

# Canadian Women's Health the network

fall 2005

volume 8

numbers 1/2

## GLOBAL CRISIS

### The silent voices of the HIV/AIDS epidemic

Improving access to  
emergency contraception

Intimate partner violence linked to  
poor health, chronic conditions

Women want reliable  
drug information,  
not drug advertisements

First national women's health  
roundtable and reception  
on Parliament Hill

Canada needs a Health  
and Healing Strategy for  
First Nations, Inuit and Métis  
women

## editor's note:

**WELCOME** TO THE AUTUMN 2005 issue of *Network* magazine. Sadly, we can no longer afford to publish *Network* on a quarterly basis, but are instead moving to a twice yearly publication timetable. However, we hope to keep each issue larger than the quarterly version, and packed full of useful women's health news and information—so stay tuned!

Of course, our magazine is only one way to keep you informed of what we've been up to and what's new and pressing in women's health. We also have an electronic daily listserv, CDN-WOMEN, a monthly e-news bulletin, *Brigit's Notes*, and a website that is updated weekly with new women's health content. For more information on any of these free services, visit our website, [www.cwhn.ca](http://www.cwhn.ca)

We know that not everyone is able to access email or the Internet, so we also have a toll-free number for those who would like more information on our services, and for those with health information requests. Call us at 1-888-818-9172.

We also wanted to meet more of you, face-to-face, so we recently held a "magazine launch party" in a Montreal café for the Spring 2005 issue of *Network*, with guest editor Gwynne Basen. It was a great success with more than 60 women, girls and men turning up to join us in our celebrations and meet with one another in a relaxed and friendly environment. We hope to ►

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## network / le réseau

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have more of these magazine parties, held in different towns and cities across the country, each time a new issue of *Network* is released.

At the Canadian Women's Health Network we've had a very productive spring and summer, and are already heading into a busy autumn. As you'll see from this issue, there's no shortage of work to be done on many pressing women's health issues both here at home, and internationally. We've been active on a number of hot women's health files, including safety and approval issues around Depo-Provera and silicone breast implants, among other drugs and devices targeted to women. We've also worked hard to change the regulatory status for emergency contraception so that it is available to women across the country without a doctor's prescription. And we've continued to raise awareness of the importance of gender based analysis in health research and policy at a variety of consultations and planning sessions with regional, provincial and federal governments.

We've also had some strong successes too in the past many

months. Our Executive Director was presented with an Honorary Doctorate from the University of Ottawa for her decades long work on women's health. We also successfully held the first ever national women's health roundtable and reception on Parliament Hill, with almost 50 health advocates, key researchers and representatives from various health professional organizations across Canada joined by senators and MPs from every political party to discuss important women's health issues.

And that's just a sample of what we've been up to! As always, we need your continued involvement. Help us to strengthen the women's health movement in Canada by becoming a member—and if you aren't already, why not become a regular subscriber to *Network* magazine?

**Join your voice to ours!** Here's how (below).

Sincerely,  
Kathleen O'Grady  
Director of Communications

# Subscribe to Network magazine!

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- I want to subscribe to *Network* magazine (2 issues per year), \$15 individuals, \$35 organizations
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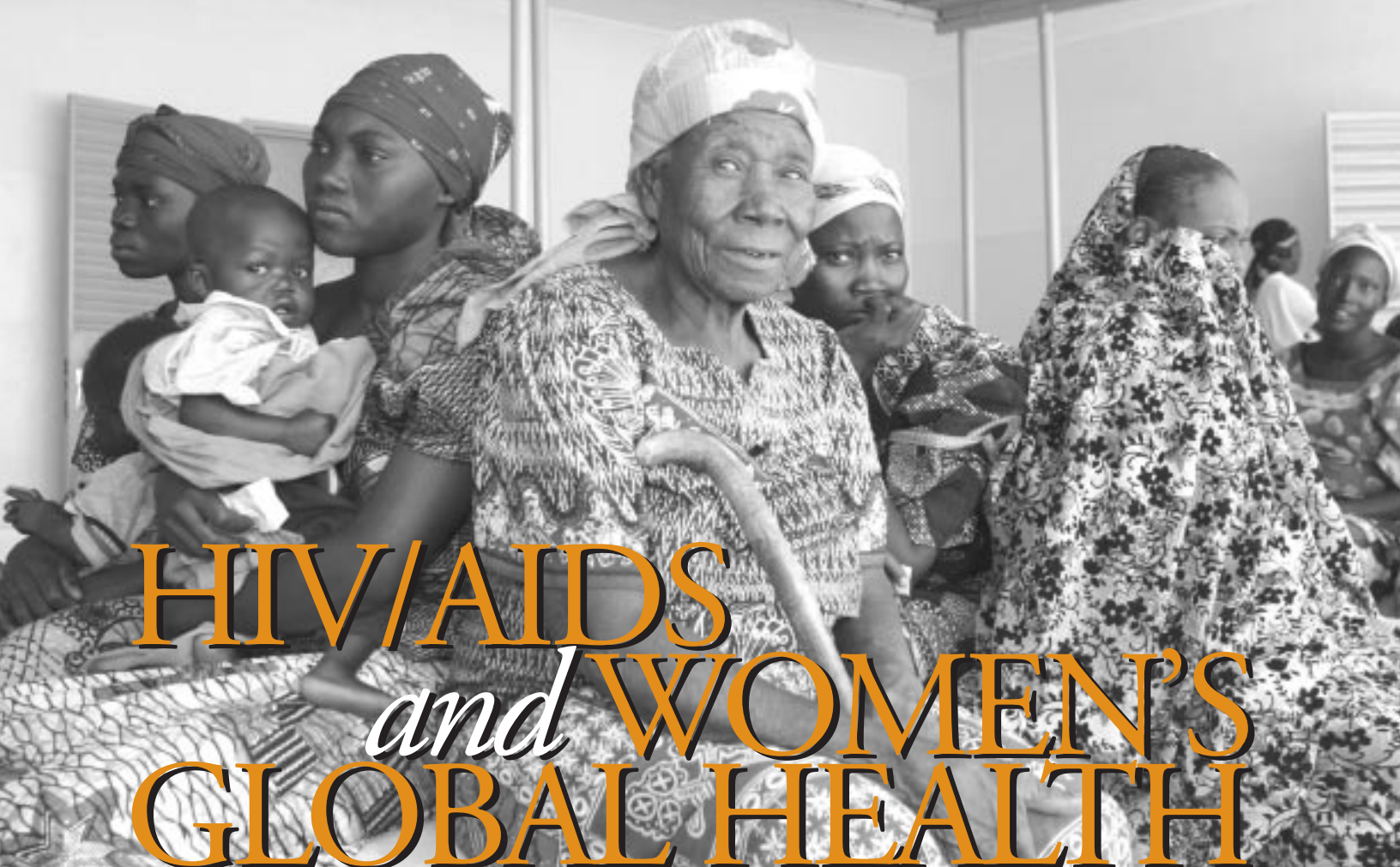
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UNAIDS/Hervé Vincent-AVECC

BY STEPHEN LEWIS, SPECIAL ENVOY FOR HIV/AIDS IN AFRICA  
*Abridged text of speech delivered at the Summit on Global Issues in Women's Health,  
University of Pennsylvania, Philadelphia, April 2005*

I'VE BEEN THE UN SPECIAL ENVOY FOR HIV/AIDS IN AFRICA FOR FOUR YEARS. THINGS ARE CHANGING IN AN INCREMENTAL, IF PAINFULLY GLACIAL WAY. IT'S NOW POSSIBLE TO FEEL MERELY CATASTROPHIC RATHER THAN APOCALYPTIC. INITIATIVES ON TREATMENT, RESOURCES, TRAINING, CAPACITY, INFRASTRUCTURE AND PREVENTION ARE UNDERWAY. BUT ONE FACTOR IS LARGELY IMPERVIOUS TO CHANGE: THE SITUATION OF WOMEN. ON THE GROUND, WHERE IT COUNTS, WHERE THE WILY WORDS CONFRONT REALITY, THE LIVES OF WOMEN ARE AS MERCILESSLY DESPERATE AS THEY HAVE ALWAYS BEEN IN THE LAST 20 PLUS YEARS OF THE PANDEMIC.

Just a few weeks ago, I was in Zambia, visiting a district well outside of Lusaka. We were taken to a rural village to see an "income generating project" run by a group of Women Living With AIDS. They were gathered under a large banner proclaiming their identity, some 15 or 20 women, all living with the virus, all looking after orphans. They were standing

proudly beside the income generating project: a bountiful cabbage patch. After they had spoken volubly and eloquently about their needs and the needs of their children (as always, hunger led the litany), I asked about the cabbages. I assumed it supplemented their diet? Yes, they chorused. And you sell the surplus at market? An energetic nodding of heads. And I

*"The women of Africa have always known whose face it is that's withered and aching from the virus."*

take it you make a profit? Yes again. What do you do with the profit? And this time there was an almost quizzical response as if to say what kind of ridiculous question is that—surely you knew the answer before you asked: “We buy coffins of course; we never have enough coffins.”

It’s at moments like that when I feel the world has gone mad. That’s no existential spasm on my part. I simply don’t know how otherwise to characterize what we’re doing to half of humankind.

I want to remind you that it took until the Bangkok AIDS conference in 2004—more than 20 years into the pandemic—before the definitive report from UNAIDS disaggregated the statistics and commented, extensively, upon the devastating vulnerability of women. The phrase “AIDS has a woman’s face” actually gained currency at the AIDS conference in Barcelona two years earlier, in 2002, and even then it was years late. Perhaps we should stop using it now as though it has a revelatory dimension. The women of Africa have always known whose face it is that’s withered and aching from the virus.

I want to remind you that when the Millennium Development Goals were launched, there was no goal on sexual and reproductive health. How was that possible? Everyone is now scrambling to find a way to make sexual and reproductive health fit comfortably into HIV/AIDS or women’s empowerment or maternal mortality. But it surely should have had a category, a goal, of its own. Interestingly, the primacy of women is rescued (albeit there’s still no goal) in the Millennium Project document, authored by Jeffrey Sachs.

And while mentioning maternal mortality, allow me to point out that this issue has been haunting the lives of

women for generations. I can remember back in the late 90s, when I was overseeing the publication of *State of the World’s Children* for UNICEF, and we did a major piece on maternal mortality and realized that the same number of annual deaths—between 500,000 and 600,000—had not changed for 20 years. And now it’s 30 years. You can bet that if there was something called paternal mortality, the numbers wouldn’t be frozen in time for three decades.

I want to remind you that within the UN system, there’s something called the Task Force on Women and AIDS in Southern Africa. Permit me to tell you how it came about, and where it appears to be headed, and I beg you to see this as descriptive rather than self-indulgent.

In January of 2003, I traveled with

agricultural productivity and household food security were being clobbered by AIDS. We were shocked by the human toll, the numbers of orphans, and the pervasive death amongst the female population. In fact, so distressed were we about the decimation of women that we appealed to the Secretary-General of the United Nations to personally intervene.

And he did. He summoned a high level meeting on the 38th floor of the UN Secretariat, with TV conferencing outreach to James Morris in Rome and to the various UN agencies in Geneva, and after several agitated interventions, the Secretary-General struck a Task Force on Gender and AIDS in Southern Africa, to be chaired by Carol Bellamy of UNICEF.

If memory serves me, Carol Bellamy

*“The needs and rights of women never command singular urgency.”*



UNAIDS/Herve Vincent-AVECC

the Executive Director of the World Food Programme, James Morris, to four African countries beset by a combination of famine and AIDS: Zimbabwe, Zambia, Malawi and Lesotho. We had surmised, at the outset, that we would be dealing primarily with drought and erratic rainfall, but in the field it became apparent that to a devastating extent,

determined to focus on seven of the highest prevalence rate countries: studies were done, recommendations were made, costs of implementation were estimated, monographs were published. And here’s what festers in the craw: the funding for implementation is not yet available. The needs and rights of women never command singular urgency.

There’s an odd footnote to this. Within the last two months, a number of senior students at the University of Toronto Law School compiled papers dealing with potential legal interventions on a number of issues related to HIV/AIDS in Africa. One of the issues was, predictably, gender. Not a single student, over the course of several weeks, whether on the Internet or wider personal reading, came across the ▶

## HIV/AIDS *and* WOMEN'S GLOBAL HEALTH

Secretary-General's Task Force (although one student said that she had a vague recollection that such a thing existed). The Task Force findings are clearly not something the UN promotes with messianic fervour.

I want to remind you that as recently as March, there was tabled, internationally, the Commission on Africa, chaired by Prime Minister Tony Blair—indeed established by Tony Blair. It has received

find only three women. It doesn't even begin to meet the Beijing minimum target of 30 percent. We're not just climbing uphill; we might as well be facing the Himalayas.

I want to remind you, finally, of the arrangements we've made within the United Nations itself. HIV/AIDS is the worst plague this world is facing; it wrecks havoc on women and girls, and within the multilateral system, best-

*“Notice the rancid irony: women have achieved parity on the receiving end of conflict and AIDS, but nowhere else.”*

nothing but accolades, particularly for the analysis and recommendations on Official Development Assistance, on trade and on debt. The tributes are deserved. The document goes further down a progressive road than any other contemporary international compilation.

With one exception. I want it to be known—because it's not known—that the one aspect of this prestigious report which fails, lamentably, is the way in which it deals with women. There is the occasional obligatory paragraph which signals that the Commission recognizes that there are two sexes in the world, but by and large, given that women are absolutely central to the very integrity and survival of the African continent, they are dealt with as they are always dealt with in these auspicious studies: at the margins, in passing, pro forma. And it's not just HIV/AIDS; it's everything, from trade to agriculture to conflict to peace-building.

Maybe we should have guessed what was coming when there were only three women appointed out of seventeen commissioners. They had the whole world to choose from, and they could

placed to confront the pandemic, we have absolutely no agency of power to promote women's development, to offer advice and technical assistance to governments on their behalf, and to oversee programmes, as well as represent the rights of women. We have no agency of authority to intervene on behalf of half of the human race. Despite the mantra of 'Women's Rights are Human Rights,' intoned at the International Conference on Human Rights in Vienna in 1993; despite the pugnacious assertion of the rights of women advanced at the Cairo International Conference in 1994; despite the Beijing Conference on women in 1995; despite the existence of the Convention on the Elimination of

Discrimination against Women, now ratified by over 150 countries; we have only UNIFEM, the UN Development Fund for Women, with an annual core budget in the vicinity of \$20 million, to represent the women of the world. There are several UNICEF offices in individual developing countries where the annual budget is greater than that of UNIFEM.

More, UNIFEM isn't even a free-standing entity. It's a department of the UNDP (the United Nations Development Programme). Its Executive Director ranks lower in grade than over a dozen of her colleagues within UNDP, and lower in rank than the vast majority of the Secretary-General's Special Representatives.

More still, because UNIFEM is so marginalized, there's nobody to represent women adequately on the group of co-sponsors convened by UNAIDS. You see, UNAIDS is a coordinating body: it coordinates the AIDS activities of UNICEF, UNDP, the World Bank, UNESCO, UNFPA, WHO, UNDCP (the Drug Agency), ILO and WFP. UNIFEM asked to be a co-sponsor, but it was denied that privilege.

So who, I ask, speaks for women at the heart of the pandemic? Well, UNFPA in part. And UNICEF, in part (a smaller part). And ostensibly UNDP (although from my observations in the field, "ostensible" is the operative word).

Let me be clear: what we have here is the most ferocious assault ever made by a communicable disease on women's health, and there is just no concerted coalition of forces to go to the barricades on women's behalf. We do have the Global Coalition on Women and AIDS, launched almost by way of desperation, by some international women leaders, like Mary Robinson, like Geeta Rao Gupta, but they're struggling for significant sustainable funding, and



UNICEF/UNAIDS

their presence on the ground is inevitably peripheral.

I was listening to the presentations at the conference dinner last night, and thinking to myself, when in heaven's name does it end? Obstetric fistula causes such awful misery, and isn't it symptomatic that one of the largest—perhaps the largest—contributions to addressing this appalling condition has come not from a government but from Oprah Winfrey?

I was noting, just in the last 48 hours, that Save the Children in the UK has released a report pointing out that fully half of the 300,000 child soldiers in the world are girls. And if that isn't a maiming of health—in this case emotional and psychological health—then I don't know what is. And perhaps you notice the rancid irony: women have achieved parity on the receiving end of conflict and AIDS, but nowhere else.

Female genital mutilation, the contagion of violence against women, sexual violence in particular, rape as a weapon of war—Rwanda, Darfur, Northern Uganda, Eastern Congo—marital rape, child defilement, as it is called in Zambia, sexual trafficking, maternal mortality, early marriage. I pause to point out that studies now show that in parts of Africa, the prevalence rates of HIV in marriage are often higher than they are for sexually active single women in the surrounding community; who would have thought that possible?

The overall subject matters you're tackling at this conference strike to the heart of the human condition. All my adult life I have accepted the feminist analysis of male power and authority. But perhaps because of an acute naïveté, I never imagined that the analysis would be overwhelmed by the objective historical realities. Of course the women's movement has had great successes, but the contemporary global struggle to secure women's

*“I want a kind of revolution in the world's response, not another stab at institutional reform, but a virtual revolution.”*



health seems to me to be a challenge of almost insuperable dimension.

And because I believe that, and because I see the evidence month after month, week after week, day after day, in the unremitting carnage of women and AIDS—God it tears the heart from the body, I just don't know how to convey it. These young young women, who crave so desperately to live, who suddenly face a pox, a scourge which tears their life from them before they have a life, who can't even get treatment because the men are first in line, or the treatment rolls out at such a paralytic snail's pace, who are part of the 90% of pregnant women who have no access to the prevention of Mother to Child Transmission and so their infants are born positive, who carry the entire burden of care even while they're sick, tending to the family, carrying the water, tilling the fields, looking after the orphans; the women who lose their property, and have no inheritance rights, and no legal or jurisprudential infrastructure which will guar-

antee those rights, no criminal code which will stop the violence—because I have observed all of that, and have observed it for four years, and am driven to distraction by the recognition that it will continue, I want a kind of revolution in the world's response, not another stab at institutional reform, but a virtual revolution....

I'm 67 years old. I'm a man. I've spent time in politics, diplomacy and multilateralism. I know a little of how this man's world works, but I still find much of it inexplicable. I don't really care anymore about whom I might offend or what line I cross: that's what's useful about inching into one's dotage.

I know only that this world is off its rocker when it comes to women. I must admit that I live in such a state of perpetual rage at what I see happening to women in the pandemic, that I would like to throttle those responsible, those who've waited so unendurably long to act, those who can find infinite resources for war but never sufficient resources to ameliorate the human condition....

I have to say that I can't get the images of women I've met, unbearably ill, out of my mind. And I don't have it in me either to forgive or to forget. I have it in me only to join with all of you in the greatest liberation struggle there is: the struggle on behalf of the women of the world. 🌸

*For the full text of the speech, visit:*

[www.unaids.org/html/pub/media/speeches02/sp\\_lewis\\_globalissueswomenshealth\\_26apr05\\_en\\_pdf.pdf](http://www.unaids.org/html/pub/media/speeches02/sp_lewis_globalissueswomenshealth_26apr05_en_pdf.pdf)

*In audio:* <http://beansidhe.isc-net.upenn.edu:8080/ramgen/summit/lewis.rm>

# HIV/AIDS on rise for CANADIAN women

Prevention, treatment, care and support programs  
and policies do not address needs of girls and women

BY BARBARA CLOW

*From the Atlantic Centre of Excellence for Women's Health*

AS THE INTERNATIONAL AIDS CONFERENCE DRAWS CLOSER—TO BE HELD IN TORONTO 2006 WITH MORE THAN 20,000 PARTICIPANTS AND MEDIA FROM AROUND THE WORLD—IT IS TIME FOR CANADA TO LOOK AT ITS OWN HIV/AIDS EPIDEMIC WITH FRESH EYES. HIV/AIDS IN CANADA IS NOT WHAT IT WAS A DECADE AGO.

Although the majority of those living with HIV and AIDS-related illnesses in Canada are men who have sex with men and intravenous drug users, growing numbers of women—especially young women—are becoming infected through heterosexual contact. Many programs and policies in Canada do not adequately address the needs of diverse groups of women at risk of HIV infection. Without immediate and appropriate action, the HIV epidemic in Canada may well follow the same devastating path as it has elsewhere in the world, spreading through the general population with heterosexual contact as the primary route of transmission.

Since the early 1990s, the rate of new HIV infections has declined among men who have sex with men and among injection drug users. This is good news. But in contrast, infections arising from heterosexual contact have risen steadily, from 13% in 1993 to 43.8% in 2003. And the greatest increase in new infections has been among young women, aged 15 to 29. At present, heterosexual transmission accounts for nearly 75% of all new infections in women.

Physiological differences between females and males—sex—place women at greater risk of infection. Delicate tissues in the female reproductive tract and concentrations of the virus in semen make it easier for infected males to transmit the disease to their female sexual partners than vice versa.

But social roles and cultural expectations—gender—are critical factors in women's heightened vulnerability to HIV infection. Because women often have less power—social, economic, political—than men in our society, it can be difficult or even

impossible for many to refuse sex or negotiate safer sex.

Gender roles and stereotypes also hinder women's ability to manage HIV and AIDS-related infections. Women diagnosed with HIV tend to, according to Health Canada, have a lower survival rate than men in part due to "late diagnosis and delay of treatment because of misdiagnosis of early symptoms; exclusion from drug trials and lack of access to antiviral treatment; lack of research into the natural history of HIV in women; higher rates of poverty among women and lack of access to adequate health care; and the tendency of many women to make self-care a lower priority than the care of children and family."

While women as a group are more vulnerable than men to HIV infection and AIDS-related illnesses, some populations of women face significantly greater risks. For example, HIV affects more than twice as many Aboriginal as non-Aboriginal women in Canada. As elsewhere in the world, women in Canada who are most disadvantaged and marginalized are also most vulnerable to HIV.

On the whole, policies and programs aimed at HIV prevention, treatment, care, support and impact mitigation have not focussed on, nor—in some cases—even taken account of the differential needs of women and the gender dimensions of the epidemic.

Governments and policy makers can help to stem the tide of the epidemic in Canada and abroad by advancing the work of the National Ministerial Council on HIV and AIDS, by promoting further gender-based analysis of the Canadian Strategy on HIV/AIDS and of provincial and territorial strategies, where

they exist, and by encouraging the development of gender-appropriate HIV/AIDS strategies in all regions of the country.

In particular, we should be promoting the understanding of the ways in which females and males are differentially affected by HIV and AIDS-related illnesses, specifically through support for research as well as public and professional education. All levels of government also need to make certain that gender is mainstreamed into all policies and programs pertaining to HIV/AIDS prevention, care, treatment and support.

In general, we need to foster a broader and more inclusive approach to HIV/AIDS in order to recognize and respond to the needs of all Canadians, regardless of sexual orientation, gender, ethnicity and life circumstances. This may mean protecting existing resources and securing new resources to help support agencies and programs that foster positive living for those infected and affected by HIV/AIDS.

The Canadian government also needs to honour international commitments and agreements aimed at poverty reduction, elimination of discrimination and violence against women, child development, human rights, and HIV/AIDS prevention, treatment, care and support around the world. And we need to hold our government to these promises.

If Canada does not respond swiftly and appropriately to these changing patterns of infection, the HIV epidemic threatens to become endemic—with appalling consequences for all Canadians. ☞

*For more information, visit the Atlantic Centre of Excellence for Women's Health: [www.acewh.dal.ca](http://www.acewh.dal.ca)*

\*All statistics taken from *HIV and AIDS in Canada, Surveillance Report* to December 31, 2003, Health Canada; *HIV/AIDS Epi Update*, 2003, Health Canada; *Women and HIV/AIDS Factsheet*, Bureau of Women's Health and Gender Analysis, Health Canada, 2004.

## Useful Websites on Women and HIV/AIDS

Compiled by Barbara Bourrier-LaCroix

### Voices of Positive Women

[www.vopw.org](http://www.vopw.org)

Voices of Positive Women aims to empower women living with HIV/AIDS through confidential support, outreach, information and education. The organization advocates to improve the health and quality of life of HIV-positive women. VOPW promotes accurate, affirming images of HIV-positive women and offers peer support programs in Toronto and throughout Ontario.

### HIV, Women & Youth

[www.ppfca.ca/ppfc/HIV](http://www.ppfca.ca/ppfc/HIV)

This site, a project of Planned Parenthood Federation of Canada, provides resources including: information sheets on HIV testing, pregnancy prevention, and healthy HIV positive living; resources for service providers, including statistics and advocacy guidelines; a quiz, story archive and a glossary.

### HIV/AIDS: Know Your Risks—Know Your Choices

[www.cdn aids.ca/risks/choices](http://www.cdn aids.ca/risks/choices)

This website, created by the Canadian AIDS Society, is part of a national awareness campaign on HIV/AIDS targeting young women. The site includes a quiz, a look at the different campaign materials, a glossary and a listing of other good sites.

### Positive Women's Network

[www.pwn.bc.ca](http://www.pwn.bc.ca)

Positive Women's Network provides information, resources and services, as well as leadership in advocacy, training and community inclusion of health issues affecting women with HIV. Their website offers newsletters, trends and research reports, and contact information for some AIDS service organizations in British Columbia.

### Head and Heart

[www.criss.org/En/journal.htm](http://www.criss.org/En/journal.htm)

This magazine, published by the Centre of Resources, Interventions and Services in Sexual Health (CRISS), offers information for women who are infected or affected by HIV/AIDS. Articles deal with issues such as family life, HIV in the workplace, HIV treatment and HIV and women's health.

### Canadian HIV/AIDS Information Centre

[www.aidsida.cpha.ca](http://www.aidsida.cpha.ca)

The Canadian HIV/AIDS Information Centre provides information and communication services on HIV prevention, care, treatment and support. The Centre maintains Canada's largest library of HIV/AIDS resources and distributes thousands of posters, pamphlets and manuals every year.

### Canadian AIDS Treatment Information Exchange (CATIE) [www.catie.ca](http://www.catie.ca)

CATIE provides information to help people living with HIV/AIDS, and their caregivers, make informed health care decisions, and assists physicians and other health care professionals to access the latest information on AIDS treatment advances. The group advocates for improved research, better treatments and easier access to treatments.

### Canadian AIDS Society

[www.cdn aids.ca](http://www.cdn aids.ca)

The Canadian AIDS Society (CAS) is a coalition of community-based AIDS organizations that advocates for people and communities affected by HIV/AIDS. CAS facilitates the development of programs, services and resources for member groups, and provides a national framework for community-based participation in Canada's response to AIDS.

Pour consulter les sites Web en français sur le VIH/sida, allez à la page 10.



# Blueprint for Action on HIV/AIDS in Canada: Towards 2006

*Coalition will make sure women's voices are present*

Nine months after its founding, the *Blueprint for Action on HIV/AIDS in Canada: Towards 2006 (Blueprint)* has grown from a small group of representatives from five organizations to a thriving coalition of over 60 organizations, and numerous more individual members.

The purpose of *Blueprint* is to bring together groups and individuals working across the country in the area of HIV/AIDS and women, and to find ways to bring women's issues forward on the national agenda.

In April of this year, *Blueprint* hosted a national meeting in Ottawa where 30 participants came together to ratify the agenda for *Blueprint* and begin identifying areas for advocacy over the coming year.

In addition to planning for the upcoming International AIDS Conference in 2006, to be held in Toronto, four areas were identified as requiring attention:

- Care, Treatment, Support, Prevention and Diagnosis
- Research on Women's Health and Social Issues
- Public Policy, Legal, Ethical, Human Rights and Determinants of Health
- Stigma and Discrimination.

Committees were formed to address each area, and are already working to identify priorities and specific desired

responses from governments, corporations and the public.

A formal list of these demands will be prepared for endorsement this fall and released on World AIDS Day this year. This will give us the opportunity to seek a response to these needs and prepare a report that will be released at the 2006 International AIDS Conference.

In preparation for the conference, *Blueprint* has also begun advocating for the full integration of women's issues into the conference, as well as equal representation among presenters (both invited and in abstract selection processes), and in the granting of scholarships.

To date, members of *Blueprint* have met with representatives of the Conference Organizing Committee and have received positive feedback on the requests, indicating that there is support for gender equity within the conference planning process. *Blueprint* will continue to monitor and push this agenda to ensure that women's issues are well represented in Toronto 2006. 🌸

**If you or your organization are interested in participating in *Blueprint***, either as a member of one of the committees described above, or as an endorser of the demands to be released on World AIDS Day, please contact Kim Thomas at the Canadian AIDS Society: 1-800-499-1986, ext. 121 or [kimt@cdnaids.ca](mailto:kimt@cdnaids.ca)

## Mark your calendars! Toronto will be the site of the XVI International AIDS Conference, August 13-19, 2006.

**AIDS2006 Toronto** will bring together over 15,000 participants from around the world to address the global HIV/AIDS epidemic. Conference participants will include researchers, clinicians, community organizations, government representatives and people living with HIV/AIDS.

**Let's make sure women's voices are heard at this important international forum.**

- For more information on how to take part, visit: [www.aids2006.org](http://www.aids2006.org)
- Join the AIDS 2006, XVI International AIDS Conference electronic mailing list: [www.aids2006.org/maillinglist.asp](http://www.aids2006.org/maillinglist.asp)



# Alarming rates *of* HIV/AIDS *for* Canada's Aboriginal women

## NATIONAL RESPONSE LONG OVERDUE

*From the Canadian Aboriginal AIDS Network*

BY TRACEY PRENTICE

**ABORIGINAL WOMEN ARE GREATLY OVER-REPRESENTED IN HIV/AIDS STATISTICS, YET THERE IS A STARTLING LACK OF GENDER-SPECIFIC, ABORIGINAL-SPECIFIC, HIV/AIDS RESOURCES, PROGRAMS AND SERVICES TO SUPPORT THEM.**

Aboriginal women are the caregivers of their communities, and while they have repeatedly shown themselves to be strong, resilient and undaunted by hardship, they can not be expected to bear the burden of HIV/AIDS in Aboriginal communities alone. Governments, communities and AIDS services organizations must recognize their responsibility to Aboriginal women and begin to provide the Aboriginal, women-specific research, programs, services and supports they need.

The rate of new HIV infections among Aboriginal women in Canada has been steadily increasing over the past two decades. Aboriginal women now account for approximately 50% of all HIV-positive test reports among Aboriginal people, compared with only 16% of their non-Aboriginal counterparts (2003). Aboriginal women comprise nearly 25% of reported AIDS cases among Aboriginal people, while non-Aboriginal women account for only 8.2% among non-Aboriginal cases (2003).

Alarmingly, a large and increasing portion of HIV infections are occurring in young Aboriginal women between 15-29 years

old. Between 1985 and 1995, roughly 13% of HIV-positive test reports among Aboriginal women were in young women in this age group. However, this percentage has increased steadily to approximately 37% in 1998, and 45% in 2001.

Injection drug use (IDU) is the main mode of HIV transmission for Aboriginal women, followed by heterosexual contact, sometimes with partners who use injection drugs. In 2002, 64.9% of reported AIDS cases among Aboriginal women reported their exposure category as injection drug use, and 30.9% reported the mode of transmission as heterosexual contact (2003). Research studies with injection drug users in Vancouver indicate that Aboriginal women are over-represented in the IDU population, and consequently, are over-represented in HIV positive test reports with IDU as the known mode of transmission.

Of the many factors that increase Aboriginal women's vulnerability to HIV infection, a common undercurrent is colonization. Intensive and sustained efforts on the part of the ►

## Aboriginal women cannot be expected to bear the burden of HIV/AIDS in Aboriginal communities alone.

government to colonize Canada's Aboriginal peoples have had affects on the socio-economic status of Aboriginal women. Aboriginal women are twice as likely to be poor than their non-Aboriginal counterparts, and they are more likely to live in an environment where substance abuse and spousal violence are widespread.

These socio-economic conditions are strongly associated with a positive HIV test result for Aboriginal women, and they contribute to the creation of harsh living environments in which techniques used to simply survive often include high-risk behaviours, such as rural to urban migration, homelessness, sex trade and/or sex work, injection drug use and alcohol abuse.

There are also many factors associated with gender, and a power imbalance between genders, that increase Aboriginal women's vulnerability to HIV infection. For instance, studies show that repeated physical and sexual abuse is strongly associated with a positive HIV test report, and that Aboriginal women are significantly more likely than non-Aboriginal women to have experienced all kinds of violence, including physical and sexual abuse.

When women are forced or coerced into having sex against their will, the likelihood of contracting HIV is increased; their abusers are unlikely to wear condoms and women are unable to insist that they do so. As a result, the likelihood of tears or abrasions to the women's genitals is increased, which in turn, increases the likelihood of HIV transmission.

Repeated sexual or physical abuse affects women's vulnerability in other ways as well. Women who experience abuse are highly likely to be poor, have limited access to education and employment, have low levels of self-esteem and often turn to alcohol and drugs as a way of coping and reducing the pain or post-traumatic effects of sexual abuse and other traumas. The experience of abuse often results in powerlessness in intimate relationships and an inability to negotiate safer sex, even during consensual sex.

It is clear that we need to develop a national response to HIV/AIDS that is designed, developed and implemented by Aboriginal women. Aboriginal women and Aboriginal women with HIV/AIDS must be integral in the design and delivery of these initiatives. In particular, we need to have targeted preven-

tion and educational initiatives for Aboriginal women in relation to IDU, and we need to target prevention and educational initiatives for Aboriginal women between 15-29 years old.

We also need to make sure these programs address:

### Substance abuse:


- Provide short and long-term supports for Aboriginal women struggling with addictions.

### Poverty:

- Since poverty is directly related to HIV vulnerability, increasing meaningful job opportunities and job training for Aboriginal women will, over time, decrease their vulnerability to HIV infection.

### Power:

- HIV prevention efforts for Aboriginal women must also begin to address the imbalance of power that is often a feature of intimate relationships. Prevention and education must target Aboriginal heterosexual men as well as women, and prevention efforts must address domestic and sexual violence against women.
- We must develop cultural sensitivity training for health professionals to equip doctors, nurses and other health practitioners with appropriate skills to communicate about HIV with Aboriginal women.

Many Aboriginal women do not have the information or the skills they need to protect themselves from HIV, and many HIV positive women live in isolation and fear of having their status revealed. On the whole, however, the voices of Aboriginal women have not been silenced, nor have their spirits been dampened. On the contrary, Aboriginal women, and Aboriginal HIV positive women are speaking out in record numbers, offering their experiences to others as learning tools, telling their stories, breaking down stereotypes, acting as role-models, and changing the way we think about Aboriginal women living with HIV/AIDS. For this they may be applauded. For this, they must be respected. In this, they must be supported. 

*For the full report on HIV/AIDS and Aboriginal women, children and families, visit: [www.caan.ca](http://www.caan.ca) or call: 1-888-285-2226.*

# the silent voices of the HIV/AIDS epidemic in Canada **African and Caribbean women in Toronto**

*From Women's Health in Women's Hands*

BY ESTHER THARAO, NOTISHA MASSAQUOI AND SENAIT TECLOM

UNAIDS ESTIMATES THAT WOMEN ACCOUNT FOR HALF OF THE 40 MILLION PEOPLE LIVING WITH HIV/AIDS GLOBALLY, AND OF THESE 20 MILLION WOMEN, AFRICAN AND CARIBBEAN WOMEN BEAR THE GREATEST BURDEN OF THE DISEASE (UNAIDS, 2003). THE HIGH RATES OF HIV INFECTION AMONGST AFRICAN AND CARIBBEAN WOMEN IN SUB-SAHARAN AFRICA AND THE CARIBBEAN ARE ALSO REFLECTED, ALBEIT TO A LESSER EXTENT, IN THE DEVELOPED COUNTRIES OF EUROPE, AUSTRALIA AND NORTH AMERICA, INCLUDING CANADA—COUNTRIES THAT HAVE BECOME THE FINAL DESTINATION OF WOMEN FLEEING TO ESCAPE WAR, GENDER AND/OR RELIGIOUS PERSECUTION OR IN SEARCH OF BETTER ECONOMIC OPPORTUNITIES FOR THEMSELVES AND THEIR FAMILIES. MANY OF THE WOMEN WHO HAVE CHOSEN TO MAKE CANADA THEIR HOME HAVE SETTLED IN LARGE METROPOLITAN CITIES, WITH THE MAJORITY LIVING IN TORONTO. ACCORDING TO THE 2001 CENSUS OF STATISTICS CANADA, MORE THAN HALF OF THE 310,500 MEMBERS OF THE BLACK COMMUNITY LIVING IN TORONTO ARE WOMEN.

Emerging data indicates that African and Caribbean communities have now become a significant component of the HIV/AIDS epidemic in Ontario. In the period between 1994-1996, more than 70% of all maternal HIV transmissions in Ontario were amongst African and Caribbean women, and in 1996, they accounted for 32% of AIDS related deaths among women in Ontario. More recently, African and Caribbean communities accounted for 20% of all AIDS cases diagnosed in 2001 and 2002. According to University of Toronto researcher, Robert Remus (2003), HIV prevalence among African and Caribbean communities has continued to increase at a rate of 13.1% annually, and has increased by 85% in the last five years, with a large proportion of the infections (22%-59%) occurring after settlement in Ontario.

While statistics indicate a real and growing problem, very little is documented to highlight the context within which transmission is occurring, the factors that facilitate or reduce transmission and those that foster the ability to cope with HIV for those who are already infected. In addition, African and

Caribbean women and their communities have traditionally played a very limited role in efforts mounted to deal with the HIV/AIDS epidemic in their new host country, creating an unfortunate situation in which service providers are struggling to provide services with an insufficient understanding of the forces that are driving the epidemic. The result is limited access to, and involvement of, African and Caribbean communities, and a lack of evidence on which to base programs and services.

## **Few HIV/AIDS services available for African and Caribbean women**

*Women's Health in Women's Hands* undertook a study (2004) in order to assess the HIV/AIDS services available to African and Caribbean women in the Toronto area. Our study found that most of the HIV/AIDS prevention, support, treatment and care services available are delivered primarily within "mainstream" agencies/institutions, with most having originally been developed to meet the needs of the groups that emerged into the epidemic first—primarily men who have ►

## the silent voices of the HIV/AIDS epidemic in Canada

sex with men. In addition, the majority of services are targeted primarily to people living with HIV/AIDS, with limited services targeting those at risk of infection or designed to raise awareness and prevent transmission.

As well, very few agencies provide prevention and outreach services targeted to African and Caribbean women at risk of HIV infection, and those that do

so, are limited. Those individuals in the community who are informed about HIV tend to have discovered necessary information on their own or are informed of the resources after testing HIV positive. Struggling to deal with the impacts of the diagnosis with limited information about the disease and available services, and without family or community support, affects the coping

ability of African and Caribbean women living with HIV/AIDS. To ensure maximum confidentiality, they deal with HIV/AIDS in silence and secrecy.

In general we found that governments and agencies do not have either short-term or long-term strategies and plans in place to develop and deliver services that are tailored to meet the identified needs of African and Caribbean women.

### MOVING FORWARD

## African and Caribbean Council on HIV/AIDS in Ontario

April 2005 saw the launch of a *Strategy to Address Issues Related to HIV Faced by People in Ontario From Countries Where HIV is Endemic* by the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), a group of organizations and individuals committed to HIV prevention, education, advocacy, research, treatment, care and support for African and Caribbean communities in Ontario.

"It is crucial that ACCHO works in partnership with community members, faith leaders, activists, social and health service agencies in the implementation of this strategy to ensure healthy communities," says Dr. Winston Husbands, Co-Chair of ACCHO. The goal of the Strategy is to reduce the spread of HIV among African and Caribbean people in Ontario, and improve the quality of life for those infected and affected by HIV/AIDS.

The Strategy has four main areas of concern:

- HIV among African and Caribbean peoples is an urgent issue that requires immediate attention and dedication of resources;
- African and Caribbean communities should be involved in planning and delivering services for people;
- Racism, gender discrimination, homophobia and other forms of discrimination affect the care and services people receive; and
- Programs and services should meet the needs of a wide range of people and groups from the African and Caribbean communities in Ontario, namely, youth, women, gay men, lesbians, transgendered people, men who have sex with men, and injection drug users.

The Strategy will also focus on coordinating resources for HIV services, promoting and creating appropriate programs for the community, and establishing new research priorities.

**For more information on the Council and the Strategy, contact:**  
**ACCHOntario@hotmail.com or 1-866-615-3506.**

### Engaging African and Caribbean women in the solution

There is a critical need to engage African and Caribbean women and their communities in prevention, support and care activities. In particular, agencies and individual providers must understand and address the context in which people live and the community values, beliefs, and norms that shape both individual and community behaviours.

Infected and affected African and Caribbean women and their communities must be involved in the design and delivery of programs within an empowering and community development framework based on trust and mutual respect. Strategies targeted to individuals must be complimented with broader community strategies designed, not only for African and Caribbean communities, but also for the Canadian society at large to change norms, values, practices and stereotypes inherent in multiple intersecting frameworks of oppression. 

*For the full report, The Silent Voices of the HIV/AIDS Epidemic, contact:*  
*esther@whiwh.com or call: 416-593-7655.*

*For more information on Women's Health in Women's Hands, a community health centre for women, please visit:*  
*www.whiwh.com*  
*or phone: 416-593-7655.*

# the final PUSH



Christina Gapic Photography/www.christinagapic.com

## *Making midwives part of the Nova Scotia health system*

*From the Atlantic Centre of Excellence for Women's Health*

**LEADING EXPERTS IN THE FIELD OF MIDWIFERY ARE CALLING ON THE NOVA SCOTIA GOVERNMENT TO MAKE MIDWIVES A CENTRAL PART OF HEALTH SERVICES ACROSS THE PROVINCE.**

“Our focus is to improve maternity and newborn care services for women and their families. An integral part of improving these services is for women to have access to the publicly funded services of midwives,” says Dr. Christine Saulnier, Senior Research Officer and Coordinator, Midwifery and Women’s Reproductive Health, with the Atlantic Centre of Excellence for Women’s Health (ACEWH).

Health experts and activists joined the ACEWH in Halifax this year by celebrating the International Day of the Midwife with a public panel entitled, “The Final Push: Making Midwives Part of the Nova Scotia Health System.” Dr. Saulnier was one of four panelists who gave an overview of the current status of midwifery in Nova Scotia and the long-range goals of those seeking change.

At present, midwives in Nova Scotia have no formal or legal standing and are able to work only in a private, fee-for-service manner. Most of the births they attend are at home, but some do occur in hospital where midwives must take a supportive, rather than care management, role.

Over the past 15 years, two governments have failed to move forward on recommendations to integrate midwife services in the province. Last June, the government convened The Working Group on Primary, Collaborative

Maternity Care to explore, once more, how that can be accomplished. The mandate of this group came to an end in June 2005.

“Women choose midwives because they want to be able to make fully informed choices and to be the primary decision-maker around their own care,” says Kerstin Martin, Vice-President of the Canadian Association of Midwives. “These choices include where to give birth, whether that is in a hospital, in a birthing center or at home. Research also indicates that women under midwifery care are happier with their childbearing experiences and more successful with breastfeeding.”

Currently midwives are legislated and regulated in Quebec, Ontario, Manitoba, Alberta, British Columbia and the North West Territories—and publicly funded in each of these areas except Alberta. There are 450 practicing midwives in Canada. The standard of education is a four-year university degree available in Ontario, Quebec and British Columbia.

“We are hopeful that Nova Scotia will join the mainstream and accept midwives as part of Nova Scotia’s health care system—and be covered by MSI [Medical Services Insurance; medicare],” says Octavia James, Co-Chair of the Midwifery Coalition of Nova Scotia, and a ►

## the final PUSH

consumer of midwifery.

“Research indicates that a midwife’s care is as safe as a physician’s care, and requires far fewer medical interventions,” she notes.

This means lower rates of Caesarean sections, less vacuum and forceps deliveries, and fewer episiotomies (surgically enlarging the vagina at birth). Subsequently, health care costs are reduced.

Midwives and their supporters throughout Nova Scotia remain cautiously optimistic that the government will announce plans to introduce midwifery legislation sometime this coming year, says Dr. Saulnier. ☺

*The Canadian Association of Midwives presents*

### **Midwives in the Balance: Partnership and Practice for Normal Birth**

November 9-11, 2005 • Halifax, Nova Scotia

**For details, visit:**

<http://ca.geocities.com/canadianmidwives@rogers.com/home.html>

Or email: [admin@canadianmidwives.org](mailto:admin@canadianmidwives.org)

**Sign up today!**

**Join the Atlantic midwifery listserv (electronic mailing list).**

Just contact [christine.saulnier@dal.ca](mailto:christine.saulnier@dal.ca) for details.

## All About Midwives

Midwives are autonomous, primary health care professionals, experts in normal pregnancy, labor, birth and care of the newborn. Midwives care for healthy women throughout pregnancy, conduct deliveries on their own, and continue follow-up of the mother and baby for six weeks after birth.

Midwives have the knowledge to detect abnormal conditions, to collaborate with physicians and other health professionals, and to execute emergency measures in the absence of medical help.

Midwives are an essential component of most maternity services and the senior attendant at a majority of the world’s births. Canada was the only developed nation to exclude midwives from its health care system, but has experienced a midwifery renaissance in the last decade.

In Ontario, for instance, there are now 266 midwives delivering 9000 babies each year.

### **Why women want midwives**

Women most often choose midwives for their expertise in supporting normal birth. Midwives regard childbirth as a natural physical function of a woman’s body—something women do well when adequately supported.

Women also choose midwives to receive continuity of care, so that women get to know the midwife who will help them deliver their baby, and who will provide on-going home visits for postnatal and breastfeeding support.

Women who choose midwives want to give birth with little or no medical intervention, in the environment where they feel most comfortable, attended by familiar and trust-

ed caregivers to create a birth experience that is joyful, empowering and safe.

### **Why integrating midwives into the Nova Scotia health system is a good idea**

Midwifery care is safe, and offers the added benefit of reducing the number of medical interventions. For instance, in Ontario, midwives have the same outcomes as family physicians but a 30% lower rate of Caesarean section, 50% fewer vacuum and forceps deliveries, and perform 50% fewer episiotomies (a surgical enlargement of the vagina at birth).

New Ontario mothers have twice the rate of early discharge and 65% fewer re-admissions to hospital with midwives.

The Ontario Minister of Health recently stated that a midwife’s course of care is, on average, \$800 cheaper per hospital birth and \$1800 cheaper per home birth, due in part to lower rates of intervention and higher rates of early discharge from hospital. A new study in Alberta confirms this finding, and estimates the savings to be between \$700 and \$1100 per birth.

A study in British Columbia comparing a similar low-risk population of women giving birth in hospital found that midwives have a Caesarean section rate of 12% while GPs had a rate of 18%. Among those women planning to give birth at home, the rate of Caesarean section was a low 6.5%.

### **For more information, visit:**

- The Atlantic Centre of Excellence for Women’s Health: [www.acewh.dal.ca/midwifery.html](http://www.acewh.dal.ca/midwifery.html)  
Or call (902) 494-7850.
- Midwifery Coalition of Nova Scotia:  
<http://mcns.chebucto.org/index.htm>

# New Canadian Consensus Statement on Intimate Partner Violence

## Violence linked to poor health, chronic conditions

*From the Society for Obstetricians and Gynaecologists of Canada*

**INTIMATE PARTNER VIOLENCE** is a significant, underlying cause of poor health for women and is well-documented as a serious public health issue. In addition to being at increased risk for physical harm, victims of all forms of violence are vulnerable to health complications, which eventually lead to chronic health problems. In June 2005, the Society of Obstetricians and Gynaecologists of Canada (SOGC) released their *Intimate Partner Violence Consensus Statement* developed by experts from across Canada.

“Helping to reduce the risk of violence in a domestic situation benefits women, children and society as a whole,” says Vyta Senikas, Associate Executive Vice-President of the SOGC. “As physicians we have an opportunity to lessen the chance of miscarriage, low birth weight, and preterm birth for the mother and unborn child faced with this violence. Obstetricians, gynaecologists, nurses and midwives, and all healthcare practitioners, must play a role in ending intimate partner violence.”

Women experiencing violence have an increased risk of substance abuse, psychiatric disorders and suicide, chronic physical disorders, sexual complaints and recurrent pregnancy termination. Contact with a healthcare provider often provides a unique opportunity for the victim of violence to disclose her situation.

“We recognise that women’s health is directly affected by the phenomenon of intimate partner violence,” says Margaret Burnett, Chair of the SOGC’s Social and Sexual Issues Committee. “The purpose of the consensus statement is to provide an understanding of some of the important issues affecting these vulnerable individuals. It outlines practical strategies and tools with which to assist patients whether or not they are ready to make a change in their domestic situations.”

One of the goals in establishing the consensus statement and guidelines was the hope that SOGC members and other healthcare providers would facilitate disclosure of violence as an essential component of clinical practice. The Consensus provides a framework for an appropriate response that will allow an assessment of risk, and referrals to community resources for information-sharing, advocacy-counselling and protection.

“I do believe it is of utmost importance to have physicians trained properly on how to deal with abused women and their children,” says Renee Parent, Executive Director of Nelson House of Ottawa Carleton. “I have seen thousands of women fleeing abuse since 1992, of which many had seen a doctor regularly, but were never referred to a shelter. This document, once put into place, will hopefully help women and their children find their way out sooner rather than never.” 🍷

*To read the Consensus Statement and IPV Assessment Toolkit, visit: [www.sogc.org](http://www.sogc.org) or call: 1-800-561-2416.*

### Important Facts about Intimate Partner Violence and Women’s Health

- Canadian surveys of IPV, the most common form of violence experienced by women, have found between 6% to 8% of woman are affected; this is considered a conservative estimate due to under-reporting. Rates among pregnant and adolescent women appear to be greater.
- Women, regardless of socio-economic status, race, sexual orientation, age, ethnicity, health status and presence or absence of current partner are at risk for IPV.
- Women abused during pregnancy are more likely to be depressed, suicidal, experience pregnancy complications and poor outcomes, including maternal and fetal death.
- Women who are immigrants or refugees, lesbians, women of colour, Aboriginal women, and women with disabilities may experience forms of IPV, may experience IPV differently, and may have more barriers to disclosure, than mainstream women.
- For pregnant women, clinical interventions that included counselling to increase safety behaviours resulted in the adoption of these practices and reductions in abusive incidents.
- Children whose mothers experience IPV are at greater risk of developmental difficulties and may themselves be abused.

# improving access to EMERGENCY CONTRACEPTION

*Must be affordable  
and easily available to all women*

*From Women and Health Protection and the Canadian Women's Health Network*

BY DIANE SAIBIL



## GOOD NEWS!

ON APRIL 19, 2005 HEALTH CANADA JOINED AN INTERNATIONAL TREND BY ANNOUNCING THAT IT WOULD MOVE FORWARD FEDERALLY WITH A PROPOSAL TO CHANGE THE EMERGENCY CONTRACEPTIVE PILL (ECP), ALSO KNOWN AS PLAN B OR “THE MORNING AFTER PILL,” FROM A PRESCRIPTION DRUG TO A NON-PRESCRIPTION PRODUCT. IN CONCERT WITH THIS MOVE, THE NATIONAL ASSOCIATION OF PHARMACY REGULATORY AUTHORITIES (NAPRA), WHICH DETERMINES ACCESS STATUS FOR NON-PRESCRIPTION DRUGS FOR MOST OF THE PROVINCES, ALSO IMMEDIATELY MADE ECP A “SCHEDULE II” STATUS DRUG. THIS MEANS THAT ECP IS NOW AVAILABLE ACROSS CANADA “BEHIND-THE-COUNTER,” WITHOUT A VISIT TO THE DOCTOR OR A DOCTOR’S PRESCRIPTION, BUT REQUIRING PHARMACIST ASSISTANCE.

We strongly endorse Health Canada’s decision to change the status of ECP from a prescription to a non-prescription product. But to make ECP even more accessible to all women in Canada, governments need to go a step further and make ECP available without a scheduled status—that is, *without pharmacist assistance or intervention as a requirement*.

## CONTINUED CONCERNS

**Access behind-the-counter:** Increasing access to ECP can help reduce unintended pregnancy. Given that this is a safe, effective and easy to use medication, a key consideration is the need for timeliness in its use. ECP is most likely to prevent a pregnancy if taken within 24 hours of intercourse. As more time passes, the effectiveness rate

decreases. It is clear that timely access to the medication is crucial and the determination of its scheduling status must take this into account.

ECP must be available to women and adolescent girls in a location that is accessible daily, including on weekends and holidays, and that is accessible to rural as well as urban consumers. It should be easy to find and purchase.

Behind-the-counter (Schedule II) status means that only pharmacies can carry ECP—a significant limitation in small towns and rural communities. Some pharmacists, due to religious or other convictions, have already declared their unwillingness to dispense ECP. While such pharmacists are expected to refer clients to other sources for these products, this can still pose substantial problems for timely and equitable availability, particularly in small towns and rural areas where there may be only one local pharmacy.

**The right to privacy:** Current guidelines for pharmacists require a consultation with a woman before providing ECP. This is, in our view, an unnecessary intervention that interferes with women's right to privacy. Women should not be treated as patients when there is no evidence of medical necessity. Women and teenagers are able to diagnose their need, understand the labeling and directions, ►

## Emergency Contraception: The Facts

**What it is:** The emergency contraceptive pill (ECP), also known as Plan B or “the morning after pill,” is a hormonal product, taken orally, to prevent pregnancy after unprotected intercourse. This same hormone is used in some birth control pills.

**Effectiveness:** ECP has been shown to have an overall 89% rate of effectiveness if used within 72 hours of unprotected intercourse. The rate climbs to 95% if the medication is taken within 24 hours of intercourse, but it drops to only 58% if taken more than 49 hours after intercourse. Some experts have noted that ECP can provide benefit if taken up to 5 days after intercourse.

**Safety record:** ECP is safe. There have been no reports of deaths or other serious consequences from taking Plan B. Pregnancy is listed as a contraindication only because, like all contraceptives, ECP will not work if a woman is already pregnant. If a woman takes ECP while pregnant, it will not affect her pregnancy and it will not harm the fetus. ECP does not cause an abortion.

**Side effects:** Women using Plan B may have side effects like nausea, diarrhea and spotting. Their period may come early or late and look a little different.

**Ease of use:** No individualized instruction is needed when taking ECP because the dose is identical for all women. Explanations for use are simple and easy to follow.

**Other jurisdictions:** Women have direct access to ECP in a growing number of countries, including Brazil, Dominican Republic, France, Israel, Kenya, Madagascar, Malaysia, Netherlands, South Africa, Sweden, Thailand, UK and Vietnam.

Governments need to go a step further  
and make ECP available without pharmacist  
assistance or intervention as a requirement.

## EMERGENCY CONTRACEPTION

and use ECP safely and effectively without medical intervention. A greater role for pharmacists as health educators is welcome. But it is inappropriate to make counselling mandatory for every woman or girl seeking to purchase ECP.

The need for ECP is a private matter and it must be available in a manner that respects an individual's privacy to the greatest extent possible. If ECP is only available by consultation with a pharmacist, the purchaser may well find herself having this consultation at a very public prescription counter. While pharmacists

ly friend is working at the cash register. Having another option of where to purchase the medication would greatly enhance her privacy and, therefore, increase the likelihood of her making the purchase and taking the pills within the optimal time frame.

**Costs behind the counter:** Finally, there is the question of cost. Government and private drug insurance plans do not generally cover non prescription drugs or pharmacists' consultation services. Therefore, it is likely that the cost of

# It is inappropriate to make counselling mandatory for every woman or girl seeking to purchase ECP.

are encouraged to provide a private area for consultations, a private room away from the retail area frequently does not exist.

Complete privacy is obviously impossible because of the need to purchase ECP in a public place. However, being able to take a product off the shelf and directly to the checkout counter provides a greater degree of privacy than having a discussion at a prescription counter.

Even greater privacy can be achieved if the consumer has a number of options available for purchasing the product. Imagine a woman or an adolescent girl having to purchase her ECP on a Sunday at the only pharmacy in town open at that time. On arriving at the pharmacy, she discovers that a fami-

ECP will increase as provinces remove emergency contraception from provincial formularies, with the result that low-income women and women with drug plans will have to cover the cost themselves.

As predicted by researchers Joanna Erdman and Rebecca Cook, behind-the-counter status for ECP has resulted in women having to pay the cost of the medication, plus a pharmacist consultation fee. Consultation fees range from \$15 to \$45. If ECP is available over-the-counter, there is no consultation fee, resulting in a more affordable cost.

Although not the responsibility of those regulating the schedule status, provincial governments should see ECP as an essential drug to which all women

can have access, no matter what their income level.

### A CALL TO ACTION

Access to emergency contraception is a key element in any comprehensive program addressing women's reproductive and sexual health. It is of particular importance to the health of teenaged girls and young women, the age group at greatest risk, relative to the general population of women, of unintended pregnancy.

Effective access to emergency contraception requires that it be readily available, quickly, regardless of a woman's age. It must be accessible to rural as well as urban women and to women of limited financial means. Finally, it must be accessible in a way that respects women's right to privacy, as well as their right to freely make informed health care choices. The use of emergency contraception represents a responsible and informed decision by a woman seeking to prevent an unintended pregnancy and must be respected as such.

Women and Health Protection (WHP) and the Canadian Women's Health Network (CWHN) want access to emergency contraception to be improved. A lack of awareness about emergency contraception, the costs of obtaining it, and existing regulations unnecessarily restrict this access.

As a first step in improving access, we are planning to submit a request to Canadian regulatory authorities for Plan B to become an "off-schedule" medication, available for sale at any retail outlet. *We invite and encourage you to give your support to this position.* 🍷

*For more details, and to join our initiative, see [www.whp-apsf.ca](http://www.whp-apsf.ca) or contact: 1-888-818-9172.*

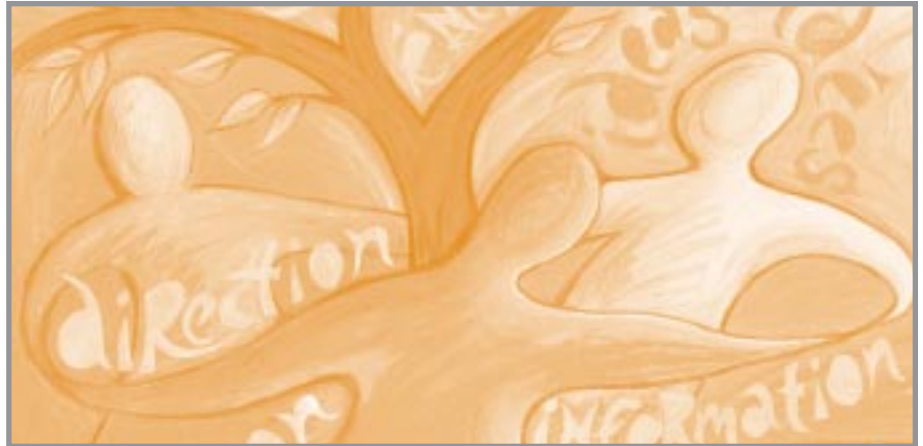
# CANADIAN WOMEN'S HEALTH MOVEMENT celebrated by University of Ottawa

## EXECUTIVE DIRECTOR OF THE CANADIAN WOMEN'S HEALTH NETWORK AWARDED HONORARY DOCTORATE

*Madeline Boscoe, the Executive Director for the Canadian Women's Health Network, and the Policy and Advocacy Coordinator for the Women's Health Clinic, Winnipeg, was awarded an Honorary Doctorate from the University of Ottawa on June 5, 2005. Boscoe was recognized for her substantial contributions promoting the health of women and girls in Canada.*

*For over 20 years, Boscoe has worked in health education and advocacy at the Women's Health Clinic in Winnipeg. She is also a founding member of the Canadian Women's Health Network (CWHN), and has been the Executive Director of the CWHN since 1995.*

*The University of Ottawa annually awards Honorary Doctorates to those individuals who have made a substantial contribution to their profession or society at large. "An Honorary Doctorate acknowledges that the recipient deserves to be recognized for their unsurpassed abilities due to life's learning and experiences," says the Office of the President.*



BY MADELINE BOSCOE

*Commencement remarks (abridged), delivered at the University of Ottawa*

**MADAME CHANCELLOR, MEMBERS OF THE UNIVERSITY OF OTTAWA'S ACADEMIC COMMUNITY, AND INVITED GUESTS. I AM PRIVILEGED TO BE HERE WITH YOU TODAY. ESPECIALLY TO BE IN A UNIVERSITY THAT HAS IDENTIFIED RESEARCH ON WOMEN'S HEALTH AS A PRIORITY.**

Since learning I would receive this honor, I have been trying to figure out what insights or lessons I could share with you that might have some meaning on this special occasion.

There are some, which I believe, could be useful to you as you go forward as health care providers, researchers and citizens. Lessons that I am confident will contribute to better health for women, and also, better health for men.

I have been lucky. I've been able to spend my time working to advance the health and status of women with an extended and diverse community: the women's health movement.

I can visualize my colleagues standing here with me this evening. And I see this award being given to me as really an award for our collective work.

Like most social movements, the women's health movement has given voice to those who are often marginalized by society and given limited, if any, decision making power in setting health policies and priorities.

It rose out of, and with, the broader women's movement—with shared critiques and dissatisfactions. It was a growing rejection of the narrow and unequal social roles forced on women, roles that undermined our social as well as health status. We were very concerned about a health care system that did not—and still, often, does ►

## CANADIAN WOMEN'S HEALTH MOVEMENT CELEBRATED

not—take women into account. We were frustrated as recipients of care and as those who worked providing care.

We—and we used the word “we” intentionally to ensure we maintained a commitment to equity, and to resist thinking that some of us were more “expert” than others—we came together to share experiences and knowledge. We looked at our cervixes, fitted diaphragms, fought for home care and “caught” babies.

We shared stories about our interactions with the medical system. And we started asking questions.

We came to understand that knowledge is power—and sought to get our experiences counted as knowledge. We realized that those who formulated the research questions controlled the answers. And so, we initiated our own research, about the problems that concerned us most.

*“Like most social movements, the women’s health movement has given voice to those who are often marginalized by society and given limited, if any, decision making power in setting health policies and priorities.”*

Through discussion and debate, we developed new approaches to health care services, approaches that would not over-medicalize our health and well-being.

For example, we looked at the high use of tranquilizers and mood elevators and realized that we were not “mad,” but we were angry; angry that the impact of poverty, violence and racism on our health was ignored. Angry because much of the focus on our health was because we were seen as “containers” for developing fetuses or because we were seen as the (unpaid) agents to provide health information and care within our families and communities.

We understood that access to reproductive health care was critical to the equality and human rights of women.

We were frustrated that normal events in our lives, like birth and menopause, were reduced to abnormalities requiring interventions.

In short, we understood that women’s health is a political, social and economic matter and, to quote Sharon Batt, a long-time breast cancer activist, we would be “Patient No More.”

When I think of some of the projects with which I am currently involved—preserving and enhancing medicare, organizing public involvement in decisions about the “safety” of breast

implants, advocating for access to midwifery or birth centres, and drawing on the work of colleagues in Quebec to implement “anti-poverty legislation”—a couple of themes emerge.

One is about the need for changes in the relationships between health care providers and their clients/patients and the other is related to the role that we, as health professionals, can play within our democracy.

On the wall of my office is a quote from a woman who participated in an endometriosis support group I facilitated years ago. “The more I know, the fewer doctors I can talk to,” she said. What did she mean by this?

Several things, I think:

- that she had had to become an expert in her own health issues;
- that she was not prepared to blindly accept the information or treatments suggested to her; and

- that, by asking questions and questioning the status quo, she created tensions between her and her health care providers—to the point that, at times, her providers began to see her, and patients like her, as “bad patients” to whom they did not want to provide care.

She already knew that we need to rethink how we structure care. That new approaches are called for, ones that:

- engage our patients/clients much more directly in the design of, and control of, health care delivery services;
- encourage innovative services models;
- are based on multidisciplinary teams of providers with professionals and para-professionals working together;
- engage citizens in the development and synthesis of research; and last but not least,
- provide for new collaborative and equal relationships between health care providers and the citizens we serve.

As well, we need to rethink our roles as health educators—even when we are not at work.

Health care providers have a long history of contributing to advancing healthy public policy: safe water and waste

management, nutrition programs, the value of good hand washing and tobacco control, to name but a few examples.

We have always been advocates for public health.

I believe there is, now, a critical leadership role for all of us to promote the understanding that health is, in many ways, a product of, or one could say, a “side effect” of, public policy, and not just of personal behavior.

Health care providers have always understood intuitively that poverty is hazardous to health—not only for those living in poverty but to the health of everyone.

We urgently need to help the rest of society understand this relationship—that social exclusion and inequities in income affect the health of all. It will take time, but is no less challenging, I think, than explaining the germ theory or the relationship between smoking, depression and heart disease.

And so, I urge you to get involved, get involved in minimum wage reviews, demands for supportive housing programs, reviews of the tax structure and other public policy debates that affect health. If we fail to reduce poverty and social inequality in our society, we will never fully be able to protect or improve the health of women—or men....

All of us can learn, and learn richly and deeply, from the critical voices working on the margins of society. Remember: “First do no harm,” and that compassion and empathy are critical skills for the work that awaits you. Seek joy. And, have the courage to challenge assumptions and to make a real difference. 🍷

Full commencement remarks available at: [www.cwhn.ca/resources/cwhn/madSpeech.html](http://www.cwhn.ca/resources/cwhn/madSpeech.html)

## Gearing up for a review of Canada's *Women's Health Strategy*

# The Canadian Women's Health Network wants to hear from you!

Health Canada has recently announced a plan to review the current *Women's Health Strategy*, and more importantly, to develop a renewed action plan. This is great news.

In preparation for this review, the CWHN will be undertaking an informal outreach and consultation project in the coming months. The results of this work will be compiled into a report to be presented to the Federal government.

### What is the Women's Health Strategy?

The Women's Health Strategy arises from Canada's international and national commitments to gender equality. Adopted in 1999, the overarching goal is to advance the health of women in Canada by improving the responsiveness of our health system to women and women's health.

The four objectives of the Strategy outline a commitment:

- To ensure that Health Canada's policies and programs are responsive to sex and gender differences, and to women's health needs;
- To increase knowledge and understanding of women's health and women's health needs;
- To support the provision of effective health services to women;
- To promote good health through preventive measures and the reduction of risk factors that most imperil the health of women.

In order to meet these goals, the Bureau of Women's Health and Gender Analysis is responsible for promoting and advancing the Strategy within Health Canada.

### How you can contribute

You can help by letting us know what you think. The objective of our survey is to collect the opinions of Canadians on the relevance of existing goals and activities of the Strategy, and new issues and solutions for the future. We would also like to identify groups and individuals that would like to be engaged in the review process in an ongoing way.

In order to get your views and opinions, we have posted a survey on our website (also available in paper format). Volunteers will also be hosting some informal and thematically based discussions in regions across Canada (locations to be determined).

*To participate in our survey, become involved in consultation meetings, or for more information, visit [www.cwhn.ca](http://www.cwhn.ca) or call 1-888-818-9172.*

To see the full document of *Canada's Women's Health Strategy* (1999), visit: [www.hc-sc.gc.ca/ahc-asc/pubs/strateg-women-femmes/strateg\\_e.html](http://www.hc-sc.gc.ca/ahc-asc/pubs/strateg-women-femmes/strateg_e.html)

# *First National* **WOMEN'S HEALTH ROUNDTABLE** *and Reception on Parliament Hill*

BY MONA DUPRÉ-OLLINIK

ON FEBRUARY 22, 2005, parliamentarians and women's health experts gathered "on the Hill" for the First National Women's Health Roundtable and Reception. Hosted by the Canadian Women's Health Network (CWHN), this event recognized the contributions that parliamentarians make to their communities and our country as "health ambassadors."

Almost 50 health advocates, key researchers and representatives from various health professional organizations across Canada, including the CWHN, and the Centres of Excellence for Women's Health joined in Ottawa to share our knowledge and explore how we can support parliamentarians' ongoing work. This was also an opportunity to discuss with key decision makers the importance of women's health to the well-being of our nation.

Women's health issues cross party lines and representatives from all parties in the House of Commons attended, along with several Senators. All clearly demonstrated their commitment to improve the health of girls and women in Canada.

A highlight of the event was a round table discussion exploring women's health issues emerging as priorities for the second half of this decade, 2005-2010, chaired by the Honourable Senator Maria Chaput (Manitoba) and Dr. Abby Lippman, CWHN Co-Chair and Professor of Epidemiology at McGill University.

The speakers included the Honourable Carolyn Bennett, Minister of State, Public Health (LIB); the Honourable Senator Lucie Pépin, member of the Social Affairs, Science and Technology Senate Committee (LIB); Bonnie Brown, MP (LIB), Chair of the Standing Committee on Health; Nicole Demers, MP (BQ); Anita Neville, MP (LIB), Chair of the Standing Committee for the Status of Women; Jean Crowder, NDP Health Critic; and Steven Fletcher, Conservative Health Critic. Prepared remarks from the Honourable Liza Frulla, Minister Status of Women (LIB) were also presented.

This round table discussion explored the importance of relationships between Parliamentarians and women's health experts as crucial to keeping informed about issues and to ensure the collaborations necessary to advance a comprehensive women's health agenda.

Speakers noted how the work of women's health experts has helped them "connect the dots" so that issues do not get lost in one department, and so that the health implications of diverse policies are recognized. Almost all recognized the importance of the determinants of health, in particular, gender, poverty, violence, aging, race and culture, for understanding women's health, and acknowledged the need to focus policies around and on these concerns.

Some of the up-and-coming issues that were identified by the speakers included the urgency of creating a regulatory agency for assisted reproductive technologies, ensuring the safety of pharmaceutical products for Canadians, the lack of resources for home care and mental health, as well as Aboriginal women's health needs—in particular, the importance of training a range of Aboriginal health care professionals. Some of the speakers also addressed the importance of implementing gender-based analysis (GBA) for all policies in all departments.

Many also agreed that there is an urgent need for "evidence-based" decision making in policy decisions, and also stressed the need for "citizen engagement" to help the government ensure that there is a cooperative approach to the issues.

A reception followed the round table discussion and provided the chance for more informal conversations amongst the participants, networking with peers, and in depth discussions with decision makers.

There are hopes and plans to revisit this experience in the following year with a Second National Women's Health Roundtable and Reception, so that we may, once again, bring women's voices to the national health agenda. ☺



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# information, **not** ADVERTISING

**Women want reliable drug information,  
not drug advertisements**

*From DES Action Canada*

BY ELLEN REYNOLDS, WITH BACKGROUND FROM BARBARA MINTZES

**IT SEEMS THAT EVEN WHEN WE DO KNOW HISTORY, WE'RE DESTINED TO REPEAT IT.**

In 1948, diethylstilbestrol (DES) was advertised to women as the “wonder drug” recommended for all pregnancies. The face of a cherubic infant grinned up from the pages of medical journals next to the caption: “Really? Yes, *desPLEX* to prevent abortion, miscarriage and premature labor...bigger and stronger babies too.”

Advertising works. It worked for DES, which was prescribed to an estimated 200,000 to 400,000 pregnant women in Canada between 1941 and 1971. Despite sci-

entific evidence from 1952 that proved DES did not prevent miscarriage, this harmful drug was advertised and prescribed for 18 more years. Only after it was linked to cancer in the daughters of women prescribed DES was it finally restricted for use in pregnancy. Those exposed to DES continue to face the effects of infertility, reproductive abnormalities and cancer decades after initial exposure, with other possible third generation effects still unknown. ▶

## INFORMATION, NOT ADVERTISING

But that was over 30 years ago. Surely we've learned that prescription drug advertising needs careful regulation. Apparently not.

We only have to look at the recent news surrounding the arthritis drug Vioxx that is credited with causing thousands of senseless deaths from heart attacks. During its five years on the market, its manufacturer, Merck, spent around US \$500 million advertising the drug to the American public (with spillover to a Canadian audience). Vioxx was no more effective than other similar drugs to treat arthritis symptoms, it was a lot more expensive, and turned out to be much less safe.

It is time to remember the DES legacy, including the lesson that prescription drug marketing cannot continue to upstage science. And prevent the same mistakes from being made again and again.

Back in the 1950s and '60s, doctors were the target for most drug advertising. Direct-to-consumer advertising of prescription drugs wasn't permitted in any form in Canada. We can only imagine how many more people would have been exposed to DES if it had been promoted on television, billboards, bus shelters, newspapers and magazines as prescription drugs are today.

What many people don't realize is that direct-to-consumer advertising is still illegal in Canada, as it is in almost all industrialized countries of the world, with the exception of the United States and New Zealand. The reason we are bombarded with drug advertising in this country is that Health Canada isn't adequately enforcing the law, and companies have rushed to take advantage of this situation.

Most of us have seen the ads that slip past the border in American magazines and on cable television. But prescription drug ads created for a Canadian audience are slightly different. A 1978 amendment to *The Food and Drugs Act* was introduced to allow consumers to compare drug prices. Advertisers were permitted to post the drug's name, price and quantity as long as they made "no other representations." However, in November 2000, citing the 1978 price advertising clause, Health Canada published a policy paper saying

that companies could advertise prescription drugs as long as they didn't include the drug's name and information on its intended use in the same ad.

The law hadn't changed—just its interpretation. Needless to say, drug companies are taking advantage of this legal loophole to introduce more and more direct-to-consumer advertising. And Health Canada is letting it happen.

So we see "help-seeking ads" that encourage the public to call a 1-800 number if they're suffering from obesity, high blood pressure, high cholesterol, sexual dysfunction and more.

Or branded ads that name a drug but don't refer directly to the condition it treats. Neither type of ad fits with the intent of *The Food and Drugs Act*. It is not incidental that most of these ads seem to be targeted to women, all with the aim of "improving" the quality of her life—with a pharmaceutical cure.

In April 2004 in the report *Opening the Medicine Cabinet*, the Standing Committee on Health admonished Health Canada for a lack of enforcement and vigilance. Among other recommendations, they highlighted the need to increase transparency and improve post-market surveillance of prescription drugs; the Committee also stated that Health Canada should enforce *The Food and Drugs Act* by enforcing the ban on direct-to-consumer drug advertising.

Yet, as part of the current legislative renewal process at Health Canada, the department seems to be proposing the exact opposite—legalization of direct-to-

consumer advertising of prescription drugs as a form of public "information."

Advertising is an effective business tool. It sells products. That's why companies spend billions of dollars each year on drug marketing budgets—a lot more than is spent on drug research and development. Women in particular are considered a lucrative market for pharmaceutical marketers, and convincing women that they need medical interventions for natural life cycles, such as menopause or aging, means profits for pharmaceutical coffers.

But advertising does not provide reliable public information.

Advertising sells products. That's why companies spend billions of dollars each year on drug marketing budgets.

Prescription drug ads are often misleading. They downplay the risks, exaggerate benefits and imply that drugs may be used to treat a wider range of conditions than they are approved to treat. The ads also focus mainly on the newest drugs available—drugs that are usually more expensive and not necessarily the most effective or safest choice. The Vioxx example proves the point once again. With celebrity endorsements, free trial offers and emotive imagery suggesting complete relief, was the public ever really being “informed” or “educated”?

Let’s quit heaping illegal advertising down the throats of Canadians who are simply looking for reliable drug information. Let’s learn from the mistakes of the past and take our cue from most other industrialized nations of the world where direct-to-consumer advertising continues to be illegal.

Look to the European Parliament where an attempt to introduce direct-to-consumer advertising in 2002 was soundly rejected in the name of public health. Parliamentarians voted

overwhelmingly against legalizing direct-to-consumer advertising and stated that the pharmaceutical industry was “incapable of providing impartial information on its medicines.”

When will Health Canada come to the same logical conclusion? It’s time to stop this drive to legalize direct-to-consumer advertising of prescription drugs in Canada—before it’s a done deal. 🌊

*For more information on DTCA legislation in Canada, visit the website of Women and Health Protection:*

*[www.whp-apsf.ca/en/documents/doc\\_index2.html#dtca](http://www.whp-apsf.ca/en/documents/doc_index2.html#dtca)*

*For more information on DES in Canada, visit DES Action Canada: [www.web.net/~desact/](http://www.web.net/~desact/)*

*Ellen Reynolds is the project coordinator at DES Action Canada and lives in Victoria, BC. Dr. Barbara Mintzes is a drug researcher and vice-president of DES Action Canada.*

## REMEMBERING RUTH COOPERSTOCK:

# Women and Pharmaceuticals 20 Years Later

### Mark your calendars for Tuesday, November 1.

Women and Health Protection, in collaboration with the Ruth Cooperstock Memorial Lectureship Committee, is co-sponsoring a symposium called “Remembering Ruth Cooperstock: Women and Pharmaceuticals 20 Years Later.”

The event will include three concurrent workshops from 2 to 5pm:

- **“Healthy health policy: encouraging alternatives to drug therapy” with Warren Bell**
- **“Diane, Julie, Jasmin . . . who are these women and what are they doing in your medicine cabinet?” with Barbara Mintzes**
- **“The medicalization of women’s sexuality” with Leonore Tiefer.**

The workshops will be followed by a reception with light refreshments, prior to a panel discussion that will take place from 6 to 8 pm.

Panelists Connie Clement, Paula Caplan and a representative of Women and Health Protection will speak on the theme, “Women and Pharmaceuticals, where have we come from, where are we now, and where are we going?”

The symposium will take place on the University of Toronto campus.

**For more information, visit: [www.whp-apsf.ca](http://www.whp-apsf.ca)**

# NATIONAL WORKSHOP *for* CANADIAN WOMEN *with* DISABILITIES

To address  
concerns  
with urban  
environments

*From the National Network on Environments and Women's Health*

BY GAIL LUSH, WITH ASSISTANCE FROM  
FRAN ODETTE, EDUCATION WIFE ASSAULT



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WHILE HEALTH SERVICES AND PROGRAMS HAVE TENDED TO FOCUS ON BIOLOGICAL ASPECTS OF CANADIAN'S HEALTH NEEDS, THERE IS INCREASING RECOGNITION OF HOW A RANGE OF SOCIAL AND ECONOMIC FACTORS AFFECT OUR HEALTH. NO ONE UNDERSTANDS THIS BETTER THAN THE WOMEN AND MEN WHOSE OPPORTUNITIES FOR HEALTH HAVE BEEN NEGATIVELY AFFECTED BY INACCESSIBLE BARRIERS TO SAFE AND AFFORDABLE HOUSING, TRANSPORTATION, EDUCATION AND TRAINING, AND THE GOODS AND SERVICES THAT PROMOTE WELLNESS.

In the past decade, research related to the health status of women with disabilities has been carried out by the women themselves, and is beginning to bring to light the ways in which health care providers and policy makers can meet the full range of their needs and concerns.

Women with disabilities living in urban environments

are particularly concerned about how the organization of city spaces (where they live, work and seek services) affect their health and well-being. While well-populated communities can offer greater options for employment, entertainment, education and health services, discriminatory attitudes toward women with disabilities have a dis-

appointing impact on their desire to benefit from these opportunities, and fully participate in urban life.

In a recent consumer survey, Canadian women with disabilities indicate that they face a range of physical, environmental, attitudinal, communication and structural barriers to health care and services (Council of Canadians with Disabilities, 2004). As Fran Odette from Education Wife Assault says, “one of the issues impacting the health of women living with disabilities (WWD) is the lack of accessible services that focus on all facets of sexual health, including reproduction. Oftentimes, many of us do not get our annual pap tests because of inaccessible examination tables or the assumption by practitioners that wwd are ‘asexual’ and therefore, at less risk for gynecological concerns or STIs.”

Many of the disability-related barriers to health services are further compounded by factors, such as ageism, heterosexism, cultural discrimination, language barriers, racism and barriers to employment.

Since 1996, the National Network on Environments and Women’s Health (NNEWH), housed at York University in Toronto, has been coordinating projects between community representatives and academic researchers that promote equitable access to health services for women. NNEWH is currently one of four Centres of Excellence for Women’s Health that is supported by the Bureau of Women’s Health and Gender Analysis to increase knowledge and understanding of women’s health, and to ensure that the health system is responsive to women’s needs and concerns.

Over the next three years, NNEWH will continue to work for change by collaborating with women with disabilities, including researchers, policy makers,

and disability activists on a three-phase project entitled *Urban Women’s Health and Disabilities*. This project will provide women with disabilities across Canada a clear and strong voice in the strategies, supports and policy responses needed to remove health care barriers in urban environments.

**Women with disabilities living in urban environments are particularly concerned about how the organization of city spaces affects their health and well-being.**

To carry out Phase I, NNEWH has been awarded a Canadian Institutes of Health Research (CIHR) workshop grant through the Institute of Gender and Health. This grant will allow the Network to organize a national, virtual workshop, where women with disabilities can discuss health barriers well beyond issues about physical accessibility. This workshop will be conducted in French and English through the use of web-based technology on Enablelink, maintained by the Canadian Abilities Foundation.

In the autumn of 2005, project participants will be invited to log on to real-time chat rooms and message

boards from their home computers and community access sites. Four main focal areas of the discussion will include reproductive health services, primary health services (e.g., general practitioners, hospitals and clinics), mental health services and health services related to violence and abuse.

Women interested in participating will be mailed a package, prior to the workshop, containing information about the overall project, a consent form, an evaluation form about the project, and a short survey to help team leaders identify and establish access needs for participation.

Outreach efforts for workshop participation will be inclusive of all women with disabilities including, but not limited to, racialized women, Francophone women, women contending with mental health issues, women who are deaf, deafened, or hard of hearing, and transgendered women.

Discussions between women with disabilities in the workshop will help the team identify the issues and questions needed to plan the research for Phase II. Recommendations based on the final results will be launched publicly during Phase III, and communicated through policy briefs, press releases, quarterly updates in *Abilities* magazine, community and academic publications, and presentations to key stakeholders in the health sector. ☺

*For information about this project or to learn how to become involved, contact Sandra Kerr at [skerr@yorku.ca](mailto:skerr@yorku.ca) or (416) 736-2100, ext. 20715. Or visit NNEWH’s website at [www.yorku.ca/nnewh](http://www.yorku.ca/nnewh)*

*An earlier version of this article appeared in *Abilities* magazine (Spring 2005).*

# Canada needs a **Health and Healing Strategy** for First Nations, Inuit and Métis women

*Health system fails most Aboriginal women across the lifespan*



*From the Aboriginal Women's Health and Healing Research Group*

**F**IRST NATIONS, INUIT AND MÉTIS WOMEN CONTINUE TO ACCEPT BOTH TRADITIONAL AND MODERN ROLES AND RESPONSIBILITIES IN HEALTH AND HEALING. SUSTAINING THESE EFFORTS IS CRITICAL IF FAMILIES AND COMMUNITIES ARE TO SURVIVE AND THRIVE, AND ABORIGINAL CULTURES ARE TO HOLD A DISTINCT PLACE IN COMMUNITIES AND IN THE LARGER SOCIETY.

Pre-colonial and contemporary traditions help to define First Nations, Inuit and Métis women, but global or all-inclusive approaches still mask the experiences, interests and concerns of female infants, children, youth, adults and elders in these communities. Despite some gains, the health system fails most Aboriginal women across the lifespan and over generations.

The Cree word *kitimakisowin* refers to poverties of all kinds, notably those fundamental human needs that are not adequately met and which eventually lead to health and healing problems. First Nations, Inuit and Métis women suffer from the:

- **Poverty of subsistence** due to food insecurity, climate change, lower average incomes than men, lone parenting,

homelessness and matrimonial property provisions in the Indian Act;

- **Poverty of sexual and reproductive health** from inadequate or inaccessible forms of contraception, lack of control over one's fertility, devaluation of Aboriginal girls and women as sexual and reproductive beings, sexual abuse, cervical cancer and sexually transmitted diseases like HIV/AIDS;
- **Poverty of identity** due to forced disenfranchisement, forced urbanization and the residential school legacy;
- **Poverty of safety and security** due to spousal and family violence, incarceration, disabilities, motor vehicle accidents, poisonings, diabetes and poor drinking water;

- **Poverty of mental health** due to historic trauma, depression, suicide and substance abuse;
- **Poverty of participation** due to discrimination based on gender, race, class, sexual orientation and age, chronic health problems and “burn-out”; and
- **Poverty of power and knowledge** due to research gaps, capacity deficits, loss of culture and languages and gender inequality.

Many First Nations, Inuit and Métis women face *impahi-kitimakisowin*—a Cree word for deadly or extreme poverities—and are at very high risk of severe emotional, mental and spiritual problems, and premature death.

Gender equality is imperative for securing the health and healing of First Nations, Inuit and Métis women. In this respect, we need a Health and Healing Strategy for First Nations, Inuit and Métis women. This Strategy must conform to Health Canada’s Women’s Health Strategy and Health Canada’s Gender-based Analysis Policy, and pay special attention to Indian and Northern Affairs Canada’s Gender Equality Analysis Policy, without losing sight of health determinants, intersectoral approaches and ongoing health reforms.


A Strategy would also go some distance in promoting the explicit recognition of First Nations, Inuit and Métis women by the federal government and male dominated Aboriginal organizations, along with guaranteeing equal health and healing opportunities and outcomes. Eliminating discriminatory and exclusionary practices foisted on First Nations, Inuit and Métis women, and supporting balanced gender relations will require government support.

## Many First Nations women are at high risk of severe emotional, mental and spiritual problems, and premature death.

A gender-based analysis (GBA) has to be adopted in First Nations, Inuit and Métis communities and in all Aboriginal policy. A GBA should acknowledge Aboriginal women’s dual emphasis on health and healing, giving weight to the absence of disease and to existing strengths like resilience, spirituality and cultural traditions. A Strategy could seek to determine the actual

capacities of First Nations, Inuit and Métis women in promoting the well-being of families and communities. Currently they include praying to the Creator for divine grace; reasoning through research and being personally involved in resolving difficult social and health problems.

Aboriginal women’s organizations like the national Aboriginal Women’s Health and Healing Research Group (AWHHRG) present a way for getting and holding public influence and services for women. The AWHHRG has hosted two national gatherings in which Aboriginal women researchers have been able to identify the connection between health research and change at the community level. The AWHHRG is an emerging organization that is increasing the capacity of Aboriginal women to influence policy through research, advocacy and participation at all levels.

It is essential that we develop a health and healing strategy for First Nations, Inuit and Métis women that considers the perspectives of these important groups of women, and that examines overlapping health and healing options. 

**The Aboriginal Women’s Health and Healing Research Group (AWHHRG)** is a national network of First Nations, Métis and Inuit women researchers interested in community-based research focused on the health and healing of Aboriginal women, their families and communities. The AWHHRG receives financial support from the Women’s Health Contribution Program, Health Canada, and is working toward the establishment of a Centre of Excellence for Aboriginal Women’s Health and Healing. For more information contact [carawehkamp@sympatico.ca](mailto:carawehkamp@sympatico.ca) or visit [www.centres.ca](http://www.centres.ca)

## WHAT WE'RE READING | recommended resources from our library

By Barbara Bourrier-LaCroix, Information Centre Coordinator, with Ghislaine Alleyne

### Inaugural International Institute on Gender and HIV/AIDS: Strengthening the Connection Between Practice, Policy and Research

**Barbara Clow (International Institute on Gender and HIV/AIDS, 2005)**

The Inaugural International Institute on Gender and HIV/AIDS (IIGHA) was held 7-11 June 2004 at the Kopanong Conference Centre in Johannesburg, South Africa. Eighty-eight participants, including senior government decision makers, researchers, programme managers and practitioners, activists and advocates from Botswana, Canada, Lesotho, South Africa and Swaziland, gathered together with representatives from regional and international organizations. They met to share their experiences and expertise on the HIV/AIDS pandemic, and to build partnerships and capacity to address the role of gender in HIV prevention, treatment, care, support and impact mitigation, share expertise and experience, and enable mutual learning based on good practices and lessons learned.

The goal of the Institute is to strengthen the connections between practice, policy and research in order to enhance or extend existing efforts to tackle issues of gender and HIV/AIDS through the creation of a global network of expertise on gender-based analysis and planning in HIV/AIDS.

This document not only provides us with a comprehensive report of the conference, but also introduces and presents the rich history of the Institute. Available online, in PDF format at [www.acewh.dal.ca/IIGHA\\_files/IIGHA\\_2004\\_final\\_report.pdf](http://www.acewh.dal.ca/IIGHA_files/IIGHA_2004_final_report.pdf)

#### Retro Woman:

#### Navigating Advanced HIV/AIDS Treatment CD-ROM (BC Persons With AIDS Society, 2004)

Women with HIV/AIDS face unique clinical issues. They are often diagnosed later and generally have poorer access to care and medications. Women tend to have higher viral loads and lower CD4 counts. They must also contend with vulnerability related to reproductive issues and domestic violence. Finally, women living with HIV/AIDS are usually relied upon to meet the care needs of children and other family members.

HIV-positive women, and their health care providers, need access to treatment information on topics specific to women, such as disease progression, gynaecological health, side effects, hormones, gender and viral load, sexually transmitted infections and antiretrovirals. Recognizing this need, the BC Persons With AIDS Society and the Positive Women's Network developed this comprehensive CD-ROM. Users will find fact sheets, articles and lectures all relating to HIV treatment (and some pretty cool animation in the introduction!)

### Beyond the Blues: A Guide to Understanding and Treating Prenatal and Postpartum Depression

**Shoshana S. Bennett and Pec Indman (Moodswings Press, 2003)**

Becoming a mother—either for the first or fifth time—is a life-altering event. And contrary to popular belief, motherhood isn't instinctive and it certainly isn't easy. Feeling sad and anxious and depressed after childbirth makes it even harder, especially when people tell you to "cheer up," or "you just need some more sleep."

Our healthcare providers rarely screen for postpartum depression, yet it is a real condition that can have many negative effects on our health, and our babies' health. Thankfully, the authors of this work are around to help! This small book provides a large amount of information about risk factors, diagnosis, treatment and prevention of mood disorders in pregnancy and postpartum. It's written not just for sufferers of postpartum disorders, but also their families and healthcare professionals.

I wish I had this book after my daughter was born; I would have learned that I wasn't alone and that I could have gotten the help I needed. This book should be required reading for anyone working or caring for pregnant women.

### Prenatal Genetic Testing Facts

**The Roeher Institute with the National Network on Environments and Women's Health (2005)**

Faced with the results of prenatal testing procedures such as fetal ultrasound, maternal serum screening (MSS) and chorionic villus sampling (CVS), future parents may find themselves unprepared to make decisions based on balanced and accurate information. This fact sheet presents some basic information about prenatal tests, the ethics of testing, and an overview of how prenatal diagnosis has developed into such a ubiquitous part of pregnancy. The resource also provides a discussion of the relationship between prenatal testing and negative perceptions of people with disabilities, arguing that these two issues are very much intertwined. Also included is a list of resources for individuals and couples seeking information and assistance.

For copies of the fact sheet, contact The Roeher Institute at: [info@roehler.ca](mailto:info@roehler.ca) or (416) 661-9611. The fact sheet can also be downloaded from the National Network on Environments and Women's Health: [www.yorku.ca/nnewh](http://www.yorku.ca/nnewh)

### Lose Weight... or be Yourself?

**(Association pour la santé publique du Québec, 2004)**

"Lose weight while you sleep." "Lose weight and keep it off for good."

"New scientific breakthrough...a medical miracle!" We've all seen or read these advertisements for quick weight loss. The weight-loss industry offers a multitude of choices for women (and men): diets, meal replacements, weight-loss programs, natural products, and other devices that promise to give us a flat stomach, slender legs and a model-thin figure. But most of these weight-loss products, services and methods do not live up to their promises.

The Association pour la santé publique du Québec (ASPQ) asks, "Should we continue to encourage an industry with such poor performance, an industry that fails to fulfill its promises?" This educational guide provides an excellent overview of popular weight-loss methods and the health risks associated with them. The weight-loss industry is unregulated in Canada, and it is clear that the industry cares more about filling its pockets than fulfilling its promises.

NOW AVAILABLE

## Postpartum Depression

A Guide for Front-line Health and Social Service Providers

by Lori E. Ross, Cindy-Lee Dennis, Emma Robertson Blackmore and Donna E. Stewart  
(Centre for Addiction and Mental Health)

A new guide for front-line health and social service providers who work with pregnant women or new mothers. Particularly useful

for public health and other nurses, new moms' group leaders, lactation consultants, midwives, doulas, family doctors or GPs and obstetrician-gynecologists.

The guide answers key questions that front-line workers may have about postpartum depression (PPD) and presents the most up-to-date research. The guide offers practical, usable advice based on that research, and on clinical experience. It also addresses issues of diversity and provides a uniquely Canadian perspective.

The guide includes information on:

- Risk factors for developing PPD
- Detection of and screening for PPD
- Prevention
- Assessment and referral
- Treatment
- Support for family members
- Self-care for women

For more information, visit: [www.camh.net](http://www.camh.net) or contact 1-800-661-1111.

## Fuelling Body, Mind and Spirit: A Balanced Approach to Healthy Eating

Miriam Hoffer (Sumach Press, 2003)

The Atkins Diet. The South Beach Diet. Shun Carbohydrates. Load up on protein... Women are tired of hearing about fad diet plans that don't really work. The diet industry is just that—an industry. Its only concern is making money. This book challenges the industry by looking at food, eating and women's relationships. The author not only looks at what we eat, but also when, why and how we make the food choices we do. The goal of a healthy, balanced diet shouldn't be to lose weight and be desperately thin. It should be, as Miriam Hoffer shows us, about respecting our bodies and enjoying an energetic, healthy life.

## Shameless magazine

(Toronto: [www.shamelessmag.com](http://www.shamelessmag.com))

Tired of reading *Jane* or *Seventeen* or *Cosmo Girl*? Looking for a magazine for teens that talks about more than just makeup? Introducing *Shameless*, a fresh alternative for smart, strong, sassy young women. Each issue of *Shameless* is packed with articles about arts, culture, current events, profiles of amazing women, health and sexuality advice, and many other hot topics. This is a magazine that prides itself on reaching out to readers who often get ignored by mainstream media, i.e., freethinkers, queer youth, young women of colour, punk rockers, feminists, intellectuals, artists and activists. It really is, as their masthead proclaims, "for girls who get it."

## Policies of Exclusion, Poverty & Health: Stories from the Front

Compiled by Chrystal Ocean

(Wellbeing through Inclusion Socially & Economically, 2005)

We've all heard the statistic: one in five Canadian women is living in poverty. That's more than 2.8 million women. There are too many reasons why more women are poor than men. But what's it like to be poor? For those of us lucky to live above the poverty line, it's hard to imagine. We can read the reports or the research results. However, these documents are written by academics or policy makers who are often outside of the story.

As Lynda Laughlin has said, "Every woman has a story. Too few have a safe place to tell it." Thanks to the Wellbeing through Inclusion Socially & Economically (WISE) project, 21 women now have that safe place. This book contains their stories of what it really means to live below the poverty line, and also how and why it happens. There isn't a lot of happiness in these pages, but readers will find an enormous amount of strength from women that society has tried (and failed) to beat down.

## Young Women Work: Community Economic Development to Reduce Women's Poverty and Improve Income

Molly McCracken, Kate Dykman, Francine Parent and Ivy Lopez (Prairie Women's Health Centre of Excellence, 2005)

Young women work—in their homes, in our community, in schools, with other youth and in the labour force. But young women who live in poverty continue to find themselves unable to make our economy or society work for them. Struggling to stay in school, working for low wages, and lacking childcare, young women face many challenges. At risk of a future living in poverty, and possibly raising another generation to do the same, young women want to work to build a better future and community.

This participatory feminist research project sought to describe the barriers and opportunities for young women in the "new" economy, and outlines Community Economic Development approaches to preventing poverty among young women ages 15 to 24. The authors found that young women are ready and willing to participate in holistic programs that respect their cultural backgrounds, and build strong futures for themselves, their families and their communities. This report is available online at: [www.pwhce.ca/youngwomenwork.htm](http://www.pwhce.ca/youngwomenwork.htm)

## Women in Medicine: A Celebration of Their Work

Ted Grant and Sandy Carter (Firefly Books, 2004)

Many of us may believe that the history of women in medicine is a recent one, dating back perhaps a few hundred years. In actuality, the first known female physicians were in Egypt as early as 1300 BCE. It would take more than three thousand years, however, before Canada would see its first female physician, Dr. Emily Howard Stowe, and about another 150 years before women would make up the majority of the workers in the health care system. Grant and Carter's book is a celebration of these women.

Through photographs we see images of women in all fields of medicine, illustrating the distance they have come and the progress they have made. The images reveal not only female physicians and surgeons, but also nurses, technologists, therapists, physicians' assistants, researchers and volunteers, each of whom is vital and integral to a successful and well-rounded health care system.

### Understanding Lumpectomy: A Treatment Guide for Breast Cancer

Rosalind Benedet  
and Mark C. Rounsaville  
(Addicus Books, 2003)

A common question women ask after getting a breast cancer diagnosis is, "What kind of treatment will I have?" For years the standard treatment was a mastectomy—the surgical removal of the breast. Now women have many options and may be asked by her surgeon to decide between a lumpectomy and a mastectomy. Given the large amounts of conflicting information available, this can be a daunting task. The importance of this book is that it provides women with a reference guide to understanding lumpectomy. The authors cover variations in diagnoses, treatment, adjuvant therapy, and radiation in plain language. Women reading this can then make informed decisions regarding their care.

### Transitions Through the Perimenopausal Years: Demystifying the Journey

Lissa Zala, Andrea Swan and Jerilynn C. Prior  
(Trafford Publishing, 2004)

What is perimenopause? What are hot flashes? Why can't I sleep at night? Is there sex after menopause? These are all questions too frequently heard from women who are leading up to and going through menopause. As the authors learned, women aren't only looking for biological information, they also want to know how perimenopause will impact their daily lives.

Thankfully, women now have a resource to help "demystify the journey." *Transitions*, available in book, video and DVD formats, defines the terms of perimenopause and offers the most recent scientific findings on hormone therapy. Most importantly, the book is based on women's own stories and concerns, and is written by women who have themselves made the journey.

### Estrogen's Storm Season: Stories of Perimenopause

Jerrilyn Prior  
(Centre for Menstrual Cycle and Ovulation Research, 2005)

*Estrogen's Storm Season* is an engaging and thoughtful account of the various struggles many women may experience with perimenopause. Prior teaches the essential facts of perimenopause through stories instead of cold medical diagrams and jargon. In so doing, she proves that complicated medical facts and debates may resonate more with women if they are embedded first in women's actual lives.

## JUST RELEASED! Primary Health Care Reform and Women: A Guide

*From the National Coordinating Group on Health Care Reform and Women*

- Community-based
- Integrated services
- Access 24/7
- Telehealth
- Electronic health records
- Alternative payment methods

### Why are these women's issues and what are the issues for women?

This new guide is intended to encourage debate about primary health care reform in Canada and why it is important to women.

Given that women are both the majority of the users of the health care system and the majority of health care providers, how do we ensure that reforms work for **all** women—no matter where we live, what our income levels, education, language or health issue, our sexual orientation or level of physical disability?

### Women's Primary Health Care Needs

Women's health needs are different from men's, both as a result of differences in men's and women's bodies and as a result of the ways that women live, work, play and study.

### Women's Lives

Women's lives are different from those of men. Overall, women have *less* financial security and *less* social status than men, but *more* responsibility for caring for others. These differences affect our health, our use of the health care system and our ways of responding to the care we receive. If primary health care is going to be effective, it must be provided in ways that recognize that many women have limited resources but significant responsibilities. Primary health care must also recognize differences *among* women.

### Women's Voices, Women's Experiences

Women have a great deal of experience in and with primary health care. However, women's voices are hard to hear in current discussions and reforms and there is little indication that women's views will be included in ongoing decisions about the organization and delivery of primary health care.

Read about these issues, and more, in this important new publication, funded through the Women's Health Contribution Program from the Bureau of Women's Health and Gender Analysis.

*To order a copy of the guide,  
or for more information contact:*

Phone: 1-888-818-9172

Website: [www.cewh-cesf.ca/healthreform](http://www.cewh-cesf.ca/healthreform)

