Vancouver Women's Health Collective
HER VOICE
January 2005

Are you interested in...

Doing research on complementary therapies, reproductive issues, or endometriosis? Knowing about the health resources available to you in your community? Finding a new doctor or therapist? Inviting the VWHC to your meeting to do a women's health workshop?

Then please call our health information line: 604-736-5262, visit our Health Information Centre at 1 - 175 East 15th Avenue in Vancouver, or check out our web site: www.womens healthcollective.ca

Staffed predominantly by volunteers, the information centre is open:

Mondays and Wednesdays
4:00 to 8:00 p.m.

Saturdays
Noon to 5:00 p.m.

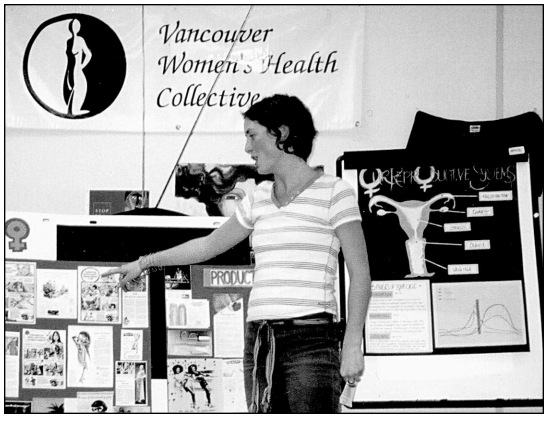
What is Primary Health Care and Why Does it Need Reforming?

Today, primary health care in Canada is about hospitals and doctors. In order to reform primary care, the focus needs to shift from hospitals, prescription drugs and doctors to prevention, health education, and community-based integrated care. We need interdisciplinary teams of health care providers including social workers, nutritionists, midwives, nurses, nurse practitioners, naturopaths, massage therapists, and doctors. These health care teams need to be available in community health centres that are open 24-hours a day, each and every day.

Health Reform is a Women's Issue

The National Coordinating Group on Health Care Reform and Women, in their critique of the final report of the Commission on the Future of Health Care in Canada, *Reading Romanow*, explained that there are at least six reasons why health reform is a women's issue (p. 3-5, Pat Armstrong et al.):

"**First**, care work is women's work."
"**Second**, women are the majority of those requiring health care services."
"**Third**, women have fewer financial resources than men to assist them in getting or giving care."
"**Fourth**, in spite of the fact that almost all health care is provided by women and women are most of those who receive care, women are a minority of those making policy decisions about health care."
"**Fifth**, the emphasis on evidence in the provision of services may also have a negative impact on women because women are less likely than men to be the subjects in developing evidence (Grant 2002)."
"**Sixth**, cutbacks that increase the reliance on purchased care and reforms that fail to accommodate differences increase inequality among women."



VWHC volunteer Hillary Quinn at a workshop on menstruation.

Poverty and Women's Health

Society needs to realize that anti-poverty programs as well as policy that seeks to eliminate women's inequality is health policy. The focus of government tends to be on the health care system and on changing individual health practices. While this is important, we must also pay attention to income inequality in order to build a healthy community. A livable wage, employment programs, accessible education, affordable housing, a higher minimum wage, public transportation, land use, and community development must be focused on the common goal of improved health.

The 2004 Health Canada report *Surviving On Hope Is Not Enough: Women's Health, Poverty, Justice and Income Support In Manitoba*, states that income has long been recognized as one of the most important of the many determinants of health. "People living in poverty have a lower life expectancy and higher rates of illness across a wide spectrum of diseases" (p.2). And, as we know, women are more likely than men to live in poverty. The Feminist Alliance for International Action recently reported that "57 percent of all persons living in low-income situations in Canada were women." Also,"single mothers and other 'unattached women' are most likely to be poor, with poverty rates for those groups reaching as high as 57.2 percent for single mothers under 65 and 43.4 percent for unattached women over 65 years of age" (*Toward Women's Equality: Canada's Failed Commitment, p.4*.)

In Canada, an inadequate income is the reality for many women who work and all women who rely on social assistance. Social assistance has a very negative impact on women's lives – on their physical and emotional health. Women must deal with the stress of living in a state of dependency on a system that shames them and scrutinizes them. The stress of these conditions not only harms the overall wellbeing of women living on income support, but also worsens pre-existing health concerns.

Today, women earn 73 cents for every dollar a man earns. And many women must deal with the stress of having two jobs – one underpaid job in the workplace and one unpaid job at home. Stress is associated with a wide variety of health problems, such as poor pregnancy outcomes, high blood pressure, diabetes, cancer, respiratory infections, and heart disease. Another reality is that women resort to prostitution and get involved in unhealthy relationships for food and shelter.

The Prairie Women's Health Centre of Excellence study *Women and Health: Experiences In A Rural Regional Health Authority*, states that "women are disproportionately affected by many social factors – such as poverty and violence – that put them at risk for ill health and bear a high burden of health

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Women Need Community Health Centres

Community health centres are an important part of primary health care reform. Ideally, a community health centre would offer patients preventative care as well as teams of health providers: counsellors, nurses and doctors. Unfortunately, there are only a handful of these centres in BC: the Mid-Main Community Health Centre and REACH Community Health Centre in Vancouver, and the James Bay Community Health Centre in Victoria. We need more community health centres accessible to women across the province.

Sexist bias favouring men is entrenched in the Canadian medical system, from research that focuses on the health of men over women, to the fact there are still so few women doctors and specialists in the current system. So how will community health centres improve health care for women? Community health centres could address and eliminate many of the obstacles women face to accessing appropriate, quality health care.

- Women often live below or close to the poverty line, even when employed, therefore affordable or free health care at community centres (counselling, massage, eye examinations, support groups) is a necessity.
- Most traditional medical clinics only have general practitioners, the majority of whom are male, while community clinics could provide access to nurse practitioners and other mostly female health service providers.
- Many women both work and are responsible for the health of their families, therefore neighbourhood community clinics, close at hand, would increase the likelihood that women and their families get prompt care.
- Community clinics could ensure that their doctors offer women-centred care and are current with medical research concerning women's health (reproductive health, mental health and prevention and treatment of diseases that primarily effect women).
- A full range of maternity health care services could be available at community clinics.
- Community health centres would offer workshops and health prevention information for women and their families.
- Assistance for women caregivers would also be available so that care giving doesn't just fall on women.
- Health centres could also partner with feminist-based abortion service providers, transition houses, and sexual assault counselling and advocacy groups.

The bottom line is that women face unique challenges to receiving adequate and fair health care. Women should not have to deal with practitioners that exploit them, ignore their concerns, or abuse them. Community health centres that integrate health care and race, class and gender could prove to be the one of the most equalizing health reforms for women – dismantling an archaic male dominated health system.

Belinda Shelton *is a member of the VWHC steering committee.*

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problems linked to reproduction, mental health, family violence, and aging" (p.12).

Poverty enlarges every dimension of inequality. It is a manifestation of long-standing, structural discrimination against women. The continuing unequal social and economic status of women in our society has direct consequences on women's health. Given these realities, equality for women will not be possible until society acknowledges and addresses the gendered nature of poverty and health. Until all women have equal access to education, a livable income, clean water and air, a life free of violence, parks and recreational activities, safe streets, and good housing, women will be at risk of poor health.

Lesia Hnatiw *is a member of the VWHC steering committee.*

New Books at the VWHC Resource Library

Hot Pantz
by Isabelle Gauthier
- gynecological herbal advice and remedies

Some Yoga Asanas for Gynecological Health
(author unknown)
- yoga postures for pain management and endometriosis

Wive's Tales
by Britton
- zine style booklet of gynecological herbal remedies

Witches, Midwives and Nurses - a history of women healers
by Barbara Ehrenreich and Deidre English
- Euro-american feminist history of the medical system

Complaints and Disorders - the sexual politics of sickness
by Barbara Ehrenreich and Deidre English
- how the medical system supports discrimination rooted in sexist, classist and racist ideologies

Nourishing Endometriosis
by Alhena Katsof
- nutritional advice and other information on endometriosis

A Difficult Decision - a compassionate book about abortion
by Joy Gardner
- the physical, medical, herbal, political, emotional and spiritual aspects of abortion

Red Alert #1 - #4
- four classic zines relating to the experience of menstruation, by the Montreal-based feminist organization Blood Sisters

Women who Care too Much

It is no secret that most of the world's caregivers are women. In Southeast Asia, where families are large and social safety nets small, tradition until recently dictated that the eldest daughter remain single, to care first for her younger siblings and later for her aging relatives. In North America, with our more egalitarian attitudes towards gender, we have developed institutionalized arrangements to share the burden of care. But have they succeeded? While health care in particular falls prey to cutbacks and privatization, women in Canada continue to assume informal, unrecognized and unpaid roles as caregivers for other family members, often their own parents. As money for long-term care and home services leaves the public system, the burden shifts to women.

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Many women care for their parents in their own homes. Caring for more independent seniors may include such tasks as housecleaning and shopping, giving baths, accompanying patients to doctor's appointments, ordering health products and prescription drugs and ensuring that they are taken, and preparing and serving meals – activities that can constitute a full-time job. The few who can afford to may pay someone else to do them instead. When they do, it is often a woman from Southeast Asia, who works for low wages to support her own family overseas.

Other women devote many hours a week to visiting parents at care facilities. Without the support of their families, patients in long-term care facilities may not receive the attention they need because the staff (again, usually poorly paid immigrant women) is overburdened with many responsibilities. A friend of mine whose mother died recently from an Alzheimer's-related illness recounted,

"The staff at my mother's home was very reliable, in the sense that they knew the protocols to follow for falls, seizures, or any number of critical incidents. But in order to qualify for public funding, the facility had to maintain a specific staff-to-patient ratio. Many of the patients couldn't eat quickly. My mother took nearly an hour and a half for an average meal. With the number of patients in their care, the caregivers were required to spend no more than half an hour on a meal. They could try to feed a number of the slow eaters simultaneously, but I knew that more often than not, my mother simply wasn't eating as much as she should be. So malnutrition was a constant worry."

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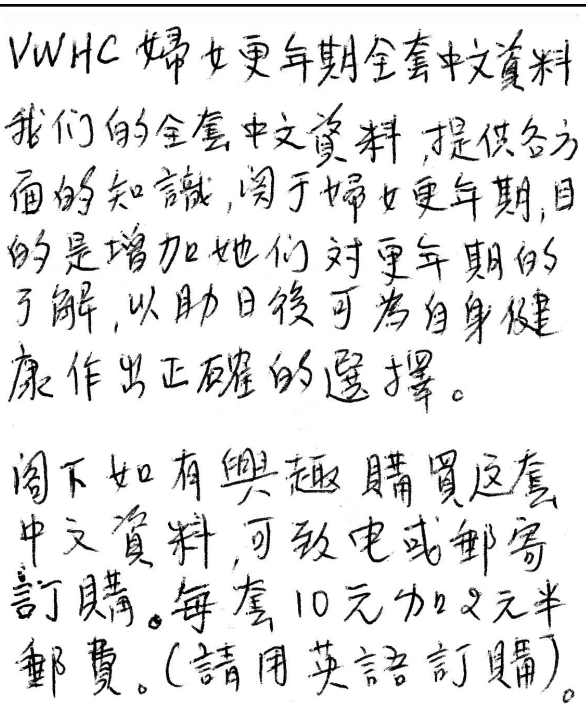
Faced with such concerns, women devote more time to elder care, progressively eroding the time they spend earning a living or engaging in other activities. Not surprisingly, frustration, depression, social isolation and loss of income are well-documented conditions among unpaid women caregivers in Canada. When their parents die, women sometimes find that their social networks have disappeared and they are left with few to turn to for emotional support, compounding their grief.

The greatest need for most women caregivers is simply respite — a break from constantly having to take care of others, in order that they can take care of themselves. Yet there is no sign for most that relief is coming any time soon. The current approach to long-term care requires change. More instead of less funding is certainly crucial. We need to provide more home care options that do not rely on women family members as principle caregivers. We should also recognize that a "one size fits all" approach might not be appropriate for patients with complex conditions. Greater specialization of jobs within long-term care facilities may be one way of achieving that. As Canada's aging population grows, we must find new and creative ways to care for older people that ensure both the patients and the caregivers are getting what they need. Our common health depends on it.

Brenda Belak *is the VWHC's Information Centre Director.*



VWHC Menopause Kit

Our Menopause kit is designed to provide women with a range of information about menopause so they can make more informed choices about their health.

You can contact us by phone or mail to order the kit in Chinese or English for $10 plus $2.50 postage. We regret that we are only able to process requests in English.

Are You an Expectant Mother?

The South Community Birth Program is a publicly funded, primary maternity care service that offers complete care for pregnant women living in Vancouver. A team of doctors, nurses, midwives and doulas provides support through pregnancy, during labour and birth, and after the baby is born. Women have access to regular prenatal care and education sessions throughout their pregnancies with other women who share the same due date. Doulas are available to provide physical and emotional labour support in the woman's own language. Home visits are provided by skilled community health nurses during labour and after the baby is born. The South Community Birth Program focuses on individual women's needs and provides a safe and positive birth experience, while bringing a sense of community for childbearing women. For more information, or to make an appointment call 604-321-6151.

Iona Elgabry *is a member of the VWHC steering committee.*

Maternity Care is Primary Care

Until recently, a pregnant woman would visit her general practitioner for prenatal care, go to the hospital when in labour, be attended by a nurse during labour and have the doctor arrive for the actual birth. This model has changed. Currently only 30.6% of general practitioners in BC actually deliver babies, and this number is continuing to decline as more GPs stop providing obstetric care. Most general practitioners view obstetrics as an inconvenient and time consuming practice with insufficient payment. As a result, more births are attended by specialized obstetricians and gynecologists with increased cost to the health care system.

This problem is compounded in rural areas where a shortage of GPs already exists. Women frequently can't deliver in their own communities. This means pregnant women must travel long distances at both financial and personal cost and have their babies delivered by someone they don't know or trust, far from their own support network. Studies have shown that women who travel great distances to give birth frequently have small, premature infants with increased maternal and newborn complications due to lack of support and delays in transfer to the care centre.

One of the possible solutions to this problem is midwives. The philosophy of care for midwives in BC is, "A woman's caregivers respect and support her so that she may give birth safely and with power and dignity" (College of Midwives of BC , 1997). Midwives provide personal and individualized care by explaining what is happening during pregnancy and involving the woman in decisions about the birthing process. Women form relationships with their midwives so that they have someone they can trust during what may be for some the scariest and most painful experience of their lives. Appointments with midwives are every 3-5 weeks in the first and second trimester, every 2-3 weeks after 30 weeks and weekly after 36 weeks. Appointments usually last between 30-60 minutes, far exceeding the standard time a patient spends with her GP. Midwives provide follow up care for three months after birth with home visits the first week after birth. MSP pays for the services of a midwife, though coverage only provides for one primary caregiver for the duration of a woman's pregnancy and six weeks postpartum care.

Regulated midwifery was established in BC in 1998. As of September 2004, there were 74 registered midwives in the province. Two thirds of them practice in and around Vancouver and Victoria. There is currently a shortage of midwives. This can be attributed to the newness of the regulation of midwifery and the limited space in midwifery programs. Only 10 students per year are admitted at the midwife program at UBC and only 70 new midwives graduate each year in Canada.

Midwifery practice in BC is also constrained by inflexibility in that midwives must attend a certain number of births per year in order to stay current, so part-time

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Women and the Four Pillars Drug Strategy: What's in it for Us?

One year after the opening of InSite, North America's first supervised injection site (SIS), the BC Centre for Excellence in HIV/AIDS has issued a summary report, and the news is all good, so they say. But the report says nothing about the specific problems and crumbling social conditions faced by addicted women. The report has little meaning outside the context of the other three pillars and how they have been implemented (or not) over the past two years.

When city council put an extra 60 police officers in Vancouver's downtown eastside in 2003, it was heavily criticized by women's groups. Extra police officers alone would only drive women in the area – regularly targeted by police as prostitutes – into even darker corners, further from safety. In addition, the pillar of enforcement, which was evidently a detriment rather than a boost to women's health and safety, is only one of the four pillars to materialize thus far. This leaves prevention, harm reduction, treatment, and the lives of those who need these services blowing in the wind.

A year later, many women are still waiting for the goods. Drug treatment, detox and prevention programs are scarce but integral elements to primary care and good health care. The questions remain to this day: How will the establishment of a supervised injection site benefit the prostituted woman, whose primary emergency is the john or pimp she's dealing with? How will it help the battered woman, who needs somewhere safe to stay? How will it help the woman who wants to quit her addiction?

It's worth noting that the police sweep and the supervised injection site both came after the provincial government began announcing extensive cuts to the social fabric of BC. This includes $16 million cut from the Vancouver Coastal Health Authority, a major partner in the Four Pillars strategy. The VCHA is financially responsible for the SIS as well as for providing new treatment and detox beds. It's still unclear why Vancouver got the supervised injection site before more treatment. And while the city is only required to fund enforcement, as per the Vancouver Agreement, it should have modified its budget to provide treatment when the province pulled out. By shirking this responsibility, both levels of government have acted in extreme disregard for women, and all people addicted to drugs.

So we are back where we started. The situation for women, addicted or otherwise, won't get better without meeting the demands we've had all along: a guaranteed livable income, re-instatement of funding to women's centres and legal aid to name a few. As for the Four Pillars, don't believe the hype.

Sacha Fink *is a member of the VWHC steering committee.*

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midwifery practice is often not possible. As well, midwives' caseloads are capped at 40 births per year. Fee-for-service payment for midwives often does not allow for pregnant women who may require more care such as teenage moms and women struggling with addictions. Rural midwives face additional problems as they have limited access to specialists, peer support, continued medical education and often practice in isolation. All of these factors lead to burnout in rural midwives.

Maternity care must be an integral part of primary care reform. Increased space in midwifery education programs is needed. Province-wide quality maternity care is also dependent on the establishment of programs such as the South Community Birthing Program that integrate doctors, nurses, midwives, and doulas into maternity care. As well, the Maternity Care Network, in which doctors form shared care networks to provide maternity services, needs to be expanded. All of these initiatives constitute a small step in the right direction.

Janis Drozdiak *is a member of the VWHC steering committee.*

VWHC Membership Application

Please choose the membership that suits you:

❑ **Individual Member** (women only)	$10-25/yr	$_____
❑ **Community Member/Organizations** (women's organization, health practitioner, union, business, etc.) • As community organizations may include men, we require that you respect our women-only policy.	$50/yr	$_____

All VWHC Members

- Support the mission statement, values, and goals of the VWHC
- Receive the VWHC's newsletter, HER VOICE
- Are invited to special events, workshops, and the VWHC AGM
- Please contact us at 604-736-5262, or vwhc@vcn.bc.ca, if you are interested in becoming a **VWHC Volunteer**.

❑ I wish to make a donation to the VWHC (a charitable tax receipt will be issued)	$_____
❑ Full amount of my membership fee and donation	$_____

VWHC Universal Purpose
Health for all women in an equitable society.

VWHC Mission Statement
We are women who value women's knowledge, support one another to take charge of our own health, and raise awareness and inspire action for the feminist advancement of women's health.

I have read, understood, and support the VWHC Universal Purpose and Mission Statement.

Please sign:_____ Date: _____

Name: _____

Address :_____
(street) (city/province) (postal code)

Phone: _____

Contact Us

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