening. It is worth noting that the participation rate for women in Quebec is among the lowest in Canada.
- The importance of developing consistent and structured sex education programs.
- The decision to invest in a new and extremely costly vaccine without considering other sexual health issues, in particular prevention of the main sexually transmitted infections, such as Chlamydia, which infects more than 12,500 girls every year in Quebec.
- Public health officials' unwillingness to undertake an independent and complete information campaign on the realities of cervical cancer, HPV, the vaccine and screening tests.
- The government's inaction in the face of marketing strategies and aggressive advertising by the manufacturer of Gardasil.

The Minister's response, delivered by his national director of public health, was a disappointment to the FQPN. Reiterating his intention to proceed with the campaign, the Minister pledged his unconditional support for the recom-

mendations of the *Comité sur l'immunisation du Québec* [Quebec Committee on Immunization]. In its December report, the Committee recommended that all girls in Grade 4 be vaccinated against HPV in two doses, at the same time as the Hepatitis B vaccination. When the full details of the program were released in April, the government announced that a third dose will be given when the girls reach Grade 9, and that girls under 18 years may receive the free vaccine on request. Finally, the Minister made no reference to the issue of the manufacturer's influence; moreover, he said nothing at all about the need for awareness and independent information.

Now that it seems unlikely that the government will change its position, the FQPN will continue to raise public awareness about the many concerns related to the Quebec vaccination campaign. For anyone interested in learning more or indeed in getting more involved in this issue, the FQPN invites your participation. ❧

Nathalie Parent is Coordinator at the Fédération du Québec pour le planning des naissances (FQPN) in Montreal, Quebec.

For more information, including tools for education and action on this issue, visit:
FQPN website at
www.fqpn.qc.ca/contenu/autresdossiers/vph.php

CHARTER CHALLENGE ON DRUGS ADS: A CHALLENGE IN THE WRONG DIRECTION

From Women and Health Protection

Last year we reported in Network that a public interest coalition of groups, including Women and Health Protection (WHP), was granted intervener status in the Charter challenge on direct-to-consumer prescription drug advertising (DTCA) in Canada. With cross examinations underway since the beginning of this year and the case to be argued before the Superior Court of Ontario in June 2008, it's time for an update.

A legal case that has had little attention in the Canadian media could lead to enormous repercussions for Canada's health-care system. In December 2005, CanWest MediaWorks mounted a legal challenge against Canada's prohibition of direct-to-consumer advertising of prescription drugs. In this Charter challenge, the company is claiming that the law infringes its freedom of expression. The case is being heard in the Ontario Superior Court.

A coalition of unions and citizen groups was granted intervener status in the case early in 2007 to address two issues that had not otherwise been brought to the case: effects on workers and on women. As a major cost driver, direct-to-consumer advertising is expected to have a strong negative effect on employee health benefits plans, as well as more generally affecting the sustainability of publicly funded health-care services. The history of prescription drug advertising raises alarm bells about specific harm to women because of the way women have been targeted in ad campaigns for drugs with serious risks, and because of the role of advertising in stimulating unnecessary medicalization of normal life.

Dr. John Abramson, a family practice

clinical instructor at Harvard Medical School and author of *Overdosed America: The broken promise of American medicine* is an expert witness for the public interest coalition.

"This Charter challenge marks a critically important crossroad for the Canadian people—whether greater priority will be given to maximizing corporate free speech or optimizing Canadians' health and containing their health care costs," says Abramson. "The drug industry now produces most of the medical science that informs doctors' decisions. Their fundamental responsi-

bility is not to the public's health, but to their shareholder's wealth."

In 2002, Abramson left his 20-year practice as a family practitioner in the United States to dedicate his time to researching the impacts of pharmaceutical industry influence on health care. When he was in Ontario for cross examination in March 2008, the WHP hosted a public lecture by Abramson at the University of Toronto. Abramson's presentation "Drug ads: Is corporate free speech more important than your health?" on March 4, 2008 was a riveting account of the potential threats to

Looking for information about direct-to-consumer drug advertising and the Charter challenge?

The Women and Health Protection website www.whp-apsf.ca includes:

- Brochures on DTCA and the Charter challenge
- Letters of complaint to regulators about ads that violate Canada's laws
- Affidavit from John Abramson presenting evidence on the impacts of DTCA on women (for the coalition)
- Affidavit from Montreal-based consultant, Jean Belleville, on the impacts of DTCA on workers' health benefits (for the coalition)
- Affidavits and accompanying exhibits from expert witness for Health Canada and CanWest MediaWorks
- Links to public interest coalition partners

Canada's health-care system posed by drug advertising.

"There are lessons to be learned from the United States where DTCA's fundamental purpose is already being realized: to increase revenues from drug sales often at considerable risk to consumer health and well-being," says Abramson.

Information about direct-to-consumer advertising and the Charter challenge is available on Women and Health Protection's website (www.whp.apsf.ca), including background on the issues, WHP activities related to DTCA and affidavits by expert witnesses in the Charter challenge [see box on facing page for more detail].

The outcome of the CanWest Charter challenge will not be known until after the court hearing in June, but with the wide-reaching implications of the case in terms of drug safety and public health in Canada, it's important to "watch this space"—or, more accurately, to watch the WHP website for updates. ❧

Women and Health Protection (WHP) is a coalition of community groups, researchers, journalists and activists concerned about the safety of pharmaceutical drugs.

Members of the public interest coalition represented by Dr. Abramson include the Canadian Federation of Nurses Unions, Canadian Union of Public Employees, the Canadian Health Coalition, Women and Health Protection, the Communications, Energy and Paperworkers Union of Canada, the Society for Diabetic Rights, the Medical Reform Group and Terence Young. Lawyer, Steven Shrybman, with the law firm, Sack, Goldblatt, Mitchell is providing legal representation for the coalition.

Labels, laws and access to health care

How history continues to affect health-care access for First Nations and Métis women

BY KATHY BENT, JOANNE HAVELOCK

AND MARGARET HAWORTH-BROCKMAN

From the Prairie Women's Health Centre of Excellence

ACCCESS TO HEALTH SERVICES DIFFERS AMONG ABORIGINAL PEOPLE. UNDERSTANDING THE HISTORY BEHIND THESE DIFFERENCES AND WHAT THEY MEAN FOR WOMEN NOW IS CRITICAL TO IMPROVING HEALTH SERVICES USED BY ABORIGINAL WOMEN.

Indian, Métis and Inuit people are all recognized as Aboriginal people in the Constitution of Canada. However, there are differences in legal status within and among these groups that determine what health services they are entitled to receive. Often the word "Aboriginal" is used as a blanket term, when researchers and policy-makers actually should be looking more closely at specific groups within that population.

To address these issues, researchers at the Prairie Women's Health Centre of Excellence (PWHCE) wrote the paper, *Entitlements and Health Services for First Nations and Métis Women in Manitoba and Saskatchewan*.

"The first idea of developing this report came from a member of our Board who was frustrated that many policy-makers, researchers and the women with whom she works don't understand why these terms are so very important and that they are hugely important when it comes to health-care access," says Margaret Haworth-Brockman, Executive Director at PWHCE.

Part 1 of the report reviews the history behind the different entitlements to health services in Canada and outlines current developments. Part 2 provides information about the health services available to First Nations and Métis women. A qualitative research project, described in Part 3, documents the experience of front-line workers who work with Métis and First Nations women and provides their suggestions for reducing barriers to good health. And Part 4 provides suggestions for policy-makers and researchers, based on the findings of the preceding sections.

In keeping with PWHCE's mandate, the focus is specifically on Manitoba and Saskatchewan and, in this case, on First Nations and Métis people, who comprise the vast majority of Aboriginal people in the two provinces. ►

History's long shadow

Entitlements to health-care services are complicated by over 400 years of colonization and more than 150 years of legislation. In Manitoba and Saskatchewan, the early land treaties set principles of federal responsibility for many services, including health care. Members of First Nations were referred to as "Indians" by the Europeans. Under the Indian Act, First Nations individuals who were members of Indian Bands that had signed treaties (or other agreements) were defined as having "Status." People with Status are entitled to access the Non-Insured Health Benefits Program of the federal government and other services. However, some Indian people either never did have Status or lost it due to provisions of the Indian Act and are classified as non-Status. As a result they are not eligible for the federal services. Bill C-31 was introduced in 1985 for several reasons, including the move to restore Status to women who had lost their Status through marriage to a man without Status. While the Bill was intended to address some problems, it has introduced another layer of complexity in communities and within families.

Complicated as the provisions for health care for First Nations, there is no such federal provision for Métis residents in Manitoba and Saskatchewan. Métis people were not included in the treaties and some did not even receive scrip (a government-issued certificate for land or money to compensate for loss of Aboriginal title). Métis residents are provided with only those provincial health-care services available to all residents.

Effects on access

Service providers interviewed for the PWHCE study reported that many factors affect women's access to health ser-

vices, but the different entitlements to health services have significant impacts on women's daily lives. The rules determining what specific services are included in programs are complex and difficult to understand, and changes in policies create additional uncertainty. The confusion about what services are available to whom is compounded when members of the same family have different Status. There are many communities in Manitoba and Saskatchewan (Cross Lake and The Pas, for example) where reserve and non-reserve lands are adjacent to each other and the residents are involved in both communities, but cannot necessarily seek or receive the same health-care services. One person may get flown to Winnipeg for a medical appointment, while her neighbour or cousin across the road has to take the bus for 12 hours.

"It almost seems like the general population doesn't understand that there's specific benefits for each of us and if you are First Nations you can access as long as you have that 10-digit number but First Nation women without Treaty Status, Métis women, and other women are distinctly different and if they do not have that 10-digit number they do not have access to the same kinds of services and programs." - Service Provider

Health research and policy

New policy-related research and policy development are important to improving health services and health status. This work may be carried out by Canadian-based or international researchers who may not be aware of history and legislative developments in Canada.

PWHCE's paper on health entitlements emphasizes that researchers and policy analysts must be clear about

whom, and with whom, they are conducting their studies. Any study examining determinants of health, healthy living, health-care access, wait times, or service provision must be specific about the populations involved and their entitlements to health-care services.

Entitlements to health-care services are complicated by over 400 years of colonization and more than 150 years of legislation.

Researchers must bear in mind that, as mentioned, even members of the same family may have different entitlements to health care. Analysis of health-care access requires a consideration of history and entitlements to set the context fully, as it will affect results and subsequent recommendations.

Information gathering for policy purposes should include news items, reports and consultations that draw on and recognize the views of people with differing health-care entitlements. And naturally, they also need to recognize the differences between men and women regarding determinants of health, health status and health services accessed.

In decision-making processes, it is also critical to involve men and women with different health entitlements and access to services. This includes considering Status as well as geographic location, in particular. Protocols for decision making and appropriate consultation methods will vary by community. Communication about consultations

and policy recommendations also needs to take into account the approaches that will work successfully with Aboriginal men and women locally.

Aboriginal organizations are now taking more of a lead in guiding new research that is culturally appropriate. Protocols and ethical standards have been developed for doing research with, for and by Aboriginal women.

Data sources and limitations

Having a Register of First Nations people with Indian Status means that federal and provincial administrative data such as vital statistics and statistics on the use of health services are more readily available. For example, health data can be retrieved about people who voluntarily declare their Status to Manitoba Health or Saskatchewan Health, including separate data for women and men. However, there are wrinkles in the system. The Manitoba Vital Statistics registry of deaths, for example, includes as "First Nations" all those, and only those, who were residents of a First Nations reserve when they died.

For non-Status Indian people or Métis people this type of data is not available because they are not identified separately in health-care records.

At Statistics Canada, survey and census respondents self-identify as having North American Indian, Métis or Inuit ancestry, as members of an Indian band or First Nation, or as a Registered or Treaty Indian. However some First Nations reserves have refused to take part in national surveys (the Canadian census, for example), and in other cases survey design has not included the people in northern territories, most of whom are Aboriginal, or residents of reserves (Canadian Community Health Surveys, for example). Separate data for women and men are available, but are not always presented in public reports.

Returning to the women

This study in Manitoba and Saskatchewan demonstrates that women do recognize the inconsistencies in the treatment of First Nations people with Status, those who do not have Status, and Métis people. Women health-care providers who were interviewed for the study and the women they work with recognize the various health determinants affecting women's access to health services, and insist that these factors be considered and addressed. They also emphasize that work needs to be done to ensure a more sensible and equitable way to provide health services to all

Aboriginal people, whether First Nations, Métis or Inuit. ❧

Kathy Bent is an independent researcher and a research associate of PWHCE based in Manitoba. Joanne Havelock is a policy analyst with PWHCE and lives in Regina. Margaret Haworth-Brockman is the Executive Director of Prairie Women's Health Centre of Excellence and lives in Winnipeg.

To download a copy of the full report, *Entitlements and Health Services for First Nations and Métis Women in Manitoba and Saskatchewan*, visit the Prairie Women's Health Centre of Excellence website at www.pwhce.ca

FROM THE PRAIRIE WOMEN'S CENTRE OF EXCELLENCE
NOW AVAILABLE!

Fertile Ground, Healthy Harvest: A Decade of the Prairie Women's Health Centre of Excellence by Alex Merrill

This retrospective from the Prairie Women's Health Centre of Excellence (PWHCE) follows a decade of work in Saskatchewan and Manitoba, addressing the health needs of women in these two Prairie provinces.

PWHCE has shown leadership in health issues for Aboriginal women, women living in poverty, rural, remote and northern women, and gender-based analysis across Canada, and internationally. *Fertile Ground, Healthy Harvest* records the Centre's successes and accomplishments over the past decade and presents plans for planting new seeds in the seasons ahead.

Selected photos and commentary from two PhotoVoice projects in Winnipeg and Saskatoon are included throughout *Fertile Ground*.

TO DOWNLOAD A COPY, VISIT:

Prairie Women's Health Centre of Excellence website:
www.pwhce.ca/fertileGround.htm

TO ORDER A COPY, CONTACT:

Prairie Women's Health Centre of Excellence
Phone: (204) 982-6630
Email: pwhce@uwinnipeg.ca



The PWHCE is financially supported by the Women's Health Contribution Program, Bureau of Women's Health and Gender Analysis, Health Canada.

BARBARA SEAMAN (1935-2008): *Pioneer in the women's health movement*

BY ABBY LIPPMAN, ANNE ROCHON FORD AND KATHLEEN O'GRADY

PHOTO: BETTYE LANE. COURTESY OF SEVEN STORIES PRESS.



Science journalist
and activist,
Barbara Seaman,
twirls a cervical cap
at a 1980s press
conference about
women's health.

WOMEN'S HEALTH LOST A POWERFUL CHAMPION WITH THE DEATH OF BARBARA SEAMAN, AN AUTHOR, JOURNALIST AND PATIENTS' RIGHTS ADVOCATE, ON FEBRUARY 27, 2008, AT HER MANHATTAN HOME IN NEW YORK CITY, NEW YORK. SHE HAD BEEN LIVING WITH LUNG CANCER.

Seaman was a founder of the women's health movement in North America in the 1970s and paved the way for patients' rights. She is best known for her writings on drug safety, particularly her early warnings about the dangerously high levels of estrogen in the first generation of contraceptive pills, and more recently, the overprescription of hormone therapy for menopausal women.

For sounding the alarm on the safety profile of these and other medications, and for insisting that there be proper warning labels on drugs, Seaman was publicly castigated and labeled an uninformed troublemaker. But, as with so much of Seaman's work, time proved

her both prophetic and deeply wise.

Her landmark book on hormonal contraceptives, *The Doctors' Case Against the Pill* (1969), initiated congressional hearings into the safety of birth control pills (1970) in the United States and catapulted women's health issues into the national spotlight. By the 1980s, the dosage of estrogen in oral contraceptives had been drastically reduced.

The hearings she helped bring about also resulted in the creation of patient package inserts for all US pharmaceutical products. Moreover, her insistence on public participation encouraged the US Food and Drug Administration (FDA) to open all future hearings to the public and to include patients' voices in the

assessment of pharmaceutical products—something not yet the case in Canada.

As one of her friends wrote: "Her daring critiques, her courageous persistence in the face of major efforts to silence and discredit her, provide a model for many and gave us all strength to ensure that women's voices be heard and our concerns taken seriously."

In 1975, Seaman and four other women founded the National Women's Health Network, a women's health advocacy group based in Washington DC that continues to raise public consciousness and influence public policy on women's health issues and concerns, as well as highlight the need for women to become knowledgeable about their bodies and care options.

Seaman was also one of the first to question the medicalization of women's natural cycles, including the common practice of prescribing hormone therapy to "treat" menopause, raising concerns decades before the landmark Women's Health Initiative study (2002) demonstrated that long-term use of hormone therapy significantly increases the risk of breast cancer and stroke, among other harmful effects.

In her book, *The Greatest Experiment Ever Performed on Women* (2003), Seaman soundly demonstrates the failure of the FDA and the medical establishment to demand rigorous testing of hormone therapy before mass prescribing took place and castigates the pharmaceutical industry for putting profits above women's lives.

Throughout her life, Seaman was never too busy, too battle-weary or too distracted to provide caring support for others. There was never a request for her insights, her review of some piece of work, her presence at some event that she rejected; her warmth and generosity of spirit and time are legendary.

Seaman's crusading for women's health and drug safety had a major impact beyond the borders of the United States and many in Canada also mourn her loss. We will miss this pioneer of the women's health movement. We are all in her debt. ✎

Abby Lippman is Professor of Epidemiology at McGill University and board member at CWHN; Anne Rochon Ford is Coordinator of Women and Health Protection; and Kathleen O'Grady is Director of Communications at CWHN (maternity leave) and Research Associate with the Simone de Beauvoir Institute, Concordia University. The authors have had a professional relationship with Ms. Seaman on various initiatives.

"Barbara Seaman (1935-2008): pioneer in the women's health movement" Reprinted from, CMAJ 08-Apr-08; 178(8), Page(s) 988 by permission of the publisher. ©2008 Canadian Medical Association

Cherchez la femme in minority francophone communities

A REPORT BY MARIE DUSSAULT

THERE COULD NOT HAVE BEEN A MORE APPROPRIATE TITLE for the workshop presented at the *2^e Forum national de recherche sur la santé des communautés francophones en milieu minoritaire* [Second national research forum on health in minority francophone communities]. Planned in collaboration with the *Alliance des femmes de la francophonie canadienne (AFFC)* [Alliance of francophone Canadian women], the *Cherchez la femme* workshop was the first of its kind in Canada and speakers had set their sights high.

Since the creation of the *Société Santé en français (SSF)* [French health society] in 2002 and the *Consortium national de formation en santé* [National consortium for health education] in 2003, francophone institutions and organizations have seen increased opportunities for exchanges, networking and training in the health field. However, women's groups trying to gain recognition for their expertise and projects carried out by their members in the provinces and territories felt excluded. At a national meeting of minority francophone women's groups in March 2003, participants drafted a list of their accomplishments in the health field (published in the *Compte rendu de la rencontre nationale sur la santé des femmes francophones*, Coopérative Convergence, Ottawa, 2003). Although the list was not exhaustive, it spoke volumes about women's involvement in health and the creative ways they have contributed to the well-being of their communities. The participants also challenged the dominance of a cure-based biomedical approach and the direct provision of services, with little regard for a public health or holistic approach.

Today the situation is evolving and francophone women from both the community and academic sectors spoke out at the *2^e Forum national de recherche sur la santé des communautés francophones en milieu minoritaire*—where the women were present, but still not particularly visible. The purpose of *Cherchez la femme* was to take a first step toward understanding the problems and challenges faced by francophone women in their roles as health-care consumers, workers and volunteers.

In her opening remarks, Marie Dussault, Knowledge Exchange Coordinator at the British Columbia Centre of Excellence for Women's Health, set the stage by discussing gender-based analysis (GBA), its advantages and its role in health research. Caroline Andrew, a professor in the School of Political Studies and director of the Centre on Governance at the University of Ottawa, made a presentation on governance in women's health from the perspective of the francophone minority and discussed opportunities and challenges they face. Cécile Coderre, a professor in the School of Social Work and Vice-Dean (Academic) at the University of Ottawa, gave the presentation *Femmes, pauvreté, santé et violence : un mariage nocif* [Women, poverty, health and violence: A toxic combination]. Observing that women are more at risk of poverty than men, she analyzed ▶

CHERCHEZ LA FEMME

the situation for minority francophone women. The last speaker, Maggy Razafimbahiny, executive director of the *Alliance des femmes de la francophonie canadienne*, presented the results of the first Canadian study on the role of volunteer caregivers and their needs, and the chair of the AFFC, Agathe Gaulin, provided the final summary comments of the meeting.

Problems particular to francophone women's health, or indeed women's health in general, are not yet routinely the focus of studies, but hopefully this exercise will lead to other collaborations and an increased number of researchers—men and women in the community and academic sectors—will focus on gender as a biological and social determinant. Ignoring such questions could compromise the quality of research and the collection of evidence. But dealing with them could contribute to improving and even saving lives, promoting the well-being of families and communities, reducing health costs in some cases, and eventually could contribute to increased social justice. ❧

Marie Dussault serves on the board of directors of l'Alliance des femmes de la francophonie canadienne as well as on the board of the Canadian Women's Health Network. She is also Knowledge Exchange Coordinator at the British Columbia Centre of Excellence for Women's Health.

For more information, visit:

2^e Forum national de recherche sur la santé des communautés francophones en situation minoritaire

www.documentsetc.ca/CNFSFORUM/index.html

L'Alliance des femmes de la francophonie canadienne <http://affc.ca>

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Women and Wait Times: Why are wait times women's issues, and what are the issues for women?

We all want quality health care when and where we need it. Even though wait times for some health-care services have been stable in recent years, the "crisis" of wait times has become a key political issue. Waiting for care is indeed a critical concern for women because they are the majority of care providers (paid and unpaid) and because they are more likely to use the health-care system on behalf of others as well as for themselves.

Using the example of hip and knee replacement surgery, this 16-page booklet published by Women and Health Care Reform explores questions surrounding wait times and the impacts on women's health.

Written and published by Women and Health Care Reform, with financial support from the Women's Health Contribution Program, Bureau of Women's Health and Gender Analysis, Health Canada.

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STATUS POSITIVE

Supporting women immigrants and refugees with HIV/AIDS

INTRODUCTION BY ELLEN REYNOLDS

A ROUTINE BLOOD TEST IS PART OF THE PROCESS FOR ANYONE SEEKING LANDED IMMIGRANT STATUS IN CANADA. YET, FOR SOME PEOPLE ENTERING THIS COUNTRY—IN PARTICULAR THOSE FROM COUNTRIES WHERE HIV/AIDS IS ENDEMIC—THE TEST MAY REVEAL AN HIV POSITIVE STATUS. SUDDENLY, THE STRESS OF BEING A NEW IMMIGRANT OR REFUGEE IS COMPOUNDED BY A STIGMATIZED ILLNESS. BEING IN A NEW COUNTRY, NOT NECESSARILY SPEAKING ENGLISH OR FRENCH, AND NOT HAVING ANY IDEA OF WHERE TO GET SUPPORT IS AN EXTREMELY ISOLATING EXPERIENCE. ADD TO THAT HIV POSITIVE STATUS AND CHILDREN TO LOOK AFTER AND THE SITUATION QUICKLY BECOMES OVERWHELMING.

In 2005, an estimated 39 million people were living with HIV worldwide; 17.6 million of them were women. According to the Public Health Agency of Canada, between 1998 and 2004 there were 15,876 new HIV infections and 2,989 AIDS cases in Canada; 467 of the new HIV infections and 340 AIDS cases involved immigrants and refugees. Women accounted for more than half (51.6%) of the new HIV infections and almost 42% of the AIDS cases.

With Canada's Citizenship and Immigration system ill equipped to provide the necessary support and information for newcomers with HIV/AIDS, AIDS Service Organizations (ASOs) and government-funded projects help fill in the gaps. However, stigma is a major barrier even to seeking help. Refugees in particular may be afraid to disclose their HIV status for fear of deportation or, in some cases, for fear that family members back in their home countries would be in danger if their status were known. This keeps many people from seeking the help they need.

The Government of Canada's Federal Initiative to Address HIV/AIDS provides funding for HIV/AIDS prevention and support programs and research and public awareness through

the Public Health Agency of Canada and ASOs across the country. The Initiative's goals include: prevention of new infections, slowing disease progression and improving quality of life, reducing the socio-economic impacts of HIV/AIDS, and supporting global efforts to prevent infection and address the impacts of the disease. The Initiative describes three policy priorities "to guide federal action on HIV/AIDS": 1) partnership locally, nationally and globally, especially with community-based initiatives; 2) integration of health-care programs and services to address barriers and improve accessibility; and 3) accountability through annual reporting in the World AIDS Day Report (published annually on December 1). In collaboration with community organizations, researchers and others, the federal government helped create a national framework for action on HIV/AIDS in Canada from 2005 to 2010. This so-called "blueprint for action on HIV/AIDS" was released in October 2005 with the strategy document *Leading together: Canada takes action on HIV/AIDS*.

A collaborative federal strategy on HIV/AIDS is commendable; however, the lack of women's involvement in HIV/AIDS research and decision making is a significant

problem that results in limited access to treatment and supports specifically for women. In 2005, a number of HIV-positive women, HIV/AIDS organizations, and women's health and women's rights groups in Canada formed the coalition Blueprint for Action on Women and HIV/AIDS to increase women's involvement in Canada's HIV/AIDS strategy. The Canadian Women's Health Network is a member of the

...the lack of women's involvement in HIV/AIDS research and decision making is a significant problem that results in limited access to treatment and supports specifically for women.

coalition which released its "manifesto" and a report card on women and HIV in Canada prior to the 2006 World AIDS conference in Toronto.

Some programs and supports prove exceptions to the rule. Here are three projects that demonstrate some of the successful community-based initiatives to support women immigrants and refugees with HIV/AIDS in Canada—from a community kitchen in Vancouver, and community theatre in Ottawa, to a training and support pilot project for refugees in Montreal. ✎

Sahwanya Community Kitchen: Bringing African women with HIV together in Vancouver

BY JEANNE NZEYIMANA

FOR AFRICAN WOMEN LIVING WITH HIV, VANCOUVER CAN BE A LONELY PLACE. THIS DIDN'T SURPRISE ME, A WOMAN FROM RWANDA WHO ARRIVED IN VANCOUVER IN 2004 AND EXPERIENCED THE ISOLATION FIRST HAND. BUT THE EXPERIENCE DID MAKE ME THINK ABOUT WHAT MIGHT BE DONE IN RESPONSE. A CONVERSATION WITH DR. ROLANDO BARRIOS, A VANCOUVER DOCTOR WORKING WITH PATIENTS WITH INFECTIOUS DISEASES REALLY BROUGHT THE SITUATION HOME: DR. BARRIOS SAID THAT HE SEES AFRICAN PEOPLE WITH HIV DYING IN VANCOUVER, NOT FROM LACK OF ACCESS TO TREATMENT, BUT DUE TO SHEER ISOLATION.

My first suggestion was to arrange hospital visits for patients to ease the isolation, but Dr. Barrios knew that this idea wouldn't work. In his experience, most African people living with HIV don't want to be publicly identified, lest they suffer from discrimination and stigma associated with HIV and AIDS. We both agreed that what would work was a program that Positive African women could *choose* to attend and meet other women from African countries. And so the idea of the Sahwanya Community Kitchen was born.

The word "sahwanya" in the Rwanda-Burundi region of Africa refers to the common struggles that bring people together—a fitting name for this collective of African women with HIV supporting one another socially, medically and spiritually.

Created for and coordinated by African women with HIV, Sahwanya Community Kitchen is a program where once a month women and their children get together to share food that they prepare together. Operating out of the Bridge Clinic in downtown Vancouver, the program provides an opportunity for women to make friends, share their needs and worries and learn new coping skills in a linguistically and culturally sensitive place. The women talk about how HIV affects their lives and communities in a stigma-free and non-judgmental environment. Organizers describe it as a place for ideas to be born, strength to be shared, and challenges to be met.

Women attending the kitchen for the first time are free to participate as they wish, although they are expected to sign a confidentiality agreement. Because they come from different African communities, some are less comfortable than others in

identifying themselves as HIV positive. They worry about having their HIV status revealed in their communities, where everyone may know everyone else's business. Organizers stress the importance of the confidentiality agreement, telling women "it is the law to guard confidentiality."

After cooking together, and eating the meal that's prepared, the women have some time to talk amongst themselves—sharing their everyday challenges or learning new skills from invited guest speakers while the children play down the hall, supervised by volunteers from AIDS Vancouver.

"We won't live by hiding ourselves," says Julia, one of the Sahwanya members. "We encourage people to bring family issues—that's the point! But we don't force anyone to talk."

With the children out of earshot, women can speak freely without the worry of their children hearing. Disclosure of HIV status to family members and

Dr. Barrios said that he sees African people with HIV dying in Vancouver, not from lack of access to treatment, but due to sheer isolation.

friends is a popular topic of discussion. Since the community kitchen began in June 2007, and most of the children who have attended are 8 years old or younger, disclosure to children has not been a major issue for the women—yet. But organizers are very aware that it will soon become an issue for many of the women. The possibility of children discussing their mother's HIV status presents a difficult challenge for the women, who want

to make their own decisions about how and when they disclose this.

The Positive Women's Network and the Oak Tree Clinic help promote and support the program. And, along with supervising the children, AIDS Vancouver initially helped organizers with project development.

Sahwanya is one way to ease the isolation that African women living with HIV face. As it says on the poster, "Let's break the chain of isolation and pull together for our common good." The community kitchens are held on Saturdays once a month at the Bridge Clinic in Vancouver. ✂

Jeanne Nzeyimana is the founder of Sahwanya whose goal is to make a positive impact on the Positive African women's lives in Vancouver.

For more information, contact: Sahwanya at (778) 998-2692 or e-mail sahwanya_ck@yahoo.com

The GOAL Project: University-community action on HIV/AIDS

BY LAURA M. BISAILLON

WHAT HAS BEEN MARINATING IN THE KITCHENS ON THE WOMEN'S HEALTH RESEARCH UNIT (WHRU) AT THE UNIVERSITY OF OTTAWA'S INSTITUTE FOR POPULATION HEALTH IS FAR FROM JUST ANOTHER HIV AND AIDS PROJECT. CREATED IN 2004 IN RESPONSE TO THE INCREASING RATES OF NEW HIV INFECTION WITHIN AFRICAN AND CARIBBEAN COMMUNITIES IN OTTAWA, THE *Global Ottawa AIDS Link (GOAL) Project* HAS GROWN SIGNIFICANTLY FROM ITS EARLY DAYS AS THE VITAL BUT RESOURCE-STARVED ORGANIZATION KNOWN AS THE "UNPROJECT."

Immigrants and refugees from countries where HIV is endemic made up 19% of new male HIV cases and 70% of new female cases in Ottawa between 2001 and 2003. Motivated by this growing health concern, Ottawa community members and the WHRU got together to brainstorm how to address barriers to health and social care, systemic racism, stigmatization and discrimination faced by people with HIV/AIDS within the African and Caribbean communities in Ottawa. ▶

After Toronto, Ottawa counts the largest African and Caribbean communities in Ontario and, according to the Ontario HIV Epidemiological Monitoring Unit, these communities made up over 16% of all new HIV diagnoses in Ontario in 2007. Yet supports for people from these communities affected by HIV and AIDS are still in the early stages of development. In the words of one woman working with GOAL, “We need forums through which we can meet to discuss overcoming cultural barriers and generational gaps. We need to communicate with service providers so that health service delivered in sensitive ways will really make a difference in the long run.”

“South-North and North-South knowledge sharing about human health and community research capacity is a big part of GOAL,” says Carol Amaratunga, Chair of WHRU and co-founder of the GOAL Project. In 2004 and 2006, GOAL delegates participated at Bangkok and Toronto International AIDS Conferences and cultivated partnerships with Thai and Rwandan universities, including a strong relationship with its Twinning Linkage partner, *la Ligue Universitaire de lutte contre le sida* at the National University of Rwanda in Butare, Rwanda.

GOAL focuses on issues related to HIV and AIDS, but its mission is broader. Project organizers have studied and learned from the multitude of community-based research (CBR) projects—the success stories and the not-so-successful stories from St. John’s to Victoria.

In mid-2006, GOAL led six focus groups in Ottawa with members of the African and Caribbean communities and the service providers who work

with them. One of the ideas that emerged was to host a workshop on the role of art as an HIV/AIDS prevention and health promotion tool.

Approximately 60 people, including researchers, AIDS service providers, students, youth and theatre specialists attended the two-day workshop “Art-based HIV/AIDS prevention: Best practices.” With a line-up of international, local and national guest speakers as well as performances by poets and actors, the

“South-North and North-South knowledge sharing about human health and community research capacity is a big part of GOAL.”

event showcased a range of art forms such radio and TV soap operas, “forum theatre” from Rwanda, photography and even health-promoting hairdressers from Ottawa’s Operation Hairspray, as effective ways to communicate sensitive sexual health messages.

At the helm of the GOAL Project are women leaders from Ottawa’s African and Caribbean communities, such as Félicité Murangira, GOAL’s project coordinator and co-founder and current co-chair of the African and Caribbean Health Network of Ottawa. In 2006, Murangira was presented with the YMCA-YWCA Women of Distinction Award and the Planet Africa Volunteer of the Year Award. Community leaders involved in the GOAL Project set the pace and provide vision for the project

which has received funding since 2005 from the Canadian Institutes for Health Research (CIHR), the Canadian Development Agency (CIDA) and Health Canada. The women work with in the WHRU team and are supported in research endeavors by nearly a dozen scientists from the Institute of Population Health. GOAL Project’s founding team includes: Jack McCarthy of Ottawa’s Somerset West Community Health Centre, Department of Public Health of Ottawa; Melissa Rowe of the African Caribbean Health Network of Ottawa (ACHNO); Heather Smith Fowler; Dr. Lucie Kalinda, Félicité Murangira; and Carol Amaratunga.

The GOAL Project aims to provide a platform for the theory and practice of healthy community development. Drawing from domestic and international expertise and knowledge, it builds on past successes in community-based research and applies those best practices in the context of HIV/AIDS health services. Organizers hope that GOAL will serve as a model for community health services related to HIV/AIDS that will be adopted or franchised by other communities prepared to invest the effort over the long term. ✎

For more information, visit:

University of Ottawa, Women’s Health Research Unit
www.whru.uottawa.ca/en-home.php

African and Caribbean Council on HIV/AIDS in Ontario
www.accho.ca/index.aspx?page=hiv_facts

Operation Hairspray, Ottawa Public Health
www.ottawa.ca/residents/health/living/sexual/hairspray_en.html

Refugee + Support Project

BY LAURA M. BISAILLON

“Being at the same time a refugee, a woman, and a woman diagnosed with a chronic illness such as HIV is big! We cannot live forever. My wisdom tells me that we all have to die of something, and die one day we will. We must enjoy every new day and focus on living in a healthy way!”

~ Participant of the Refugee + Project

For most newly arrived refugee women with HIV/AIDS, their first point of contact with social service or health support in Montreal is through the medical establishment. Doctors, nurses and social workers then refer women to the AIDS service organizations (ASOs) in the city. If they had landed in Toronto, these women would have had access to a greater selection of support networks and more highly developed community groups that cater specifically to women. Unfortunately, in Montreal such women-specific services are limited or nonexistent. One program that did provide support for women from sub-Saharan Africa is the Refugee + Support Project [*le Projet réfugié plus*], a three-year pilot project that wrapped up its programs in December 2007.

Funded by the Public Health Agency of Canada as part of the Federal Initiative to Address HIV/AIDS, the project provided multilingual training of support workers and assistance for refugee women with HIV/AIDS to access health, legal or community services. Project organizers based at the *Centre de ressources et d'intervention en santé et sexualité* (CRISS) [Centre for resources and intervention on health and sexuality] established peer support groups and helped create a network for better communications and referrals among the ASOs and other service providers. According to the women participants, peer support was an important element of the Refugee + Support Project and helped them form close friendships and a support network that has extended beyond the term of the project. In the words of one participant: “We share common issues—estrangement from and commitment to family, financial

worry, strong faith in God—so communing in a non-threatening setting is valuable.”

Women supported each other using the buddy-system pioneered by cancer survivors in Montreal’s “Hope and Cope” groups, although the system was not without challenges for HIV-positive refugees. Women from the same country were not necessarily eager to provide peer support to a compatriot because of fears about their HIV status being revealed to their community. Issues related to stigmatization, disclosure and discrimination related to HIV and AIDS are well-recognized barriers to health intervention programs, public education and prevention efforts.

Participants of the project initiated and assisted with events and activities. The health and wellness workshop for “HIV information overload,” for example, was organized by participants in July 2007 to talk about how to find accessible information about HIV/AIDS medications, treatment and nutrition. The women had access to the Internet to search for HIV-related health information; however, word-of-mouth was the most common way to exchange information. “In so many ways and for so many reasons women and men experience migration and HIV-related health matters differently. That is why it is nice to have activities that are women-only so that we can talk openly,” said one participant.

As a pilot project, the Refugee + Support Project was limited to a three-year term of funding, therefore an effective evaluation was important to capture what was learned. When asked about the strengths and weaknesses of the project, the women offered candid feedback that ►

organizers hope will be useful to other groups or service providers assisting women migrants to manage HIV in Canada. Their comments relate to four different themes:

Women's leadership – Organizations can better support women's leadership and on-going education. Integrating the skills of women and capitalizing on their knowledge and networks here in Canada and in home countries is very valuable. Many women associated with the project were highly educated and at least one woman with senior-level experience in HIV/AIDS activism and education commented that she was disappointed that there was little outlet for her skills. Projects geared to women refugees should aim to involve women in program design, implementation, monitoring and evaluation.

Linking women to provincial, national and international opportunities and supports – Organizations can actively network across borders, linking with efforts in other Canadian jurisdictions and internationally. Women can be encouraged to apply for provincial and national opportunities open to persons with HIV/AIDS (PHAs). The Canadian AIDS Society (CAS), for example, offers a range of scholarships, and awards monies to attract and include women from countries where AIDS is endemic. In June 2008, CAS is sponsoring a PHA forum that emphasizes leadership development and provides networking opportunities for PHAs across Canada.

Thinking outside the HIV/AIDS box – Organizations can help women reach organizations that are outside of what has been called the "AIDS ghetto." This could mean referring women to training and skill-building programs offered through the YWCA and other local non-profit organizations. It incumbent on ASOs serving women to cultivate collegial and professional relationships over time—in Canada and overseas.

Project viability – The viability of a project or program is dependent on the viability of the ASO housing it. In this case, the project design had a number of strengths and weaknesses. Its effectiveness was limited by the viability of the

ASO where it was housed (the organization has since closed). For such a project to remain pertinent to the women it serves, the host ASO must recognize that women and their needs are diverse and evolving; the organization must show leadership and be comfortable with change and unexpected developments that invariably present challenges.

The Refugee + Support Project confirms that asylum-seeking and refugee women diagnosed with HIV have specific health and social needs when they arrive in this country. But it also confirms that the gendered dimensions of the refugee experience for those managing HIV are under explored in Canada. Having a more complete portrait and broader understanding of asylum-seeking and refugee women's experiences from the time of their arrival is a starting point. Organizers of the Refugee + Support Project suggest charting the experiences of immigrant and refugee women with HIV/AIDS over time as they navigate various channels of support and services. This information could then be used to improve services, inform policy, promote understanding and create awareness. ❧

Laura M. Bisaillon is a PhD student in Population Health at the Institute for Population Health and Research Assistant to the GOAL Project at the Women's Health Research Unit, University of Ottawa.

Additional resources:

Blueprint for Action on Women and Girls and HIV/AIDS
<http://womensblueprint.org/en/resources/>

Leading together: Canada takes action on HIV/AIDS
(2005-2010) www.leadingtogether.ca/

Federal Initiative Federal Initiative to Address HIV/AIDS in Canada, Public Health Agency of Canada
www.phac-aspc.gc.ca/aids-sida/fi-if/index.html

The Positive Side: Uprooted Lives
www.positiveside.ca/e/V8I1/Uprooted_e.htm

Fern Charlie,
VANDU
researcher
and steering
committee
member.



PHOTO: LAUREL DYKSTRA

‘Women CARE’ in Vancouver’s Downtown Eastside

From the BC Centre of Excellence for Women’s Health

VANDU Women Clinic Action Research for Empowerment Project (VANDU Women CARE) is a unique research collaboration between the BC Centre of Excellence for Women’s Health (BCCEWH), the UBC School of Nursing, and the Vancouver Area Network of Drug Users (VANDU) Women’s Group—a peer-driven, community-based organization that provides support, education and advocacy by and for women who use drugs in Vancouver’s Downtown Eastside. Using an approach grounded in participatory action research methods and popular education, the goal of the VANDU Women CARE project is to produce new knowledge about the primary health-care experiences of women who use drugs, while supporting their health, well-being, and leadership. To date, this project has provided training, remuneration, and support for 13 VANDU Women’s Group members to design and use research tools to interview 50 women about their primary health-care experiences at community clinics. Fern Charlie, who has contributed to the study as a peer-interviewer and project Steering Committee Member, describes her experience with this project, and the value of peer-driven research by, with, and for women who use drugs.

BY FERN CHARLIE

THIS WAS THE FIRST TIME I HAVE TAKEN PART IN A RESEARCH PROJECT BUT I WOULD DO IT AGAIN. THE ONLY WAY ANY WOMAN CAN BE REALLY HEARD DOWN HERE IS TO OPEN UP AND TALK, TALK ABOUT THE SOCIAL SERVICE, CHILDREN, DRUG USE. EVERYBODY I INTERVIEWED WAS DIFFERENT; EVERYBODY HAD THEIR OWN STORY, BUT MOST I COULD RELATE TO BECAUSE I WENT THROUGH IT MYSELF, LIKE THE DRUG USE, AND HOW SOME OF THE WOMEN LOST THEIR KIDS FROM BEING DRUG USERS. ►

People who don't live down here in the Downtown Eastside don't know what it's like—but they should. Like the high numbers of Aboriginal people who have HIV. A few of my friends have HIV, a lot of the women open up to me. They don't go around telling people, but I'd like to see them be able to talk about things, open up and not be ashamed of their HIV or when their kids were taken and they were kicked off the reserve—more or less run off. I want a forum for the Native people.

One thing that was upsetting was the subject of children who were taken from their mothers. One woman shut down, turned her back, it really did upset her. Usually she'd really open up to me but I could tell she was upset; she was crying. I want to see women get support, treatment, counselling, whatever they need to get the kids back that they lost. Because women were upset we changed the way we asked that question.

The project is about the health clinics downtown, and I don't care too much for any of the clinics down here. Being a walk-in patient isn't easy. Sometimes, I can go at 9 o'clock in the morning and maybe not be seen until the middle of the afternoon. At the clinics there's a lot of waiting. If you get there too late or you miss your name, they put you down at the bottom of the list and then you're lucky if you get in that day. It doesn't matter if you're sick or not.

I don't find a whole lot of women doctors down here and when it comes to a Pap, I won't let a man do it because of the sexual abuse I experienced as a child. I don't see a lot of female counselors down here either and if I do, then after a while they're gone.

Another thing women told us about in this study is the problem they can have getting prescriptions for medication



PHOTO: LAUREL DYKSTRA

“A lot of things I am scared to talk about, to open up myself. But when it comes to other women I will speak, because I lost a lot.”

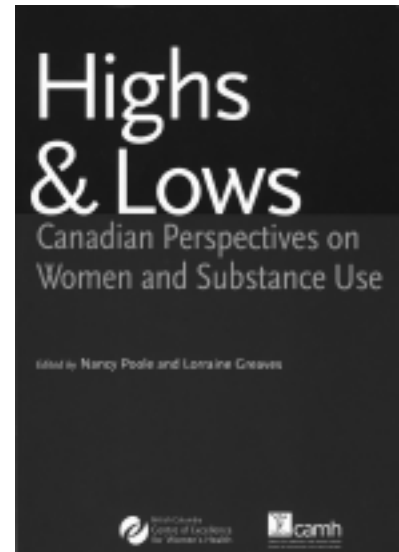
to cope with pain. When I go to a clinic downtown, I can't get Tylenol 3s or sleeping pills because I use drugs. The one time I did get T3s down here was when I was assaulted. Some of the women were the same as me, being assaulted and abused by your partner, physically hurt. I have seen a lot of

women with bruises all over their faces; they need someone to go to, not just a doctor but a counsellor. I went through that and there were not a lot of people who would listen to me. I have a doctor in a different part of town that will prescribe for me. Winter is the worst because I have to walk 20 blocks there, and 20 back. We need decent health care within walking distance.

I think this project will help women. I got into this to help these young girls and women. A lot of things I am scared to talk about, to open up myself. But when it comes to other women I will speak, because I lost a lot. I used to have a house full of kids and grandkids and once they found out about the drug use, well—what I had 10 years ago I don't have today. ❧

Fern Charlie is a peer-interviewer and project Steering Committee Member at the VANOU Women CARE project.

HIGHS & LOWS: CANADIAN PERSPECTIVES ON WOMEN AND SUBSTANCE USE



BY LORRAINE GREAVES AND NANCY POOLE

IT IS NOW WELL RECOGNIZED THAT SUBSTANCE USE AMONG GIRLS AND WOMEN IS AN IMPORTANT HEALTH, ECONOMIC AND SOCIAL PROBLEM IN CANADA. HOWEVER, THIS RECOGNITION HAS NOT ALWAYS EXISTED. IN 1970, THERE WERE FEWER THAN 40 PUBLISHED STUDIES ON WOMEN AND SUBSTANCE USE (EXCLUDING TOBACCO USE). LATER THAT DECADE, HOWEVER, AS PART OF THE “SECOND WAVE” OF THE WOMEN’S MOVEMENT, AGENCIES AND PRACTICES BEGAN TO EMERGE THAT FOCUSED ON PROVIDING A FEMINIST RESPONSE TO THE ISSUES OF SUBSTANCE USE AND ADDICTION IN WOMEN. ALONG THE WAY, BOOKS AND ARTICLES APPEARED ON VARIOUS ASPECTS OF WOMEN’S SUBSTANCE USE, ALONG WITH STUDIES OF WOMEN’S USE OF PARTICULAR SUBSTANCES SUCH AS ALCOHOL, TOBACCO AND ILLEGAL DRUGS.

Even so, it was not until a quarter-century later that the first major Canadian collections on women and substance use were published by the Addiction Research Foundation (now part of the Centre for Addiction and Mental Health [CAMH]): *Women’s Use of Alcohol, Tobacco and Other Drugs in Canada* (1996) and *The Hidden Majority: A Guidebook on Alcohol and Other Drug Issues for Counsellors Who Work with Women* (1996). The first of these books laid a foundation of knowledge about the history and epidemiology of substance use among women in Canada, while the second offered suggestions for responses. Since then, much change has occurred

in the field, and contributions to our knowledge have come from many disciplines and professions, from research and practice, and most importantly, from women themselves.

What substances do Canadian women use?

Alcohol remains the substance most commonly used by women and girls. Although women’s drinking rates have historically been lower than men’s, recent studies of international populations show that the gender gap in the prevalence of alcohol use is closing. Further, studies of school-aged children report alcohol use by girls as early as Grade 6. These findings ►

HIGHS & LOWS

are of particular concern given that the health risks of substance use—including liver damage, brain damage and heart disease—are greater for girls and women.

Tobacco use among girls and women is also a serious problem in Canada. Although overall smoking rates are decreasing, the rate for young women under 24 is higher than that for women as a whole. Girls and boys aged 15 to 17 smoke at roughly the same rates, but girls smoke more cigarettes per day than boys. In addition, the smoking patterns of some subpopulations—such as women with low incomes, lone mothers and young pregnant women—are of key concern. Among Aboriginal teens, not only are smoking rates much higher than among Canadian teens as a whole, but Aboriginal girls are more likely to smoke (48.5%) than Aboriginal boys (42.7%), and a greater proportion of

Aboriginal girls than boys begin smoking by age 11.

As with alcohol use, there are sex differences in the health consequences of tobacco use. Women have different patterns than men of developing smoking-related illnesses, and are prone to smoking-related health issues associated with hormonal status and reproductive function. There is also a strong association between smoking and cervical cancer, and an emerging link with breast cancer.

Mood-altering medications are much more likely to be prescribed to women than to men. In fact, women report higher rates of use of most categories of prescription drugs, including sleeping pills, tranquilizers, antidepressants, painkillers and diet pills.

Women and older adults are the two groups most likely to be prescribed benzodiazepines, and the most vulnerable to their adverse effects. (Women of all

ages become addicted to both prescription and illegal drugs more quickly than men, and suffer greater physical, psychological and social consequences.)

Illegal drugs pose particular risks and present differing patterns and trajectories of use. Historically, men have been more likely than women to use illegal drugs. However, as with legal drug use, the gender gap may be closing, putting more women at risk. The health effects of illegal drug use vary among women, between women and men, and across the various drugs available. There are reports of increasing cannabis use among both women and men in Canada, and women appear to be accessing treatment for methamphetamine use at a similar rate to men. A study of people in Vancouver using injection drugs found that the rate of HIV infection among women was about 40% higher than the rate among men.

IN CONVERSATION

Nancy Poole, co-editor of *Highs & Lows: Canadian Perspectives on Women and Substance Use* discusses the publication with Ellen Reynolds.

ER – Where did the idea for the book come from?

NP – The women's treatment program, Aurora Centre, based at BC Women's Hospital hosted a conference on women's treatment issues in Vancouver in the fall of 2003 and we initially thought we would do conference proceedings. Then we thought there's so much to be said and wanted to honour the contributions on women and substance use issues in Canada over the past decade, so we thought bigger and it became a book. We were really interested in

multiple perspectives—the opinions and work of researchers, of service providers, policy-makers, where possible, and especially wanted to make sure the voices of women who had substance use problems were included.

ER – You express the hope in the Preface that *Highs & Lows* will contribute to the “development of a more women-centred response in Canada and beyond.” Who do you see as the main audiences for this book to be able to achieve that goal?

NP – We were definitely interested in influencing the people in universities and colleges who are learning about how to work with women on these issues. We saw it as important to contribute to their understanding as they are beginning to work in the field. We also felt that it might influence the kind of research questions that are posed by researchers in the future, and as well an opportunity to influence policy and service organizations such as the Centre for Addiction and Mental Health or other leading addiction and health organizations.

What are the gendered influences on women's substance use?

Along with many sex-specific factors that affect both women's substance use and its effects, there are also many gendered influences that determine the course of prevention, use, treatment or recovery. In particular, the pathways to substance use for girls and women are often influenced by gendered experiences. Girls and women experience sexual and physical abuse and trauma—which are strongly related to substance use problems—at higher rates than their male counterparts. Women are also at higher risk for substance use problems due to the greater impact (demonstrated by research) on women of life transitions, and their greater use of substances to cope with emotional and relational problems. Compounding these risks are the gendered marketing practices of the alcohol and tobacco industries, and the

societal stigma carried by women—especially pregnant women and mothers—who use substances, which creates enormous barriers to care.

What are the challenges?

Despite significant progress in research, policy and practice over the last 10 years, many challenges remain.

The range of substances. There are many different substances to consider—some newly recognized, such as crystal methamphetamine, and some long-established, such as alcohol or benzodiazepines. Each substance creates different health and social problems, and calls up different social, medical and advocacy responses, forcing government and others to consider new approaches to controls, health promotion or regulation. Legal drugs, such as tobacco and alcohol, are more widely used and cause

more damage, though illegal drugs, such as heroin and cocaine, often get more attention. Behind legal drugs are corporations that profit from people's addiction to their products, and that promote and advertise them aggressively. Illegal drugs depend on criminal activity for distribution and so evoke enforcement and judicial responses, creating another layer of economic and social issues for individuals and society. Equally complex is the challenge of dealing with the overuse of, and addiction to, prescribed drugs—a significant issue for women, and so also for women's health advocates.

Prevention and treatment. Many of the contributors argue strongly for providing women-centred prevention and treatment responses that empower and strengthen women with substance use issues—but this is not always easy in

ER – In the Introduction, there's a section devoted to the use of language in the book that explains why some terms such as "substance use" is used and not substance abuse or addiction and the terms "patient" and "client" are used rarely if at all. Why was this important?

NP – Language is really important when working in this area. We were interested in capturing the fact that substance use does appear on a continuum. Not all substance use is harmful and not all problem substance use is actually addiction. We are also really interested in making the differentiation between abuse and substance use and that we use the term "abuse" only when we are talking about violence against women, making "abuse" about people and "problem use" about substances. Since violence against women and problem substance use often occur together, it certainly made it easier in forming the sentences around talking about these multiple intersecting problems. We were also concerned about not using words like "patient" and "client" and encouraging peo-

ple to talk about women and women to speak to their lived experiences rather than defining themselves in relation to a system.

ER – Can you talk about the role of the narratives in the book?

NP – You can talk about how you need to consider women's experience of violence and their substance use problems, yet when you hear the stories, it really gives you a different sense of what we need to do and pulls you more forcefully to engage with what we need to do. We felt that the narratives were a really important piece that will guide policy and practice as much as the research.

ER – The final section of *Highs & Lows* is about ongoing challenges and opportunities—challenges such as the misuse of prescription benzodiazepines and smoking. Do you see these challenges being addressed in the near future? ▶

HIGHS & LOWS

systems that are complex, traditional, medically oriented and designed for men. Nonetheless, women-centred approaches can be embedded not only in care, but also in program design, research and policy development. There is a rich, ongoing discussion about what this could look like, and how we can collectively move forward to create positive, safe and productive responses to women's substance use.

The multiplicity of issues. A range of issues—such as mental health concerns, trauma, violence and substance use—often overlap in women's lives. Problems such as unstable housing, HIV infection or poverty complicate women's treatment and recovery, and compromise their overall health. Responding adequately to women who may experience a constellation of these

issues is complicated, and requires innovation, skill and understanding. A promising avenue is greater integration of services: more comprehensive and appropriate responses to women with substance use issues, in a wider range of agencies and locations, such as shelters, sexual assault centres, community centres and doctors' offices.

Further evidence. An undercurrent that runs through the book is the urgent need for more research evidence to support our understandings of, and responses to, women's and girls' substance use. In Canada, funding agencies increasingly require researchers to consider both sex and gender in their work, which is a helpful development in improving our evidence base. In 2003, the Canadian Institutes of Health

Research facilitated the development of a research agenda on addiction and substance use in Canada, including a section on research on sex and gender influences, to create evidence more relevant to women. In addition, the Government of Canada has a requirement for gender-based analysis (GBA) in its policy development, and Health Canada has applied GBA to research and programming.

There are many different ways of knowing, beyond research-based evidence. Chapters from researchers, policy advocates, health practitioners and community-based service providers are presented side by side with pieces from women who have experienced substance use issues first-hand. This presentation recognizes each perspective's unique and valid contributions to our

NP – Gradually we're going to see many more discrepancies about what we know and what we are doing, or not doing. I think that will create movement, especially in the areas like benzodiazepine use. Look at the chapter "The Silent Addiction" by Janet Currie about benzodiazepines. She and the organization Women and Health Protection have been doing some excellent work on the policy level with governments across Canada and I think that we will begin to see the impacts of that, moving things forward.

ER – At the end of the book, you highlight the work of the Amethyst Women's Addiction Centre in Ottawa as an advocate for a women-only treatment services as well as two provincial frameworks for treatment in Alberta and Ontario for women-specific programming. Are you optimistic about similar programs becoming the norm in the near future?

NP – A number of governments have approached me about being involved in helping them plan service systems, both territorial and provincial governments in Canada. So, I do

think that we will see more of those system-wide frameworks that recommend that we have both women-specific as well as mainstreamed approaches to working with women. I'm quite confident on that level. In terms of the numbers of individual women-specific services like Amethyst, I'm not so sure. I hope that we will see that but it hasn't been as common in the last decade as we'd like it to be.

Governments have moved more toward frameworks in general. In Alberta, they developed an extra layer to the treatment system called "Enhanced Services for Women" that is more of an outreach approach designed to engage women in care and help them get to treatment or other resources. It's been a tremendously effective program. So, while it isn't a women's stand-alone treatment centre it's actually a very interesting and creative approach that has won awards in Alberta. If we can do more things like that we'll be definitely on the road in the next decade. ☞

Ellen Reynolds is Director of Communications at CWHN. This is an excerpt from a radio interview that was broadcast in February 2008 on CFUV Radio in Victoria, BC.

understanding—and also raises the challenge of how to successfully merge what we “know” from each domain to create more effective solutions for women.

Stigma. Women and girls who use substances are often vilified, both in the media and in everyday conversations. This stigmatization is particularly strong when women who are pregnant or mothering use substances, or when women do not fulfil the gendered expectations of society as a result of their substance use. While the book illustrates some of the great strides that have been made over the last few decades in understanding girls and women and substance use, we cannot assume widespread support. Nor can we assume that there is a general motivation to respond respectfully to women

who have substance use problems. Indeed, both public and private opinion often reveal a lack of sympathy and patience with women who struggle with substance use, and “blaming and shaming” is still very much evident in Canadian society. Clearly, advocacy and political action are still needed as part of a positive response to women with substance use issues.

These are all daunting challenges for the years to come. Based on the successes, innovations and tenacity reflected in this book, and assuming an ongoing and thriving women’s health movement, there is much to be optimistic about. ❧

This excerpt is adapted from the Introduction of Highs & Lows: Canadian Perspectives on Women and Substance Use, edited by Lorraine Greaves and Nancy Poole and

published by the British Columbia Centre of Excellence for Women’s Health (BCCEWH) and the Centre for Addiction and Mental Health.

Lorraine Greaves is president of the International Network of Women Against Tobacco and Executive Director at the BCCEWH.

Nancy Poole is a research associate with the BCCEWH and acts as the provincial research consultant on women’s substance use, for BC Women’s Hospital.

Highs & Lows: Canadian Perspectives on Women and Substance Use is available in English only. Order from the Centre for Addiction and Mental Health website <http://www.camh.net/>

From the National Network on Environments and Women’s Health

NATIONAL WORKSHOP ON ENVIRONMENTS AND MATERNAL HEALTH

On March 4-5, 2008, members of the Women’s Health Contribution Program, Health Canada, hosted a national workshop in Toronto to address research and policy issues related to health risks for women in the critical childbearing years. The **National Workshop on Environments and Maternal Health** brought a gender lens to an examination of maternal health hazards associated

with home and paid work, the physical environment, pharmaceuticals used in pregnancy, and the environment of birth. Sandra Steingraber, author of *Living Downstream: An Ecologist Looks at Cancer and the Environment* gave the keynote address, speaking about her research in the report *The Falling Age of Puberty in US Girls: What We Know, What We Need to Know*.



ENVIRONMENTS
and maternal health

TO ORDER A COPY OF THE WORKSHOP CD AND REPORT, CONTACT:

Jyoti Phartiyal, Projects Coordinator of the National Network on Environments and Women’s Health

Website: www.nnewh.org

Phone: (416) 736-2100 (ext. 20715)

TWO NEW PUBLICATIONS FROM THE BREAST CANCER FUND IN THE US

The Falling Age of Puberty in US Girls: What We Know, What We Need to Know

Sandra Steingraber (Breast Cancer Fund, 2007)

Steingraber is the author of *Living Downstream: An Ecologist Looks at Cancer and the Environment*. This report highlights possible causes and impacts of early puberty—a known risk factor for breast cancer—and offers strategies to protect our daughters' health.

State of the Evidence 2008: The Connection Between Breast Cancer and the Environment

Edited by Janet Gray (Breast Cancer Fund, 2008)

This comprehensive report examines the chemicals and radiation linked to increased risk of breast cancer. "A much more complex picture of breast cancer causation than traditionally accepted emerges, one in which timing, mixtures and dose of environmental exposures interact with genes and lifestyle factors."

Both reports are available at the Breast Cancer Fund website:

www.breastcancerfund.org/site/pp.asp?c=kwKXLdPaE&b=3266489

Parenting Children with Health Issues: Essential Tools, Tips, and Tactics for Raising Kids with Chronic Illness, Medical Conditions & Special Healthcare Needs
Foster W. Cline and Lisa C. Greene (Love and Logic Press, 2007)

Parents of children afflicted with a chronic illness face daily challenges. While they often feel desperate and alone, there are actually thousands of other parents coping with the same issues every day. An estimated 10 to 15% of children in Canada face medical conditions that don't go away, such as diabetes, asthma, epilepsy and cystic fibrosis. Raising a child with a chronic illness involves an often-confusing state of mixed uncertainty, apprehension, and heightened responsibility. Parents have to learn to cope with special diets, medication, schooling challenges, repeated hospitalizations, behavioural issues and more. Parents of children with special healthcare needs will see themselves and their children in the pages of this book. The authors discuss the essential skills parents need to help their children comply with medical requirements, cope well with health challenges, and live a hope-filled life. They also offer practical answers to some of the tough questions that crop up regarding psychological issues, sibling relationships, and dealing with death.

Body of Work: Meditations on Mortality from the Human Anatomy Lab
Christine Montroll (Penguin Press, 2007)

For first-year students in medical school, the dissection of a cadaver is an important rite of passage in their quest to become doctors. The author was herself a nervous student, standing outside the anatomy lab on her first day of class, preparing herself for what was to come. When she first met the cadaver, however, she was utterly intrigued by the person the woman once was, humbled by the sacrifice she had made in donating her body to science, fascinated by the strange, unsettling beauty of the human form. She and her fellow students named her Eve. This book is a moving memoir of the relationship between Eve and the first-year medical student who cuts her open, augmented with accounts of some of the history of the study of anatomy.

A Promise of Hope: The Astonishing True Story of a Woman Afflicted with Bipolar Disorder and the Miraculous Treatment that Cured Her
Autumn Stringam (Harper Collins, 2007)

It is estimated that between 1 to 2% of the adult population may experience a bipolar disorder, a potentially serious, debilitating illness that can affect how a person feels, thinks, and ultimately how that person behaves. Bipolar disorder also appears to run in families. The author, Autumn Stringam, and her brother Joseph were diagnosed with bipolar disorder—the same illness that led to their mother's and grandfather's suicides. *A Promise of Hope* is the personal story of Autumn Stringam's flight from illness to wellness, all due to the vitamin and mineral supplement that works on the premise that some forms of mental illness are caused by nutritional deficiencies. Whether or not the reader is convinced of the validity of the supplement's power to cure bipolar disorder, this book certainly challenges us to re-examine how we look at mental illness, what causes it, and most importantly, how we treat it.

All Our Sisters: Stories of Homeless Women in Canada

Susan Scott (Broadview Press, 2007)

Homelessness is a complex issue. Some of the factors that contribute to this condition relate to Canada's social policies, while others come out of the individual's background, health, and life experiences. When we look at what has happened in Canadian society over the last 30 years or so, it is easy to see why there are so many women without a safe place to lay their heads at night, and yet when we see a person panhandling or bottle-picking, it is alarmingly easy to blame her instead of recognizing her as someone we as a society have failed. Canada is one of the few countries in the Western world without a social housing policy; the result is suffering for people at the lower end of the economic spectrum.

In *All Our Sisters*, the author interviewed more than 60 women at shelters, drop-ins, and other organizations in Calgary, Edmonton, New Westminster, Ottawa, Toronto, Vancouver and Winnipeg. With honesty and empathy, she retells their stories while highlighting the underlying problems they face. These include personal histories of abuse, addiction, and violence, as well as systemic conditions of gentrification, a paucity of affordable housing, and a lack of social services sensitive to women's needs. Anyone who reads this can no longer turn a blind and complacent eye to women and men in desperate straits.

Surviving Adversity: Living with Parkinson's Disease

Edited by Gord Carley (Surviving Adversity, 2007)

Parkinson's disease is a progressive disorder that results from the loss of nerve cells in the brain that help control movement. These nerve cells produce a chemical called dopamine, which sends signals between brain cells. The destruction of those nerve cells causes a shortage of dopamine, which works with another chemical messenger called acetylcholine to make muscle movement smooth. The shortage of dopamine results in tremors, rigid muscles and impaired coordination and balance. Parkinson's disease is more prevalent in men than in women.

The first thing people hear about Parkinson's is complicated medical language (see paragraph above). It's often confusing and a little frightening, especially for someone with a new diagnosis, and their friends and family. This book, containing 28 profiles of individuals who share their stories of how they have adjusted to Parkinson's, will help alleviate some of that anxiety by providing readers with perspective and hope.

Dialysis Without Fear: A Guide to Living Well on Dialysis for Patients & Their Families

Daniel Offer, Marjorie Kaiz Offer and Susan Offer Szafir (Oxford University Press, 2007)

Healthy kidneys work to clean the blood. They also make hormones that keep bones strong and blood healthy. When the kidneys fail, treatment is needed to replace the work the kidneys used to do. Unless a person in kidney/renal failure has a kidney transplant, they will need a treatment called dialysis. Over 30,000 Canadians suffer from kidney failure and require dialysis or a transplant to stay alive. For many people, the prospect of a regular appointment with a dialysis machine may seem like the end of life itself. According to the authors of this book, one of whom has been on dialysis since 1999, that reaction could not be more wrong. They provide the reader with a true-to-life account of what being on dialysis is like and what one can do to maintain as normal a life as possible during treatment. They acknowledge the difficulties of being on dialysis (such as 4-hour treatments 3 times a week), and offers realistic tips on travel, work and enjoying life.

Feminist Reflections on Growth and Transformation: Asian American Women in Therapy

Edited by Debra M. Kawahara and Oliva M. Espin (Haworth Press, 2007)

Understanding multicultural feminist perspectives is vital for clinicians working to effectively help women in therapy. This book provides therapists with insight and research into the identities of Asian American women, all toward the goal of being more effective when providing therapeutic help. Our identity is made up from several factors, such as worldview, beliefs, values, race, ethnicity, gender, sexual orientation, class, age and religious orientation. The articles included explore how these common factors impact psychotherapy approaches for women of Asian backgrounds. This text presents the current research, what the data mean for adjusting clinical strategies and personal accounts from Asian women. The different articles share perspectives on Asian American women's lived experiences and psychological issues relevant to them as women. Topics explored include stereotypes of Asian women, gender identity, domestic violence, lesbian issues, and specific therapeutic approaches that can be considered when working with women of Asian descent.

Change from Within: Diverse Perspectives on Domestic Violence in Muslim Communities

Edited by Maha B. Alkhateeb and Salma Elkadi Abugideiri (Peaceful Families Project, 2007)

Violence against women occurs in every community, in every culture, faith and race. To date, however, domestic violence in Muslim communities has received little attention. It has been argued that Muslims face a double bind—as a minority community, Muslims are conscious of their image both inside and outside of their communities. They are cognizant of how they are portrayed in the media, and some may hesitate to address internal social problems for fear of adding fuel to the proverbial fire. Muslim advocates recognize that non-Muslim service providers are keenly aware of the prevalence of domestic violence in Muslim families since Muslims receive services from mainstream organizations and shelters due to the lack of sufficient social services in Muslim communities. The contributions in this book all work to bring awareness to the reality of domestic violence in some Muslim families, and offer tools to address such issues. These articles examine the reality of domestic violence, share survivor stories, and provide solutions and strategies. It should be noted that the legal references in this book are all American-based, but by using this book as a model, Canadian advocates will surely be able compare Canadian law to Islamic law. The authors hope that this work will help dispel stereotypes about Islam and Muslims by explaining rulings in the Qur'an, *Sunnah*, and *fiqh* in relation to domestic violence.

Women's Experiences of Social Programs for People with Low Incomes

Marika Morris (Canadian Research Institute for the Advancement of Women, 2007)

This fact sheet is based on a 2007 study entitled *Integrating the Voices of Low-income Women into Policy Discussions on the Canada Social Transfer (CST): First Nations Women in Vancouver, Immigrant and Refugee Women in Calgary and Women with Disabilities in Winnipeg*, and is divided into three parts. The first gives some background about the federal-provincial/territorial funding mechanisms for Canada's social programs, including the different barriers women face when trying to access these programs.

The second part features the stories of low-income women and their allies. The third outlines the findings and key recommendations of the research.

Available online at:
www.criaw-icref.ca/

Forsaken

Lana Slezić (House of Anansi Press, 2007)

In 2004, Canadian photographer Lana Slezić went to Afghanistan assuming that the situation for women in this country had changed for the better since the Taliban was ousted in 2001. Slezić assumed girls were back in school, women could choose whether or not to wear the burka, and the environment was less oppressive. However, during her travels through the many regions of Afghanistan, she discovered the truth. Together with a translator Slezić travelled unobtrusively and was able to talk to and photograph women and girls throughout the country. Those she met greeted her warmly but, without exception, they had encountered domestic violence, forced marriage, illiteracy, and a basic lack of freedom. In her book *Forsaken*, Slezić reminds the reader that Afghan women do not need saving, they need help, and that it is the Afghan women themselves who are most knowledgeable about their situations. Through these moving stories and photos, the everyday lives of Afghan women and girls are brought to light.