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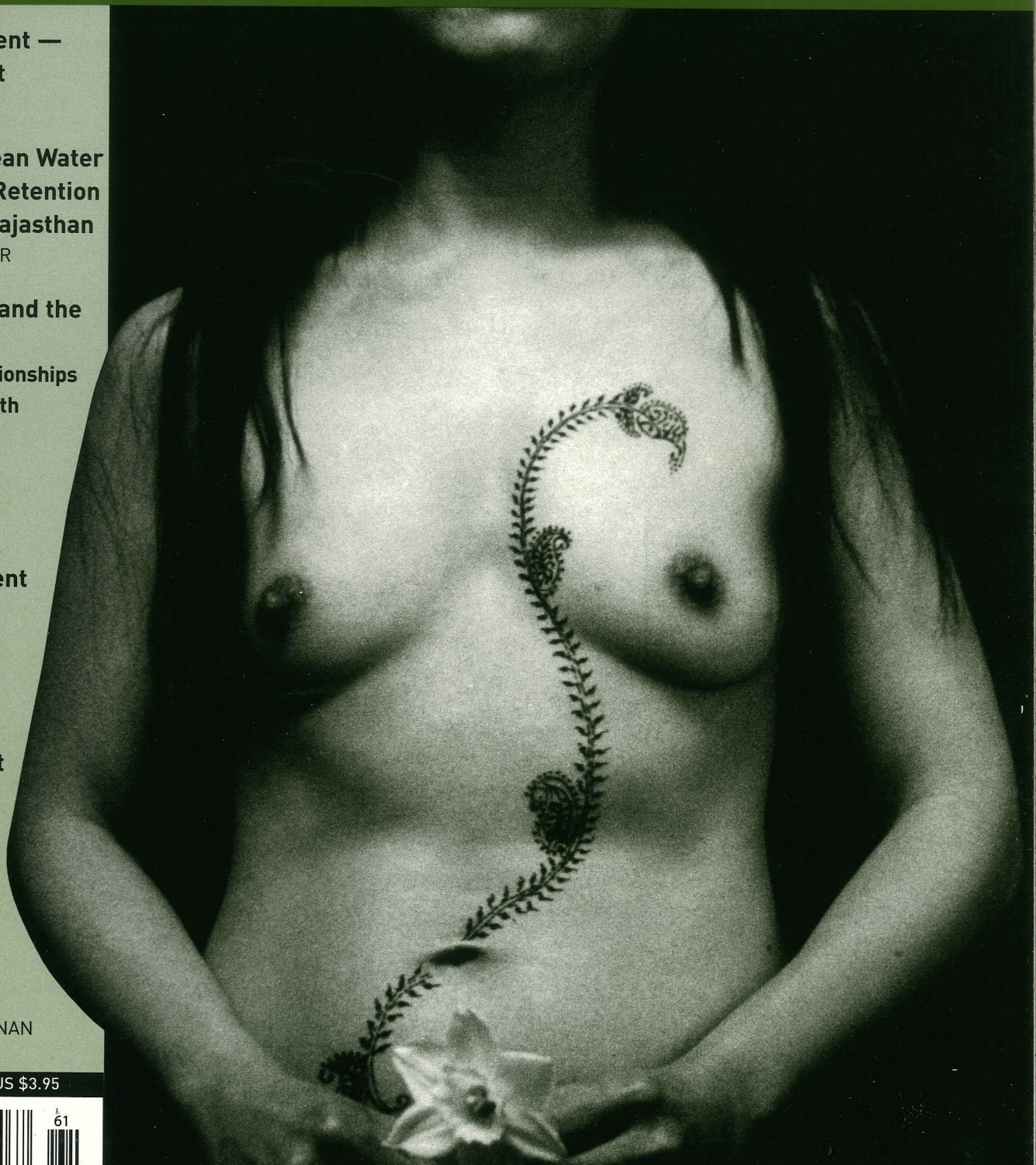
Women & Environments international



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DOUBLE ISSUE

WOMEN'S HEALTH & ENVIRONMENTS

— Based on the 9th International Women's Health Meeting, Toronto

Women & Environments international

Mission Statement
Women & Environments International is a unique Canadian magazine, which examines women's multiple relations to their environments — natural, built and social — from feminist perspectives. It has provided a forum for academic research and theory, professional practice and community experience, since 1976. Produced by a volunteer Editorial Board the magazine contributes to feminist social change. The magazine is associated with the Institute for Women's Studies and Gender Studies at New College, University of Toronto.

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Upcoming Issues

We are working on the following issue themes:

WOMEN & THEIR BUILT ENVIRONMENTS — an update on women's projects and thinking to realize homes, jobs, services, ways of getting around and communities that meet women's needs.

WOMEN GLOBALIZATION AND ACTIVISM — the feminist and environmental politics of women, North and South, in the anti-globalization movement. How is that movement reflecting feminist and environmental feminist positions?

WOMEN & WORK — AN UNEASY UNION? — Explorations of women's work experiences in a rapidly changing environment and increasingly globalized market place. We will look at public, private, cooperative sectors, small/micro business ventures and organized unions from comparative and analytical perspectives.

EARTH BASED SPIRITUALITIES, COMMUNITY AND FEMINISM — exploring diverse traditions that foster healthy communities and organize for social change

Your participation in issue teams, ideas, articles, news and funds are a critical to the survival of Women & Environments International Magazine. For Editorial Guidelines, Calls for Papers and more visit our website: www.weimag.com

Thank You

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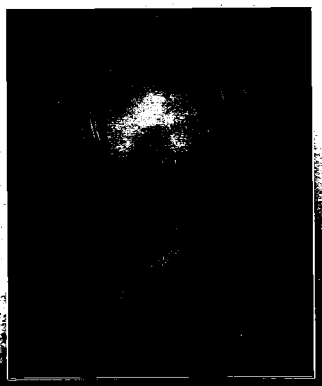

ON THE COVER

"How can I get fit and go green at the same time? — Pesticide Free Gardening for Healthy Gardens and Healthy People" April 2003 Breast of Canada Calendar. Photographer Melanie Gillis has a unique background in fashion, psychology, and fine art. She has completed fine art courses and an Honours B.Sc. in psychology, at the University of Toronto. Melanie started a Masters degree at the University of Guelph. "Guelphites are comfortable in their skin," she finds. Melanie has been the principle photographer for the Breast of Canada calendar since it's inaugural year 2002. The calendar draws attention to issues surrounding women's health with a specific focus on breast health issues.

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A Labour of Love

Women & Environments International is pleased to have Nuzhath Leedham, Executive Director of the Riverdale Immigrant Women's Centre and Co-chair for the 9th International Women's Health Meeting introduce the Women's Health and Environments edition of the magazine, which is based on the Meeting.

Since 1975, the International Women's Health Meetings have provided a forum for activists to develop and advance the international women's health agenda from the ground up. Two principles have underpinned them: equality as a condition of health, and distributive justice for women of the North and the South. The Meetings have provided an international forum for women to act locally, nationally and globally to deliver and advocate for essential health resources and the rights of women and girls. Over the years, the Meetings have dealt with such critical issues as the decriminalization of abortion, maternal health and morbidity, HIV/AIDS and sexual and reproductive rights. Canada hosted the 9th IWHM in Toronto from August 12-16 2002.

The Meeting conducted in Spanish, French and English — brought together over 450 women from seven continents and 62 countries to develop an international women's health agenda based on social justice and human rights. The three themes, sexual and reproductive rights, violence (both state and family), and environmental issues were developed at international planning meetings in Geneva and Toronto. A steering committee with key partners that included the Canadian Research Institute for the Advancement of Women (CRIAW), Riverdale Immigrant Women's Centre (RIWC), and Réseau Québécois d'Action pour la Santé des Femmes(RQASF) took overall responsibility for coordinating the Meeting which I co-chaired with Lise Martin (CRIAW). The Meeting was the culmination of two years of very hard work, and this look back highlights the challenges, complexities and satisfactions of organising Canada's IWHM. Given the extreme shortage of funding and resources, and the additional difficulties created by a post 9/11 world, this Meeting can only be seen as a labour of love.

Integrating the Themes

The opening plenary, moderated by Anne Firth Murray set the tone and the framework for a participatory approach to the Meeting. Issues were addressed with a clear awareness of global North/South inequities in the context of globalization and from a strong rights based, distributive justice agenda. Marie-

MARLIES BOXCH

Nuzhath Leedham addressing IWHM in Toronto, 2002.

Jose Oliveira Arujo, organizer of the 8th IWHM in Brazil, provided a historical overview and located this Meeting within the international women's movement.

Elizabeth May, Executive Director of the Sierra Club of Canada, voiced her grave concerns about the destruction of the environment and the ways air pollution, contaminated water and environmental toxins threaten our lives on a daily basis. Madelaine Dion Stout, a Cree activist, traced the trajectory of domestic and state violence within First Nations communities from colonization to globalization. She spoke about her personal experience of violence in the residential school system. She emphasized the importance of personal storytelling for its own sake and for its role in creating community solutions. Farida Akhter, from Bangladesh, spoke about health as "not only of body and disease, but the entire environment and the happiness of the person." She also highlighted the corporate values that have left us with "health care where the care is gone, and agriculture where the culture is gone."

From the beginning, we wanted to broaden the scope and discussion of health and make our collective way to a more holistic understanding and analysis. In pre-meeting discussions, we worked to build connections between essential indicators of the state of women's health, going beyond sexual and reproductive rights to include environmental issues as well as state and domestic violence.

It made sense to us that any discussion of health must include every element of our lived environment — the air we breathe, the food we eat, control over our bodies, our ability to make choices about where we live, how we live and who we live with, as well as our right to live a life free from oppression and violence. In other words, we wanted to see women's health not

simply in terms of disease but in terms of reaching our full potential physically, mentally and spiritually. For this to happen, the conditions under which all women live must be right, that is, conducive to realizing this potential. Equality — which seems to elude us — is one such condition.

Certainly, in this Meeting, we took great care not to dilute the integrity of the core issues as we sought to address them in a combined perspective. We recognized that this could mean a potential loss of focus. There was no escaping the fact that these issues truly are experienced in an interconnected and cumulative manner in our lives. We, therefore, adopted a broader, more integrated interpretation and analysis of health.

Building and Broadening Support

Another reason for aiming toward a more integrated analysis of health was to bring activists from these different areas together to broaden our overall base of support for action. We felt that it was extremely important to begin to talk together seriously and sincerely about the convergence of these issues. We recognized the need for relationships that will sustain us, grow stronger and deeper over time, and become an unstoppable force for change in the world. With the onslaught of corporate globalization, we need a broad base of resistance just to hold onto the gains achieved to date.

Recognizing all of this, our Call for Participation highlighted the issues. It noted the erosion of gains in health and public policy throughout the world, and the role of corporate globalization in deepening disparities between rich and poor within countries and around the world: hard won labour rights, wages and benefits are on a downward spiral; debt repayment and structural adjustment policies have impaired the ability of governments of the South to provide basic education and health services to their citizens; restructuring and privatization are creating a "South in the North," as aboriginal women, women of colour, disabled women and others become more impoverished. More and more governments have decided that health and other social services are no longer their responsibility and have started offloading services onto the private sector.

Environmental degradation has increased exponentially, especially in countries of the South, as have state and family violence. Increased militarism has resulted in large-scale death, illness and destruction, accompanied by migration and a refugee crisis of enormous proportions that has left women and children at risk. The rising tide of fundamentalisms around the world, both religious and market, has made the lives of women and children increasingly vulnerable to violence. There is a growing backlash against a woman-centred interpretation of sexual and reproductive rights. Reproductive rights are being redefined as reproductive health issues while sexual rights are barely recognized. In this climate, the 9th IWHM hoped to develop and present an alternative and revisioned framework of political analysis and action.

We were committed to bringing together women who have been relentlessly working in each of these areas in different parts of the world. We wanted this collective power and energy to generate a strong and deep impact. To strengthen the women's movement, we need new ways to build solidarity based on the richness of our diverse contexts and experiences. This continues to be a challenge.

Honouring Diversity and Equity

It was also a challenge to address issues of diversity, representation, participation, and equitable distribution of resources both in the North and the South.

It was fundamental to the goals and values of the IWHM that women on the frontlines, from diverse backgrounds attend the Meeting. Thus, we sought participation from women of all ages, and from different ethnic backgrounds, disabled women, lesbians, immigrant women, and others. Our efforts were successful. A significant number of indigenous women from Canada, Australia, Latin and Central America and India participated in the Meeting.

TheMeeting opened and closed with a Native ceremony initiated and concluded by Native elders. There were a number of panel presentations by Aboriginal women from around the world, and a special panel was dedicated to 'non-state' women that included Aboriginals and Palestinians, and others who spoke to the issues of Kurdish women.

MARLIES BOXCH

First Nations Ceremony at IWHM in Toronto, 2002.

We did our best to reflect and capture the diversity of the women's health movement; nonetheless, some participants felt that there was not enough representation of African women on opening and closing panels, as well as a lack of representation and limited involvement from lesbians, disabled women, and young women. We intend that the next Meeting will improve in this regard.

Over the course of the Meeting, women actively connected, networked, and met to set regional and issue based priorities. There were caucuses of youth, African women, South East Asian and

Latin American women, as well as lesbian and indigenous women. Each group developed recommendations and positions that were read in plenary on the final day. A comprehensive plan of action from the Meeting is currently being developed by CRIAW and RIWC; this will become part of the IWHM's final report.

MARLIES BOXCH

Participants at IWHM in Toronto, 2002

Endorsing Women's Concerns

Women also met to develop and endorse petitions reflecting solidarity in the international women's health movement. The Meeting approved petitions against state violence in Gujarat, India, and the genocide against the Muslim minority, especially women and children. A petition on Palestine supported the peace efforts of both Israeli Jewish and Arab as well as Palestinian women in their work for non-violent ways of resolving conflict and the building of peace with justice and security for all. The petition also expressed deep concern about the Israeli occupation and supported Palestinian self-determination and peace in the region. Another petition criticized the United Nations for minimizing the sexual exploitation of women and girls in West Africa and Bosnia.

North/South Issues

From the very beginning, organizers of the Meeting intended this Meeting to be of both the North and the South, and we determined that a Northern perspective and agenda would not be imposed. To guard against this, we included North/South inequities as an integral part of our Meeting, especially with respect to ownership of the issues and decision-making. We also paid attention to differential impacts on the North and the South — both in terms of the way issues were defined and solutions put forward. We, in the North, also acknowledged our privilege and access to resources as well as our nations' disproportionate consumption of the earth's resources. As a result, discussions of health necessarily involved our collective responsibility and readiness to hold ourselves accountable to women in the South about what, how much, and at whose expense we consumed. Because we truly wanted to strengthen the bonds and links with our sisters in the South, the debate on North/South inequities was a vital part of this Meeting.

Communicating Powerfully and Widely

The range of ideas and issues addressed was both stimulating and inspiring. We entered the Meeting, recognizing historical continuity with past IWHMs, acknowledging gains over the years and accomplishments to date, while keeping a clear eye on the future. Five days of discussion, dialogue and debate — with a bit of dissension thrown in — highlighted the tasks ahead and brought us much closer to consensus about our future direction.

Meeting the challenge

Finally, linking all of these themes, was the overarching challenge of the corporate agenda which continues to be anti-health, anti-women, anti-state, anti-environment and anti-life, while pro-violence. We saw this Meeting as a site of resistance against these values. Collectively, collaboratively, in harmony. we came up with actions, strategies and solutions that challenge and counter the negative impact of the neo-liberal agenda which seems to threaten our very existence.

The next IWHM is India in 2005.

Nuzhath Leedham was Co-Chair of the 9th IWHM. She has been Executive Director of the Riverdale Immigrant Women's Centre since 1991. She can be reached at **nuzhathl@sympatico.ca**. For information about IWHMs, see **www.iwhm-rifs.org**

Although this issue of the magazine is based on the 9th IWHM, the Editorial Team was unable to obtain several of the submissions they had requested. Included instead are articles from other sources to provide balanced coverage. The content is structured under the headings of Environmental, Socio/Political, Mother - Child and AIDS related health issues.

The Editorial Board of Women & Environments International Magazine would like to thank the authors and congratulate the Editorial Team of the issue: The Board would also like to thank the National Network on the Environment and Women's Health, Centre of Excellence on Women's Health, York University for providing support and funding for the issue.

LETTER TO THE EDITOR

DEAR WOMEN & ENVIRONMENTS,

Just wanted to tell you again what a great job you are doing at W&E. I have been reading this latest issue, whose subject of making women's voices heard in post-war countries is particularly timely considering the situation in Iraq (and probably other places too). The article about Somali women deciding for themselves that there was nothing religious or "good Muslim" about female circumcision brought tears to my eyes — to think that even our own bodies, unamputated, cannot be taken for granted in this world.

I am writing to the women's studies department of my alma mater (Vassar College) to recommend that they look at the Web site and subscribe to W&E. Not only is it a valuable informational and educational tool for its uncompromising journalism, its mix of poetry, often with the message of hope for a brighter world, makes it a tool for activism and solutions, and keeps it from getting stuck in the mud of its difficult topics.

Lately, I, now in the eighth month of pregnancy, have become more aware of certain kinds of discrimination against women here in India — particularly the preference for male babies, which I know is an issue in other overpopulated countries like China as well.

From the subtle, like advice before getting pregnant of which foods to eat in order to attract the "y" chromosome, to the gross, like the imbalance of male to female children due to couples aborting girl babies (which continues even though it has been made illegal for sonologists and doctors to disclose to the parents the sex of the child just for this reason).

I guess a large part of the reason for this discrimination is the cultural tradition of the son's obligation to always live with and care for his parents in their old age; although underneath there seems some lurking idea that there is something inherently more valuable about males than females. I'm sure you're aware of the problem with dowry issues in India which I recently read account for the deaths of almost 10,000 women each year, not including "kitchen accidents and suicides" (India Today Magazine).

In cultural and family customs, there seems something almost apologetic about the bride's parents always having to pay money to the husband's family — in some cases even for her funeral expenses. But what can be done about the traditions and values that run so deep? These things are not matters of government policy or something like that. I guess awareness, like those Somali women found, is the only way to bring change.

Sisterly and brotherly blessings,
Brook, Guarav and Oshan-to-be.

Masculinisation of Child Sex Ratios — Sex-Selective Abortion, Infanticide and Neglect — New Reproductive Violence in India

2001 Census of India reveals a steep decline in female to male ratio in the 0-6 age group

GIRLS PER 1,000 BOYS AGED 0-6, INDIA		
Year	**Sex Ratio**	**Variation**
1961	976	
1971	964	- 12
1981	962	- 02
1991	945	- 17
2001	927	- 18
(Census of India, 1991, 2001)		

- India's 2001 Sex Ratio at Birth is107 boys to 100 girls, reaching 117 boys in the state of Punjab. The normal ratio is 103 to 105 boys to 100 girls.
- Far more girls than boys die between 1 and 4 years. Normally boys have a higher mortality rate.
- States such as Punjab have high literacy for men and women, relatively low fertility rate and are relatively prosperous. This shows that economic development and literacy do not always result in gender equality but can even increase the oppression of women.
- Excessive dowry demands for brides make daughters financial burdens on their families.
- Abortion of female fetuses, infanticide and neglect of girls "reflect reduced tolerance of female children in a patriarchal culture which values sons more than daughters."
- This "culture" roots back to the chaos when the Mughal Empire disintegrated and the British imposed a colonial, highly exploitative economic system by re-enforcing landlords, impoverishing tenants and agricultural labor and vesting property rights in the hands of men.
- Ironically the media focus "on plight of men unable to find brides rather than on that of girls being killed."
- A court case initiated in 2000 to challenge the state to implement its 1994 ban of prenatal sex determination tests is still without a verdict.

Based on Submission by Navsharan Singh to the 9th International Women and Health Meeting "Masculinisation of Child Sex Ratios, Sex-Selective Abortion, Infanticide and Neglect New Reproductive Violence in India"

Environmental Health Issues

The Environment: A Place to Visit

Elizabeth May

Humanity has a tendency to live divorced from the natural world. At least in the industrialized world, we see ourselves as separate, as superior to the environment. Our human constructed world of homes, cars, highways, office towers deludes us into seeing the environment as something like a zoo — a place to visit if you like that sort of thing.

The reality is that we are all animals. We need the environment for our very life. The air we breathe, the water we drink, and the food we eat is essential for life and is part of the biosphere. Given this intimate level of connection to nature, it is hard to imagine how we can dump toxic and radioactive substances into our environment and imagine that these hazardous materials will never reach us. The delusion of our separateness is actually a health risk. We need to recognize that poisoning our environment is indirect poisoning of ourselves.

A Correll University study determined that pollution or other environmental factors cause 40 per cent of deaths, worldwide — a condition which climate change will only worsen due to its increased stress in water as well as air quality.

Health Canada conducted a poll a few years ago and discovered that over 90 per cent of Canadians felt the environment would affect human health and a majority felt that a polluted environment had already impacted negatively on their own health or the health of their family. The concerns are of air pollution, smog and asthma, fear of chemical carcinogens and cancer, of slow toxic poisoning.

The perceptions of health and the environment are very different if you are a woman in the South. The connections are immediate. Globally, 50,000 children die every day due to a lack of clean drinking water. And, 1.4 billion people on the planet cannot access clean water. Of all infectious diseases recorded around the world, 80 per cent of them are due to water-borne infection.

Air pollution is also increasing in the South. Annually, five million children under 5 die of acute respiratory illness. This is twice the number of such deaths recorded in 1985, not even two decades ago.

There are three million cases of pesticide poisoning every year. In addition to the use of pesticides, there are 500 million cases of malaria, with 2.7 million fatalities..

In the North our health and environment concerns turn to the products of our technological advancement — chemicals and radiation. Every Canadian carries 200 synthetic chemicals in our body that were unknown to our grandparents. Our discovery of the chlorine molecule led to a vast array of chemicals and pesticides, that are now virtually ubiquitous in our environment: PCB's, DDT, DDE, furans and dioxins.

In the last few decades, we have seen a 500 per cent increase in pesticide use. These substances impact even the unborn. And, the newborn babe who reaches for her mother's breast receives such contaminated food, that as human mother's milk — could not legally be sold. It is too heavily laden with toxic substances to meet food guidelines.

This is an outrage. We accept it as though contaminated breast milk is some sort of inevitability. It is particularly acute for Inuit women in Canada's, and the circumpolar, Arctic. The concentration of toxic substances works its way through the climate system to the poles, and through the food chain to high level omnivores, such as human beings. None of this is with our permission. The reality of it tends to provoke more denial than anger.

MARLIES BOXCH

Elizabeth May addressing IWHM, in Toronto, 2002.

As breast cancer rates soar, with the fastest increased incidence occurring in the developing world, the connection between chemical exposure and contaminated breast tissue seems even stronger. It was only a few decades ago that a Canadian woman had a one in twenty lifetime risk of getting breast cancer; now the risk is one in eight. What changes explain the increased incidence in developing countries if not the increased chemical use in those countries?

Most of these chemicals act as endocrine disrupters, mimicking hormones in the human body. The environmental estrogens (xeno-estrogens) can have a signifi-

cant impact at vanishing small doses. Radiation is a known carcinogen, mastogen and teratogen affecting the fetus. The evidence shows that the pre-natal impacts can be highly dependent on the timing of the exposure. The 300 per cent increase in testicular cancer in young men may well be due to exposure in utero to environmental estrogens.

But chemicals do not confine their impact to birth defects, cancer and increased mortality. In the industrialized world, we are seeing ever more learning disabilities and behavioral problems. At the same time, we know many of these substances, including gasoline additives, have impacts on the neurological system. The chemicals can also have an impact on the immunological system.

At the time of this conference, we were in the lead-up to the World Summit on Sustainable development held in Johannesburg. It was billed "Rio plus 10," but as Vandanna Shiva said, in reference to the 1972 first U.N. conference on the environment and development held in Sweden, it was really "Stockholm minus 10."

Johannesburg turned out to be a big nothing. The agenda lacked ambition. Even worse, it lacked accountability. There was no stock taking of promises from Rio and the extent of their delivery. We needed to revisit the commitments made to the environment and the women of the world at the Rio earth summit, in Beijing and in Cairo. The need is still urgent. As the United Nations Environment Program reported, a "Markets First" scenario going forward thirty years takes us to a 70 per cent loss of nature on the planet. It leads us to devastation.

The tyranny of corporate rule can be overthrown. We can assert a different vision, where profit-making activity takes place within a framework of respect for all living things, for women's rights and health care for every child. We can and must reclaim democracy. We must reject the ideology of the dollar and the sanctification of greed.

Now is the time for all of us to establish that Equity matters over Exploitation. That Cooperation replaces Competition. That Love and Community are valued above Marketplace. We can and must meet the basic human needs of all and protect our biosphere so that every women knows her daughter will grow up in a word where she is safer, healthier, and can bring her baby to her breast without fear.

Elizabeth May is the Executive Director of Sierra Club of Canada

Women's Environments: the Struggle for a Healthy & Sustainable Planet

Prabha Khosla

Women, Health, and the Environment — These three words together speak to a web of issues and concerns that challenge us to think outside the proverbial box and silos that keep us narrowly focused and divided. We must think and act from a holistic perspective if we are ever to reverse the environmental degradation and social inequalities on the planet and create environmentally sustainable, economically viable, and socially equitable gender-sensitive societies.

A discussion of women's health and the environment must also include issues of poverty, hunger, food, security, racism, water, sanitation, agriculture, trade, energy, species extinction, biodiversity and climate change. Our agenda for women's health and environment must also address access and right to live with dignity, sustainable livelihoods, shelter, education for girls, political power and decision making, sexuality, and freedom from violence, conflict and war.

Women, Water, and Sanitation

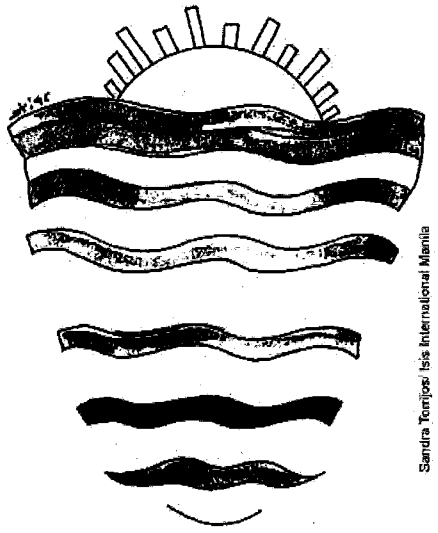
Consider a basic issue — women's everyday living environments and women's access to water and sanitation. Millions of poor women in urban and rural areas around the world do not have access to safe and affordable water or toilets. Unsafe water causes health problems such as diarrhea, schistosomiasis, trachoma, hepatitis, malaria and poisoning (e.g. arsenic). The care of sick family members is usually the responsibility of women and takes time away from their income generating initiatives. To ill health, add the loss and suffering from the death of an estimated three million children a year from contaminated water-related diseases. In the rural area of Garla Mare, Romania, the majority of the water sources — the wells, are contaminated with nitrates, chemicals, heavy metals and bacteria. Amongst other

things, high nitrate levels in drinking water are linked to "blue baby disease" or acute infantile methaemoglobinaemia (WECF, 2003). Women in Romania along with Women in Europe for a Common Future (WECF) are working together to document sources of contaminated water, develop strategies to "clean" water with local authorities and run educational campaigns demonstrating the links between polluted water and ill-health.

Due to deforestation, the loss of vegetation, and the lack of toilets, rural women have to rise earlier and walk further to attend to their daily needs. In urban areas, slums often lack hygienic and secure toilets for women. Women and girls in many countries have been sexually and physically assaulted in the night when attempting to use the "outside," or toilets that are too far from their homes (WEDO, 2003). Women in the US are also organizing to question poor water quality as water supplies in many US cities and towns are contaminated with industrial and agricultural chemicals. Access to safe and affordable sanitation services is critical for women's and girls' dignity, health, and safety.

Impact of Toxic Chemicals on Nature and Women

Human-made chemicals and metals that are persistent (do not readily break down in nature or humans), biomagnifying (accumulate in larger concentrations in animals higher in the food chain) and endocrine disrupting (substances that mimic human hormones and disrupt normal hormone functions) such as atrazine, 2,4-D, and lindane, have been used extensively in agriculture, industry, and the home and garden. Some of these chemicals are also called POPs (Persistent Organic Pollutants). They are the subject of the United Nations Stockholm Convention for the protection of human health and the environment. These same chemicals are readily found in household sprays and cleaners, pesticides, herbicides, fungicides, insecticides, and in our food. Chemicals enter into natural systems and are having devastating impacts



Sandra Torrijos/ Isis International Manila

on wildlife. For example, there is evidence that some alligators, Western gulls, and Rainbow trout are developing rudimentary sexual organs, Western and Herring gulls are exhibiting mating behavior of both genders, frogs are being born with missing limbs and eyes, and Beluga whales are dying from immune suppression and cancer.

Human beings are at the top of the food chain and health impacts similar to those on wildlife are being documented around the world. Widely documented are the health impacts on agricultural and horticultural workers, many of whom are poor women and children with limited options for other livelihoods. Lead, dioxins, DDT and PCBs are found in women's breast milk, from indigenous women in the informal economy in Quito, Ecuador, to Inuit women in Canada's north, to women in the Aral Sea region of Central Asia. Human exposure to these chemicals is linked to endocrine disruption, learning impairment and hyperactivity in children, as well as cleft lip and palate, spina bifida and limb anomalies.

Environmental contamination has resulted in women in the North and in greater numbers in the South facing increased risks of fertility problems, spontaneous abortion and miscarriage, reproductive system abnormalities, immune system disorders and cancer. Breast cancer has become a major women's disease, transcending class, race, ethnicity, culture, sexual orientation and geographical location. The complexity of women's sexual and reproductive health issues and illnesses underlines the need for women's right to decision making and control of their sexuality, sexual and reproductive health, and their right to relevant services through the public health care system.

Women, Energy and Climate Change

While women are often dismissed from discussions on energy, it is a central issue concerning women's quality of life. Poor women who use wood fuel and charcoal to cook indoors are exposed to poor air quality and an increased risk of severe respiratory problems. While nuclear proponents advertise nuclear energy as "clean" energy, they deliberately ignore the impacts of radiation and nuclear waste and the work of many women who have researched and critiqued the dangers of nuclear energy and weapons. Seventeen years after the Chernobyl nuclear disaster of 1986, medical research shows that 70% of pregnant women in the Ukraine have extra-genital and obstetrics disorders including anemia, late toxicosis, cardiovascular disorders and urogenital diseases (WEDO 2003).

Gender analysis has been ignored in the negotiations and policy development on climate change, as in the case of the United Nations Framework Convention on Climate Change (UNFCCC) and follow-up processes and agreements. However, consider the following two examples from Cambodia and Canada of the implications of climate change on women.

Increases in the frequency and severity of floods and drought have been linked to changing global climate regimes. A recent study on the impact of floods on women and girls in Cambodia highlights a number of issues. These include an increase in food insecurity and loss of crops; fear of losing children to the floods; risk of drowning because women and girls are not taught to swim; disaster-related debt and the corresponding increase in workloads of women as men migrate to cities; and the resulting stress and fear of HIV and

sexually transmitted infections brought back from men engaging with other partners in the cities. While the study did not document an increase in wife assault during the disaster period or after, it did identify that the fear of assault is a constant factor enmeshed in women's daily life and an ever present threat that colours women's actions and involvement in decision making (CARE Cambodia, 2002).

Using data from 1995, Public Health Department of Toronto, Canada, estimates that as a result of air pollution, about 1000 people died earlier than expected and 5,500 hospital visits were linked to heart and lung diseases related to high air pollution. As air pollution in Toronto has not changed since 1995 these estimates are still valid today (Toronto Public Health, 2000). Furthermore, asthma is now a chronic disease in urban children in Canada. Recent statistics show that between 10 to 18 percent of Canadian children have asthma. It is mainly women who carry the burden of looking after sick family members, miss work while they take their children to hospital, or give up paid work outside the home and face increasing poverty while they care for the sick.

Governments, Environmental Degradation and Women's Health

And finally, what is the role of governments in environmental protection and safeguarding of women's health? The lack of political will and commitment from many national governments and major international bodies, like the International Monetary Fund (IMF), have degraded natural environments and subjected women citizens to increasing poverty by a loss of livelihoods and a reduction in accessibility to health, education, and other basic services (e.g. GERA 2003). Extensive research and documentation has demonstrated the negative economic and social impacts of programs like the structural adjustment programmes of the IMF on African women.

Increasingly, in countries of the South and the North, many governments are failing to defend and enhance women's hard earned rights to live free of violence from either family members or the State, and to have right and access to health services, as well as specific programmes to address gender concerns as in the case of the HIV/AIDS pandemic. For poor rural women, government supported privatization of common property resources such as forests, wetlands, fallow fields, pasturelands, etc. make it nearly impossible to maintain precarious levels of subsistence living; thus, further marginalizing those women who rely on common property resources for food, fodder and raw-materials.

The beneficiaries of the current neo-liberal economic climate are national political and business elites and the corporations who are behind the current wave of corporate globalization. The World Trade Organization, the IMF and the World Bank are all assisting multi-national corporations in "freeing" trade, de-regulation, and maximization of profits at the expense of the environment and poor women and children. Seventy percent of the 2.8 billion people living on less than US $ 2 a day are women and children.

Women Organizing for a Healthy and Sustainable Planet

While the conjunction of environmental destabilization and women's ill health paints a devastating picture — take heart. Women's organizing can change this picture. Women in the North and the South are organizing to challenge the so-called scientific, and neo-liberal development paradigm of the West/North. High-consumption lifestyles, poverty and under consumption are both unsustainable for a healthy planet. For example, women in Kenya are working together to enhance and sustain local biodiversity while at the same time securing economic livelihoods. Women's groups across the UK are doing "toxic tours" of homes, workplaces and local environments to gather evidence of health problems and develop strategies to address them. MAMA 86, a Ukrainian NGO initiated and led by women, runs a drinking water campaign and mobilizes civil society at the same time. The women of REDEH (Rede de Desenvolvimento Humano — The Network of Human Development) a feminist NGO in Brazil works from a sustainable development perspective to address health, education, and civil rights issues of ethnically and racially diverse women. It also assists 400 women's radio stations in the country to develop programmes for, about, and by women. Women's groups are getting involved locally, nationally and internationally in advancing women's human rights, poverty eradication, environmental policy development, and in defining a global sustainability agenda that reflects and incorporates women's lives and aspirations.

What can you do? Women in the North should demand that their governments dedicate 0.7 percent of their GNP (Gross National Product) to development assistance and that 50 percent should specifically be targeted to women's priorities. Additionally, the North should acknowledge its ecological debt to the South. All women should demand that 50 percent of resources for HIV/AIDS in Africa are channeled through women's organizations. Women and women's groups should be active participants in defining the parameters of all national policies and programmes including those related to poverty reduction strategies (PRSPs), national and local budgets, environmental protection legislation, national sustainable development strategies, land-claims and the right to self-determination of indigenous women and men, and for women's right to inherit and own property. National women's groups should call for gender mainstreaming of the Millennium Development Goals, the international commitments to poverty reduction, and for their involvement in national reporting on them. Women need to continue presenting a gender impact and analysis of current and proposed international trade agreements. Women should constitute 50 percent of all elected seats in all countries.

There are millions of actions that you and your friends and neighbours can take in this international movement of women. Get involved!

This article is abstracted from a forthcoming Final Report publication of the 9th IWHM(January 2004), Organize: A tool to strengthen women's rights to health. The book will consist of thematic analysis and case studies from the organizing efforts and strategies of the participants of the 9th International Women's Health Meeting held in Toronto in August 2002. It is jointly produced by the Canadian Research Institute for the Advancement of Women (CRIAW) and The Riverdale Immigrant Women's Centre (RIWC).

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Relevant Web Sites and Resources

Groundwater Foundation **http://www.groundwater.org** (2003) a US organization started by a woman who's child was sick due to pesticide contamination of water. The foundation is largely run by women and also works extensively with children and youth.

Women In Europe for a Common Future, **http://www.antenna.nl/wecf/WECFRomaniaproj.html** (2003)

WEDO. (2003) Untapped Connections: Gender, Water and Poverty. **http://www.wedo.org/sus_dev/untapped1.htm** (2003)

United Nations Environmental Programme site on POPs. **http://www.pops.int/**

Pesticide Action Network **http://www.pan-international.org** (2003) — an organization with numerous women in leadership.

WEDO. Ukraine's Drinking Water Grossly Polluted. **http://www.wedo.org/ehealth/ukraine.htm** (2003)

Flood impact on women & girls, Prey Veng Province, Cambodia. (June 2002) CARE Cambodia.

Millennium Development Goals, **http://www.un.org/millenniumgoals** (2003)

The Woes of Women in Drought

Social, Environmental and Economic Impacts

Kiran Soni Gupta and Madhukar Gupta

The failure of rain for the fourth consecutive year has given rise to both fear and concern. Rajasthan is one of many States that is being hit hard by scanty rains. While Rajasthan contains 10.4% of the country's land, supporting 5.2% of India's population, it depends entirely on rainfall for meeting its biomass needs. The region is acutely gripped by water scarcity, crop failure, a fall in agricultural production, shortage of food and fodder, environmental degradation and the consequential desertification. The State has a total land area of 34 million hectares, making it almost twice the size of Bangladesh and larger than New Zealand. The impact of drought has far reaching implications for economy, industry, the banking sector and the public at large. The robust 'Rabi' crop, which had shown signs of recovery, now indicates a production fall from 3.5% to 2% for 2002-03. This diminishing the prospect of industrial security.

The erratic monsoon has adversely affected the agricultural sector. Sowing has already suffered and the yields have fallen substantially, making it an irretrievable situation. Groundnut production is likely to fall by 25% in Andhra Pradesh and Karnataka, and soyabean production will be slashed by 50% in Madhya Pradesh. Demand for petroleum products has fallen coupled with income loss. The average consumer will have to get used to spending less and working more. Even big businesses like Hero Honda and Tata's which depend on rural consumers for growth, are beginning to be affected. Hydro-electric generation is estimated to fall by 30%, while the demand is likely to increase by 40%. The pinch of this drought is already being felt throughout Rajasthan, whose Rs.130.million worth of special grants have been slashed by the Rajasthan Government.

It is wrong to assume that drought affects everyone equally and that it is confined to people in the hit areas. The differential impact on people according to class, race, age, ethnicity and gender determines the degree of vulnerability. Gender inequality, which is a critical dimension in all social relationships, is the root cause of social vulnerability. Women's subordinate position in the family and society impinges on them in terms of exposure to risk, preparedness, access to information and recovery from disasters. Family and work roles are the key issues. This vulnerability reflects an unequal work burden

due to protective as well as re-productive responsibilities, lack of control over means of production, restriced mobility, and limited facilities for education and employment.

There is no doubt that drought has affected everyone, notwithstanding the impact on women that is mostly due to their social, cultural and economic positioning within the family and the community. Because there is an increasing number of men migrating to urban centres in search of food and employment, women are often left behind heading households. The absence of men is a very hard fate for women, particularly for those living on the fringes of the desert. In addition to their traditional work, which is becoming increasingly difficult, these women have to earn incomes to survive. But even if a woman succeeds in growing a crop and producing handicrafts, she usually cannot decide what to do with it in the absence of her husband. Women who are left behind with elders and children often feel abandoned and find that their family life is at stake. This results in break-up of traditional family structures, illegitimate marriages and other social problems.

Migration is a significant development in drought hit areas, often stimulated by greater availability of food and water elsewhere. However, when the drought has abated many of these people do not return home, depriving rural areas of the valuable human resources necessary for economic development. As much as poor rural women need paid work, conflicts with child care and other domestic work, gender restrictions on certain tasks, low wages and difficult working conditions impose a serious limit on their ability to convert 'hard work to income'. This difficult situation robs women of time, health, autonomy and security.

The absence of rainfall for the past three to four years has failed to recharge ground water tables and created scarcity of water. People now have to wait longer hours to collect water. Women and children are now spending six to eight hours daily collecting water. Rural women's work is highly resource dependant. During drought, dependable water resources dwindle, and the quality of water deteriorates. The lack of water reduces women's opportunities to earn income through wages on the farm. Exhausted women toil exhausted land.

Some of the other social determinants are health, food, medicine and vaccines. Women's health deteriorates due to reproductive roles and the subordinate position they have in the family. Women are always the last and have least to eat. Prolonged malnutrition and an increasing workload have an adverse effect on women's health in general and on pregnant and lactating mothers in particular. Women also suffer more psychologically due to the lack of control over the situation. Yet they have to manage their families with reduced income, insufficient food and deal with sick members of the family. Today, 30% to 80% of children and 70% to 80% of women in the childbearing age, suffer from anemia. Many anemic women do not receive adequate attention and treatment. This leads to a continuous increase in infant mortality as well as a growing number of childhood and birth defects. The situation is further aggravated by the lack of basic supplies in hospitals and inadequate knowledge of preventive measures. Women are reluctant to take unknown pills. The rise in respiratory and water borne diseases in drought affected regions needs a close watch. Other social impacts involve issues of public safety, conflicts between water users, and inequities in the distribu-

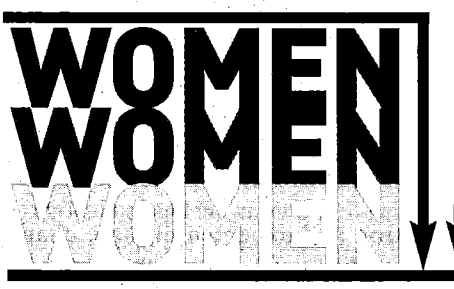
Drought Impacts on Women

Social Impacts
- Lack or poor distribution of resources (food and water)
- Increased quest for water
- Reduced crop yields
- Employment layoffs
- Food insecurity
- Inequitable drought relief
- Urbanisation and Migration

Consequences
- Migration, less income, reduced quality of living, malnutrition and health risk, social pressures
- medical burden on women.

Environment Impacts
- Damage to natural habitats
- Reduced forest, crop, productivity
- Lowering of water levels
- Reduced cloud cover
- Increased daytime temperature
- Increased evapotranspiration
- More dust and sandstorms
- Decreased soil productivity
- Increased pollutant concentrations
- Decreased water resources
- Reduced water quality
- Increased forest and range fires
- Increased incidence of animal diseases and mortality
- Soil desiccation
- Degradation of landscape quality
- Species concentration near water

Consequences
- Shortage of food — fodder, soil degradation, erosion, crop withering, loss of bio diversity



Economic Impacts
- Reduced business for retailers
- Food and energy shortages
- Loss of crops for food and income
- Reduction of livestock quality
- Water scarcity
- Loss of jobs, income and property
- Less income from tourism and recreation
- Forced financial loans
- Marginal income from land

Consequences:
- Increased prices
- increased unemployment and debt
- capital shortfall, fall in real income
- increased transport costs

tion of disaster relief. Young girls, elderly women and widows are seriously impacted because they are perceived to have a greater need of paid work.

What's extraordinary is the determination of these women. They organize at the local level and plan participatory action to cope with the situation. Women all over the world are "defacto crisis managers." Their local coping strategies are important for emergency practitioners, policy makers and administrators. Women create the next best thing to normal life i.e. space for eating, sleeping, and the care of children and vulnerable groups. Women's instinct for survival is very acute.

The failure of the Government to assess the impact of drought on women and the general gender blindness of administrators and policy makers, needs to be considered. There is a need for an urgent paradigm shift in drought relief work. Gender analysis is needed with respect to gender division of labour and the psycho-social pattern, which limits women's ability to respond to droughts.Traditional views on gender differences and inequalities are too easily imposed in the absence of gender perspective. The strengths, knowledge, skills, capabilities and resourcefulness of women are ignored and they are seen as "helpless victims". It is imperative to remove this bias and to accept individual capacities of men and women, thus demystifying stereotyped roles.

Another important shift that is urgently required in the disaster paradigm is a move from relief to mitigation and risk reduction. For this, targeted awareness needs to be promoted among women. Increasing gender awareness among the media, school children and teachers is needed. Inclusion of women's human rights training, drought management, improvement in local hazards, better communication and delegating primary responsibility in management of emergency food, shelter and medical supplies would no doubt help to lay a foundation to understanding, mitigating and distributing the effects of the drought more equitably.

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Health and Clean Water: Rainwater Retention Helps Green Rajasthan

Aradhana Parmar

"Of all the social and natural crises we humans face, the water crisis is the one that lies at the heart of our survival and that of our planet Earth."

Koïchiro Matsuura. Director-Genera, UNESCO

ARADHANA PARMAR

Rajasthani Women at Water Retention Project

Clean water, a basic ingredient for good health, is not available to the majority of people on Earth. Currently, one billion people lack access to safe drinking water and three billion are without basic sanitation. A report compiled by 23 UN agencies predicts that two billion people in 48 countries will suffer water shortage by the middle of the century. The World Water Development Report, 2003, says that water resources will steadily decline because of population growth, pollution and expected climate change. According to the report, "the 21st century is the century in which the overriding problem is one of water quality and management." Today, more than 2.2 million people die each year from diseases related to contaminated drinking water and poor sanitation. Water vector-borne diseases result in a significant number of deaths: about a million people die from malaria each year and more than 200 million suffer from bilharzias (World Water Development Report, 2003). The UN report said that legislative reform, better valuation of water and more private-sector involvement is needed. It is estimated that the first interventions would cost $12.6 billion US.

A multi-faceted approach is needed to solve water problems. These problems are preventable and don't require spending billions of dollars for building mega dams or to tie water into market relations. Vandana Shiva claims "that the water crisis is an ecological crisis with commercial

causes but no market solutions. The solution to an ecological crisis is ecological." A traditional water conservation technology is demonstrated in the Alwar district of Rajasthan, India, where rural people, with the help of the local NGO, revived a traditional watershed technology of johads (water reservoirs made of mud and rubble barriers built across the contour of a slope to collect rainwater) in order to face the looming crisis of fresh water.

Rajasthan is the second largest, and one of the poorest regions in India. It is situated in the Thar Desert and prone to drought. In the west, Rajasthan is relatively dry and infertile. In the southwestern part of the state, the land is wetter, hilly, and more fertile. The climate varies throughout Rajasthan. On average, temperatures range from 8 to 28 C in the winter and 25 to 46 C in the summer. Average rainfall also varies; the western deserts accumulate about 10 cm annually, while the southeastern part of the state receives 65 cm annually. Most rain falls during monsoon season: between July and September. The annual rainfall in the Thar Desert is 10 to 40 cm and is technically arid. Rain distribution in Rajasthan is extremely uneven and averages do not give a true depiction of the state's rainfall; it can be up to 100 cm in some places and 25 cm in others. The terrain of Rajasthan — where water is sacred and the heat is strong — inhibits the lifestyle of its people.

For centuries, people in Rajasthan have survived on frugality, ingenuity and patience. They did not allow the lack of rain to translate into a scarcity of water, and thus customs, rituals and practices of indigenous culture continued. In his book, The Radiant Drops of Rajasthan, Anupam Mishra articulates the relationship between Rajasthanis and water: "Rajasthan scaled the peaks of trade, culture, art and standard of living because of the depth of their philosophy of life. This philosophy [gives] a special space to water." Rajasthanis dedicate time and effort in obtaining and optimizing the use of water they receive. Water is regarded like nectar or amrit (ambrosia) in Rajasthan. Over thousands of years, traditions evolved for collecting rainwater in the desert state. Both humans and camels can manage without water for considerable lengths of time. Housewives perform chores with minute amounts of water.

Retention of Rainwater

Water sustains societies and nurtures human life, but societies in desert areas revolve around water. The water collected in johad during monsoon season is used throughout the year for irrigation, drinking and other domestic purposes.

Traditional techniques and systems of water and land management were devastated by colonial rule. According to Prem N. Sharma:

> "The people lost their resources while the government gained bureaucratic control. The process of recording, settlements, adjudicating, administration and politics played havoc with the commons and community. This was largely due to the fact that the operational values and ideals of the post-independent state were about privatization, within a bureaucratic vision of a paternalist, welfare State in charge of everything. The 'preeminence' of the State, disinvested the people of their own eminence, worth and identity along with the resources which had been the domain, the wealth and the capital of the indigenous communities. The system aided and abetted private manipulations, encroachment, allotment and plunder of natural resources — the common pastures, forest lands, the water bodies, tanks, ponds — and flouted the traditional modes and rights of people."

Local NGO, Tarun Bharat Sangh (TBS) revived the traditional water conservation technology of *johads* in the 1970s. With the help of the local people, TBS constructed over 2500 *johads*. This water-harvesting technique has transformed the ecology, agriculture and the general well-being of the people in the Alwar district. Since the main sources of livelihood in this area are subsistence agriculture and livestock rearing (largely fed by rain), the construction of johads has made a visible impact on the socio-economic scenario of this district.

Rural Women and Water

Traditionally women are responsible for fetching water, fuel, wood and fodder. In Rajasthan, the average time spent on these activities is 12-14 hours per day.

Women in this region have suffered as a result of fetching water for household maintenance. This shortage of water has sapped time, energy and the health of women and young girls. Girls are forced to drop out of school to collect water. According to the International Women's Tribune Center, 1982: "Sometimes the strain of carrying water in huge vessels on their head can lead to pelvic deformity and complications in child birth."

Many of the women I talked to in the Bhikampura village of the Alwar district of Rajasthan said that lack of water in the household is also responsible for domestic violence. Kajori Mai, an activist and grandmother of two said: "Water is essentially a woman's issue. Men are not really bothered about it. They just wash their hands and sit down for food. It's the woman who has to arrange water for all day. Women need the water. And if there is no water in the house, the man will take stick in his hand and ask — 'you didn't get water?' It's the women who have to pay the price. It's the woman who needs water for the household work and to sustain the family. It is a woman's resource."

Health and Rural Women

Health issues of women in rural households in India are affected both through material conditions such as poverty, diet, access to water and fuel, and also social, cultural economic conditions. When there is no water in the villages, no crops grow. Men migrate to the cities for work, and women are left to fend for themselves, their children, the elderly and their cattle.

Because obtaining water takes up so much time, the education of women in Rajasthan is affected. The literacy rate for women is the lowest in India, 1.7 per cent compared to 87.8 in Kerela. The sex ratio is 910 females to 1000 male compared with 1058 females to 1000 males in Kerala.

In the case of Alwar district, the construction of *johads* increased the availability of surface water in the region, consequently

creating more employment opportunities in the village for men. The increase not only liberated women from backbreaking work, it improved the health and quality of their lives. According to Rajendra Singh, head of TBS: "women had to travel 7-8 kilometres a day to fetch only one or two buckets of water, now they go to the village well and finish off this work within 10 minutes. Since they have some time at their disposal, they have also started educating their children. It is worth mentioning that the villages where water became freely available were the ones where girls started going to school first." Prabhat Devi confirms: "Take education — at first girls did not study, and they were married off early. Now they go to school, get married when they are old enough and even the gap between pregnancies is now proper."

Aradhana Parmar PhD. teaches Development Studies at the University of Calgary. Parmar is the author of "The Techniques of Statecraft: A Study of Kautilya's Arthasastra" (1987)and several articles and reports. She co-authored "South Asia: Historical Narratives" (2002). Aradhana's areas of interest also include gender and development, South Asia, immigrant women in Canada and ancient Indian political thought. Committed to breaking the gap between the university and the community she has played leading roles in the India-Canada Association of Calgary and Calgary Immigrant Women's Association and Canadian Association for the Study of International Development.

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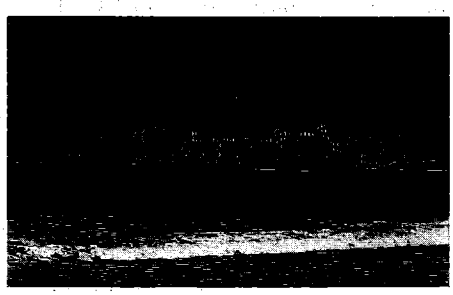
Coastal Pollution and Women's Health in Ada-Foah, Ghana

Elaine Tweneboah

Ghana has a beautiful coastline of 550 kilometres, more than half of it being made up of sandy beaches, several forts and castles built between the 15th and 18th centuries, attracting many domestic and international tourists. [Plate 1] The current major uses of the coastal environment of Ghana are fishing, human settlements, tourism, industrial developments, and sand mining. Coastal resources are important in providing food, fuel, household materials (such as thatch and other building materials), and medicines for many communities. Despite this wide range of values, the coastal resources are being overexploited and certain groups are feeling the effects of this more strongly than others. The over-use of resources is linked to increasing pressures from human settlements (as a result of migration and population increases), and pollution from economic activities, all of which impact adversely on the entire coast. Levels of pollutants, both sea and land based, as well as the rate at which biodiversity is being lost, have risen remarkably in the past twenty years.

The primary sources of sea-based pollution of the marine environment in Ghana are discharges of untreated wastes from ships and residual oil in ballast waters from oil tankers. Land-based sources of pollution include waste from industries, agriculture, and settlements along the coast. The main producers of industrial waste are the textile and food processing industries and the petroleum refineries. However, the most common forms of pollution — faecal waste and refuse — are from domestic sources. Refuse and human waste is dumped directly on beaches and is washed into the sea and later deposited on beaches elsewhere. These poor sanitary practices contribute to health problems and the degradation of the coastal environment. There is also a decrease in the aesthetic value of the coastal environment, which seems the major draw for the foreign tourists. Poor sanitation and pollution from domestic sources are perhaps the most widespread and pervasive of all the problems affecting the coastal zone of Ghana.



E. TWENEBOAH

Plate 1 - The Elmina Castle found in the Central Region of Ghana was built by the Portuguese 1482 and is one of the most visited in West Africa.

Making the Link — Women, Coastal Pollution and Health

Though the links between human health and pollution have long been recognized, the health impacts of exposure to pollution and poor sanitation cannot be generalised. The issues of coastal pollution given above affect both men and women,

E. TWENEBOAH

Plate 2 - Women fetching water from Volta Estuary.

but there is an abundance of evidence indicating that rural coastal women are among the most affected groups. As managers of natural resources, food providers and caregivers for other family members, women interact most closely with the biophysical environment to enable them to provide the basic needs of water, food and energy. In addition, they depend on available natural resources for augmenting their families' diets and income. Thus any deterioration in environmental resources as a result of pollution not only creates hardships and difficulties but impacts adversely on women's health and their ability to deliver care to their families.

The Situation Among Women in Ada-Foah

In Ada-Foah, a coastal community in the Greater Accra Region of Ghana, environmental health hazards facing women have been more of "traditional" hazards arising from their daily activities and natural phenomena. However, with globalisation and industrialisation, "modern" hazards such as chemical pollution and natural resource depletion are impacting the health of these women. As they go through the day, they carry out various activities such as searching for water and fuel wood, cooking, growing food, processing and marketing of fish, all of which bring them into close contact with the environment. These activities also expose women to various forms of pollution and health hazards, many of which go unnoticed by the women themselves.

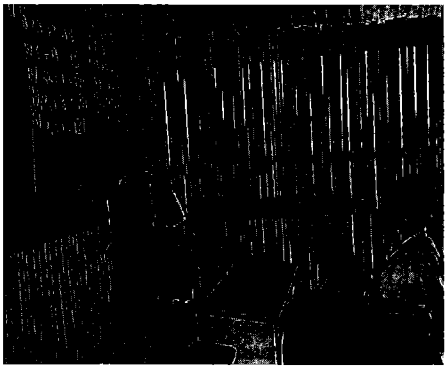
Water Pollution

In 2000, only 40 percent of the rural population had access to safe water in Ghana. Many rural communities like Ada-Foah lack potable water. Alternative sources of water in Ada-Foah are the Volta Estuary, bore-holes and hand dug wells. Water pollution affects the health of the women in two main ways. As available water sources are increasingly being contaminated, women are using unsafe and polluted waters. For example the Volta Estuary is known to harbour the snail vectors for schistosomiasis (Bilharzia). Schistosomiasis is a chronic snail borne infection. Studies show that the high-risk groups are women and children. Continued interaction with the river has maintained the disease at appreciable levels. [Plate 2] Secondly, polluting of water sources previously fit for human consumption adds to women's workload in fetching water from alternative sources, which consistently are much further from the home. Fetching water is a gendered activity, limited to women in most cases. They have to walk many kilometres in search of water, setting out each day at dawn and returning in the morning. It is estimated that on the average women use as many as 3 hours a day searching for water and transporting it on their heads, causing neck, back and leg injuries.

Air Pollution

In Ada-Foah, cooking takes up the bulk of the woman's day. It is done outside on open stoves and 'coal pots', or in poorly ventilated indoor kitchens. The source of energy is invariably wood fuels, which emit substantial amounts of pollutants, including particles and carbon monoxide. Outdoor cooking lowers likelihood of respiratory problems. Women are exposed to high levels of air pollutants during cooking and processing of fish products. Studies have shown consistent and strong links between the indoor use of wood fuel and a number of diseases such as lower respiratory infections, lung cancer, tuberculosis, cataracts, heat, watery eyes, coughs and asthma. Many of the women are unaware of the health implications of their cooking activities. Their 'red eyes', developed after years of exposure to smoke, is seen as a normal phenomenon. Yet over 60 percent of the women interviewed did not view air pollution as an environmental problem or a health hazard.

Women in Ada-Foah have always played an important role in every aspect of the fishing industry, from marketing to processing, from repairing fish mesh to selling catch. Women forage rivers, mangrove swamps, and lagoons for shrimps, crabs, and shellfish for their own families or for sale in local markets. Besides being a source of extra income, in most cases, it is their main occupation. While some of the fish is sold fresh, a significant amount is preserved by drying in the sun, salting and smoking. Fish smoking in Ada-Foah uses preferred species of wood on traditional cylindrical clay ovens. Only very few women use the 'Chorkor'. This relatively fuel efficient fish oven smokes large quantities of small pelagics. Here too smoke is inhaled and particulate air pollution enters the body. Other harmful smoke associated pollutants include lead and carbon monoxide. When pregnant women inhale these it may threaten the growth and mental development of their foetus. Young children are also at risk since they are often at the sides of their mothers as they cook or smoke fish.



E. TWENEBOAH

Plate 4 - Educating them whilst still young.

Pesticides

Many of the women farmers in Ada-Foah do not own land. They are mainly helpers on the farms belonging to their husbands and their husband's families. Some grow vegetables for sale in the market. Many farms use a lot of pesticides. Pesticides leach into ground water, and persist as

residues on land to then enter the plant/animal food chain and penetrate the human body. So far there have been no reported deaths as a result of pesticide poisoning, yet available data shows that the pesticides concentrate in body fat and in breast milk, making women and infants particularly vulnerable to their toxic effects.

Solid Waste and Poor Sanitation

People in Ada Foah are too poor to have toilets and adequate waste disposal and unaware of the health hazards of this situation. The growing number of refuse dumps make solid waste disposal a critical issue. These dumps breed many insects and animal vectors such as flies, cockroaches, and rats, which can end up in the home. Empty containers collect water and breed mosquitoes. Unsanitary excreta and domestic waste disposal cause diarrhoea, schistosomiasis and malaria. Soil samples in many areas along the coast show high coliform counts.

Loss of Natural Resources

The loss of natural resources such as fisheries, land, and mangroves, as a result of pollution and over exploitation affects the health of women in Ada-Foah. Loss of vegetation cover has increased erosion in many of the communities in Ada-Foah. As the quality and quantity of mangrove forests are being depleted faster than they can regenerate, women have to walk 3-5 hours a day to collect wood fuel for cooking and heating. Not only do they get sore feet from walking long distances but also they get back and neck pains as a result of over loading.

Looking Ahead

Unfortunately, many of the women have very little knowledge of the potential impacts pollutants have on their health. Since women are major stakeholders in the environment they need to be empowered to play a more active role in environmental issues. This means formal and informal education, training and awareness programs. Only then will they understand the value of coastal resources and the adverse impacts their everyday activities have. [Plate 4] Adult literacy classes, which seem to have collapsed, need to be reopened in Ada-Foah. This will also make their education on environmental issues easier. Only aware and actively involved women can bring about clean water, toilet facilities, the efficient disposal of garbage and the use of clean cooking fuels.

Acknowledgement

I will like to thank the African Gender Institute of the University of Cape Town, South Africa for providing me the space to think out the initial concept of this paper and Prof. Christopher Gordon, University of Ghana and Mr. Daniel Nukpezah of the Brandenburg University of Technology, Cottbus for their comments.

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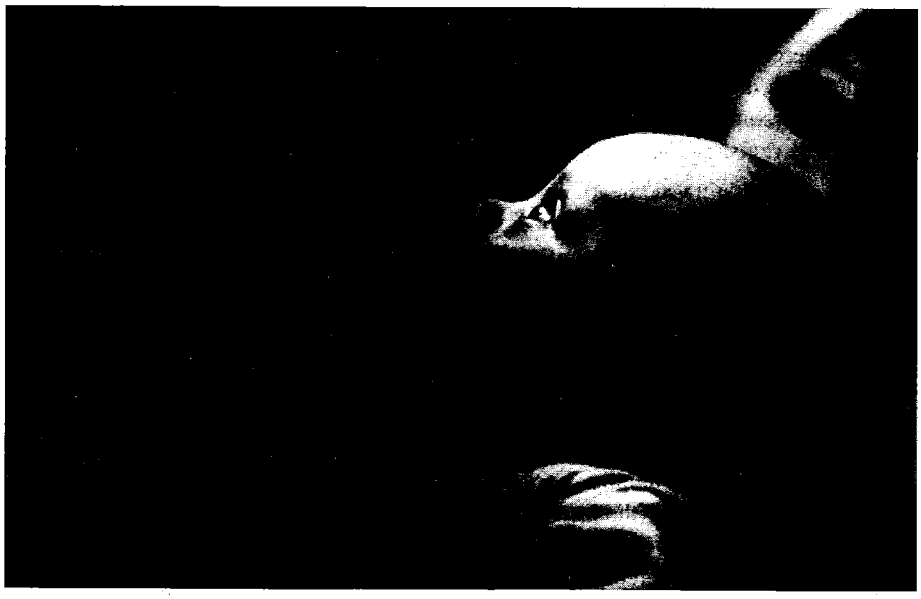
The Insidious Elixir — Mercury, Sources, Effects and What to do About It

Ann Montgomery



STEPHANIE FANSOLATO

Breast feeding baby

In 2001, the Centres of Disease Control and Prevention (CDC) noted that as many as 375,000 children born each year in the United States are at risk of neurological development problems resulting from maternal fish consumption.

Mercury, named after the Roman god, patron of merchants and commerce, was mined by the Romans. Prized for its unique properties, it is the only metal that remains a liquid at room temperature. It is shiny, denser than a billiard ball, and is soluble in just about anything. It is the universal alchemical symbol. And it was once believed by both the East and West to hold the secret to physical immortality.

Historically it was used in ointments, laxatives, skin-lightening soaps, vermilion face blush, teething powders, topical antiseptic drug, and paint pigments. Even with a place in our storybooks, mercury is the reason behind the Mad Hatter's strange behaviour in *Alice in Wonderland* (his felt hat was rubbed soft with mercury).

At the Stockholm Convention on Persistent Organic Pollutants, the United Nations Environment Programme called for an immediate ban on mercury in 2001. This followed a global decrease in its use. Yet the persistence of mercury in the environment has led to the accumulation of mercury in women's bodies and subsequently, in babies and breast milk.

In 1953, Minamata Bay and Niigata, Japan, people reported chronic headaches, malaise and diarrhea. Their fingertips started to tingle and tremor, their muscles weakened and their steps became uncoordinated. Many found it painful to swallow. Some became blind and deaf. A few slipped into a coma and died. Five years later, high levels of mercury compounds were measured in the Agano River and Minamata Bay. These compounds came from a factory, which manufactured vinyl chloride and acetaldehyde. The mercury released into the water was concentrating in the fish, a prominent part of the residents' diet. By the time, the emissions of mercury were stopped, the death tally was 55 and there were 3128 cases of mercury poisoning, many with irreversible symptoms. The devastating ecological costs were not recorded and can only be speculated.

At a time when the common belief was that the human placenta could effectively protect the fetus from exposure to toxins, the medical diagnosis *Fetal Minamata Disease* was coined. Of newborns exposed *in utero* during this time, cerebral palsy was seen in 6%, twelve times Japan's national average, and one-third were categorised with an IQ of less than 70 and "non-specific neurobehavioural dysfunction".

In decades following the Minamata disaster, methylmercury was being used as a fungicide. Stored grain was coated with methylmercury so that it would not rot before planting season. The grain was distributed in Iraq in sacs with toxicity warnings written in English. Farmers used the grain not only for planting but ground it into flour for bread. In 1956, they had 100

cases of mercury poisoning; in 1960, 1022 cases; in 1971, 6530 hospital admissions, 459 deaths; 25% of infant exposed *in utero* had microencephaly (extremely small head circumference) and cerebral palsy.

There were also illnesses and deaths from contaminated seed grain reported in the United States, Nicaragua, Ghana, Guatemala, and Pakistan. The treated seed grain worldwide was also responsible for elevated mercury levels entering the ecological food chain. It wasn't until 1995, that mercury-containing fungicides could no longer be registered for use in Canada.

Today mercury is still used in gold mining, chlorine and caustic soda preparation, and iron and steel production. It is found in laboratory and medical equipment such as, fever thermometers, sphygmomanometers (to measure blood pressure), and dilation and feeding tubes. Some consumer goods containing mercury are fluorescent lamps, button batteries, fever thermometers, thermostats, and children's running shoes that light up when they walk (the liquid mercury sloshes back and forth creating an electrical connection). Mercury is released into the environment from hydroelectric dams, pulp and paper production, smelting, incineration of solid waste and sewage sludge, and fossil-fuel burning, as well as forest fires, volcanoes, volatilization from the ocean, and natural leaching of mercury from geological deposits, a process accelerated by deforestation. 50 to 70 % of mercury emissions are due to human activities and levels of atmospheric mercury are two to six times greater than in pre-industrial times. The atmospheric burden is increasing by 1.5% a year despite a dramatic global decrease in mercury mining and use.

At current levels of mercury and methylmercury contamination in the environment, acute poisoning scenarios like those seen in Japan and Iraq are less likely to occur. But what is known about mercury's effects at levels that are currently observed in our environment?

Children are at greater risk than adults due to mercury's mode of toxicity and their state of development and increased metabolism. They consume more food, water and air per kilogram of body weight compared with adults. They are also exposed *in utero* and during breastfeeding. Their behaviour in early childhood makes them vulnerable to increased exposure; they crawl in the dirt, they put their toys and their hands in their mouth. A study published in Pediatrics in March 2003 from researchers in the Philippines followed 48 mothers and infants from a gold mining community over a two-year period. At birth, infants had a greater burden of mercury compared to their mothers, indicating that mercury was accumulating in the fetus. This study, along with studies in the Inuit, Cree, and New Zealand populations, found physical and mental developmental delays in children exposed to mercury during pregnancy. A study from the Faeroe Islands found that despite high levels of mercury in mother's breast milk, the developmental benefits of breastfeeding outweighed that of the toxicity of the mercury. A study in the Seychelles Islands found no observed adverse effect in children with relatively high maternal mercury levels measured in the hair.

> The EPA estimates that 7 million women and children regularly eat fish containing unsafe levels of mercury and 3 million American children have elevated mercury levels in their blood.

More research is needed, particularly in the area of accurate indicators of mercury exposure. Generally mercury exposure is measured with hair or blood samples, however, mercury accumulation occurs in the muscles and kidneys. There may also be sex-related differences in the metabolism, storage and excretion of mercury.

The general public's largest source of mercury is from fish consumption. Fish accumulate methylmercury directly from the water or via the food chain. Not only does methylmercury *bioaccumulate*, it also *biomagnifies* (i.e., mercury concentrations increase as you move up the food chain).

The United States Environmental Protection Agency (US EPA) and the European Union (EU) have the most conservative mercury consumption guideline for the general population of 0.1 microgram per kilogram of body weight per day (ug/kg/d) (for a 60 kg woman, this would be 6ug/day). Health Canada's guideline is 0.2 ug/kg/day for women and children. Fish and shellfish available in stores in Canada (salmon, cod, shrimp, et cetera) have less than 0.5 ppm or 0.5mg/kg of mercury in them. Therefore, a daily serving of fish (100g, roughly the size of the palm of your hand) may exceed the US EPA and EU guideline. And this does not take into account exposure from other sources (discussed below). Shark, swordfish, tilefish and fresh or frozen tuna are to be avoided by woman and children because they regularly contain mercury levels greater than 0.5 ppm. Canned tuna is younger and smaller with mercury levels less than 0.5 ppm. Fish with levels of 1.5 ppm or greater are not available in stores but some fish in Canadian waters may have levels this high. This poses a risk to populations who rely on caught fish as a source of food. Provincial government websites post warnings for sports anglers, but Canada does not have labelling requirements for market fish.

Elemental mercury in amalgam tooth fillings is measurable in the blood, urine and breast milk, and varies based on the number of fillings, the age of the fillings, and the amount the person chews. A range of 1-27ug/day of elemental mercury can be release from fillings. An alternative is composite fillings, which are inert and white but require fastidious placement and may not last as long. The Canadian Dental Association does not know what percentage of dentists continue to use amalgam fillings compared to composite fillings, but the US EPA estimates a 75% reduction in amalgam fillings in the last 30 years.

DTP (diphtheria, tetanus, and pertussis) and some hepatitis B vaccines contain the preservative thiomersal, or ethylmercury, effective to prevent bacterial contamination, especially in opened multi-dose

vials. The World Health Organization (WHO) Global Advisory Committee on Vaccine Safety concluded in March 2003 that the "balance of risk is clearly in favour of continuing to vaccinate." Multi-dose vials are more cost-effective and switching over to single dose vials, the Committee stated, would increase production, shipping and storage costs, and ultimately lead to a vaccine shortage. They added that switching to an alternative, albeit inferior preservative would mean that the vaccine is a 'new product' for licensing purposes and, therefore, would need to be tested and fully licensed, which is an arduous process.

Studies have shown that in thimerosal-containing vaccines, ethylmercury blood levels in the child remain within a range set by the National Academy of Science in the US and the WHO. Critics of these studies state that the ethylmercury was measured in the babies' blood days after vaccination, not hours. Therefore, half of the ethylmercury would have been excreted (the half-life of ethylmercury is thought to be 7 days). Another criticism is that every infant receives that same dose; therefore, a smaller infant will receive a relatively greater dose. And finally, researchers considered the exposure in isolation and did not consider a total budget of mercury exposure, when considering the effects of the exposure.

Mercury's proponents (and they are fierce) often consider effects from a single, isolated source. But the reality is that the mercury emitted is added to our collective, global budget. The mercury in amalgam fillings that does not end up in our brain, ends up in our breast milk, our toilets, our water. The ethylmercury injected in our recently vaccinated child goes into the diaper and into the landfill. If we continue to use mercury, like quicksilver, it escapes us. Whether we use it in chlorine production, amalgam fillings, vaccines, or thermometers, the mercury gets away from us and sneaks into our food chain, into our bodies, into our babies.

True: Over the last decade, there has been a dramatic global decrease of mercury emissions.

WHAT YOU CAN DO

1. Limit your intake of mercury.

- fish: consult provincial guidelines for angler advisories, go to www.inspection.gc.ca/english/corpaffr/foodfacts/mercurye/shtml at the bottom of the page, click on provincial authorities and go to www.schs.state.nc.us/epi/fish/whatfisharesafe.pdf for a summary. If you take fish oil supplements, buy only those labelled "mercury-free". Albeit, an unregulated area, there is a new, very expensive, pharmaceutical-grade fish oil available through www.drsears.com, the author of The Zone Diet.
- Alternative fillings: if you need a new tooth filling, or an old filling replaced, discuss alternatives with your dentist (if he or she is dogmatically attached to amalgam fillings, find another dentist). Note that not every insurance plan covers alternatives to amalgam — if yours does not, encourage your employer and insurer to change this

2. Remove mercury-containing products from your house and dispose of them properly. Contact your Municipal Household Hazardous Waste Depot (under Waste and Recycling in the Blue pages of the telephone book).

3. Conserve energy. Your electricity may come from coal-generated power plants. Switch from your old round thermostat to a new, electronic thermostat. Programme it to keep the heat down when you are sleeping or away from the house. To dispose of the old thermostat, take it to your Municipal Household Hazardous Waste Depot or call Honeywell 1-800-345-6770 or http://content.honeywell.com/yourhome/ptc-thermostats/thermostat.htm for a local retailer who will properly dispose of it.

WITH SOME ADDITIONAL EFFORT

1. Organize a fever thermometer exchange at your day-care, school, hospital or workplace. www.noharm.org , click on mercury to find information on how to plan and hold a mercury thermometer exchange. Encourage your local pharmacy to only carry electronic and alcohol thermometers; Shopper's Drugmart, PharmaPlus, Jean Coutu, and Walmart have stopped carrying mercury thermometers but smaller pharmacies still need encouragement. One manufacturer, Becton-Dickinson, stopped making mercury thermometer two years ago, but until stocks are depleted, these thermometers will continue to appear on store shelves.

SANDRA TORRIJOS/ISIS INTERNATIONAL MANILA

2. Lobby your Member of Parliament and the Minister of Industry, to bring in labelling requirements on consumer items that contain mercury. Vermont currently has this requirement. (To locate contact information for your Member of Parliament, go to www.canada.gc.ca/directories/direct_e.html)

3. Lobby your Member of Parliament and the Minster of Agriculture and Agri-food, to have fish labelled with the mercury content, educating consumers to limit consumption and warning pregnant women and children to restrict consumption of these species of fish.

4. Vehemently oppose garbage incineration in your municipality.

PRODUCTS THAT CONTAIN MERCURY

- Thermometers
- Thermostats (round, non-electric models)
- Button Batteries (some)
- "Silver" Dental Amalgam
- Quicksilver Maze Toy
- Old Latex Paint (pre-1991)
- Some Running Shoes that Light Up
- Switches (including "silent" light switches, tilt switches in appliances)
- Contact Lens Solution (with Thimerosal)
- Nasal Spray (with Thimerosal)
- Flame Sensor (used in some residential and commercial gas ranges)
- Fluorescent and High Intensity Discharge (HID) Lamps

Source: Modified from "Mercury Awareness for Michigan Citizens." (Revised December 2000).

True: Naturally occurring levels will still continue to enter our food-chain.

These two points cannot be used to argue that things can continue the way they are. We can continue to quantify the effects of mercury but the available science keeps telling us the same thing — 'a lot is bad, a little is not good'.

There exists a sufficient body of evidence compelling us to take the cautious approach. As women, as members of communities concerned about children and their future health and environment, we must continue to phase out the use of mercury, to collect mercury that is in our homes, and to capture mercury that is unintentionally released in industrial processes. We do not need mercury in childhood vaccines nor children's running shoes. We do not want mercury in the fish we eat when we're pregnant. We do not want mercury to contaminate our breast milk. And it is time to acknowledge that mercury does not hold the answer to physical immortality.

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Further Reading:

"The Mercury Primer", May 2003 www.pollutionprobe.org, in publications. Concise and complete report on consumer, environmental and health information. Lists of valuable Canadian websites for the activist.

Current research on drug or chemical exposure during pregnancy and lactation — a searchable database. **www.motherrisk.org**

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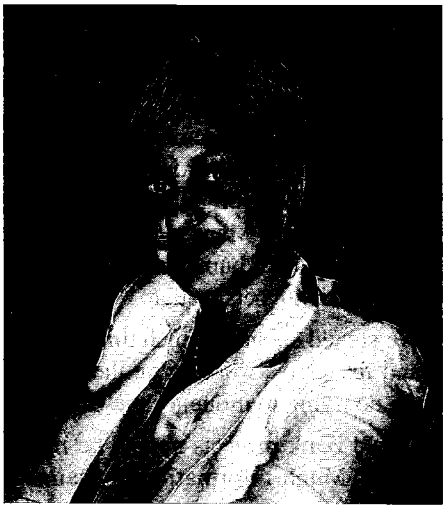
Sociopolitical Health Issues

State of Our Globe — Globalization & Women's Health

Joanna Kerr's remarks to the final plenary session of the 9th IWHM, Toronto, 2002



AWID PHOTO ARCHIVES

Joanna Kerr

As a result of globalization, we live in a world

- where the largest economy is that of Walmart — an American store chain that profits from women's cheap labour;
- where, according to the UN Human Development Report released last month democracy is actually in decline — women actually have less representation in government than before;
- where thousands of women leave their countries to find work as nannies and nurses or worse — get forced into prostitution;
- where millions of women are entering jobs in great numbers though many of them concentrate in irregular, low paid and unhealthy precarious work — especially in the informal sector;
- where global corporations are seeking monopoly of the fresh water lakes and rivers to export it denying women and men access to this precious resource;
- where human cloning is around the corner with the attendant human rights and ethical questions we have barely even grappled with;
- where the U.S. has gained such economic and political strength it is able to unilaterally deny rights to women and girls (through the Gag rule or cuts to UNFPA, for example) — not to mention get away with spending almost half a trillion dollars this year on "defense spending;"
- where the religious right just seems to gain strength in numbers, dollars and political clout by the day;
- where North-South inequities and inequities based on race, gender, class, ethnicity, ability, caste is expanding at an unimaginable pace;
- where definitions of terrorism with legitimate civic action are being blurred;
- and where all governments keep cutting their spending on healthcare, education, the environment, food subsidies and social services — though increasing their military budgets.

And alongside all this, "CNN ization" — where corporate media conglomerates propagate such profound myths — myths such as

- Globalization is good for the poor — it is benign and irreversible: the free market will solve our problems;
- Terrorism is the most important problem facing the world;
- Pollution is equitably distributed;
- Science brings only positive progress;
- US unilateralism represents a most benign form of empire;
- International law is simply a pipe dream... or
- What is good for men is also good for women.

So what does all this mean for us — for our agendas — and our strategies?

How can we not get overwhelmed by such major global forces, ideological divides, in addition to such a lack of political will to stand up for women's rights? I see hope by us building more feminist leadership to tackle the forces behind globalization. Why? Because most of the challenges we are facing in terms of women's lack of reproductive and sexual rights, violence against women, and environmental degradation are directly linked to globalization processes. As we all know, corporate expansion and concentration, privatization, government cuts, reduced power of the state, US domination...these are all intrinsically part of globalization. They create the underlying conditions and determinants of women's health, autonomy and security.

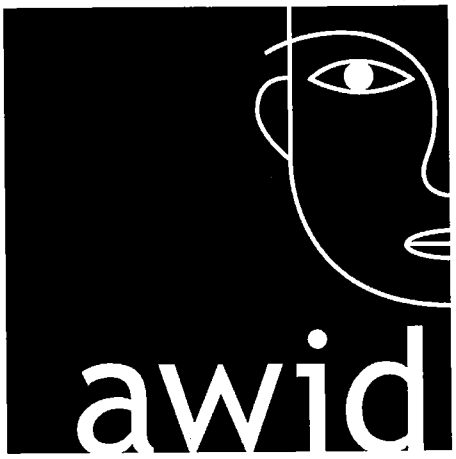
The three themes of this conference are linked under the umbrella of globalization. If we are to truly put forward a revisioned framework for political analyses and action we need to transform globalization processes. So let me put forward these following suggestions as a starting point for this afternoon's discussion of strategy and "where we should go from here." Some of these 5 points are obvious,

some more controversial and intentionally provocative:

1 Link to the Global: Holding international financial institutions (IFI) accountable to women's rights. The architects of the current globalization model are primarily the World Bank, International Monetary Fund, World Trade Organization, and of course the governments of the G-8.

- We need more groups, making the links with the policies, programs and agenda with the IFI's.
- Many within the feminist communities leave working on reproductive rights to economic justice and development organizations. Many of these are not working from a human rights or reproductive rights perspective.
- We should spend as much time, energy and resources, working on the IFI's as we do trying to influence the U.N.
- World Bank projects should be monitored. Much information is available online.
- Overall — related to holding IFI's accountable.
- We need to be making links — doing the research, and sharing it with each other to develop complimentary strategies.

This strategy also includes influencing what is happening at the World Trade Organization. With regards to trade policy related impacts on women's health, much is still unknown, because so many of the rules are still being negotiated. However, the General Agreement on Trade in Services (GATS) could and does in some cases implicate healthcare services, especially if they have already been partially privatized. Gradual privatization in many countries is paving the way for further public service liberalization. The U.S. and Great Britain have been doing this voluntarily. Developing countries have had to privatize as a condition of structural adjustment policies to get further loans and any form of debt forgiveness. As we know, women tend to be the most affected when healthcare is privatized without safeguards to ensure that peoples' basic needs — especially the



poorest, the majority of whom are women — are given priority over the market. As one study notes, rural areas throughout Latin America often don't receive any healthcare services once they are privatized.

The TRIPS (Trade Related Intellectual Property Rights) agreement of the WTO is also a highly contentious and still largely ambiguous instrument that could seriously endanger women's rights and health. The TRIPS allows transnational corporations to appropriate, patent and profit from indigenous knowledge and life forms. These benefits they get without having to compensate the communities from which they acquired the knowledge. The holders of the patent under TRIPS are allowed to have monopolistic use for 20 years — thus the company holding the patent has exclusive rights to manufacture, sell and distribute the product. Not only are women's rights advocates concerned about access to AIDS drugs (as in the highly publicized South Africa case) but also because this provision threatens the livelihoods of women indigenous farmers and healers in developing countries and the many thousands of people in the communities that depend on them.

2 We need to link with other social movements. That is what we saw in Porto Alegre and other fair globalization movements. There is power in numbers. Another world is possible.

3 Start from the grassroots: We want to make sure that we are forging solutions and positions from the grassroots up.

- SEWA (India's Self Employed Women's Association) for example, takes a pragmatic view of policy shifts by asking the most basic question: how will this affect our membership? In this way, SEWA has supported certain trade liberalizations, which increase work for poor Indian woman and opposes other aspects of free trade when these do the opposite.
- The more we put the interests of the poorest and marginalized, as defined by them at the center, and then link these with macro or global policies, the more effective our solutions will be. In this way they are better influenced by reality, instead of ideology.

4. link to the future — be proactive! — especially about technology

The production of new reproductive technologies (such as a controversial anti-fertility vaccine) as well as new bio-engineered organisms (such as genetically modified foods) by corporations is raising new, but very complex, issues with regards to women's safety and bodily integrity.

In other words, with the new advances in genetics, technology can now happen inside the body. Testing is most often conducted on women in the South where fewer enforceable civil and regulatory protections exist. This work is in its infancy. While the entire social justice and scientific community come to grips with the implications and ethics of these new technologies, more of us need to ring the alarm bell and name new technologies as central concerns to the human rights of future generations.

The feminist community has largely neglected other advances in human genetics, beyond those relating to reproductive technologies. Even more difficult technologies, such as biotechnology, neuroscience, robotics, and nanotechnology (e.g. mechanical antibodies) are quickly coming into our reality and our markets. The implications of these new technologies are profound and far reaching and are inextricably linked to other forces at play in the world today — globalization, economic change, militarization and health care. Thus far, decisions about these technologies have been left largely to the private sector, with

little or no analysis by feminists or even basic government assessment. It will be critical in the coming years to address these questions head on while there is still time to take a measured and careful look at the changes facing the world through these new technologies.

5. Finally — make better linkages within our own movement — We face similar challenges and tackle the same problems. We need a convergence to keep us from working in our little corners in isolation. Diversity is key, but we have to guard against fragmentation and depoliticization.

More sophisticated work therefore will be needed to understand intersections of identities and discrimination, linking experience and perspectives from local to global perspectives, and applying these in effective ways to gender equality and human rights work.

No small task!

Joanna Kerr is the Executive Director of the Association for Women's Rights in Development (AWID) **www.awid.org**

Presentation at the Ninth International Women and Health Meeting

Health, Peace and the Environment: Integrating Relationships in Women's Health Movement

Dorothy Goldin Rosenberg

In this century, it is most urgent that we focus on the interrelationships of militarism, sexism, health and the environment. We must do so, not only because of the social justice, peace, violence, feminist, economic, refugees etc. concerns that we in the Canadian Voice of Women for Peace (VOW) have focused on, but now also because of cancer epidemics, other environmentally linked illnesses and the state of the planet. Never have these gendered links to militarism been made more visible in the media than in the four U.S. led missile bombing wars in the last decade — Iraq in 1992, Yugoslavia in 1999, Afghanistan in 2001 and Iraq again in 2003. If U.S. atomic bombs dropped on civilians in Hiroshima and Nagasaki (made with Canadian uranium), agent orange and other defoliants destroying human and ecosystem health in Vietnam were not enough evidence, the bombing of oil and munitions depots, chemical plants and other toxic sites as well as the use of depleted uranium in weapons, tanks, bullets and missiles in the last decade alone compel us to address these links more effectively in our work for women's health, peace, justice and sustainability in this new millennium.

It is well known that since the Second World War, military strategists have developed chemical agents to destroy the jungles, biological warfare agents to attack the reproductive, immune, respiratory and central nervous systems of all living things as well as thermonuclear devices of staggering megadeath proportions. The waste spin off of these destructive forces has spawned a global health and environmental crisis in both the military and civilian corporate spheres. The major environmental problems — acid rain, ozone depletion, climate change, loss of topsoil, forest destruction, desertification, increased radiation exposure etc. all have military overtones. These combined 'ecopathologies' have resulted in loss of species, increases in the rates of cancer, allergies, asthma and a great number of congenitally damaged children. They have produced poverty, urbanization and environmental refugees.

Marisarida Villarroel / Isis International Manila

Clearly it is important that we integrate knowledge and policy actions on demilitarization, ecological integrity and health to the greatest extent possible now and in the future. The crisis and its impacts on health is manifested by the following quote:

It was predicted that by the year 2000, weapons related environmental radiation will produce 90,000 cases of cancer, two million miscarriages and infant deaths, 10.4 million children with genetic diseases, and another 10 million who are physically deformed or mentally retarded.

This is an illustration of one of the most pervasive examples of government, corporate, industrial, political practice in this era of military industrial complexes in most industrialized countries and increasingly in those of the South.

The military is the single largest polluter and waster of resources in the world. According to The Research Institute for Peace Policy in Starnberg, Germany, it is estimated that 10 to 30% of all global environmental degradation is due to military related activity.

From Michael Renner of the World Watch Institute:

The world's armed forces are quite likely the single largest polluter on earth...modern warfare entails large-scale environmental devastation as conflicts in Vietnam, Afghanistan, Central America, the Persian Gulf and Russia amply demonstrate. Even in "peacetime", in preparing for war, the military contributes to resource depletion, and environmental degradation as the production, testing and maintenance of conventional, nuclear, chemical and biological weapons generates enormous quantities of toxic and radioactive substances, contaminating the earth's food, soil, air and water

From the Women's Foreign Policy Council Bulletin:

War is the ultimate and most deadly form of pollution. It claims as its victims men, women, children, soldiers and civilians alike, animals and plant life, the fruits of civilization and our precious natural systems and resources. It pollutes our life support systems and undermines the world wide efforts now under way to overcome the global environment/development crisis, the worst in human history

The world's governments spend close to a trillion dollars a year on military research, commodities, infrastructure and killing — the same amount as the third world debt. It is more than that spent on health and well being, equality, education, human rights, peace, environmental security, clean water etc.

Three generally agreed upon principles of ecological integrity enunciated at United Nations conferences beginning with the UN Conference on the Environment in Stockholm 1972 stated:

1.) We now know what others have known before us: that the health of the planet is the primary context for the health of all life on it.

2.) That the life support systems of the earth are severely threatened.

3.) What we do to the planet, we are doing to ourselves.

These principles echo Aboriginal concepts of decision making in the interests of the next Seven Generations.

International Joint Commission on the Great Lakes (IJC) reports over the years have called for `zero discharge' of all persistent toxic chemicals including radionuclides, as well as the principal of `reverse onus' where the potential polluter should have to prove that the chemical being used is safe rather than the other way around. Should not this principal also apply to all military activities which have never had to undergo environmental assessments? As millions of children, women and men will be diagnosed with cancer, other diseases and disabilities in the coming decades, it is necessary to make these links in all our policy work relating to women's and indeed ecosystem health.

Rarely have women been part of peace negotiations. (It's perhaps why so many have been failures.) Increasingly, women are challenging military/ corporate polluting power relationships and practices for destroying our health and that of the earth which nourishes us and of which we are a part. Since the 90's and now, especially since September 11th 2001 and the 2003 bombing of Iraq, coalitions have formed among peace, health, environment, breast cancer activists, women's groups, labour, health professionals and scientists. They have been working together to promote awareness and policies to halt military/environmental destruction and contamination seen as leading to deleterious effects on health and ecosystems. They are focusing on primary prevention in growing communities of cancer afflicted women, their families and friends. At the many gatherings before and after the Fourth United Nations Conference on Women, Beijing (1995) and Beijing+ 5 (1990), some in VOW, the Women's Healthy Environments Network (WHEN), the Women's Environment and Development Organization (WEDO) and others have highlighted this need. However, now and in the future, I believe that these concerns require still much further integration in women's, health, peace, environmental, occupational, community and other educational and social action groups. Policies and programs are still, for the most part, dealt with separately in each sector.

An opportunity to build these bridges exists with the significant initiative passed October 31st 2000, when the United Nations Security Council unanimously adopted Resolution 1325 on Women, Peace and Security. Without the persistent advocacy efforts of women's civil society organizations, this resolution would never have been written or adopted. In this way, its adoption was an important acknowledgement of the years of advocacy work by women's groups and of the importance of women's contributions to the UN's discourse on peace and security issues. In addition, Resolution 1325 marks the first time that the Security Council, the UN's international law-making body, addressed women's distinct experiences of armed conflict. The Council recognized women's crucial, yet under-utilized roles as peace-builders within their communities. It calls for gender sensitivity in all UN missions including peacekeeping; for women to participate equally at all negotiating tables; for the protection of women and girls during armed conflict and other related points. In response to the adoption of Resolution 1325,

a number of projects were initiated to actively work toward its full implementation. The Women's International League for Peace and Freedom (WILPF) UN Office initiative, The 1325 PeaceWomen E-Newsletter is an example which helps to communicate these ideas (please see Women and Environments International NO 58/59 - Spring 2003,pp 52-53 for further details on Resolution 1325).

All of us can, and must highlight these issues, promote strategies for advocacy and invite discussion from many more groups to help enable them to integrate peace, justice, health, environment, equality relationships in their communities, organizations, and institutions. It has never been more urgent for justice for all, the continuum of the planet and all life on it.

Dorothy Goldin Rosenberg, PhD, MES is a member of Voice of Women for Peace, the Women's Healthy Environments Network (WHEN), the Breast Cancer Prevention Coalition and the Centre for Health Promotion, University of Toronto. She is principal research consultant for the film Exposure: Environmental Links to Breast Cancer, author of Taking Action for a Healthy Future and is currently producing a new film on children's health and the environment. She teaches the course "Environmental Health, Transformative Higher Education and Policy Change: Education for Social and Ecosystem Healing.

Further Reading:

The PeaceWomen is a project of the Women's International League for Peace and Freedom. Please see them at **www.peacewomen.org**.

For a comprehensive annotated bibliography of books, articles and analyses on women's peace activism, as well as NGO position papers, reports, speeches, statements and tools for organizational building, please see **www.peacewomen.org/resources/resindex.html**

For calendar events of women's peace activities, please see **www.peacewomen.org/frame/calendar/calendar.html**

Previous issues of 1325 PeaceWomen E-news can be found on-line at **www.peacewomen.org/news/1325News/1325ENewsindex.html**

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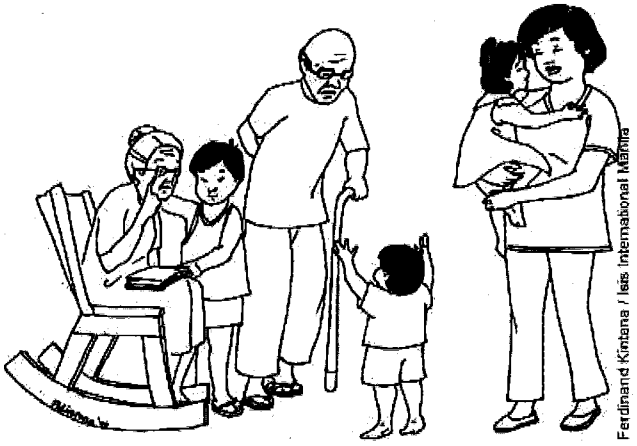
Right to Care? The Burden of Paid and Unpaid Home Care in Canada

Chi Nguyen



I was twelve years old when my mother began to relapse into episodes of schizophrenia. The illness that she had suffered from during her late twenties and early thirties had returned. Neither of my parents had ever spoken about this situation. As my mother's behavior became increasingly irrational, it become apparent that something was wrong. Through the subsequent years, our family went through difficult times. My mother confided in me, as her oldest child. I often listened to her delusions and heard her describe the voices that had started to inhabit her mind. Her experiences with mental illness were terrifying to see and to understand. Listening to her, it was impossible not to feel a sense of loss and frustration. While her episodes were random and unpredictable, they escalated both in severity and frequency.

My father became quite depressed and began to come to me for support. He needed someone to share these burdens. We shared the morning commute and during these days many mornings were filled with tears. He felt responsible for her illness though there was little he could do. He could not bear to see his wife this way. He would talk of suicide as the only option. I was sixteen and seemed to be carrying the weight of both my mother's illness and my father's depression on my shoulders. Little did I know then that millions of women share this overwhelming burden of care.

Home Care in Canada — Who is and Who Should be Responsible?

In Canada, more than 80% of paid and unpaid home care providers are women. According to the National Coordinating Group on Health Care Reform and Women, home care takes on different meanings and interpretations. While the basic definition implies that home care is "care provided in the home", it does not define the infinite range of tasks and responsibilities. This group suggests that home care's various forms and shapes include the following:

- Home care includes both paid and unpaid care
- Paid and unpaid providers are involved in coordinating and managing care
- Home care can include medical, nursing and personal care, assistance with regular household tasks, social and emotional support.

The boundaries for paid caregivers are usually relatively clear. Contracts and policies define hours and tasks. Yet, the wide range of tasks of unpaid care giving, usually taken on by family members or friends, makes it often difficult to define boundaries and limits on how much time is devoted to care. A woman living with a partner who has a chronic illness, such as AIDS/HIV, is generally expected to carry the responsibility of coordinating and managing care, particularly when the partner is frail and unable to undertake these tasks. She may need to make sure her partner takes his/her medication, provide transportation to hospital or doctor's appointments, or help with personal care, such as going to the bathroom or bathing while she also looks after cooking, shopping, laundry, home maintenance, and finances. According to Jean Lowry, former Communications Consultant with the Canadian Women's Health Network (CWHN) and long-term care provider, family members supply 70-88% of such personal care and services. Family members are often also heavily involved in emotional and social support to the patient — tasks, which are difficult to assign to paid workers.

Unpaid caregivers, often suffer physical, financial and emotional strain from these duties. Care giving often affects women's employment. In addition to the already lower-than-average pay levels, compared to men, many women lose work time or have to change to part-time work without benefits. This potentially jeopardizes their and their family's future financial security. Women tend to help more with personal care and domestic chores, men with transportation, management of finances and repair of the home. Lowry describes the duties associated with women as more intense, deeply personal and persistent while men's are less intimate and more sporadic.

Who Cares about Home Care?

Canadians have recently engaged in debate about a pillar of our identity —Medicare,

Canada's public health care system. Governments lead the charge for health care reform. Politicians demand cost efficiency. Most citizens hold to the vision that Canada's social environment includes the right to care. They see the care of the sick and frail as a public trust and they hope for a renewal of this commitment. Yet home care remains a service that is not covered under the Canada Health Act, leaving it vulnerable to user fees, eligibility tests and other barriers to access.

The National Coordinating Group on Health Care Reform and Women has demonstrated that several significant changes have created increased demands on home care. Structural changes and cutbacks to our health care institutions have had a tremendous impact on home care. More services are provided on an outpatient basis, while day surgeries and earlier discharges from hospitals require that more patients' treatment continues in the home. These are strategies to cut costs for hospitals. It means that responsibility for drugs, treatments and patient care is being shifted increasingly from the public sector to unpaid or privately paid home care. While this reduces expenditures for the public purse, it does not come without cost to individual members of the public. At the international level too, the Organization for Economic Cooperation and Development (OECD) countries are implementing an "active aging" and "aging in place" (the home and community of the elderly) strategy. They actively de-institutionalize aging by dissolving nursing homes and other institutions for the aged, as reported at the June 2000 Oslo, Norway conference.

Another important change is that more people with chronic diseases and disabilities are living longer — many in their homes. They require care on a long term and regular basis, which mostly family members provide. The demographics of an aging population place additional demands on our Medicare system. While the elderly are generally in better health than previous generations, seniors with chronic illnesses also live longer. They either stay in their homes needing care from paid and unpaid caregivers, or move into far more costly long-term care facilities.

Home care often brings with it inequalities. Those with money can pay for care while those without money are left without or with lower quality care. This especially affects elderly women, too frail to maintain a household. Reliance on next-of-kin can be difficult in Canada's diverse and changing society, with young immigrant families struggling for survival and family members thousands of kilometers apart. People's houses may not provide a secure environment for a person with disabilities or dementia. Homes can be the site of domestic abuse, while unpaid caregivers may not have the skills, strength, time or resources to look after the person in need of care.

And the Caregivers?

Paid care workers are in high demand. Yet, the competitive and privatized delivery of these services results in decreased wages. Paid home care providers work with more independence than their institutional counterparts. However, working alone can also be isolating, without the right kind of equipment or support needed for a safe work environment. Few paid home care workers are unionized. Most lack benefits, adequate time off, or support from co-workers. Cuts to institutions such as hospitals or long-term facilities, have shifted many paid caregivers to the home care field depriving them of access to professional upgrading, insurance, employment benefits and job security.

An overwhelming 95% of paid home care workers are women, disproportionately women of colour and recent immigrants. Federal immigration programs, such as the Live-in Caregiver Program, allow women to enter the country as "temporary" workers. Privatized home care operators have taken advantage of these women and been allowed to operate outside of established standards. Lowry decries this trend to de-professionalize home care work, by delegating duties to less skilled and lower paid workers.

The question we should ask is not how to reduce health care costs, but how to best respond to the needs of health care providers and health care recipients, especially women. Are the expectations of the state reasonable that someone in the home — mostly women — will be able to provide unpaid home care? Will the caregiver be putting her own and her family's physical and economic health at risk? Unpaid caregivers need to have the right to choose whether or not, and if so for how long, they wish to provide care. They need support in their homes and community when they choose to help their families. They need more flexible work policies. The duties of home care need to be valorized. Similarly, we need to support paid caregivers in their work environments to ensure that properly paid and trained professionals provide care.

Illness and tragedy can strike at any time, leaving families devastated and struggling to make adjustments. During times of crisis many take on the responsibility of care giving for family and friends. Families and their support networks will come together and provide the support needed. Yet, few have the chance to choose if or for how long.

Although at the worst times, it was impossible to imagine that my mother would ever get better, she did improve. Over several years, we were able to get her the psychiatric treatment she needed, including a dosage of medication that was effective. During my second year of university, my father suddenly passed away. My mother was now responsible for herself and her family. As the eldest daughter,

many among our family and friends pressured me to move back home and transfer schools to take care of my family; they wanted me to ensure that my mother would be all right and that someone would keep close watch over my teenage brother and sister. I was being asked to become the caregiver and give up my plans for my future.

In the end, I decided to stay at university. Many trips home, summer stays in Toronto, daily long-distance calls and weeks given to help manage my mom's home have become part of the routine of my life. We have been incredibly fortunate. My mother's schizophrenia remained well-managed. She has been a very resilient woman and was able to take on the new responsibilities of being a single parent. A strong network of family friends helped her throughout the transition. My sister and brother have also grown up remarkably and help care for my mother.

Care giving has become increasingly recognized as an area that needs urgent actions and solutions. In the past few years, the Canadian women's health movement has made calls for change. It has also undertaken research to better understand the conditions for home care. In 2001, the Charlottetown Declaration on the Right to Care was drafted by delegates of a National Think Tank on Gender and Unpaid Care Giving. This declaration takes steps towards responding to the urgent needs of our home care providers. Yet, unless health care policy implements this step, we will continue to overburden those already taxed by the responsibility for health.

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Canada's 'Healthy Immigrant' Puzzle — A Research Report

Ilene Hyman

Joanne de Leon / Isis International Manila

The 'healthy immigrant effect' has mystified Canada's health community for some time. We had observed that immigrants — male and female — are often in superior health to the native-born population when they first arrive in Canada, but they lose this health advantage over time.

We assumed that the 'healthy immigrant effect' results from a self-selection process that basically includes people who are able and motivated. Canadian immigration procedures further select the 'best' immigrants on the basis of education, language ability and job skills. The question then arises why and how do immigrants lose this health advantage? Many studies suggest that migration is stressful and this stress coupled with inadequate social support may be a risk factor for ill health. Other studies suggest that immigrants often change their health behaviors over time and adopt many of the 'unhealthy' behaviors of the new country, such as smoking, alcohol use or the consumption of high fat diets.

Many broad determinants influence the health of all Canadians. The Population Health Model proposed by Health Canada includes gender, income and social status, employment and working conditions, health practices, social and physical environments and culture. Yet, the model lacks critical determinants such as equity, social justice and women's health (the burden of multiple roles and caregiver stress). Still, it provided the framework for my research and presentation to the 2002 International Meeting on Women's Health.

My literature review also included earlier research I had done on Health Canada, the Ontario Women's Health Council, major search engines such as MEDLINE, HEALTHSTAR, and PSYCHLIT, and published Canadian and international studies. Additional studies were included to overcome the gap of gender-specific information of certain health determinants and outcomes; most notably, tuberculosis, AIDS, mental health and health care.

I paid specific attention to population subgroups of immigrant women that the literature suggested might be at an increased risk of poor health status, namely, recent immigrants, immigrants from non-traditional source countries and visible minority populations. Once I identified the relevant literature, I tested the quality of evidence against review articles, epidemiological studies, case histories, unpublished reports and personal communication. I consulted with a team consisting of members from various institutions to identify research gaps and policy implications.

The illnesses I looked for were cancer, heart disease, tuberculosis (TB), HIV/AIDS, mental health and perinatal health. Since violence is a major issue affecting the physical and mental well-being of immigrant women in Canada, I included it as well. I considered income, education and work, social support and stress, health practices and health service utilization as determinants of immigrant and refugee women's health.

Canadian Population and Immigration

Cultural diversity is a reality in Canada and our immigration policies will ensure that this diversity will continue. There is much heterogeneity within 'immigrant women in Canada' with respect to source country, length of stay, 'visibility', category of migration, socio-economic status and knowledge of host country languages. Since 1990, Canada has accepted approximately 230,000 immigrants per year and women comprise just over half (51%) of all people who immigrate to Canada each year. Immigrant women represent 18 per cent of all women living in Canada (Chard et al., 2000).

Throughout much of this century, the majority of immigrants to Canada were from the United Kingdom, the United States and Europe. The high percentage of recent Asian immigrants is due in large part to the Canadian government's emphasis on skills, education and lan-

guage abilities in its selection formula for independent applicants, as well as subsequent sponsorship of family dependents.

Immigrants to Canada fall into several categories, depending on their reasons for immigrating: economic class (56%), family class (29%), refugees (13%) and 'other' including caregivers and retirees, (3%). Sometimes these categories get blurred, for example, when family members of refugees reunite. Approximately one third of refugees were female.

Immigrants to Canada tend to be highly educated, in part reflecting the fact that the majority of immigrants who come to Canada do so through the independent or business streams. A large majority of recent immigrants report being able to carry on a conversation in at least one of Canada's two official languages. Women who are part of the most recent group of immigrants tend to be somewhat less likely than men to be able to carry on a conversation in English or French. Approximately 55% of immigrants reside in Canada's three largest urban centres — Toronto, Vancouver and Montreal.

Findings

Most of the literature reviewed confirmed that Canadian immigrants, particularly recent arrivals, enjoyed many health advantages over long-term immigrants and the native-born population. This is both in terms of their overall health status and the prevalence of certain chronic diseases such as cancer and heart disease. The risk of developing these diseases appeared to increase over several generations and was highly dependent on changes in determinants of health following migration.

I observed different patterns in the occurrence of chronic verses infectious diseases. Unlike chronic diseases, most immigrants with infectious diseases, such as TB, experienced improvements in health status over time when given appropriate treatment and follow-up. AIDS however is a growing concern. The majority of infants born to HIV-infected mothers were born to immigrant women from HIV-endemic countries.

Certain immigrant sub-groups experienced a higher risk of health problems: for example, heart disease among Asian women, increasing rates of breast cancer among Southeast Asian women and poor pregnancy outcomes among refugee women.

There was little Canadian data on violence against immigrant women. Partner abuse is particularly difficult to assess in immigrant and refugee communities due to language and cultural issues. Rates of partner abuse among women who were not born in Canada or were members of visible minorities approximated those of Canadian-born and non-visible minority counterparts.

Determinants of Health

I included income, education and work, health behaviours, social support, stress and health service utilization as determinants of immigrant and refugee women's health status (ex. Smoking, diet, physical activity).

Immigrants, especially women, were disproportionately poorer than the general population. This made poverty a confounder of any relationship between immigration and health. Although immigrant women, particularly recent arrivals, were more educated than Canadian-born women, they had more difficulty than their male counterparts in finding employment.

A number of Canadian studies suggested that immigrant health behaviors changed over time to resemble those of the majority culture. Recent immigrant women were less likely to be regular alcohol drinkers and smokers. They were less likely to be overweight than their Canadian-born counterparts, yet also less likely to engage in regular physical activity.

Many studies attest to the relationship between social support, stress, and health status in both immigrant and native-born populations. Yet, few studies specifically examine the relationship between stress, social support and health among immigrant women. Health scientists hypothesized that migration to Western, industrialized societies is stressful that this is associated with increases in blood pressure. Some also associated resettlement stress with the development of TB, diabetes and mental health problems during the early years of resettlement.

Contrary to popular belief, the literature did not indicate that immigrant and refugee women over-utilized health care services. Immigrants and non-immigrants showed similar patterns. However, there was strong evidence that immigrants underused particularly preventive and mental health services. I found barriers to health services especially in preventive, mental health and violence response services and less in acute medical care. Barriers to health services are defined as geographic, economic, linguistic, cultural and systemic factors that deter individuals from accessing health care.

Policy Implications

I focused on two questions for policy-makers and health planners.

1. What conditions (determinants) contribute to changes in the health status of immigrant and refugee women over time?

- Environment and living conditions shape the health of immigrant women. These change in response to real pressures associated with poverty, marginalization and class inequity. Comprehensive and multi-sectoral approaches are therefore needed to promote and sustain good health of immigrant women.
- Other findings highlighted the critical role of social support in promoting and sustaining good health. Policy-makers need to re-evaluate policies that limit family reunification and immigrants' choice of where to reside. Public education and social legislation efforts including recognition of foreign credentials are necessary to improve the image and value of immigrant women in Canadian society.
- Finally, some evidence suggested that programs and policies that empower immigrant women to develop and maintain their own ethno-specific institutions and health promoting practices have positive long-term effects. Increasing the proportion of immigrant women as service providers by recognizing foreign credentials would also enhance quality of care and remove

barriers to care, thus indirectly influencing health status.

2. How can health programs and services help maintain immigrant and refugee women in good health over time?

- Improving the accessibility, appropriateness and comprehensiveness of health services would help ensure the continued good health of new immigrant women and reduce the development of long-term chronic diseases such as diabetes, cancer and heart disease. This could be accomplished by providing
  - more comprehensive services that address immigrant women's health needs,
  - access to services such as job counseling and training, language and literacy training,
  - family and individual counseling and
  - transportation and child care.
- Cultural sensitivity is a critical component of effective and accountable health care. Health professionals need to learn
  - how immigrant women understand and conceptualize health and,
  - the unique circumstances of immigrant women's lives.
- Removing barriers to services is of particular importance in the area of infectious diseases such as HIV/AIDS and TB because early intervention and treatment can control these conditions.
- A selective approach is called for to address the needs of the most vulnerable sub-groups of immigrant women e.g., socioeconomically-disadvantaged, refugees, victims of torture and women who lack fluency in English or French.

Immigrant and refugee women in Canada represent a diverse group with similarities and differences that affect health status. These findings suggest the need to advocate for programs and policies that address the major determinants of immigrant women's health and promote access and equity to health services. This could prevent future health problems and ensure the continuing good health of this group.

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Sexisms & Women's Mental Health

Lori E. Ross and Brenda Toner

These days, many believe sexism to be a thing of the past. Women are enjoying equal access to education and holding higher-ranking positions than ever before, and many of the fundamental battles of the women's movement, such as equal pay for equal work, seem to have been won. A careful look however, reveals that sexist attitudes persist, and that these attitudes are expressed in subtle, and sometimes not so subtle, ways. Women continue to experience discrimination on the basis of their sex, and this discrimination has an important implication for their physical and mental health.

What is a sexist environment?

Sexist environments take many forms. Some women live or work in environments where they are explicitly physically, verbally, or sexually harassed as a result of their sex. Women who live in constant threat of violence at the hands of their husbands or partners inhabit sexist environments, as do women who are continually the focus of sexual remarks made by male employers or colleagues. Although these cases are not the norm, almost all women are routinely exposed to sexist jokes, comments or gestures made by family members, friends, public figures such as entertainers, or even strangers on the street. Even more insidious are the systemic and institutionalized forms of sexism: lack of affordable child care which forces women to be isolated at home with their children and forego education or career opportunities; social expectations that women will do the bulk of the unpaid house work and child care even after returning home from a long day of paid work. As a result of our society's assumptions and expectations of women, virtually all women are forced to live in sexist environments.

What are the consequences for mental health?

Recently, research has begun to explore the impact of explicitly sexist environments and experiences on women's physical and mental health. These studies are using a variety of research methods, including daily diaries and laboratory exposure to sexist comments or experiences. The results clearly demonstrate that when women are exposed to sexist remarks or experiences, they report increases in negative emotions, including depression, anxiety and anger. This research is in line with studies that have examined the impact of discrimination in other populations, including racial and sexual minorities. The research consistently found a link between perceived discrimination and symptoms of depression and anxiety across groups.

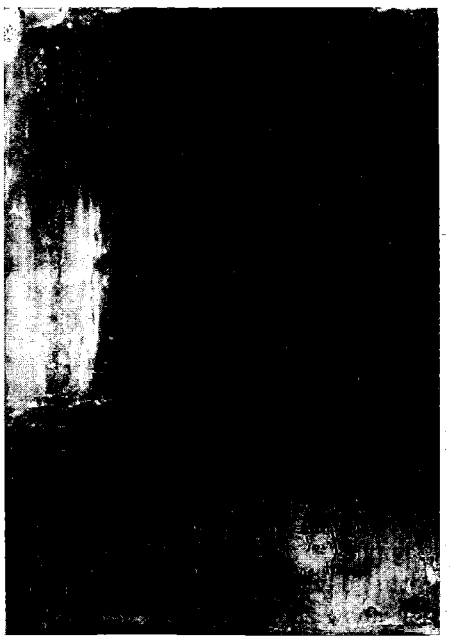
Directions for future research on sexist environments

Further research is required to enable us to better understand the impact of sexist environments on mental health, and to begin to examine how we can work to eliminate sexist environments in order to protect the emotional well-being of women. In particular, it will be important to examine the impact of sexist experiences during key life transitions, such as puberty, and to determine the complex effects of sexist media and institutionalized sexism on mental health in both women and men.

It is now well established that the lifetime prevalence of major depression is nearly two-fold higher in women compared to men. While a multitude of variables could and likely do interact to result in women's greater vulnerability to depression, environments and experiences that are sexist (both explicitly and implicitly) should not be overlooked as potentially important contributors.

Dr. Lori Ross PhD. is a Research Scientist in the Women's Mental Health & Addiction Research Section at the Centre for Addiction & Mental Health, Toronto. Her research focuses on mental health and addiction issues in women across the lifespan, and in particular, the mental health needs of women who are marginalized as a result of their sexual orientation.

Dr. Toner Ph.D. is currently Head, Women's Mental Health and Addiction Research Section, at the Centre for Addiction Mental Health and Professor and Head Women's Mental Health Program, Department of Psychiatry, University of Toronto. Dr. Toner has published and presented on a variety of health related problems that are disproportionately diagnosed in women including eating disorders, anxiety, depression, chronic pelvic pain, chronic fatigue and irritable bowel syndrome.



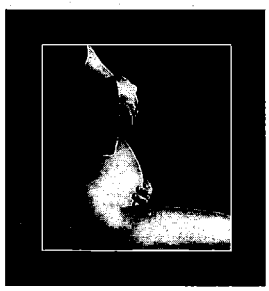
FEATURE ARTIST: LAURA CUNNINGHAM

Mother-Child Health Issues

The Story of Fetal Alcohol Syndrome

A Canadian First Nations' Response

Sylvia A. Wilson and Rebecca Martell:



Good acts done for the love of children become stories, which are good for the ears of people from other bands; they become coveted things, and are placed side by side with the stories of war achievements. (Assiniboine tradition)

Stories told by people share their "essential heart." Through sharing their stories and their intimate knowledge of Fetal Alcohol Syndrome (FAS), children and families become the "teachers" to communities and societies, providing guiding information that could lead the way in solving the deep, fundamental problems that create and are created by FAS. Children who are affected by FAS are of immense worth, for they have the greatest gift to give. Their silent message or their own life experience is a gift of knowledge that moves us from a superficial level of understanding of the effect of alcohol on the unborn child, to a deeper appreciation from which to develop solutions to the fundamental global issues of FAS.

The prospect of a healthy and happy life begins in the womb as the child develops in body, mind, and spirit. Science suggests alcohol is more damaging than once thought, even in low doses and FAS is a "silent epidemic" that does not discriminate against race, culture and class. In every 1000 babies born in Canada, up to three, and more in some Aboriginal communities, are affected by FAS. Many mothers are not aware of the consequences of alcohol consumption, as only a generation ago even most physicians did not understand it. "But when half of Canadian women drink and half of all pregnancies are unplanned, plenty of mothers are exposing their fetuses to alcohol, if only for the short time before discovering they are pregnant," wrote M. Philp in Canada's Globe and Mail Newspaper.

FAS is a birth defect syndrome that results in a life-long disability profoundly impacting development and affecting individuals families, and society. Children exposed to alcohol during intrauterine development often have a wide range of impairments and have life-long consequences. Adverse effects of prenatal alcohol exposure exist on a continuum from subtle deficits of daily life such as judgment, problem solving, memory and so forth, to complete FAS syndrome typically characterized by intellectual disabilities, facial anomalies and severe behavioral problems.

At an individual level, it takes great courage for a parent to have their child diagnosed, admit drinking during pregnancy, to accept the outcome and develop a life plan for a child affected by alcohol. Brave mothers have come forward, speaking for the first time about the difficulties they were having with their little ones, asking for support and assistance.

"Please, please, God. Do not take Daniel away from me yet. Let me raise him for you. Do not take him away just yet. He is only two months old. It's too soon. Please, please, God, give me another chance. I will change my life around. I will leave drugs and alcohol alone. Spare him and I will do anything. Don't take him," pleaded one Ontario Aboriginal mother.

The stories of children personify the condition, taking us beyond the impairment to empathy for the person. This young person described how hyperactivity feels:

"I used to like to take all the cushions off the couch. I would stack them up on the floor and then I would run circles around them all day. That's all I would do is just run, run, run. How many children do you know that are 2 or 3 years old that sweat? I was literally soaked with sweat."

It also takes courage to raise a child born with FAS. In 1975, while training in Native addiction at the Nechi Institute on Alcohol & Drug Education, Rebecca studied alcoholism and drug addiction while exploring a spiritual model for recovery. What she did not learn at that time was the effect that maternal consumption of alcohol had on an unborn child. That same year, as a young foster parent, Rebecca was having difficulty with her foster son and commented:

"This brave sounding boy was the same one who had me up repeatedly in the night. I would sit beside him, one hand resting on his heart, the other stroking his hair to soothe nightmares. Too many times I would have to change his wet sheets and dispose of food squirreled away under his pillow before finding my way back to my own bed.

"I felt inadequate and poorly trained to support him and sought assistance from my caseworker. In her wisdom, she directed me to the Child Development Centre where Dr. Jane Silvius proceeded to change my life and that of my chosen son, when she began to teach me about Fetal Alcohol Syndrome. She helped me see that my foster child's behaviors were not

a result of my failed parenting. I learned how to work with my foster son's strengths in order to maximize his abilities, including the childhood experiences captured in his stories."

"FAS is hard for even one person to deal with. For a people to face it collectively is admirable, given the stigma and denial we all share around difficult social issues," state Anderson & Wemigwans in *Healing with a deep heart — Aboriginal Approaches to Fetal Alcohol Syndrome/Effects.* FAS can be prevented, however behaviors are notoriously hard to change, as decisions to drink are not simply matters of rational choice but embedded in complex social contexts. The following is a model for health promotion and prevention in dealing with FAS by starting in the community.

Rebecca was giving a presentation on Native Addictions & Fetal Alcohol Syndrome at the Prince Rupert Friendship Centre where she met a member of the Haida community of Old Massett. This was a meeting of like minds with a purpose and passion to deal with the prevention of FAS and development of life designs for children and families living with FAS. A partnership grew from this meeting and came as a request to be involved in a community plan of action for children identified with special needs, including those children with FAS. After listening to the needs of the community, Rebecca proceeded to develop a consortium of members of the community and community development facilitators from outside the community who became a "virtual team" with the task to provide a workshop on the development of a "whole-community concept" in the intervention and prevention of FAS.

There has not been a monumental positive change in the drinking behaviour of populations and the incidence of FAS has in fact increased over the past two decades. This illustraes that prevention requires more than increased knowledge, persuasion, or health education. Initiatives need to be designed to enable communities to build and strengthen multisectoral partnerships and build community capacity to promote healthy lifestyles through integration of health messages as cultural values and accept the responsibility to improve the social conditions of people living with impairments such as FAS.

Let us put our minds together and see what life we can make for our children. (Sitting Bull)

Cultural sensitivity and community mobilization:

"Crisis changes people and turns ordinary people into wiser and more responsible ones" (Wilma P. Mankiller, Cherokee Chief, 1987). In order to be truly a part of a community and have your "gifts" embraced, a health promoter must be invited to join. By displaying the attributes valued by the culture, Dr. Silvius undoubtedly would gain respect in many communities and open the doors to design interventions using her specialized skills with children with FAS, their families, and communities. The first step therefore in community mobilization involves the establishment of interpersonal relationships that includes effective use of self, interpersonal rapport, and collaboration that characterizes the helping relationship.

The day of our arrival in Old Massett, our team had the opportunity to immediately experience Haida cultural foundations and began to build a relationship with the community through introduction to Elders, a meeting with Chief and Council, and home visits with the community representative. Whenever we are invited to come into a community, a team must be keenly aware that they come as visitors into someone else's home and are responsible to behave in a culturally respectful manner. Thus we took time when we first arrived to meet the Elders who are guardians of the culture, the Chief and Council who are the protectors and providers of the whole community, and the health practitioners and teachers who are the caretakers of programs that serve the needs of the people. We accepted gracious invitations into the homes of parents and grandparents, to share a cup of tea and let them know who we were and what our role was going to be in their community. In this moment we held ourselves up to the scrutiny of the community. The sharing of our personal and professional passion for the work we did, was a demonstration of our respect for the people with whom we were developing a working partnership.

Workshop materials were designed as a flexible tool consisting of a blueprint for problem solving and program planning that simply provided a starting point for dialogue and guided planning through community engagement. The intent was for three sectors of the community, health practitioners, teachers and families, to describe their unique cultural and collective context for social action. Early in the workshop, we honed our ability to "listen with our hearts" through the talking circle, a process that allows for the collective "humanness" and the virtue of listening without directing others. Listening fully and completely to a speaker is the symbol of kindness that embraces the concept of interaction of mind, body, and spirit without judgment of the positive and negative aspects within the person and among the collective. In this First Nation community the ancient cultural teachings of respect taught us the true meaning of time; as each person was granted all the time they

needed to share their thoughts and feelings about how FAS had affected their lives. We learned that culture could not be separated from daily living or spirituality, and that the values and beliefs of a culture are embedded in rituals and ceremonies and are important community capacities that can make a difference where other actions have failed.

We entered Old Masett with the belief that we brought distinct concepts in community development and mobilization. "We left Haida Gwaii with the realization that Haidas teach a cultural form of community development that comes from their established sense of identity and self-worth," concluded Rebecca. The experience confirmed that the more genuine the expression, particularly regarding personal experiences and challenges, the more people can relate to your expression and the safer it makes them feel to express themselves. Many years later, our collaborative workshops have grown to include time for ritual and ceremony, dialogue about the foundations of the culture, open discussion about spirit within and the natural order of life, sharing thoughts for the day, and building a collective spirit of hope and movement toward change.

Rebecca Martell and Sylvia Wilson came together as women with a genuine interest in the health and well-being of children and families. Rebecca brings her experience working in the field of Native Addictions. Sylvia brings passion for helping families and their children deal with impairments and disabilities, and has over thirty years experience working as a pediatric occupational therapist. Together, they share a respect for the individual, cultural sensitivity, and an eagerness to work alongside people in the quest to prevent FAS and promote healthy living for people with FAS.

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A Woman's Body is Everyone's First Environment

Roberta Stout

One may wonder how Fetal Alcohol Syndrome and Fetal Alcohol Effects fit within the framework of health and the environment. Our environment embodies airways, waterways, soils, plants, stones and all legged, winged, scaled and spirit beings. The planet upon which we depend is ever more disturbed due to human consumption, so-called development, warfare and the globalization of contamination. We are slowly recognizing that all that which disturbs our earth also disturbs life yet unborn. For human beings, the womb is the first environment. It is every person's first home, playground, picnic and concert.

Yet the womb is not always the safe and nurturing environment it should be. It is there that we experience smog and are introduced to and disturbed by hormone disrupters, polychlorinated biphenyls, DDT, dioxins, toxins, heavy metals and radionuclides. These ecological villains inadvertently invade our first sacred place through the air our mothers breathe and the traditional foods they eat. Scientists now caution of PPCPs (pharmaceutical and personal pollutants) entering our sources of drinking water and of the dangers to the developing baby presented by dibutyl phthalates found in the nail polish, night creams, deodorants and perfumes our mothers use. Contaminants ingested or accumulated in a woman's body are also ingested by and accumulated in her developing child.

There seems to be no end to the environmental injury.

Although many contaminants are global and

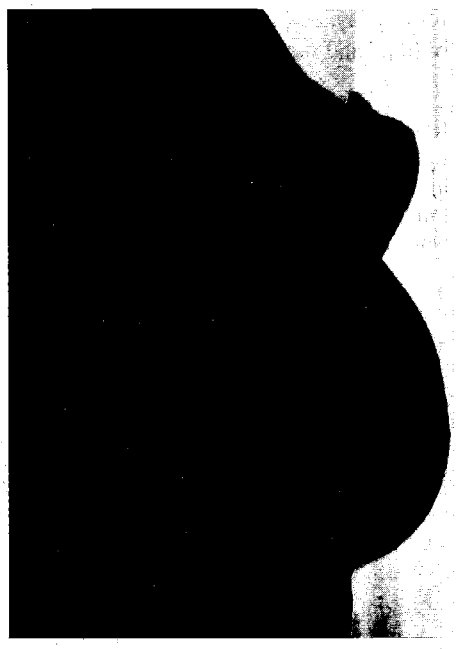
cannot be avoided by pregnant women, alcohol and its devastating effects can. Fetal Alcohol Effects and Fetal Alcohol Syndrome (FAS/FAE) are permanent conditions that can affect babies of mothers who drink alcohol while pregnant. Alcohol, like environmental contaminants such as PCBs or DDT, enters the womb through the umbilical cord and placenta that sustain the fetus.

Pauktuutit Inuit Women's Association is one of Canada's national Aboriginal organizations and represents all Inuit women in Canada. There are approximately 45,000 Inuit living throughout 53 isolated communities in Canada's north, as well as a growing population who are moving to larger cities in the south such as Montreal and Ottawa. The most spoken language of Inuit is Inuktitut, which consists of a number of regional dialects.

Pauktuutit's mandate is to create greater awareness about the needs of Inuit women and to facilitate their active participation at local, regional and national levels, especially in the critical areas of social, cultural and economic development. Since incorporation in 1984, Pauktuutit has worked on many themes including family violence, intellectual property rights, social justice issues and a wide range of health issues including FAS/FAE. FAS/FAE were raised as issues of grave concern by Inuit women attending Pauktuutit's annual general meetings since 1995. As is typical of this sort of non-governmental work, it took years to secure funding and human resources to begin the video project.

Knowing that television and radio are popular sources of entertainment and information in the North, Pauktuutit chose a video docudrama and radio play as the main products for its FAS/FAE education campaign. Because Inuit culture has a strong oral tradition, the video and radio formats were suitable and could easily convey the facts on FAS/FAE and explain the adverse affects of drinking alcohol during pregnancy. Above all, the use of video and radio provided the 'space' for teens to show when they party, drink alcohol and have sexual relationships, that this leads them to make many difficult life choices.

In order to reach Inuit youth, it was essential that the project be driven, developed,



STEPHANIE FANSOLATO

Pregnant woman

designed and owned by Inuit and reflect the realities of the North. A steering committee was established consisting of nine Inuit members from across northern Canada, including two youth representatives. In addition to providing overall wisdom and guidance throughout the project, their role included approval of the video content, script and filming location and selection of priority messages and how these messages were to be incorporated.

Taqramiut Productions Inc., an Inuit run production company based in Montreal, was contracted to produce the video and radio play. It was through the eyes of Evie Mark, an Inuk youth, that both productions were directed.

Filming took place in Iqaluit, Nunavut, the northern location determined by the steering committee. Although the video could have been filmed in southern Canada, the northern geographical, cultural, linguistic and human contexts were integral to this project as the audience would be primarily Inuit.

Once in Iqaluit, the project team recruited a keen cast from the local high school, elementary schools and the community health centre. The team hunted down willing households, clinic offices and mechanic stations as the backdrops to the video. In front of the camera, shy teens and community nurses transformed into stars. A cozy home for the drama's main family was created within the local wellness center complete with country food and an impromptu feast. Friendships were born between people who had never met before through laughter, fun and late nights of filming. The community members of Iqaluit were essential to the making of this video, which was produced in three dialects of Inuktitut and in English and French. The radio play was recorded in three locations across Canada to reflect various dialects and involve as many community members as possible.

The story line follows a young girl who finds out she is pregnant. She remembers partying with her boyfriend, drinking and having unprotected sex. When she knows that she is pregnant, a nurse explains to her what FAS/FAE are and she becomes concerned about the affects that the alcohol will have on her growing baby.

A viewing guide for facilitators was created to accompany the video and the radio play. In addition to providing health information, this hands-on-guide was written to: provide plain language medical definitions, facts and information on FAS/FAE; answer commonly asked questions about the syndromes; be used as a tool to get people talking about FAS/FAE; and, generally create awareness about the issue. Inuk artist, Alootook Ipellie, illustrated the viewing guide to emphasize its main points through non-verbal depictions.

To complement these activities and materials and to raise awareness, Pauktuutit decided to launch a national FAS/FAE poster contest among elementary and high school students. Among the many drawings submitted, the artwork of 10-year-old Hannah Flynn was selected by the steering committee for the cover design of all the Before I was Born project materials.

Once the materials were completed, they were distributed to all 53 Inuit communities. Additional reprints have been made to attempt to keep up with the demand for the materials. Clippings from the video and the radio play are on Pauktuutit's web site (www.pauktuutit.on.ca). The poster and viewing guide can also be downloaded.

Roberta Stout is an environmental and health activist in the Pauktuutit Inuit Women's Association.

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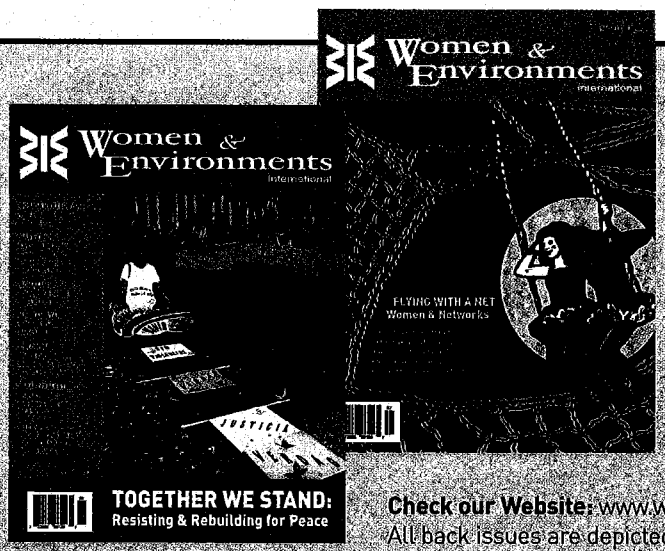

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Cuban Women Struggle with General Health Issues

Clelia Rodriquez


NIKOS EVDEMON

Urban gardening project in Cuba

The triumph of the Cuban Revolution radically changed the status of women in society and advanced them towards equality. The previous system kept widening the gap between men and women and lowering the standard of living, especially that of the women. Cuba has made impressive advances in the health sector. A dense network of health clinics covering the entire country ensures free health care for all Cubans. Cuba can pride itself of one of the world's lowest infant mortality rates. The economic blockade imposed by the United States still causes a unique and major challenge for the Cuban state and contributes particularly to the burden on Cuban women. (Nov. 4, 2003, the General Assembly of the UN passed a resolution opposing the US embargo by a majority of 179 votes in favour, 3 opposed and 2 abstentions)

Shortage of Sanitary Pads

Gender related physiological functions such as pregnancies, maternity, abortion, reproductive and sexual health affect Cuban women, like women everywhere. There are three million Cuban women of fertile age. The Cuban Confederation of Women reports that only 39% of the female population have access to pads. The lack of secure, harmless and effective way of dealing with menstruation, contributes to serious health problems. These include risks during pregnancy, unwanted pregnancies, vaginal infections, abortions, and other diseases. Many these diseases cannot be dealt with medicines, which are in short supply on the island.

Women are forced to use unsafe alternatives to pads. Most use rags, cut up fabric remnants or sheets. After use, these are washed and sterilised to be use once again. Women who fail to sterilize their rags and only rinse them with unboiled water seriously jeopardize their health. Unboiled water contains high levels of parasites that eventually travel through the urinary tract and cause kidney infections. A severe shortage of detergent and soap compounds the problem. Cuban women obtain sanitary products at the "bodega," or depot. The state set up these depots as distribution system to provide citizens with a package of articles of primary importance. In this way the state tries to cope with shortage. Every three months, the state provides all women between the ages of 12 and 55 with 12 pads. But what of the growing number of young women who get their first menstrual cycle at the ages of 10 or 11? There are also Pan-American stores that sell the pads for American currency. These, however, are not accessible to the majority of Cuban women.

There is little use of tampons in Cuba; they are even scarcer than pads. Not even US currency stores carry them. Some hotels offer tampons because their foreign guests demand them. Cuban women hardly know how to use tampons, they are therefore, not likely to practice this Westernized toxic habit. Nor are they familiar with the "cup," "sponge" or reusable cotton pads promoted by alternative health stores in the North. How about starting a cottage industry to produce reusable pads?

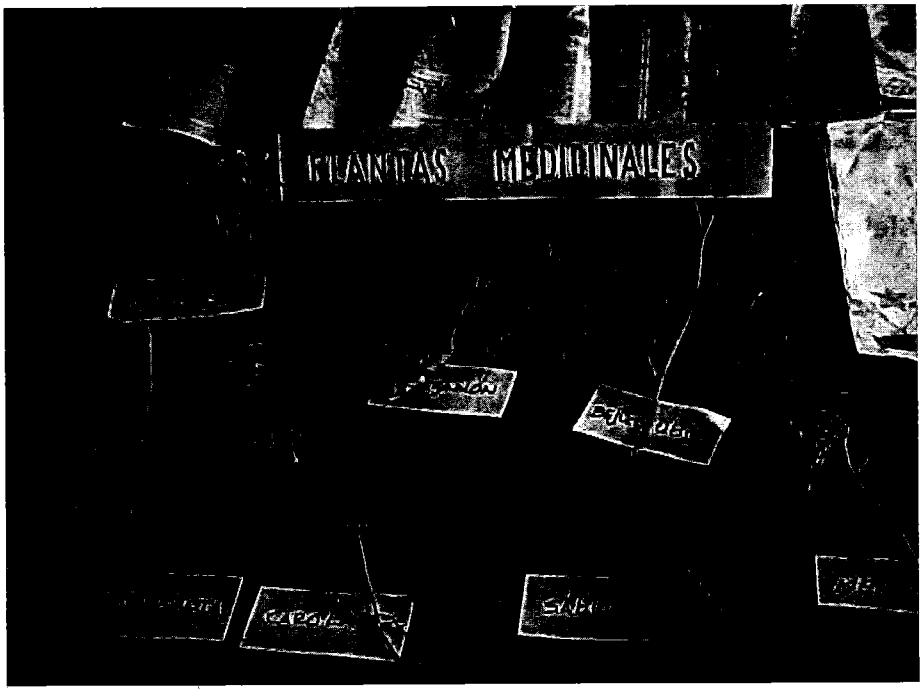
Nutrition

Nutrition is another health issue, which is still mostly women's responsibility. Here the state is more directly and creatively proactive. The effects of the US embargo and the "Special Period" — when Russia returned to a market economy and suddenly cut off economic support and subsidies — reeked havoc on the Cuban Economy. Cuba had to find resources and new countries to import food from and export its sugar. Nutrition in Cuba became a serious problem for the population at large and pregnant and lactating women and children in particular.

The Cuban government took drastic measures. State organizations are working together with the community to improve the quantity and quality of food especially for pregnant women. The Department of Health is implementing a special nutrition plan for pregnant women. The family doctor provides a special certificate that verifies pregnancies and entitles women to obtain a special food ration in the "bodegas." The ration includes food supplies, such as milk, meats, fowl and also vegetables. The medical centres monitor the weight of pregnant women to detect any symptom of malnutrition. When underweight is detected, the woman is immediately hospitalised in a nutrition ward until she has obtained the desired weight. Nutrition centres offer and promote special lunches for pregnant women.

Another state supported program is Urban Agriculture. Cuban women excel in implementing the program to ensure sustainable food production and consumption. The City of Havana, for example has several orchards and gardens that are managed exclusively by women. These orchards produce vegetables and fruits of every kind. The produce is delivered to the nutrition centres, asylums for elders and "círculos infantiles," children's day care centres. While men run most of the conventional agriculture in the interior of the country, woman work better in urban agriculture. Urban agriculture provides jobs and teaches women how to cultivate. Together women share the work and determine how to do it. Because of the lack of chemical fertilizers, the women are using organic fertilizers instead. Each neighbourhood has generally one or two orchards or gardens. The work schedules for cultivation are flexible and allow women to integrate their shifts into their lives and jobs — any hour of the day. Another advantage of these orchards/gardens is that children can participate with their mothers and gain a closer understanding of and appreciation for nature. The orchards integrate the community. Women get together there; they develop friendships while cooperating to feed themselves, their families and communities.

This state and community teamwork has succeeded in decreasing maternal and infant mortality rates. Dr. Mirta Roses, director of the Pan-American Health Organization, has stated recently that "Cuba is one of the countries that, regardless of the economic turbulence, has contributed a great deal maintaining the commitment to ensure access to free health care for all Cubans." In spite of the health problems Cuba faces, her women must be praised for the energy and efforts they contribute day in day out to enable them and their families to face and survive all difficulties. It is with this determination that Cubans have kept alive the vision of their Revolution that they fought for and won in 1959.



CLELIA RODRIGUEZ

Display of medicinal plants which a Cuban women's group cultivated on an urban agriculture site.


CLELIA RODRIGUEZ

These school children learn about the benefits and importance of urban agriculture.

Born in El Salvador, **Clelia Rodriguez** came to Canada during the civil war. Her involvement in social, feminist, environmental and international development issues took her to Mexico, Cuba and a job as Project Coordinator for Future Watch Environment and Education Partners in Cuba where she also was secretary for Se Puede Vivir en Ecopolis, an environmental sociological Magazine. **cleliaro@yorku.ca**

Breast Cancer

How to Outsmart Breast Cancer Statistics

Helen Elsaesser

NEED PHOTO CREDIT

Helen Elsesser

"A pleasant 67 year old lady" state some my medical records. I have been living with breast cancer for 10 years. Statistics put the average survival for patients with metastases at about two years. In 1996 extensive bone metastases were diagnosed, yet I enjoy a very active life. I play in chamber and symphony concerts, teach 25 music students, am involved in several community organisations and enjoy kayaking and cross country skiing.

I grew up in Switzerland. Our family practised the values of justice and equal rights between the genders, but we also were instilled with a great respect for authority be it the government, teachers, physicians or experts. We would accept their word without discussion or doubts. This set me up to become the perfect passive patient. But life taught me differently. My husband and I adopted two children, both with learning problems. I felt obliged to become the advocate for my children so that they would get a fair chance for their lives. I had been a public school teacher in Switzerland; I understood and appreciated the importance of education. Now, I had to learn to speak up, advocate on behalf of my children and question teachers, principals, school boards, physician and psychiatrists. I also learned to look for innovative solutions.

The only way to outsmart a cancer diagnosis is by taking charge of your own health. No physician knows your body as well as you, is as much tuned into your momentary needs or remembers all the health details as you do. You have to become an assertive advocate for yourself. When I was first diagnosed with breast cancer I did not receive the customary bone scan test. Since I did hear from other cancer survivors about their tests I finally insisted on one. This led to the diagnosis and treatment of the metastases.

Many women find it difficult to take charge of their health because there are different types of patient personalities. Some do not want to know any details about their health problems and follow blindly suggestions of their physicians. Fortunately they are getting fewer. Others cannot and do not want to make decisions. Still others go with a preset mind to the appointments and do not listen. Increasingly though, patients are open and listening and want to be involved in the treatment decisions.

Depending on your own and your physician's personality the relationship can be either very taxing or smooth greatly affecting treatment decisions. After three years I asked for a change of oncologist. He was the fatherly type and made derogative remarks about my complementary treatments and thought they were a waste of my money. He did not listen to my health concerns and did not think a patient could contribute to decisions about their health. Even so every patient has to sign a "statement of consent" for any major treatment such as operations or radiation. It is therefore important to find an oncologist you can trust and openly discuss any problems and treatments, even alternative ones.

Recently I was referred to an orthopaedic surgeon. "I know you," he said when he entered the examination cubical in the hospital. I was stunned. I did not remember ever seeing him before. He had seen me play in the Symphony Orchestra where his wife was playing as well. This personal introduction and his telling me about his training made it much easier for me to trust him and discuss the pending operation.

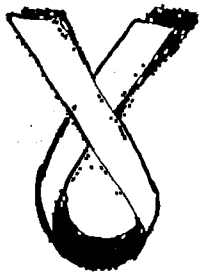
An important aspect of taking charge of your health is ensuring that the planned treatment decisions are really put into action. When I was referred to the surgeon, the cancer centre, 200 km away, was supposed to send X-rays so that he could first examine them to decide if I really needed his services. His office was then supposed to call me. The call did not come. So I called his office, where they were still waiting for the X-rays. Next step was a call back to the cancer clinic to report the missing X-rays. The nurse was very upset because she had given orders to send the films. Within three days after this I got my appointment with the surgeon. Had I not taken the initiative I might still be waiting.

Other times you have to convince receptionists and nurses who are overprotective of their doctors that you are actually a client and that you have certain rights as a patient. A few years back I needed an MRI (Magnetic Resonance Imaging). I had to go to the US to get one in reasonable time. Naturally I had to pay for that myself. The radiology clinic in the States handed me the films to take back to Canada and promised to fax the report to my family physician within two days. I tried to make an appointment with the family physician to receive and discuss the written MRI results. I only got one four weeks later! Waiting for outstanding reports is one of the most taxing things in a life with cancer. When I wanted

to pick up the report the receptionist told me the nurse who could give me the report was not there. The second time I went, the nurse took me into a treatment room and told me: "yes the report was there but she did think it was not nice if I would get the report before the doctor could read it." Even though I am usually quite calm and restrained, I blew up. I told her that the report concerned my body; I paid for it; I had the films; and that my medical chart contained a note that I should get any reports even if not yet read by the physician. She covered her face saying she would talk with another doctor, but she came back in a very short time with the report.

The official medical services offered through OHIP (Ontario Health Insurance Program) are very good for diagnosis of obvious symptoms. Usually the physicians are not interested in investigating health concerns, which do not cause severe symptoms especially in our cancer clinics. Once when I was asking for a CT scan my oncologist answered: "oh no, not for you, cat scans are not used for diagnostic purpose for patients with metastases, they are too expensive. We do not need to know in advance if it spread to other areas, only if obvious symptoms appear we will check further." I felt despair, abandonment and unworthiness which eventually turned into the will to prove the medical establishment that I could outlive their expectations of the progression of my disease.

Even famous cancer physician Dr. Susan Love admitted that the official American medical cancer establishment does not offer much more than "cut (surgery), poison (chemotherapy) and burn (radiotherapy)." I had to look further for innovative less damaging solutions. I wanted to find something, which would strengthen my immune system instead of weakening it as the commonly used modalities do. I had attended *Total Health Shows* in Toronto and had books on alternative treatment options even before my first diagnosis. I had also a friend with breast cancer and together we were discussing the different options. I chose Iscador a mistletoe preparation after my initial mastectomy. It is a herbal treatment in form of injections, widely used in Europe.



BREAST CANCER AWARENESS RIBBON
— the symbol

TEAR DROP SHAPE represents the tears shed at the time of diagnosis;

PINK RIBBON represents thousands of women diagnosed yearly;

BLACK RIBBON is in memory of the thousands of women who have died;

OUR HOPE is to remove the black ribbon when a cure is found and to wear only the pink ribbon in celebration.

Three month after my operation I was asked if I wanted to join a Tamoxifen study. I have big reservations about the ethics of medical trials especially of double blind trials where you have no idea if you get a medication. Also in my opinion it is not possible to have really controlled scientific studies, since every women has a different life style and different mental attitudes which can affect the health as much as medications. I refused to participate in the study.

Being open to any suggestions, reading many books and attending conferences I found out about many different complementary treatments. Serious physicians working with complimentary treatments do not promise you cures either. However, they greatly improve the quality of life and through that often extend life expectancy. Over the years I used many different remedies and treatments. I went four times to a well-respected clinic in Mexico. There I got great relief from severe pain. This most likely also slowed down the progression of the cancer. At the moment I try to keep the cancer under control with a combination of allopathic medicine plus complimentary treatments. They include detoxification, diet, immune-boosting antioxidants and supplements, intravenous vitamins, shiatsu, qi-gong, occasionally acupuncture and mental imaging. I am integrating the experiences I gained over the years from the Mexican clinic, my Canadian naturopath, the Swiss clinic I now visit yearly, and books.

The three 'World Breast Cancer Conferences' in 1997, 1999 and 2002 presented important research into the causes of breast cancer. The environment plays a big role. The poisons we, the human race release into nature through pesticide and herbicide use, exo-estrogens and over-medicated animals, chlorine and fluoride in drinking water, electromagnetic fields from communication towers and power lines, radiation from nuclear reactors, all jeopardize our environment and our health. Primary prevention and prevention of recurrences of breast cancer can be greatly helped by avoiding poisons from the environment as much as possible. Since it is difficult to buy organic vegetables in Northern Ontario, I had to start a vegetable garden (with carted-in soil on our rocks) so that I get them at least during the summer. I also had to convince my cleaning lady to use the environmentally friendly cleansers in our house. Before I moved up North I had to distill all our drinking water to avoid chlorine and fluoride. In our community, I joined the local water committee to help set up recommendations for the protection of the water quality in our numerous lakes. Unfortunately, there is no longer such a thing as pure environment. Even in the arctic, the pollutants of the industrial parts of the world are present. We have to consider the long-term effects of any decision and action since no nation or area can be independent from the rest of the world.

Over the years I had and still get great help from the Breast Cancer Support Group. They fill an important role to connect women so they can discuss emotional, medical and family issues, which are brought on by cancer. Often family and friends get tired of hearing about cancer problems for years. Unfortunately, once touched by breast cancer you will always have to deal with it, if not with recurrences then with emotional issues. I also learned by listening to the stories of other survivors and am now facilitating a local support group myself. Willow, the Toronto based Breast Cancer Support and Resource Services is offering workshops for group facilitators. These help to

take care of their individual needs and enable networking among different groups.

Another great information source and support is the internet group for people with metastatic breast cancer. By sharing and discussing our treatments, experiences, news and findings from conferences, I learned a lot about the allopathic medicine and new treatment options.

I still thank my friend who started me in the right direction for taking control of my health by advising me to ask for each and any report. Any woman who leaves the doctors office with a positive breast cancer diagnosis for the first time should get the following helpful advice:

1) The treatment does not have to start the next day, in most cases the cancer grew over many years. So you will have the time to look around, speak with other survivors, get second opinions, get as much information through the library, internet, Willow etc. Family physicians should encourage newly diagnosed women to get in touch with the nearest support group as soon as possible.

2) Only agree with treatments you feel comfortable with.

3) Ask for each and every report from your family physician because:

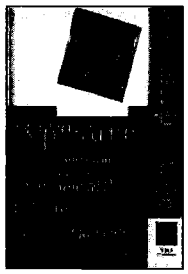
- there is a different impact if you see it in writing than just mentioned in a discussion.
- you can read it over again and study it with a medical dictionary
- you have your records together if you want to go for a second opinion or complementary treatment at another clinic.

By being open and alert to what is going on around me and by listening to any suggestions, hints, tips and leads I was able to find ways to control my disease much more than was expected by my medical team at the cancer clinic. My belief is also that nothing happens by accident, we are given guidance if we listen and act upon it.

Helen Elsaesser is an active musician living on Georgian Bay, Ontario and deeply involved in making life with breast cancer more bearable for herself and others. She can be reached at relsaess@zeuter.com.

Exposure: Environmental Links to Breast Cancer

Video (53 minutes)— And Educational Tool on Women's Health and the Environment.



Dorothy Goldin Rosenberg

One in three people will get cancer, today. One in four will die from it. In the 1950's women in industrialized countries were at a one in twenty risk of developing breast cancer over their lifetime. Today that risk has skyrocketed to one in eight. Cancer can have many causes. Seventy to eighty per cent of women with breast cancer have none of the "official" risk factors: family history (5-10%), hormonal and reproductive factors and a high fat diet. However, breast cancer rates are increasing all over the world and may be but the tip the iceberg of other environmentally linked diseases.

Timely, responsive and urgently needed, *Exposure: Environmental Links to Breast Cancer* plays a major role in raising awareness of the little understood, long-term connection between environment, health, and disease prevention. It introduces issues, raises questions, awareness and opportunities. It offers strategies for dealing with current unacceptable environmental health conditions and for generating the social and political changes needed for a cleaner, safer world.

Exposure: Environmental Links to Breast Cancer was shown at the 9th International Women and Health Meeting in English, French and Spanish followed by discussion periods in the respective languages. For many women it was the first time they were introduced to these environmental health relationships. The accompanying guide: "Taking Action for a Healthy Future" contains valuable information on the issues as well as tips on how to act on them. It illustrates how to use the film for learning and education. The women responded with an animated discussion, questions, personal stories and interest in knowing and doing more for prevention in their homes and communities. Many obtained copies to take back with them. The film has been used in workshops, community meetings, seminars, courses, the media and elsewhere in recent years.

Exposure was conceived in response to the growing public debate about the implications of our contaminated world on the health of women. Francine Zuckerman and Martha Butterfield produced while Francine Zuckerman directed the 53-minute colour documentary video. Dorothy Goldin Rosenberg served as associate producer and principle research consultant.

Exposure: Environmental Links to Breast Cancer has won awards and prizes. In 2000, it was nominated for a Gemini, Canada's Film and Television Awards. In 2001, at New York's International Independent Film Festival it received the "Best Health Documentary" award.

EXPOSURE, the Video, is available in seven languages, in VHS (North America) or PAL and SECAM (International) from **WHEN, Women's Healthy Environment Network** ,a Registered Charitable Organization (Charitable No. 11926 2533 RR0001) at 24 Mercer Street, Suite 102, Toronto ON M5V 1H3
Phone (416) 928-0880 Fax (416) 928-9640
E-mail: when@web.ca or through the WHEN website: **www.web.net/~when**

Cost:
individual $ 32+; Community Partner $50
Institutions $ 107, + Shipping and handling charges: Canada $6.00, USA $8.00, International $10.00

Breast Cancer, the Enviroment & Protection

Sat Dharam Kaur

Sandra Torrijos/ Isis International Manila

One of the things that sets humans apart from many other species is our ability to understand cause and effect and to make conscious choices regarding our well-being and our future. We set goals for the coming years, we save for our children's education, we plan for our retirement. It is with overwhelming sadness that I reflect upon the unconscious choices we make every day that undermine our planetary future and add to the plethora of risk factors for breast cancer. Many of these are choices of convenience — like using the birth control pill, spraying our lawns with pesticides, packaging and storing food in plastic containers, and flushing the toilet — which indirectly threaten the survival of our species and many other glorious inhabitants of this ailing planet. We live in denial of the effect of these and other daily actions. We must make more conscious choices for our breast health and for the planet.

As we poison our mother earth with an ever increasing array of pesticides, chemicals, plastics, pollutants, garbage, nuclear fallout and radiation, our breasts respond as sensors for environmental degradation. We poison ourselves, our children and other species as we poison the land we farm, the groundwater we drink from and the air we breathe. I think of the breast with its ducts and lobules and its ability to nurture life as the epitomy of the planetary tree of life. What does it say when many of us are struggling to keep them, or fear nursing our young because of what we may pass on to them through our breast milk? Our breasts have become the sacrificial lambs of the global environmental crisis.

Breast cancer is the leading cause of death for women in Canada between the ages of 35 and 55. It plucks us in the prime of our lives. One of us will be diagnosed with the disease every 30 minutes. One in nine of us will be diagnosed with it at some time in our lifetimes. In the 1920's, when my grandmother was a young woman, pregnant with my mother, and half of my cellular DNA was present in the ovaries of the fetus in my grandmother's belly, one in 20 women was diagnosed with breast cancer. I have a daughter who is fifteen. If the trend continues, her granddaughters will face a risk of 1 in 3. Who will nourish the young?

Breastmilk ought to be one of the most prized and protected commodities on the planet, certainly more precious than oil or gas, for our survival depends on it. Without it, we forfeit the perfect food for the next generation. When I nursed my three children and if you nursed your children, our breastmilk contained at least 17 pesticides, 13 furans, 65 PCBs, 10 dioxins and 30 other organochlorines. In only six months of breastfeeding, an infant in Canada, the United States and Europe receives the maximum recommended lifetime dose of dioxin and 5 times the allowable limit of PCBs set by international standards for a 150 pound adult. A woman passes half of her lifetime accumulation of dioxins and PCBs on to her child when she nurses for just six months. These contaminants in breast milk affect the neurological, glandular and immune health of our children for life. PCBs alone are linked to immune deficiency, chronic ear infections, learning disabilities, thyroid abnormalities and attention deficit disorders in children. People who eat fish regularly from the north shore of the St. Lawrence River in Quebec have a mean PCB level of 6 parts per million, which is over 10 times higher than the average Canadian's. The St. Lawrence Estuary contains one of the highest concentrations of PCBs in the world.

Animal studies have shown that the chemicals released from one nursing mother are still present in offspring 5 generations later. They cross the placental barrier during pregnancy and are mobilized from our bodies' fat store into breast milk when we nurse. What does it mean when this perfect food has no laws that protect it, no health practitioners who systematically test its purity, when infant nutrition is laced with hormone-disrupting, cancer-producing contaminants, and when the chemical industry is self-regulated and supported by government? How did we go so wrong?

In the last 10 years it has been found that a certain class of environmental chemicals called organochlorines are able to mimic estrogen. These include many chemicals present in pesticides, plastics, PCBs, pulp and paper manufacturing, sewage treatment and solvents. By far the greatest amount is used in the production of PVC plastic. There are many problems associated with the use of these chemicals. One is that they are persistent. They are stable molecules that resist breakdown in the environment or by our detoxification mechanisms, persisting for decades or centuries. Because they don't easily break down, organochlorines steadily accumulate in the global environment and are dispersed worldwide through air and water. They concentrate in the fatty tissues of animals and humans and move up the food

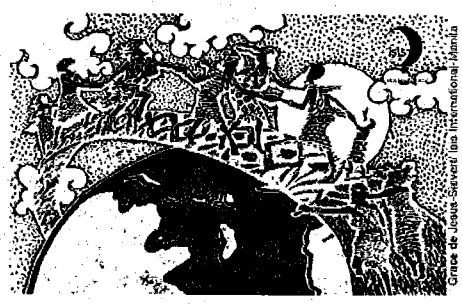
chain. The more dairy, fish and meat we eat, the higher our load of persistent chemicals that mimic estrogen in our bodies. They remain in our tissues for life and we pass them on to each successive generation in increasing amounts. The effects of many of these chemicals are synergistic. Two different pesticides together in minute doses have been found to be 1000 times more potent in affecting human estrogen receptors than either chemical alone. Unless we eat organic food, we ingest these every day.

We can make conscious choices to protect ourselves and future generations from the cumulative effects of hormone-disrupting chemicals. We can eat lower on the food chain, consuming a primarily vegetarian diet, and avoiding or minimizing meat, fish and dairy. We can choose to exercise our power as consumers and stop buying plastic, particularly PVC plastic and food stored in plastic. We can grow or buy organic food and ask our supermarket to stock it. We can educate our neighbours who spray their lawns about the effects of pesticides on health and find alternatives to chemical sprays. We can become activists and demand that government and industry phase out PVC plastic and other hormone-disrupting chemicals. We can support the World Wildlife Fund, the Sierra Club, Greenpeace and other organizations that are trying to make a difference. We can maintain a weekly schedule of saunas, through which we will sweat out many toxic chemicals. Intense sauna programs can eliminate more than 90 percent of the chemicals stored in our fat cells when done in a particular way, preceded by exercise and ingestion of a few supplements. With a supervised program, this could be accomplished in as little as three weeks. Breast cancer prevention begins before conception. Whether you are a man or a woman, if you plan to have children one day, do an intense sauna detoxification at least 6 months before conceiving. If you have children, take them into the sauna with you at least once weekly.

To protect ourselves from the damage caused by nuclear radiation, we can consume at least 2 tablespoons of seaweed daily such as dulse, kelp or nori, and learn to cook with them. Sea vegetables contain sodium alginate, which is able to bind to radioactive substances which can then be excreted. A diet rich in antioxidants or supplements containing vitamin E, and C, beta carotene, grape seed, coenzyme Q10 and the minerals zinc and selenium are also protective. Pumpkin seeds and Brazil nuts provide us with food sources of zinc and selenium. We can investigate the possibility of using solar or wind power, design our houses to be more energy efficient and use fewer electrical devices to decrease our reliance on nuclear power. We can protest the use of radioactive weapons by all countries. This is dealing with the cause.

Women who are chronically exposed to electromagnetic fields have an increased breast cancer risk. Electromagnetic fields affect the pineal gland, lowering the production of melatonin. Melatonin exerts a protective effect against breast cancer. We can limit our exposure to electromagnetic fields by keeping a distance of at least two and one half feet from electrical currents and appliances, particularly where we sleep or spend most of our waking hours. Move your clock radio further away from your bed and spend less time in front of your computer. Since melatonin is secreted at 3:00 a.m and we produce more if there is darkness around us, it is important that you sleep in a dark room to optimize these levels. Working the night shift will decrease melatonin levels and correlates with a higher breast cancer risk.

There are many other preventable causes of breast cancer, including several hormonal factors. Estrogen is a hormone produced by the ovaries from puberty through to menopause. Estrogen acts only on tissues that have receptors for it. The hormone attaches to the receptor and then is able to activate the DNA or genetic material of the cell. Receptors for estrogen are present in our breasts, uterus, ovaries, vagina, bone, skin, brain and other tissues. Estrogen promotes cell division, especially in tissues that have a high number of estrogen receptors, such as the breasts and uterus. As more cell division occurs, more mistakes can be made in DNA replication. If a carcinogen such as a chemical, excess radiation, toxic metals like cadmium or lead, or heated oils have damaged the DNA to begin with, estrogen multiplies the damage, promoting a cancerous growth. The more estrogen a woman is exposed to during the course of her lifetime, the greater her risk of breast cancer.



Therefore early onset of puberty, before age 11, and late menopause, say after age 53, each double a woman's risk of breast cancer. So does a menstrual cycle that occurs every 24 days rather than 28 days. The body makes several forms of estrogen. Some of them promote breast cancer and others are protective. The liver will convert the promoters into the protectors if we help it along. The extent to which the large intestine eliminates estrogen depends to a large degree on what we eat and how frequent our bowel movements are.

In order to prevent breast cancer, we can be taught to manage our estrogen levels to send it down the protective pathways and eliminate it efficiently, just as we are taught to manage our bank account or our mutual funds. Estrogen in itself is not bad — it's the metabolism of it that needs to be corrected. It needs careful management.

So how do we manage our estrogen? We can stall puberty in our daughters by keeping them on an exercise program from ages 9 through 16 and by encouraging weight loss if they are overweight. Before puberty, we can feed our daughters plenty of ground up flaxseeds and soy products. These foods have what are known as phytoestrogens in them — estrogens that can bind to the receptors on breast cells but are too weak to promote cell division and cancer. They prevent the body's stronger estrogens from attaching to the receptors. Other phytoestrogens include mung bean sprouts, red clover sprouts and pumpkin seeds.

We can help the liver convert the strong estrogens into protective estrogens through the foods, vitamins, minerals and herbs we use, and through avoiding common substances that interfere with liver function, such as coffee, alcohol, cigarettes, car

exhaust, pesticides, the birth control pill and other drugs. All of these things, so much a part of our lives, will interfere with the metabolism of estrogen. One third of a raw cabbage daily, perhaps as coleslaw or juice, pushes one of the strong estrogens into a protective one. So do other raw foods in the brassica family — which include broccoli, cauliflower, brussel sprouts and kale. Other liver protecting foods include turmeric powder, rosemary, flaxseed oil, soy products, legumes, oatmeal and spirulina. The liver relies on the B complex, particularly B6, and the vitamins E, A, C, folic acid, zinc, copper, calcium and magnesium to function well. Some of the herbs that regenerate the liver and assist in estrogen metabolism are milk thistle, dandelion, bupleurum, schizandra and chelidonium. We can take these in a tincture form to decrease our susceptibility to breast cancer.

We can help our colons eliminate estrogen through maintaining a vegetarian or almost vegetarian diet that is low in fat, using only unheated olive oil and flaxseed oil on our foods and supplementing with uncontaminated fish oil. Women who consume meat regularly have estrogen levels three times higher than vegetarian women. A diet high in meat and fat causes a specific bacteria to be formed in the large intestine that helps estrogen to be reabsorbed and recycled rather than eliminated. We can consume a high fibre diet, taking in at least 30 grams of fibre daily, as they do in Africa where the breast cancer incidence is the lowest in the world. We can accomplish this by using a tablespoon each of wheat bran and psyllium seed powder daily, using beans and whole grains regularly and eating six to nine servings of fruits and vegetables each day. A diet high in fibre reduces our breast cancer risk by 30 percent, as the fibre helps to eliminate estrogen. Women who have less than 2 bowel movements per week increase their breast cancer risk fourfold as estrogen is recycled. We should aim for at least two bowel movements per day.

Exercise improves the metabolism of estrogen. Women who do aerobic exercise at least 4 hours a week, or 35 minutes per day, decrease their breast cancer risk by between 30 to 60 percent. We can alter our lifestyles so that we do exercise daily — walking, rebounding, fitness classes — whatever we find enjoyable and can maintain for life is best.

Women need to support one another in their efforts to prevent or recover from breast cancer and work together towards planetary healing. Think of helping out an environmental group in your area that is active in decreasing the use of pesticides and/or PVC plastic. Join a support group or start your own to encourage lifestyle changes to improve your breast health. Link up with other sauna goers to make the sauna experience fun. For more ideas or information, you can view the website www.healthybreastprogram.on.ca or purchase a copy of my new book The Complete Natural Medicine Guide to Breast Cancer, due to be released in October, 2003. The publisher is Robert Rose Inc.

Sat Dharam Kaur, N.D. is a naturopathic doctor practicing in Owen Sound, Ontario, telephone number 519 372-9212.

Noah's Ark

Jen Green

Tears in bathwater
the flood of
rivers like veins, tracing the flow from dumpsites
to pathology reports.
poison we make we spray we clean with
Dumping dumping
in food, in walls
In the IV, chemo solution
Hair falling
sanity slipping

The hair of the dog that bit you
was your faithful companion
in white paper, saran wrap
dry cleaning and yes,
mother's milk

A pause to weep.

Radical compassion
Mastectomy

Women in fragments,
lung liver bone
pieces of mice measured out...
"Did the implanted tumors shrink or grow
shrink or grow?"

Our bodies betray us
mother grows wild in our breast
Nature run amuck
Hah.
The nature of marketing goals
the cost of
life, lost love
cancer, lost species
Cost of living
living earth.

JEN GREEN

Jen Green is a doctor of Naturopathic Medicine, and artist. She lives and works in Toronto.

Changing Attitudes — Two women speak out against HIV/AIDS in their community

Brian McDonald

In Lai Gayint, Ethiopia, two young women are working towards changing attitudes about HIV/AIDS in their communities. This is no easy task to accomplish in a place where people don't openly talk about condoms — and they certainly don't talk about HIV/AIDS. Addis Asefa and Sifresh Wondifraw are unafraid to speak out — even though they risk ridicule within a culture where women are viewed as inferior.

"I have been threatened," Wondifraw says. "Men laugh, point to their pants and say, 'show me how to use a condom,' and others won't let me near their wives, but I keep on speaking openly because if I don't, more people are going to die."

Death is something both women have seen a lot of during their work as sexual health counselors for Canadian Physicians for Aid and Relief (CPAR), a Canadian NGO working in Lai Gayint, a mountain village 500 km north of Addis Ababa, Ethiopia's capital. Many people here and in the surrounding countryside are illiterate and do not know enough to protect themselves. Nor did they have easy access to condoms until the CPAR project arrived.

In Addis Ababa, the HIV/AIDS infection rate is reported to be as high as 14 per cent and it is fast approaching seven per cent in the rural areas.

"Previously people knew nothing about HIV and had a negative attitude towards condoms. They (condoms) were supposed to ruin sex and some even said they contained the virus that causes AIDS," says Asefa. "Women, even if they were informed about sexually transmitted infections, were afraid to ask men to wear condoms, and the church prohibited their use for religious reasons. Now all of this is starting to change."

"The virus was spreading and there were a lot of deaths among husbands and wives," Sifresh says. "Many other people are suffering from chronic illnesses from which they don't recover. I wanted to do something before it was too late."

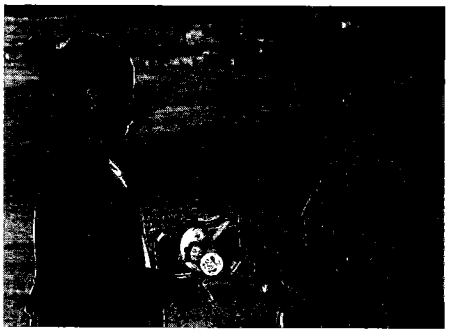
The women say their primary message is that HIV/AIDS infection is a death sentence — so if you are going to have sex, protect yourself. That message is taken into schools (where abstinence is taught as the best option), to street children and prostitutes, prisoners, demobilized soldiers, and the general community.

"I have about 40 clients and more are coming all the time," Addis says. "I teach them that you cannot tell if someone has the virus and reassure them that the condoms we supply are not contaminated. I also stress that prophylactics also help protect against other sexually transmitted infections and prevent pregnancy."

But the question still remains — is the message getting across?

"People's attitudes are starting to change," Sifresh answers. "The community is very scared of AIDS because of the devastation it brings. They are saying we should have started teaching them years ago."

Addis agrees that attitudes in the community are starting to change. She says the young people she speaks with almost always use protection, soldiers have started asking for condoms and many prostitutes are refusing to have sex without a condom. "One of them told me a man had offered her 50 birrr (one dollar) for unprotected sex and 30 birrr for sex with a condom and she refused," Sifresh says with a smile on her face. "Others have started calling for help if a man tries to force sexual relations without the use of a condom."



BRIAN MCDONALD

HIV/AIDS peer counselors help educate community members.

Seneshesh, started working as a prostitute at the age of 17 when her husband left her to take care of two young children on her own. Now at the age of 29, she has learned about the importance of protecting herself.

"Before CPAR came, people did not talk openly about sex because of the stigma. No one would buy and use condoms and the prostitutes were full of shame," she says. "Then we learned about the method and the means of transmission from Addis and Sifresh and it changed the way we think."

"Our behavior has changed — we just hope it is not too late."

Brian McDonald worked as journalist and photographer in Ethiopia for Canadian Physicians for Aid and Relief.

CPAR, a Canadian NGO, is devoted to the building and sustaining of healthy communities in rural areas of Ethiopia, Uganda, Malawi and Tanzania.

Huairout Update — AFRUS-AIDS

Michelle Cleary

AFRUS-AIDS activist

The magnitude of the HIV/AIDS pandemic, which has descended upon the African continent is staggering. Each year governments, doctors, specialists and experts have projected, researched and prophesied as to the eventual reduction and/or eradication of this destructive virus. Yet, the number of infected individuals has climbed with little sign of abatement.

In the meantime the grassroots women of Africa have responded to their deteriorating situation, unseen and unacknowledged, with innovative and skilful tactics. Drawing on their role as community caregivers, grassroots women have mobilized to build their own support networks and design interventions. Programs train neighbours to provide home-based care and peer counselling, educate in HIV/AIDS prevention, de-stigmatize those living with the virus, and transform harmful traditional practices. All emerge from the practical experience and expertise of the affected communities themselves. Although their efforts have gone largely unnoticed by much of society, the grassroots women continue to carry the burden of vanishing work forces, fading communities and parentless families. These are the women of AFRUS AIDS.

What began as a series of conversations and ideas shared between church-based women in the US and their sisters in Africa throughout 1998 and 1999 developed into a joint initiative called AFRUS AIDS. The Huairou Commission, GROOTS International, The National Council of Churches and several other committed organizations took on the financial and time-consuming burden of making these ideas into a reality. Subsequently, the first AFRUS regional meeting was held in Nairobi in September of 2000. The unique and innovative aspect of the AFRUS AIDS coalition is that the support comes in both material and non-material ways. While financial resources and equipment are often provided it is the focus on peer learning and the development of sustainable practices that AFRUS uses to fight the effects and spread of HIV/AIDS. AFRUS is a strong supporter of African development. From poverty to gender inequality; from non-sustainable development to unemployment, AFRUS is dedicated to rectifying the many conditions that continue to exacerbate the HIV/AIDS pandemic. The partnership ensures that resources are channelled directly to grassroots communities to mitigate the pandemic's spread.

The AFRUS member organizations are devoted to creating a unique and strong network, crossing regional, national, religious and communal boundaries. Diversified and experienced, this network overcomes geographic and spiritual limitations of other networks on the continent. In this way, a group of women from Kenya travelled to Lesotho to teach a Christian based group how orphans could learn practical income generating skills forging a lasting bond between the groups. The practical and often personal experiences with the HIV/AIDS virus can foster development, communication, education and hope.

The experiences of several brave and passionate African women who are facing the virus head on engendered a great deal of hope in Johannesburg at the World Summit on Sustainable Development (WSSD) in August of 2002. During Health Day in the Ubantu Village Community Karral, activists representing the AFRUS AIDS coalition and GROOTS International showed how they are empowering women and families to prevent HIV/AIDS and how they are mobilizing community care for the ill and orphaned in Uganda, Zimbabwe, Rwanda, Kenya and the Democratic Republic of Congo. This event moved Jeffery Sachs, Special Advisor to Kofi Annan, to pledge his support to link the women there to the Global Fund for HIV/AIDS, Malaria and Tuberculosis. He then addressed the Kraal by saying:

"This is billed as a side event, but it is not. This is the centre of the Summit — the

reality. What you're doing is heroic... I have learned one thing today: the simplest answer to solving Africa's problems is to let the women run Africa."

AFRUS has made an indelible mark on the international community during the WSSD. In September of 2003 AFRUS AIDS will be participating in the 13th International Conference on AIDS and Sexually Transmitted Diseases in Africa (ICASA). This is a biannual forum that brings together African scientists, social leaders, political leaders and communities to share experiences and updates on the responses to the HIV pandemic. In addition to participating in deliberations during the conference, AFRUS members will hold a four day Grassroots Women's International Academy (GWIA) to share their innovative practices and participate in valuable peer learning activities.

The devastating health crisis Africa faces has been transformed into an opportunity to improve African society as a whole. By successfully harnessing the strength of women and communities AFRUS has began placing the future of Africa in the hands of Africans.

Michelle Cleary recently graduated with her Masters from the Stony Brook School of Social Welfare. Her second year internship led her to the Huairou Commission and to AFRUS AIDS, introducing her to the inspiring and powerful world of Grassroots Organizations. For more information about AFRUS AIDS please visit www.afrusaids.org.

In Africa, AIDS has a Woman's Face

Kofi Annan

A of famine and AIDS is threatening the backbone of Africa — the women who keep African societies going and whose work makes up the economic foundation of rural communities. For decades, we have known that the best way for Africa to thrive is to ensure that its women have the freedom, power and knowledge to make decisions affecting their own lives and those of their families and communities. At the United Nations, we have always understood that our work for development depends on building a successful partnership with the African farmer and her husband.

Study after study has shown that there is no effective development strategy in which women do not play a central role. When women are fully involved, the benefits can be seen immediately: families are healthier; they are better fed; their income, savings and reinvestment go up. And what is true of families is true of communities and, eventually, of whole countries.

But today, millions of African women are threatened by two simultaneous catastrophes: famine and AIDS. More than 30 million people are now at risk of starvation in southern Africa and the Horn of Africa. All of these predominantly agricultural societies are also battling serious

AIDS epidemics. This is no coincidence: AIDS and famine are directly linked.

Because of AIDS, farming skills are being lost, agricultural development efforts are declining, rural livelihoods are disintegrating, productive capacity to work the land is dropping and household earnings are shrinking — all while the cost of caring for the ill is rising exponentially. At the same time, H.I.V. infection and AIDS are spreading dramatically and disproportionately among women. A United Nations report released last month shows that women now make up 50 percent of those infected with H.I.V. worldwide — and in Africa that figure is now 58 percent. Today, AIDS has a woman's face.

AIDS has already caused immense suffering by killing almost 2.5 million Africans this year alone. It has left 11 million African children orphaned since the epidemic began. Now it is attacking the capacity of these countries to resist famine by eroding those mechanisms that enable populations to fight back — the coping abilities provided by women.

In famines before the AIDS crisis, women proved more resilient than men. Their survival rate was higher, and their coping skills were stronger. Women were the ones who found alternative foods that could sustain their children in times of drought. Because droughts happened once a decade or so, women who had experienced previous droughts were able to pass on survival techniques to younger women. Women are the ones who nurture social networks that can help spread the burden in times of famine.

But today, as AIDS is eroding the health of Africa's women, it is eroding the skills, experience and networks that keep their families and communities going. Even before falling ill, a woman will often have to care for a sick husband, thereby reducing the time she can devote to planting, harvesting and marketing crops. When her husband dies, she is often deprived of credit, distribution networks or land rights. When she dies, the household will

risk collapsing completely, leaving children to fend for themselves. The older ones, especially girls, will be taken out of school to work in the home or the farm. These girls, deprived of education and opportunities, will be even less able to protect themselves against AIDS.

Because this crisis is different from past famines, we must look beyond relief measures of the past. Merely shipping in food is not enough. Our effort will have to combine food assistance and new approaches to farming with treatment and prevention of H.I.V. and AIDS. It will require creating early-warning and analysis systems that monitor both H.I.V. infection rates and famine indicators. It will require new agricultural techniques, appropriate to a depleted work force. It will require a renewed effort to wipe out H.I.V.-related stigma and silence.

It will require innovative, large-scale ways to care for orphans, with specific measures that enable children in AIDS-affected communities to stay in school. Education and prevention are still the most powerful weapons against the spread of H.I.V. Above all, this new international effort must put women at the center of our strategy to fight AIDS.

Experience suggests that there is reason to hope. The recent United Nations report shows that H.I.V. infection rates in Uganda continue to decline. In South Africa, infection rates for women under 20 have started to decrease. In Zambia, H.I.V. rates show signs of dropping among women in urban areas and younger women in rural areas. In Ethiopia, infection levels have fallen among young women in the center of Addis Ababa.

We can and must build on those successes and replicate.

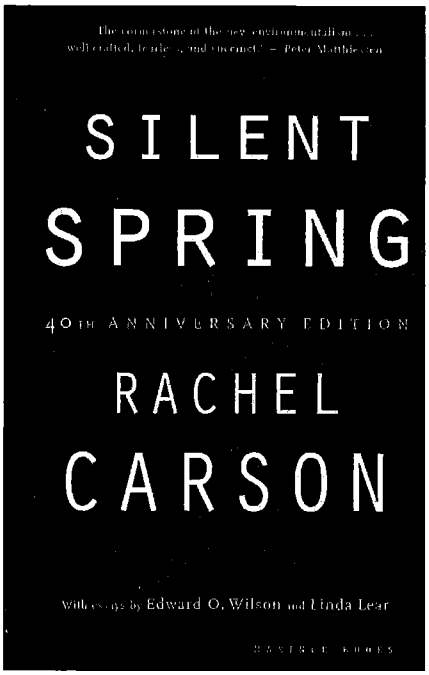
Kofi Annan is UN Secretary General; his statement was published December 29, 2002 in the New York Times

In Print

All books reviewed below are available at the Toronto Women's Bookstore, advertised in this issue.

SILENT SPRING: Anniversary Edition

Rachel Carson. (Boston, Houghton Mifflin Company, 2002)
Reviewed by Josephine Archbold



The timeless environmental classic, **Silent Spring**, celebrated its 40th anniversary with a special edition. Originally published in 1962, the book is a chronicle of the environmental damage imposed by the chemical industry.

Carson uses poetic prose while simplifying complex issues, making this book appropriate reading for a wide audience. Carson's conclusions are simple yet revolutionary: our endurance to chemical onslaught without explicit consent or implicit benefit decrees our right to know and our right to choose what is released into our environment. Carson deconstructs the myth surrounding the justification for chemical inputs into the environment, an approach she describes as conducted in the "sprit of a crisis." Carson explores the idea that industry and governments are not looking for sustainable solutions to pests, disease and an improved quality of life, but instead, are increasing reliance on toxic remedies. Explaining the self-perpetuating nature of the chemical industry, Carson illustrates how the widespread use of radical pesticides has destroyed Nature's inherent ability to control pests.

Carson cautions us of the issues the toxicological world is grappling with today: low dose exposure to multiple toxicants; concurrent and consecutive exposure; transcontinental transport of chemicals; the ecological significance of soil microfauna; toxicity of chemical metabolites; reproductive effects; heritable mutations; the inability of water purification plants to remove chemicals from our drinking water supply, and the mutagenic properties of chemicals. It is remarkable that Carson was able to predict the importance of the mutagenic potential of chemicals, considering the double helix form of DNA had only recently been elucidated.

Following the publication of **Silent Spring**, Carson was attacked by the chemical industry. Feminizing her work, they used the archetype of the witch to discredit her character, a strategy borrowed from the medical community's campaign against midwives and healers. The integrity of her work prevailed and in spite of a million dollar campaign, the chemical industry could not refute Carson's conclusions. Before her death to cancer, a year and a half after **Silent Spring** was published, Carson appeared in front of congressional hearings and countless public forums fighting for the right of every citizen "to be secure in their own home against the intrusion of poisons applied by other persons." A few years later, the US Environmental Protection Agency was formed and pesticide policies shifted from the Department of Agriculture to the Food Safety Inspection Service. In Canada, the federal department, Environment Canada, was created and in North America, DDT and other organochlorine pesticides were banned from domestic use (but not from production and export).

Rachel Carson was a pioneer in bringing widespread attention to the injustice of the unchecked forward march of the chemical industry. The evidence she collected of women's experiences across the country was the thread that she wove through her theories of humanity's irresponsible and irrational use of chemicals. Carson's impact on science, the environmental and social justice movements, and ultimately on women's role in the public arena cannot be underestimated. Rachel Carson's words still ring true today: "Have we fallen into a mesmerized state that makes us accept as inevitable that which is inferior or detrimental as though we have not the will or vision to demand what is good?" Rachel Carson's **Silent Spring** is an inspiration to anyone who questions our chemical reliant lifestyles, fights for change and dreams of a more ethical and just world.

Josephine Archbold is an environmental toxicologist and on the board of the University of Toronto's Environmental Resource Network. She served on the issue team of the WE International issue of Women, Health and the Environment.

A NEW WEAVE OF POWER, PEOPLE & POLITICS: The Action Guide for Advocacy and Citizen Participation.

Lisa VeneKlasen with Valerie Miller. (Oklahoma City: World Neighbors, 2002) US$ 40.00

Reviewed by Miriam Wyman

The Guide is like a quilt-making kit. Rather than preset designs, it contains a rich selection of patterns, pieces, and fabrics. From this colorful mix, the user can stitch together an advocacy strategy to fit particular contexts, needs, and visions.

A New Weave of Power, People & Politics is an action guide rooted in the understanding that "the very principles...of how to use citizen participation and advocacy to insure greater equity, justice, and inclusion were at the heart of how to achieve more long-lasting concepts of peace and security." It inserts notions of power, citizenship and human rights into debates on participation and advocacy, while providing valuable tools for doing so. The Guide grows out of the authors' concerns with the experiences of women's rights activists around the world.

It is designed for people and organizations grappling with issues of power, politics, and exclusion, including:

- **Non-governmental organizations and grassroots groups** interested in a rights-based approach to advocacy that combines policy influence activities with strategies to strengthen citizen participation, awareness and organization;
- **Donor institutions** interested in supporting comprehensive advocacy programs that focus on overcoming exclusion and subordination, as well as on building more democratic forms of public decision making;
- **Development agencies** interested in engaging their own service delivery structures and beneficiaries in the pursuit of development solutions through political process;
- **Trainers, activists, organizers, and researchers** interested in building bridges between civil society, government, business, and other influential people and institutions to promote more accountable political processes and responsive development policies.

The Guide has already been widely adopted as a text for courses in development, gender studies, advocacy, citizenship, and human rights.

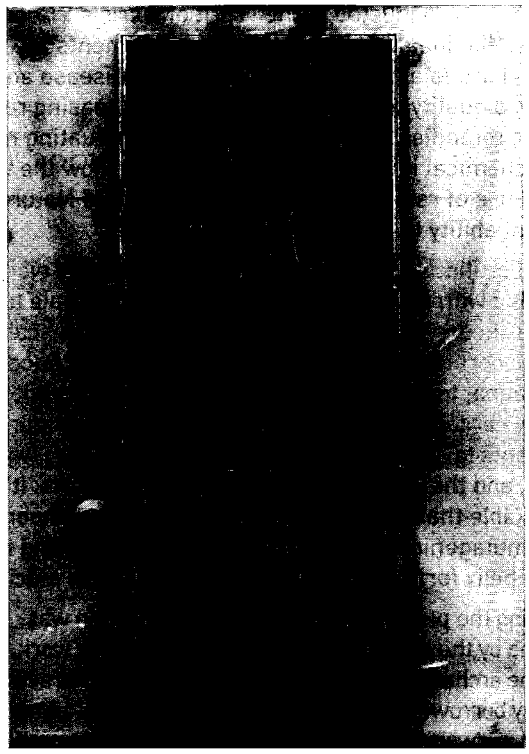
It is structured in three parts. **Understanding Politics** focuses on core concepts, assumptions and values, basic conceptual building blocks for advocacy planning and action. **Planning Advocacy** covers the tools, steps and processes of advocacy planning that build citizen empowerment. **Doing Advocacy** focuses on planning and doing as part of a cyclical process. The third part of the Guide includes stories and tips to inspire activists to be creative in their own contexts.

A New Weave is a comprehensive guide to strengthening the clout, leadership and voices of marginalized peoples in order to transform people into active citizens and real agents of change — vital elements of democratic governance.

It is easy to read, beautifully organized, well laid out and filled with graphics, sidebars, and quotations. The Guide makes no effort to short change the work involved in bringing together power, people and politics. In fact, it pays great attention to the care, thought, energy and time required. This Guide is both a "reality check" and a potent reminder: advocacy and citizen participation are central to justice, equity and inclusion.

Table of Contents and Introduction are available at http://www.wn.org/wnstore/PDFs/WeaveofPowerintro.pdf

Miriam Wyman's activism focuses on strengthening citizens' voices in decision-making. She is the Editor of "Sweeping the Earth: Women Taking Action for a Healthy Planet" (gynergy press, 1999) and co-author, with David Shulman, of "From Venting to Inventing: Dispatches from the Frontiers of Citizen Participation" (www.democracyeducation.net).

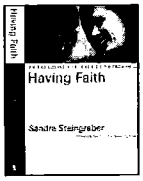


FEATURE ARTIST: LAURA CUNNINGHAM

HAVING FAITH: An Ecologists Journey to Motherhood

Sandra Steingraber (Publisher)

Reviewed by Michele Landsberg



This tale of motherhood both alarms and delights. The best way I can describe the astonishing range of Sandra Steingraber's new book — lyrical, funny, toughly scientific and unflinchingly truthful — is to single out one of the many revelatory passages.

Take this one. Steingraber is pregnant at the age of 38. A biologist on the faculty at Cornell University in Ithaca, N.Y., an environmentalist, an adoptee and a woman who had bladder cancer at the age of 20, she has ambivalently decided to have the amniocentesis test to learn if her fetus has chromosomal damage.

The obstetrician lets her hold one of the two vials of amniotic fluid that have just been drawn from her womb. It's "hot as blood." The colour is pale gold. "It's like an amber jewel!" exclaims Steingraber. She has been thinking about this fluid, which turned from drinking water to blood plasma in her body before suffusing the amniotic sac and surrounding the baby. Before that, it was rain, rivers, creeks, wells, juice of oranges, milk in her cereal, honey in her tea. "When I look at amniotic fluid, I am looking at rain falling on orange groves," thinks Steingraber.

"That's baby pee," says the obstetrician cheerfully. "We like it yellow. It's a sign of good kidney functioning." Like a cross between Rachel Carson and Oliver Sacks, Steingraber writes science as though it is poetry and prose that combines storytelling and a call to action. This is the most extraordinary pregnancy and birthing book I've ever read, as powerfully relevant to men as to women, as accessible to science dolts like me as it is persuasive to the more informed. Using women's bodies as her prime example, Steingraber makes a powerful case against the harms done by the reckless use of toxic chemicals and processes.

Having Faith, An Ecologist's Journey to Motherhood, weaves together the intimate experience of Steingraber's pregnancy, the birth and breast-feeding of her daughter Faith, with sparkling reveries on the condition of nature and nature of nurture. Many of us have backslid from our concern with the environment as we struggle through thorny times of terrorism and war. This book reawakened me to the cause.

At every step, Steingraber probes the science of procreation and questions received opinion. Amniocentesis, for example: All it can tell is whether there is chromosomal damage. Yet this very narrow test is ritualized as a rite of passage for the pregnant woman "as though pregnancy took place in a sealed chamber, apart from the water cycles and food chains." Of course, it does not.

The medical emphasis is all on a search for rare genetic defects; no one is tested for environmental toxins in the body that nourishes the fetus. (Only one study looked for contaminants in amniotic fluid, which the fetus swallows, inhales and swims in. One third of the samples had detectable levels of the long-banned DDT and PCBs).

Walking in the rain past neighbourhood lawns sprouting little white flags — TREATED WITH PESTICIDES. KEEP OFF — Steingraber thinks about the rain that runs on to the sidewalk and soaks her shoes.

This is a sobering book, not a scary one. Because Steingraber is constantly noticing and thinking about birds and the nature surrounding her, (she keeps her mind off the amniocentesis procedure by thinking of hummingbird nests, made of spiderwebs and dandelion down) every chapter rings with life-affirming delight. And also with reasonable alarm.

Anencephaly (missing brain), spina bifida, genital malformations, premature and low-weight births, neurological damage — all have been linked with the presence in the mother's body of toxic chemicals (especially POPS, or persistent organic pollutants) absorbed from the environment.

Over and over again, Steingraber says, governments and industries in the developed world have violated the "precautionary principle" that every mother practises when she fastens her child's seat belt or gets him vaccinated. When lead paint was first identified as the cause of brain-destroying lead poisoning, the U.S. paint industry went on a publicity campaign against "anti-lead propaganda." The National Lead Co. invented the Little Dutch Boy logo, merrily splashing "white lead" paint around as though it were especially good for children.

Steingraber also makes us marvel at the intricate and dazzling dance of bodily functions (invisible to us who so casually inhabit those bodies) that govern pregnancy, childbirth and breast-feeding. Nothing is more miraculous than breast milk. It is alive with antibodies and anti-inflammatories. It boosts intelligence, kills E. coli and giardia, affords substantial and lasting protection against middle ear infections, bacterial meningitis, diabetes, asthma, allergies, various cancers, colitis, lymphoma and leukemia.

It is also the most contaminated of all human foods. POPS — persistent organic pollutants like dioxin, furans, PCBs, all the toxins we helplessly breathe, drink and eat — are concentrated in mother's milk. It is not "man" at the top of the food chain, despite the school charts, says Steingraber. It is the breast-fed baby. This horrifying information should not stop anyone from breast-feeding (despite the contaminants, breast-fed children are still ahead), but it should arouse to furious political activism all of us who care about the threatened human future.

Steingraber pointed out in a phone conversation this week that the international co-ordinator of the International POPS Elimination Network (IPEN) is Morag Carter, based right here in Toronto. (The phone number is 416-960-9244). Last spring, the nations of the world signed the Stockholm Convention to ban persistent organic pollutants; the IPEN is campaigning actively to get 50 nations to ratify the agreement and begin to implement it, fast. If you want to get started, look up "toxins" at the excellent World Wildlife Fund Web site, www.worldwildlife.org, join the Toronto Environmental Alliance (416-596-0660), check out Greenpeace www.greeenpeace.org or 416-597-8408). Go hear Steingraber and buy her book.

Reprinted from Toronto Star, Nov. 18, 2001

Announcements

CALL FOR PAPERS

SPECIAL ISSUE: WOMEN'S HEALTH IN WAR-TORN COUNTRIES

WOMEN'S HEALTH AND URBAN LIFE: AN INTERNATIONAL AND INTERDISCIPLINARY JOURNAL

We are in the process of preparing a special issue on women's health in war-torn countries for the Women's Health and Urban Life journal. We are particularly interested in women's reproductive, sexual, physical and mental health issues related to wars or their aftermath. Both qualitative and quantitative manuscripts, and theoretical or empirical works are welcome. Papers should not exceed 30 pages, and four copies of the paper should be submitted. All submissions will be peer reviewed by anonymous reviewers. For more details about the goals, substantive basis and submission guidelines of the new journal, please contact or visit: http://citd.scar.utoronto.ca/sever/index.html

Submission date: December 31, 2003.

The journal is sponsored by the Wellesley Central Health Corporation and located at the Department of Sociology, University of Toronto. In general, the journal addresses a plethora of topics relating to women's and girls' health from an international and interdisciplinary perspective and link health to globalization and urbanization issues. General topics include but are not limited to: Women's health in general; Health related to reproduction; Health related to sexuality; Health related to paid or unpaid labour; Health related to parenthood; Health and the environment; Health and social policy and Health related to urbanization and globalization issues. The orientation of the journal is critical, feminist and social scientific. All scholarly articles on women's health are welcome for the regular issues.

Professor Aysan Sev'er, General Editor
Department of Sociology
University of Toronto at Scarborough
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Fax: 416-287-7296; e-mail: sever@scar.utoronto.ca

McGill

2004-2005 VISITING SCHOLAR POSITIONS McGILL CENTRE FOR RESEARCH AND TEACHING ON WOMEN

The McGill Centre for Research and Teaching on Women invites applications for the position of Visiting Scholar with the Centre.These positions are open to any scholar who wishes to spend one or two academic terms in a university environment in order to carry out research in Women's Studies.The Centre offers office space and support, an ongoing seminar program, contact with other Women's Studies scholars within McGill and in neighbouring universities — all this located at the centre of a stimulating, bilingual, urban environment. Scholars may wish to apply for external grants; limited research funding of $1,000 is available from the Centre.

If interested, please write, with a copy of your curriculum vitae, a brief outline of the research to be undertaken, copies of two recent short publications, and the names of two referees to:

Dr. Shree Mulay, Director,
McGill Centre for Research and Teaching on Women,
3487 Peel Street, 2nd floor,
Montreal, QC H3A 1W7
Phone: (514) 398-3911 Fax:(514) 398-3986
e-mail:info.mcrtw@mcgill.ca

CLOSING DATE: November 14th 2003.
Candidates requiring assurance of a position in order to obtain funding elsewhere are invited to apply one year in advance.

WOMEN'S SAFETY AWARDS 2004 — CALL FOR NOMINATIONS

Following the successes of the 1st International Seminar on Women's Safety, Women in Cities International invites you to submit your initiatives for the Women's Safety Awards 2004. The awards are designed to promote:

- good practices and policies relating to women's safety and the improvement of women's sense of safety
- municipal gender-based policies in crime prevention and community safety

Promote your initiatives now!
Submit your projects and policies before March 1st, 2004!

For more information on categories, eligibility and selection criteria or to submit an application, visit our website: www.femmesetvilles.org or contact

Femmes et villes/ Women in Cities international
507, Place d'Armes, suite 2100
Montréal (Québec), H2Y 2W8 Canada
Tel: (514) 861-6123 Fax: (514) 288-8763
email: concours@femmesetvilles.org

Now on line — Proceedings of the 1st International Seminar on Women's Safety "Making the links"

To access presentations, round table discussions and plenary sessions, visit the SEMINAR 2002 section on our website: www.femmesetvilles.org

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FEATURE ARTIST: LAURA CUNNINGHAM

IWSGS

Angela Fleury

THE INSTITUTE FOR WOMEN'S STUDIES AND GENDER STUDIES (IWSGS) at the University of Toronto welcomed a new Director in July 2003. We would like to thank our very first outgoing Director, Dr. Margrit Eichler, for five years of outstanding growth, commitment and continued vision for IWSGS. It was under Dr. Eichler's leadership that Women and Environments International magazine was welcomed into IWSGS.

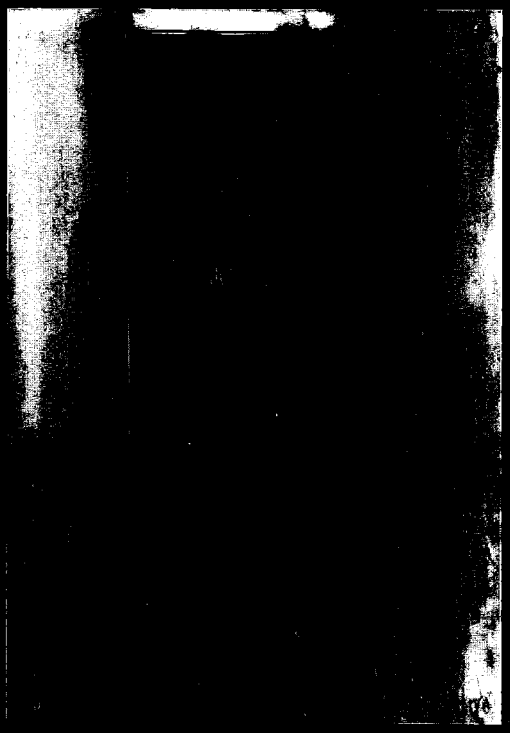
Our new Director at IWSGS is Dr. Shahrzad Mojab, Associate Professor, and academic-activist. She is currently teaching at the Department of Adult Education and Counselling Psychology, the Ontario Institute for Studies in Education at the University of Toronto. She earned her B.A. degree in English Language in Iran (1977), two M.A. degrees in comparative education and administration, higher and continuing education (1979), and her Ph.D. degree in educational policy studies and women's studies (1991) at the University of Illinois at Champaign-Urbana. She spent four years (1979-1983) in post-revolution Iran, where she became active in the women's movement and the nationalist movement of the Kurds.

Shahrzad's areas of research and teaching are minority women's access to education; anti-racism education; social justice and equality; political economy of adult education; adult education in comparative and global perspectives; women, ethnicity, war, violence and learning; feminism and nationalism; women, transnationalism, globalization and citizenship; and diaspora, war, and learning.

Her publications include, among others, articles and book chapters on Islamic Feminism; diversity and academic freedom in Canadian and Iranian universities; minority women in academe; feminism and nationalism; war, violence, and state-building; adult education and the construction of civil society in the Middle East; critical-feminist review of learning theories; and skilling and de-skilling of immigrant women. She is the editor of the first scholarly collection on Kurdish women in English Language entitled, Women of A Non-State Nation: The Kurds (2001 and second print in 2003) and with Himani Bannerji and Judy Whitehead, co-edited Of Property and Propriety: The Role of Gender and Class in Imperialism and Nationalism.

She is the President of the Canadian Association for the Studies in Education. She was the 2003 Distinguished Visitor at the University of Alberta. Shahrzad is one of the first prize winners of the international writing contest on "Women's Voices in War Zones" which was sponsored by the Women's World Organization.

Shahrzad's aproach to the study of race, gender, class, nationality, transnationality, and ethnicity is holistic, historical, and dialectical. She is critical of theoretical frameworks which treat race, gender, and class atomistically, and reduce them to the domain of discourse, text, language, or identity. She critiques monopolies of knowledge and power in education, and advocates dialogical and inclusive pedagogical practices.



Laura Cunningham studied at the University of Waterloo (BA) and York University (MFA). Her work often contains imagery culled from medical textbooks and explores issues of history, memory, narrative and the body. Her work is represented in permanent collections of the University of Waterloo and York University. She is a member of the Connective Tissue Artist Collective and lives and works in Toronto, Canada.

Cunningham comments: "in my recent work, I continue to explore medical imagery gleaned from mid 20th Century textbooks. The images strike in two ways. Firstly, their eyes are covered or blocked to "protect" their anonymity. Secondly, once removed from their medicalized context, they often appear to reference classical poses found in both secular and religious art."