Vancouver Women's Health Collective
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Interviewer: Kenzie Andrews
Interviewees: Anna-Lise Boye and Caryn Duncan

KA: Alright, there we go. We have the technical problems solved apparently. I will check at that periodically. It is supposed to run about an hour. So it's about twenty after now, so it's probably quater after three if we're still going I'll sort of stop and turn it over. Okay? Alright, so is there anything else we need to discuss before we start getting into perhaps some of the questions that I have brought? Okay, well then. The first question I like to start with is—would like to start with—is maybe if you could tell me a bit about the history of the organization. Now I personally like this question because it provides the context, in my mind, for a lot of the activities that happen within any given organization. So maybe you could tell me a bit about the history, maybe the community that the Health Collective serves, things like that.

AB: Well I know it started in 1971. A woman was angry at the treatment she got from her physician, so she put an ad in the paper asking if there was any other women that felt they had been poorly treated from their physician. And she got a response from a couple of women and they met in the basement of one of the women's homes and they called it a woman's place. And that happened for about a year. And then in 1972 it was officially established as the Vancouver Women's Health Collective. And hence the directory began, and that was where they filed these evaluation forms that they had completed on—and it started off on a rather negative tone. They were completing these evaluations because they were displeased with the service.

KA: Right.

AB: But that actually got them to get in touch with physicians that women were pleased with the treatment and felt they'd gotten appropriate, respectful healthcare from these physicians. And so this practitioner's directory was started with GPs, medical doctors and from there it just blossomed into a variety of therapists and holistic practitioners. Dentists are there. Specialists, medical specialists. And through the thirty years we've done lots of different things. From there I believe, in the documents and lots of newspapers clippings that I've read, that they started a self help clinic.

KA: Okay.

AB: And that came from female physicians and nurses that would volunteer their time at the collective. And they had an examination table and they would show women how to do breast and pelvic examinations.

KA: Okay. Yep.

AB: And I think the idea, from what I've understood, behind it was that this would help educate doctors on the importance of informing women, you know, about self-examinations and being participatory and that. But, what they found in the end was that they weren't educating the doctors, the doctors were just freeing themselves up to take more patients because they knew the

Vancouver Women's Health Collective was doing all this free, wonderful self-examination work. You know, go to the Health Collective, get your Pap smear, fit your diaphram, that sort of thing. So, I don't know how long the clinic would have existed for, but at one point in the, well I guess from the dates you mentioned some publications had come out in the late seventies, early eighties and I know right through the eighties there was money where they got for publications on—Sexually Transmitted Diseases was one booklet, birth control, and then they had the booklets translated into a few other languages.

KA: Okay.

AB: Mandarin, Spanish. We have some of the documents that we've archived. And they actually came—those were small booklets—and then they actually got in the late eighties published six larger booklets and that dealt with a feminist approach to Pap smears, miscarriage, infertility, your first period, avoiding pregnancy.

KA: Right.

AB: And through those years of the eighties, the Health Collective was often found in the community putting on workshops, education forums over a variety of whatever sort of was the main health topic of the time. And we always had the Information Centre, where we have that health resource library, that was always there. And then as they got towards the end of the eighties into the nineties they started to focus a little bit more on the Information Centre and actually expanding that, expanding the directory, expanding the library, the health information.

KA: Okay.

AB: And then we took on a lot of other projects in between that kind of brought us up to the time where Caryn and I came to the Health Collective in '97 where we were still doing educational forums and workshops and, you know, to a variety of community services: colleges, universities, other women's organizations that would call upon us to do that. And then in-house were started to hold 'Still' night and do our own educational workshops on a variety of mainstream women's health topics but also got into the complimentary therapies, we were doing that. And then the Health Collective at one point decided not to reproduce what was already being done out in the community and so we turned our focuses back to the Info Centre and expand that and secure that and extend the hours. And the Health Collective had always questioned why we weren't bringing in enough diversity of women into the Health Collective, you know we knew there were lots of women out there who were needing this health information and they just weren't getting it. And that had been a topic of concern for many, many years. And then about the time when Caryn and I were here came this project called the Community Health Advocacy Project.

KA: I saw that on the webiste.

AB: Yah. And then that was our outreach work. And that still is happening till today where that offers a place for the co-ordinator of the project to go out to the various communities and put on patient rights workshops and allow the women to ask questions and share concerns that they have over there health care treatment.

KA: It sounds almost in some ways that its come full circle, though. In that it started—I guess, well it sounds like it started as almost an advocacy type group, more in the form of support. Coming back that way.

AB: Yah, yah.

KA: So, that means then that the Health Collective is no longer doing things like the educational workshops and that sort of thing.

AB: Nope.

KA: It's focusing on the Community Health Advocacy.

AB: It focuses predominantly on the Health Information Centre.

KA: Centre. Okay.

AB: So when women phone or drop in, if we don't have those services we tap them into what's going on in the community. And the Health Collective decided not to do the educational workshops anymore because there are so many like minded organizations that are doing, you know. We did lots of work on birth control before Planned Parenthood came to be and now they're there you know, so we refer those calls over to Planned Parenthood. You know, lots of other places in the city, health agencies and doctor's offices and naturalpathic places that are putting on educational workshops and so we try to tap into those resources and sort of cycle [?] what's going on.

KA: [?]

AB: Publications, I think that was maybe a little bit of both. The funding. You know, the Health Collective I think in its thirty years of existence always struggled with funding. And, you know, you would getting project funding, so okay that's great, let's do some books. And then then years later well it's time to re-edited them or update them and the money wasn't there, yah.

KA: Right.

CD: But if you place the Collective in the broader society. You know, women were securing funding for their groups in the late seventies, the seventies into the early eighties before the goverment cut backs started at the Federal level.

KA: Right.

CD: And the whole women's movement was vibrant, strong, and moving forward. And they were a group that was supported and funded by goverment projects and that's when we were doing a lot more work.

KA: Right.

CD: 'Cause there was a lot more money funding this sort of work in general. And then the Tories got into power federally and then the money dried up through Health Canada. We haven't had Health, like federal funding for years. Many, many years.

KA: Okay.

CD: So, you know, we to some degree are affected by what's happening, you know, in the broader society and the community. And our programming has reflected that.

KA: Right.

CD: But I think the practitioner's evaluations have been with us from day one. That's what we're known for and that's what to this day many, many women come to visit us for when they're looking for a new doctor or other health practitioner.

KA: Right.

CD: And we are the place for them to come and find out whose accepting new patients and then cross reference those names with the [?] evaluations done on their services.

KA: Okay.

CD: So that's the one mainstay for thirty years, in addition to the fact that we have always been a women only space.

KA: Right.

CD: And that, you know, has been a constant in our organization. I think we've always strived to have a very positive environment where women can come to which I think is reflected here again. No we've had homes, our office has moved, our space has shifted and moved from, you know, I don't know Commercial Drive, to Robson and Burrard, we were at Granville and Broadway when Anna-Lisa and I started.

KA: I visited the Granvilled and Broadway one, office, once when I was doing some research for a Women's Studies course, trying to get some information on the—doing a paper on birth control actually.

CD: So we've always I think tried, like well we have photographs of those old spaces, try to create a welcoming, warm space. And then supported women in the space in different ways. In the past we may have had a clinic, now we make our space available to women who want to meet or we rent this space for a nominal fee to women's groups to do training, so we're supporting other women in other women's organizations by making our space available to them also.

KA: Right.

AB: I think from day one we've always been volunteer based as well. Whether the staff, now we're part-time, half-time but, even when there was full time staff we still, the Information

Centre was volunteer based.

KA: Right.

AB: And a lot of the educational workshops that went on as well, those were volunteer.

KA: It sound though, from what I'm hearing, that the Collective almost takes a much broader sense of health then what you would find in the typical mainstream health care system. You know, providing an environment for people to come, providing information, that sort of thing. Is that an accurate?

AB: Well, yah. We're known for the information we have about complimentary therapy and other alteranatives. We're even thinking of healthfullness, right?

CD: Like I think that the Health Board when they came out a few years ago with the determinants of health and when we looked through those documents and said, yah. Hey, this what we've been doing for a long time.

KA: Okay.

CD: Poverty is a determinant. You know, like there are so many.

KA: Yah.

CD: They're your broader issues that we've always been apart of what our vision of what healthfullness is, it's not just I need an operation or I'm having a baby.

KA: Right.

CD: It's much bigger than that. [?]

KA: Okay. Good.

CD: But in terms of the staffing, Anna-Lisa do you know? Like we are two, Anna-Lisa and I are the two permanent staff. We work half-time.

KA: Okay.

CD: And then there's a third project person and that's Angela who works on the Community Health Advocate Project. And that funding is only annually renewed and we don't know if it's actually going to be renewed this year or not.

KA: Okay.

CD: So we're only three half-time staff, two of us are permanent. But I think in the past the staff compliment has been much greater at times. Like significantly greater. And although our predecessors, there were two women who were here for many years, [we started working in '97

and Rain and Wendy were here for many years right?] through nineties.

AB: Yah. Rain for five years and Wendy for seven years.

KA: Okay. As you were saying earlier, obviously the funding cuts starting in the late, well I guess theTories got in in '84, didn't they? Yah, so, through the eighties. Okay.

AB: Yah, just thinking of those dates too. Another thing the Collective played a big role in was in the years where—and I'm not sure, I think I believe it was the late eighties where the abortion procedures weren't that accessible for women.

KA: Right.

AB: And so the Health Collective played a big part in setting up, you know, funds and ways of getting the women across the boarder to get the procedure done and assisting a lot in helping the women maintain their control of their own bodies.

KA: Okay. Right. I know it wasn't until 1989 that the Supreme Court of Canada finally said that to not provide it was a barrier.

AB: Yah. So maybe it was the middle eighties. Yah, I just know it was in the eighties about that I time. I can't remember all the.

KA: Yah. It was. It was.

AB: And ProCan.

CD: An abortion group that works here presently in Vancouver, it grew out of the Health Collective.

KA: Okay.

CD: And so the abortion movement and the Health Collective were in the same space for many years.

KA: Right.

CD: And then a seperate organization grew out of the Health Collective. What was Pro Can called before?

AB: BC Coalition for Abortion Clinics.

CD: Yah.

AB: When we came in '97, that was the name. That's what they were called.

KA: Okay.

CD: Yah, they grew out of the Health Collective. We were on the Broadway and Granville location, in that space there.

KA: Okay.

AB: There was another organization, Pelvic Inflammatory Disease Society, they also grew out of the Health Collective.

KA: Okay.

AB: I guess in the eighties. I'm not quite sure of the dates. But that was also something that came from the Collective.

KA: Okay. So then there has, on the part of the Collective there has actually been some involvement and a fair bit of impact on policy. I'm assuming both provincially and obviously nationally around at least the whole abortion debate.

CD: Yah. Access to women's centred health too.

AB: Yah.

CD: Pushing for that. Pushing for women centred health.

KA: Right.

CD: And I think we see that, you know, [? voice volume too low to make out words] But certainly the women's ~~CHAR~~ PHAC and the work that's being done at the Health Board level is very much embraces the sorts of things that we have for years. That is women centred Health.

KA: Yah. Okay. Alright. Well then, how would you describe then the community the Health Collective services given the broad range of, or at least the broad range of information that you obviously have available? What does that mean in terms of people who are coming in to use those services?

AB: Well, for the women that drop in and use the services, I would say it's pretty broad. You know. Yah. You know, different walks of life, different socio-economic backgrounds. Yah, yah. I think we research a lot of women that maybe that's just part of their lifestyle and their culture just to drop in.

KA: Right.

AB: So that kind of came about why the Health Collective wasn't serving some of the other groups of women out there that that just wasn't part of their day-to-day life, their culture just to drop in the door in terms of I have a pain in my breast, can you help me?

KA: Right.

AB: So, I think we're a lot, because we've been so focused on that, that we've achieved and worked really hard to get out there. I supposed there's always more women to connect up with.

KA: Right.

AB: And that's something that we were on in the CHA Project.

KA: Right.

AB: You know, we'll have women that are business women, full time, money's not a problem with them, they'll phone in for information and then you'll have other women that will phone and, you know, maybe, you know, can't even afford the bus fare to get down and get information.

KA: Right.

AB: So. A variety of. Yah, a whole variety of.

KA: Do you find that there is any particular attitude or that is common to the women who use a service like this? In that is is women centred. I didn't hear about it until '97 when it was mentioned to me by a TA in a Women's Studies course. I don't know if that might have some?

CD: Oh yah. We're forever going to meetings and someone saying, "Oh! Who are you?" And we'll say, "Well, we've been here for thirty years!" And they're going, Oh! Who are you? Yah, and that's very frustrating. But that's a part of, you know, well it's a product of many things. But, you know, I think also that the women who come to the centre, more so perhaps then the women who call the information line, they are a certain kind of women. They are a woman who is taken some initiatve around their health care. And not everyone is that kind of woman, right?

KA: Right.

CD: That means you've got to be a little more assertive around what your needs are, what you're looking for. You're looking for some complimentary information, you know you're taking the initiative around your health care.

KA: Right.

CD: And so that means, I think that's the women of our, to some degree, who come here. 'Cause they're wanting to take control of their health care.

KA: Right.

CD: But, yah, we're forever searching out ways of raising our profile in the community to get the word out that we exist.

KA: Right.

CD: And, you know, we do tend to have more younger women come in. You know, I think to some degree our volunteer base is a bit reflective, it's not wholly but somewhat reflective of who becomes active in our organization more than the public that we serve which is more broadly based.

KA: Okay.

CD: And that public also includes all of the people that are touched now by the Community Health Advocate Project.

KA: Right.

CD: Which is, that particular project is focused on what the Health Board would describe as demographics. Or, you know, certain women who have particular barriers to accessing quality health care.

KA: Okay.

CD: So, you know, we deal with a lot of imigrant women, poor women, women who are mental health consumers, women who are HIV positive, groups of women who have special health needs or more require more information around their health issues or who have language barriers and cultural barriers. That's what that Community Health Advocate Project focuses on.

KA: Okay.

CD: So clearly we're touching a whole, broad cross section of women in the community that we didn't necessarily touch in the past because we can't provide translation. If a women comes in who English is not enabling her to read our directory or look through the files or even pick up our pamphlet and understand it. You know?

KA: Right. Okay. So the Community Health Advocate Project, is that a largley an information driven project or are there other aspects involved?

CD: It's a patients, it's called Patients Rights Workshop.

KA: Okay.

CD: That's sort of the focus of it and it's about getting women information about health, health care, their rights.

KA: Right.

CD: Everything and anything you can imagine about health care.

KA: Alright.

CD: We try to describe basic things, like what the medical service plan is, what Pharmacare is,

what you can and cann't do in a, you know. Who you can complain to, what is not acceptable treatment. You know, it's just a whole range of information around health care.

KA: Okay. So there's legal issues, there's policy issues, there's access issues.

AB: Yah. [?] A little information kit that's given out to the women there and then depending on the group that the coordinator may be presenting the workship to the information in the kit may vary a bit. [? vl]

KA: And this is done in partnership with the Health Board, is that the?

CD: Well they're paying for it.

KA: They're paying for it.

CD: It's our project.

KA: Okay. So they're the funder.

CD: But if we don't get the money this year with the cutbacks to health we don't know if we'll be offering it in the future.

KA: Right.

CD: 'Cause that is, you know, that was one of the areas where you know as Anna-Lisa said in the past we kind of decided we're spreading ourselves to thin, we're doing these educational, we're doing these movie nights, we're not getting big numbers in here, this is really should we be using our resources in this way or should we re-evaluate? And we re-evaluated and decided that let's focus on the Info Centre, get the hours up, and get out in the community promoting the Info Centre and let's take on the Community Health Advocate Project 'cause it was funded, not adequately not anywhere near adequately, but at least we got some money each year to run it.

KA: Okay. Now was this money that the Health Collective applied for?

CD: Yes. [?]

KA: Okay. So the project was the Health Collective's brain child pretty much.

CD: Yes. Well, and it's changed very much since the beginning.

AB: Yah, yah.

CD: It was a huge envisioned scheme of training women advocates and it's much smaller now. It's much more about patient's rights and workshops and information.

KA: Okay.

CD: So, again it adapted to meet the reality of the day. Which is where we're pretty . . .

KA: The reality is a bit viscious when it comes to women's equality seeking groups anyways.

CD: Yah.

KA: How long has the Community Health Project been?

CD: Since '89 when we started meeting.

KA: Okay.

AB: No. Community Health Project?

KA: The Advocate.

CD: Yah.

AB: Not '89.

CD: No, no. '98. My dislexia there.

KA: Okay '98. It's been going about, it's been going about three years.

AB: Yah.

CD: Yah. '98, '99, 2000, 2001. So four. We've just finished our fourth year.

KA: Finished fourth year. Okay. Alright.

AB: Hopefully [?].

KA: Yah, here. Here, here! Okay. So there are obviously then are, seem to be a range of issues that women are looking for information for. Maybe you could lay out what some of those are.

AB: Ah, some of the women come here to access information on alternative insemination.

KA: Okay.

AB: A big one is abortion. Yah, where to go, what are the procedures.

KA: Okay.

AB: Practitioner directory. Women, we talked about this the other day, you know, we look at our log sheet, it's about a third of them that access the Info Centre looking for a new doctor, to change to a new doctor, [wanting a?] doctor anywhere from, oh, practitioner

KA: Right, some sort of medical practitioner.

AB: Yah. And non-medical practitioner. Thereapists, counsellors.

KA: Yes. Right.

AB: Then women will maybe call and come in and what they're looking for isn't necessarily a health topic or concern now but it began as one.

KA: Huh hmm. Okay

AB: So they may come to phone or drop in looking for where they can get some legal help because they had had an operation done in dadadada year and never recovered fully from it or something odd was found there.

KA: Right.

AB: You know, these sorts of things. Just like with housing, you know. Also get a lot of calls on that.

KA: Okay.

AB: 'Cause it's always related to health.

KA: Right.

AB: But the bigger sort of topics are where women are coming in looking for sort of the traditional and holisitc perspective on menopause.

KA: Okay.

AB: Perimenopause is a big topic right now.

KA: Yah. I keep seeing the advertisements on television for natural remedies.

AB: Just another way to get women that are in need of help.

KA: Yah. Yah. Menopause is certainly, its the profile for that issue has been raised significantly in the last number of years but not neccessarily in a positive or at least accessible way.

CD: Well and that's one of the other services that we are providing, right, is we've just revamped our menopause kit.

KA:Okay.

CD: We we sell for like I think for ten bucks.

AB: Ten dollars, yah.

CD: It's accessible in terms of the cost and it's a comprehensive guide to a self-help approach to menopause.

KA: Okay.

CD: So there's lots of resources around [?], lots of books you can look up if you want to, natural remedies or approaches. There's just everything and anything you could imagine in this menopause kit.

KA: Right. Okay. Does the Health Collective have a number of those sorts of kits? Or?

CD: That's our only one.

AB: That's the only one and I'm not even sure when which was the year where it was actually created. But it's been recreated a few times through the years.

KA: Okay.

AB: And updated. But that's been with us for a long time that menopause kit.

KA: Okay.

CD: That's the one thing that we had the energy to put into updating.

KA: Okay.

CD: A number of other publications which were funded years back were just grossly out of date.

KA: Right.

CD: And we decided to archive them.

KA:Okay.

CD: And we didn't have the resources to up-date them.

KA: Okay.

CD: But the menopause kit [? vl]

KA: Okay. Now because one of the issues I've been interested in in the media right now, or have been interest for a number of years largely due to my own personal background, has been the issue of violence against women. And I know at least in the media as of late, one of the perspectives they seem to be taking and also the government seems to be following or seems to be leading—I don't know which is which at this point, but is the emphasis on the health cost of

violence against women. Now, is this one of the issues that the Collective deals with in some way or has some sort of . . .?

CD: We don't do a lot of sort of what you'd call public policy or social policy work. So our perspective around violence against women in the health care system is sort of what is the underpinning of what we're trying to do here which is get good information out to women.

KA: Right.

CD: So they can make decissions or halt procedures or halt medications if they feel that it's a viola it's violating their health, healthfulness.

KA: Okay.

CD: You know, through the Community Health Advocate Project telling women that, you know educating women about what their rights are to say no. So the whole violence against women angle from our perspective is appropriate and respectful health care.

KA: Okay.

CD: And that's how we go about tackling the issue. We don't , you know, we dont' have a researcher on staff so we're not doing any public policy work around quantifying the cost of violence. We don't have those sorts of abilities here.

KA: Right.

CD: And that's a much, that's an academic kind of pursuit that which, there are some many women out there doing that kind of research now.

KA: Right. I guess I was more interested though in your particular statement how violence, the overall goal of the Collective would almost feed into a broader understanding of violence against women which takes on the very systemic kinds of violence which we've often seen in the medical system. More strongly I think in or more obviously in issues of mental health and the abuses that often happen.

CD: And hysterectomy.

AB: Yah.

CD: Like that's another.

AB: Forced sterilization.

CD: Yah.

AB: Well today this call was a little bit about a hysterectomy. It was a women who called and it had been suggested from her doctor that she have a hysterectomy. I guess she had been diagnosed

epilepsy, she needed epileptic medication. And she had just recently heard from another doctor, you know that hey you could look into carrying a child, having a pregnancy. So she called just wanting some information because she felt that was pretty drastic to be told that, you know, well it's time now to pull it out, have a hysterectomy. And we've had a number of women come. Like, I remember in our old location it was a woman who had come with her partner just from a doctor's office very distraught and I think was around the age of thirty five and I don't know what the reasons were, but her physician had said, it's time to have a hysterectomy and was very forceful on 'yes, the sooner the better' and her and her partner hadn't even explored the idea of whether they were going to have children or not. So, she just really needed to come to a place where she could read up some information and find out what her options are. Was the doctor right in saying that you need to have a hysterectomy right now.

KA: Right. Okay.

CD: Well, yah. It's really about appropriate health care and information to empower women, right?

KA: Right.

CD: And another great example that comes to mind is around mid-wifery services. Angelas was doing work with women who, immigrant women who don't want to have their babies delivered by a male doctor.

KA: Right.

CD: And were told by a physician, a woman was told by a physician that there weren't any mid-wifery services available in this province. Which is a complete and utter untruth.

KA: Well yah.

CD: And of course we shared other information with her so she and this group of women—I believe it was a group of Kurdish women—they wanted to know about mid-wifery services, if they could have their children delivered by a mid-wife, which is typically a woman.

KA: Yes.

CD: And that was information that was new to them. That, had. So, I guess, you know, it's a cultural violence.

KA: Right.

CD: And it's giving women information that makes their health care experience far more appropriate for their circumstance.

KA: Right, right. I think—you were talking about cultural violence and I think that's one of the key, personally I think that's one of the key aspects of understanding violence against women which is a culture that disrepsepcts or undervalues women's concerns, their needs, that sort of

thing.

CD: And I think the other way that we help women in terms of violence in the health care system is giving them direction around how they can complain.

KA: Okay.

CD: You know. We do a bit of that, right?

AB: Yah. You know, women will phone and when they have stories to tell and where they want to complain, yah some of them do want to go right to the College of Physicians and file a complaint. But others want to do it on a different level, they want to share their experiences with other women. So this is where the directory has been so valuable because they complete these forms anonymously and it's their experience they're sharing with other women. And some do take it to another level and just finding out that the policies of the College of Physicians too, that doctors have rights as well. And so, they leave more informed.

KA: Okay. Yah.

CD: Yah.

KA: And that's always very important for women.

AB: Huh hmm.

CD: Give them tools.

KA: Yah.

CD: And make them feel like they're in charge of their health, right? And in charge of addressing and confronting situations that are violent, that are abusive, that are disrespectful.

KA: Right.

CD: So that's another big part of what we do here.

KA: Okay.

AB: One little other thing that I thought of. We have this little log sheet and if women are comfortable giving us their name and their number we write that down and when they phone and sometimes all they want to do is meet another woman whose shared their same experience.

KA: Right.

AB: And so with that log sheet we've hooked up women together to talk and share their experiences. Maybe they don't want to take it —and I'm thinking of two women in particular 'cause they had issues of sexual abuse by their doctors and they didn't want to go to the College

of Physicians and Surgeons. You know, for both of them it had happened many years ago and it happened for many years—they were therapists not physical doctors—and they just wanted to meet other women. And so, being able to that has empowered them.

KA: Right.

AB: That they've connected up and met other women that have shared their same experiences.

KA: Right. Okay. Alright. I'm going to try and make a jump here maybe to some of the media issues. And maybe one of the places we could start is going back to your statement about how the Health Collective is always trying to raise their profile and maybe talk a bit around the Community Health Advocate Project which seems to me almost ideal for getting media attention. It almost seems something that would be appropriate that way. Just a place to perhaps start. I'm not sure where we could take that.

CD: Well, just in sort of the practical terms. We have a very small budget each year to spend on promotional material.

KA: Right.

CD: We've certainly produced a lot more pretty nice looking stuff in the last few years that we've had for some years. And that's really the first step I think in terms of organizational development, is having nice materials that you can get out.

KA: Right.

CD: And so we have taken that step. You know we are producing our news letter three times a year now.

KA: Okay.

CD: That goes out, well we distribute about a thousand copies each ~~addition~~ edition. We have a pretty nice looking pamphlet now and we have got a bookmark and we've got a webpage that's pretty good.

KA: The webpage is very nice.

CD: Yes. Good. And so we're doing, we're trying to create nice promotional material that's both woman friendly—like our logo, we really love our logo. And it's a nice, positive image of womanhood. Of a woman. A healthy woman.

KA: Huh hmmm.

CD: And that's the first sort of, when it comes to the kind of promoting that we do a lot of it's one-to-one, right? It's word of mouth. It's getting the pamphlet into the community centres, into women's hands, going to meetings. You know, getting the word out about the webpage. So that's a very sort of grassroots kind of one-on-one, woman-to-woman way of getting the word out

about the Health Collective.

KA: Right.

CD: Clearly that has limitations. You know, because it takes a long time to get the word out. And, you know, the buzz is out there, right?

KA: Right.

CD: But, yes in terms of any broader kind of strategy around advertising in the newspapers or that kind of thing. Promoting the organization. We don't have a hell of a lot of money to do it so we're not doing a lot of it. We put maybe one add in a year. Community papers. The Georgia Straight. The West Ender. Something like that.

KA: Right.

CD: Or whatever, you know. That is the formal kind of step beyond the word of mouth.

KA: Okay.

CD: [?] advertising. Now we've become very much involved with the BC Health Coalition in the last year. So we're having a lot more opportunities to get the profile of the organization into the broader community.

KA: Okay.

CD: Through our BC Health Coalition work. Around the Community Health Advocate Project, the issue around that is confidentiality, right? So in a sense in it's not really the best kind of leaping off in terms of promoting our organization. Even in terms of documenting the workshops, Angela has to ask for permision to photograph the women.

KA: Okay.

CD: So like there's issues of confidentiality. So it's not like we could have a press release, send out a press release about a workshop or use that as a kind of angle to get the media interested in our organization because we need to be respectful of the women that are participating in the workshops.

KA: Yes.

CD: And we also need to be mindful of the fact that we are a women only space. So that has its kind of limitations around media work too, in a very practical sense.

KA: Okay.

CD: And it's something that I have thought about and there's those sorts of limitations. But, so we don't tend to, like I don't have a list of media contacts that I call up and talk to about some

burning issue that is out there like our Ministry money. Our Ministry of Women's Services grant could very well be cut or slashed or eliminated in the next couple of months.

KA: Right.

CD: Maybe we'll know Thursday, tomorrow, the beginnings of something more concrete. And we really don't have the media kind of savy, the media strategy to deal with raising the profile of, you know, an issue like our funding.

KA: Okay.

CD: In the broader media [?].

KA: Okay. So what do you mean by media savy?

CD: Well I think, I think a media strategy rests upon network, a network.

KA: Okay.

CD: And we don't have a network. You know, we just haven't had the energy or the resources to do a lot of that work. But we're at a point now where I think we're wanting to go there. Well we've been talking about that. The first step was becoming involved, more involved, with the community and that was getting involved with the BC Health Coalition. And the next step I think is going to be looking towards doing more, developing some kind of media strategy for the organization. But we're really only just beginning to think about it. And to some degree because of the work we've done with the Health Coalition.

KA: Okay.

CD: Where I've had the opportunity to do some interviews. You know, CBC Radio or CJFR—I did an interview a couple of days ago. And you know, [CKN at?] Forum [their Public Community]. We've done a little bit of press work around [?]

KA: Okay. How did you find doing those interviews. The CBC, the CJFR.

CD: Me personally?

KA: Yah. I find it interesting. You've talked about how the working with the BC Health Coalition has created those opportunities and interest in doing more media work. I guess to me, I would think some of the experiences you're having now with media would shape in some way what you want to do and what you see capable of being done.

CD: Yah, I agree except that it's been very piecemeal. It's just been kind of like, oh someone calls and I do it. So we're reacting.

KA: Okay.

CD: Or, and opportunity arises and we take advantage of it. So we're really reacting right now. We don't have any strategy or any plan.

KA: Okay.

CD: And I personally have done a lot of media work in other, for another organization I worked for.

KA: Okay.

CD: But it was in Ottawa. So it was a different milleu where I had different, I had a very sophisticated network of media contacts with my other work.

KA: Right.

CD: So I know how to do, go about establishing it and we just need as an organization to figure out well: A) do we have the energy, the resources and then if we decide that it's a priority then, how do we want to approach developing something for the collective?

KA: Right. Okay. So you have a very clear idea of what needs to be done anyway in terms of developing.

CD: Well we certainly know we need more profile.

AB: Yah.

KA: Okay.

CD: Like, it's very frustrating to go to a meeting and have a woman say, "Oh! I've never heard of you," you know. And that happens more often then I would like. And we all have those experiences.

AB: Yes.

KA: Okay.

CD: For a thirty year old organization it can be a bit frustrating.

AB: Yup.

KA: Right. So that. I guess from what you're saying then the main reason for doing media work would be to try and raise the profile of the organization. Would there be any other outcomes besides that?

CD: Yah. Fighting the cutbacks to health.

KA: Okay.

CD: But that's a very difficult role for a non-profit to play given that our funding comes, the majority, from government. And so, we're trying to walk that path right now where we know our funding is going to be cut back, like everybody's funding in the next few months.

KA: Right.

CD: Because the provincial government is cutting back. And we also know that we're talking a much higher profile around these cuts and we're not wanting to jepordize our organization and the future of our organization because of the profile, you know, taking such a strong stand against government cutbacks. So that's difficult and again we're trying to figure that one out.

KA: Trying not to bite the hand that feeds you too hard.

CD: Well we are biting the hand, it's just figuring out how to enable the powers that be to understand that it's an important process. That organizations such as ourselves need to be funded and that we play an important role in raising issues such as cutbacks to health and how it's going to affect women.

KA: Right.

CD: And so that's kind of where we're at. And of course all of this has been precipitated because we've had a change of government.

KA: Okay.

CD: Things are very different now than they were a year ago. A year ago we weren't worried about the Ministry, well we had a Ministry of Women's Equality a year ago and we weren't worried about our funding being cut. Now we have no Ministry and we don't even know how much money we're going to get next time.

KA: Right, right.

CD: The political context is pushing this ahead. And it's also pushing the Health Coalition ahead, obviously.

KA: Yah.

CD: It's responding to what's happening in the community, the province.

KA: So then do you see then media as a forum within which to play out these political issues?

CD: Well, I'm a bit jaded about actually how you can really affect change in terms of public policy once government decides they're going to do something.

KA: RIght.

CD: You know, once they've decided their going to destroy our Pharmacare program. Well, Pharmacare, we dida fair bit of work on the issue.

AB: Huh huh.

CD: And it didn't change anything. In fact, the cuts are deeper than I thought they would be. So, I did public policy work for many years so I have been at that end of things and you see the frustration of trying to do that work and what you actually accomplish. I think at the end of the day the important thing is to raise the profile around the cuts. Inform people around, you know the broader public. Women around how those cuts are going to affect them. Make sure the story is out there and it's balanced and it's just not about we can't afford our health care system. 'Cause that is not the story.

KA: Right.

CD: So trying to influence the story and have the story be told in a fairer way. And I think that's part, that's some of the role of what we're doing and the Health Coalition is doing.

KA: Okay.

CD: I don't fool myself into believe that we're going to stop the cuts.

KA: Right.

CD: But getting the story out there and the nuances of how these cuts are going to affect people, that's an important role. And I think that that's some of what we're doing. That's what I did when I gave the interview at CJFR a few days ago. I did a very long, you know we did a half an hour interview on how the cuts are going to affect women.

KA: Okay. Right.

CD: Will affect the province and women.

KA: Yes.

CD: And that's important, to get the story out.

KA: Okay. I'm just going to take a look at the tape recorder. It looks like we're okay for a few more minutes there. I'll probably check it in five more.

CD: Okay.

KA: Maybe going to back to the interview you were talking about doing with the CJFR, the longer issue. How—now I'm asking this question within the context of more of my academic background. I've done a lot of reading around media and feminist analyses of media. And one of the things that has been said repeatedly since the first studies into how the media covers the women's movement and women's issues is that there are barriers put up at various points in the

media process, right down from the reporters through to editors through to the larger organization, that consistently prevent women's issues from getting into the media in a positive way. So I'm always curious when a women's group goes to the media, works with them, does something as to what the experience was like, what the outcome was like given that information that I have.

CD: Yah, well with CJFR it was great. The interviewer was a woman and she was very interested and they were very supportive. Maybe I can talk a little bit about the CBC show I did. I was on Alamanac so that's the call-in show over the mid-day. I don't know when it was, noon or something.

KA: Is that weekday?

CD: Yah. So I kind of, I know what you're talking about and I kind of used it to my advantage in that situation.

KA: Okay. In what way?

CD: Because I had the producer call. She was doing a follow-up from a Pharmacare public meeting that I'd attended and spoke at.

KA: Okay.

CD: SO a press release went out with my name on it. She called to talk to me and she said, Well we want to talk about Pharmacare. Right now we're looking at the Pharmacy Association, a fellow who represents them; a seniors group, a fellow who represents them; and yourself; and someone else. And I said, Okay. Great. Well we're certainly interested. And we had a chat as they always do to see if [?] to figure out whether you can do the job or not if they want to put you on the air.

KA: Yes.

CD: And I pitched to her and I said: It would be really unfortunate if the spokespeople were all men. And she said: I agree. And I said: I know you agree because you work for the CBC and I listen to the CBC and I watch the CBC and I think it's important from your perspective to have a woman's voice—and a man's voice—and so I kind of but that bug out there, right?

KA: Alright.

CD: And when she called me back a day later, she said: I've talked to all of them, the perspective spokespeople from the different organizations and I've decided to go with you and the fellow from the Pharmacy Association and we'll do a call-in with the gentleman from the senior's because I think that would be a good balance for the show. So in a way I used my gender to get, as a positive angle to get us on the show.

KA: Huh huh. Okay.

CD: And it worked, right? And I think to some degree I certainly think it was a factor under consideration in terms of getting the story out there from the perspective of a woman, a woman's organization, and health care is obviously an important issue for women.

KA: Right.

CD: So I thought that was good, positive. And, yah. I don't know. I think that the media—I tend to be kind of focused on the CBC. They're not brilliant but they're better then some and so sure we've seen some very biased and horrible reporting. The whole issue around the sex trade workers in the downtown eastside and how that issue was dealt with for years is the classic case study of what you're talking about.

KA: Okay.

CD: And today, five more women have been put on 'The List'.

KA: Right. 50

CD: The list now of fourty women. And now I can't believe that fourty men would die somewhere and no body would pay much attention to it for how many years?

KA: Quite a number.

CD: There are so many examples where there's just bias and sexism and structural discrimination and moral judgements made against women or women in the health context. Like you're a hypocondriac. You know, there are so many of those layers that affect getting the story out or getting the interest in the media in the story.

KA: Right.

CD: And you can use it too. And I try to use it. And I can.

KA: Okay. Fair enough, fair enough. Take another look. Ah, I think it's time to flip.

Anna-Lisa leaves interview. Some discussion of details of ethical approval form.

KA: One of the things I've found in starting to talk with women's groups around this issue is that there is a very high level of awareness around media. Perhaps it is a reflection of almost the academic or the more high-brow roots of the women's movement. I've always thought it sort of started with a pretty well educated group of women. At least you're talking a middle class movement, and from what you're saying even your own experiences demonstrates a fairly strong understanding of media and how it works. And also some of the frustrations that have been spoken of, to some degree by academics but then again a women's perspective on media is often very silent even there. I'm not even quite sure how to put this. In that it's a very broad, it's a hypothetical question in many ways. 'Cause you've expressed some displeasure particulary

around the issue of sex trade workers on the downtown eastside. What about that coverage has displeased you and how would you change it?

CD: Well, and I'm speaking really as Caryn Duncan right because we don't do, like we work with PACE. You know we work with other organizations that are working with sex trade workers.

KA: Okay.

CD: But we don't do a lot of work per se with sex trade workers unless they come here looking for health information. And they might not necessarily have any reason to identify themselves, so it's not.

KA: Right. Okay.

CD: So, what's happening to women in the downtown eastside is horrible. I live in the downtown eastside so I have a personal connection with the community. I live in a co-op in that neighbourhood. There are so many things that are wrong about the way that story's been told and there's many things wrong about the way the story about the neighbourhood's being told everyday that's in the media.

KA: RIght.

CD: Like I said earlier, they've just added the fourtieth name to the list of missing women in the downtown eastside. That seems to me to be just shocking when only a couple of years ago when people were speaking out against the idea that there was a serial killer. And now we've been reading, since the Vancouver Sun did that expose a few months ago where they had I think they had three reporters dedicated to covering the story and they did some more in-depth coverage and raised the issues of other possibilities like is this person potentially a serial killer, only a few men killed a number of women, or is this just like. I don't know, it seems to me to be too ridiculous to me to think that fourty women have died independently. But that's my own bias.

KA: Right.

CD: Any way, all of these other issues, who these women are; that they are mothers, that they are daughters, that they have lives, that they come from other communities. None of those stories were told in much detail. And as I say, I thought the reporting in the Sun was a lot better recently.

KA: Okay.

CD: But, you know, it's taken fourty women to die for that to happen and I think it's just appalling. It's been appalling.

KA: Yah.

CD: And instead of the media doing some investigative reporting years back and pushing the issue, which is the sort of romantic notion of what a journalist can do,

KA: Very romantic.

CD: they just reported like a police bulletin report about death.

KA: Right.

CD: And nobody, for some reason, seemed to feel the need to connect the dots. And I think it's because these women who were dying were sex trade workers, they had drug habits, they had issues that made them in our society valueless. And so it's so much easier to disregard the value, the value of a sex trade worker whose a drug addict, the value of her life for some reason.

KA: Huh hmm.

CD: And the media doesn't do anything to challenge that. But the whole reporting around what the whole downtown eastside is about and who lives there and all of it is just terrible.

KA: Some of the elements you talked about, things around you know they don't talk about how they're mothers, they're daughters, that they are people essentially. Do you consider things like that, information like that key to discussing women's issues in the media?

CD: I think we need a context. You know, we always need a context. Whenever I speak, if an issue touches some part of my life I talk about it. For example, you know at one of the public meetings there were, I don't know, 850 people at this particular event where we talked about cuts to Pharmacare and I talked about how it may affect my grandparents lives. I have two grandparents who live in long-term care facility on Vancouver Island. They depend on our health care system to live the quality of life they do. They get their drugs through the long-term care facility they live in. You know, if the Pharmacare program is going to be cut back in may affect them. So I like to give a context, always. I don't mean give people names.

KA: RIght.

CD: But I think it's good to draw from your life experience, to share your story, to make your point more personalized. And I always try and do that. Whenever I do any public speaking or any work with the media, I always try and make the story about my context, about the context of the health collective, about the women we serve, about the women who gather here, because that's a part of telling, well that's a part of getting your message out.

KA: Huh hmm. Right.

CD: And I think people will listen a lot more if you talk about a woman's health than talk about health policy.

KA: Right.

CD: And, I don't know. I'm kind of torn about whether—I used to be a researcher, I understand the value of the empirical and the broad brush strokes, the drawing conclusions on that academic,

grounded work, but I also see the value in getting the message out because you tell a story about a particular woman's circumstance and raising the profile by giving a face, like a the horrible personal interest story, giving a face to the story, right? And there's value in doing that. People can identify then.

KA: Right. I think identify is the key word in almost any story, whether it be the so-called hard news or the so-called personal or lifestyle stories or whatever. Because even—this is my own musing on the state of media, but even in hard news stories if it isn't a mainstream political player, for example, the issue isn't quite as important like you know, if something happens to the Prime Minister or aide to the Prime Minister, or something like that. I don't know if that's a.

CD: Yes. Well the sexy story, right. There are [?] sexy stories that get the coverage.

KA: Yah.

CD: And I must say, that's something we're going to be thinking about in terms of what kind of work we want to do in term of media strategy. And we do, as I say, a little bit of work once a year in terms of advertising and I'm hoping like, and we tend to tie it into International Women's Day so in March we'll be doing that.

KA: Okay.

CD: And this is going to be the infancy stages of us trying to get the word out in a more assertive way rather than reacting.

KA: Right.

CD: So we'll bet getting [that out?]

KA: Okay.

CD: And of course I'll be using stories.

KA: Right.

CD: And it would be nice to invite a crew here but if that were possible to do a radio story or a t.v station shot. But the problem with that of course is that respect around our space.

KA: Right.

CD: And that we're a women only space and we have to figure out how to invite people into our space in a way that's respectful.

KA: Right. I think what you're saying actually echoes a couple of the other groups I've talked to in the sense that there is a good deal of discussion around how to marry one's political goals and aspirations with their philosophy. And, in extension how media or the role of media in that organization. Some are will to cut—this put's it negatively—but to cut their losses in the

mainstream idea of getting media coverage.

CD: Yah. Well, my feeling is that if it comes our way we're going to seize it. And I don't know if we're going to be doing a heck of a lot of cultivating. If I'm going to, it's going to be me cultivating relationships with media.

KA: Right.

CD: You know, with BCTV or that sort of thing or like the Province. I can't see myself want to invest a lot of energy in that.

KA: Okay.

CD: But perhaps we'll just have to choose who we're going to develop relationships with.

KA: Right.

CD: And for me the non-corporate media is important. And we try to, well we support the community papers and I'm very supportive of students and we'll continue to support student newspapers and do radio interviews with CJFR, whatever else, right?

KA: Right.

CD: Because we draw a lot of our volunteer base from students, from amongst women students and they also need to know about the services that we provide.

KA: Right.

CD: So I don't feel, my feeling is that any opportunity we'll seize the moment, right?

KA: Right.

CD: Like I don't care that only fifteen people listen to the radio show. That doesn't matter to me. It's supporting the community, it's supporting the woman wanting the interview, getting the word out and, you know, building on that experience.

KA: Huh hmm. But what you're talking about though isn't necessarily any less valid in that you seem to be talking about cultivating more grassroots media connections as opposed to more mainstream media connections and that there are different things to be gained.

CD: Yes. Definately. Yah.

KA: Okay.

CD: And we did some work with Co-op Radio a couple years back. And we don't have a full time person doing press work or media work [?]. We're a community based organization, we'll support other community based media and then we'll take advantage of CBC or anyone else that

comes our way.

KA: Right. Okay. That's quite interesting actually. I'm not actually sure where I'm going to take this.

CD: We've never sent out a press release, for example. Like we haven't done that kind of work where we may in the future.

KA: Okay.

CD: But we don't send press releases out. Like even going sort of fishing for, you know, trying to hook someone for a story. We haven't done that in the past.

KA: Right. Okay. What about things like letters to the editor or?

CD: Yah, and we haven't done that either and that's been predominantly—well and I'm only speaking back to '97—but that's been predominantly because we just haven't had the woman power to do it.

KA: Okay.

CD: But, I see us doing more of that. Of course barring that we're open next year.

KA: Right.

CD: All of this is barring any radical shift in terms of what we can, our funding base.

KA: Right.

CD: Or finding alternative sources of funding. We do see huge cuts.

KA: Right. And that is unfortunately a very common concern, especially amongst women's groups right now.

CD: Yes. Definately

KA: And I think your particular circumstance—not just your particular circumstance but the particular circumstances of women's groups, not for profit organizations—I think is a very strong example of the relationship between money and media. And the constant statement, if you have the money, you get the attention. If you don't, you don't get the attention.

CD: Yah I think there's some truth to that. Although I must say when I worked in Ottawa, even though I was working for a much larger non-profit, but we didn't have a heck of a lot of money and we got a lot, we got a fair bit of media coverage.

KA: Right.

CD: So, yah it's a heck of a lot easier for the Fraser Institute to get media coverage or the [Council of National Issues?] in Ottawa to get coverage or, but it—and of course the business community and important and famous people—but I think you can cultivate relationships with individual reporters and use that to your advantage. But as I say, we're at the infancy stages of even doing that.

KA: Okay. Alright. My watch says 3:33 so we should probably wrap up this discussion. What I like to end with basically is there anything that you want to say or is there any question that I haven't asked that should be asked at this point? Sort of to open it up.

CD: Well I'm not sure. I'm feeling like we're just touching things at the surface.

KA: Yah. I feel that also.

CD: And so I'm not sure what's missing. I guess I'm not really sure how much more detail we're going to get into or where else we're going to go.

KA: I'm thinking it might actually be useful to have another meeting in the next, maybe the next couple of weeks or so.

CD: Okay.

KA: And maybe try to talk more in depth maybe about this example and maybe try to get underneath some of the issues. Because, like I said, your own experience has given a very strong understanding of media and how it operates and some of the things that need to be done.

CD: Right.

KA: So, from my perspective, you know a lot of what I know as basic information already anyways.

CD: Right.

KA: And I think that's what we've largely touched on. And I think we've demonstrated a common understanding, a common base of knowledge.

CD: Right.

KA: And maybe from here we can start getting into

CD: Something a bit more meaty.

KA: Yah, things that are more meaty.

CD: And so do you think it would be possible for you to send me the questions then in advance so I can look at them? That way it gives me a bit more, like I'm the kind of person who likes to mull things over.

KA: Okay. What . . .?

CD: Unless of course you want the spontenaiety of just response.

KA: Not necessarily, 'cause I think you can get spontenaiety out of whatever the resonse is anyways. I may send out a list of question and you may have some answers but you may say things that, well, trigger more questions in my mind or even when you're talking all of a sudden something will pop out.

CD: Yes.

KA: I think what I would like to do first, though, is transcribe the interview so that I can sit down and take a look at that. I can provide you with that transcript as soon as I'm done that.

CD: Okay.

KA: And then from there I'll probably try and come up with some questions and also send those on to you. And then that way you'll have both documents.

CD: That sounds good. You can email me if you want.

KA: Email?

CD: I'll give you my card and then you can send it [?].

KA: Excellent. Okay. That would be great. It might be next week, it might be the week after that I'll get everything transcribed. I'm still finishing up one and they take forever.

CD: No problem

KA: Then I'll probably turn off the recorder at this point.

CD: Sounds good.