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MAPPING FEMINIST PRAXIS AND IDENTITY: A CASE STUDY OF WOMEN'S HEALTH ACTIVISM IN NORTHWESTERN ONTARIO, 1980 - 1992

by

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A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Arts in Sociology with Specialization in Women's Studies.

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Abstract

This thesis examines women's involvement in organizing around women's health in northwestern Ontario from 1980 until 1992. By constructing a social history of the key groups - the Women and Health Sub-committee (1980-82), the Women's Health Action Group (WHAG, 1982-85), the Women's Health Education Project (WHEP, 1982-85), and the Women's Health Information Network (WHIN, 1985-1992), I establish a socio-historical context for an analysis of the construction of identity and praxis for the women activists in this social movement.

I argue that a feminist postmodern analysis helps to uncover how the women's collective and individual identities were multiple, shifting and fluid as well as contingent on the complex situational (regional and feminist) contexts in which they were being negotiated. I demonstrate how the women's collective and individual identities are connected with the evolving groups' praxis through the use and interpretation of alternative organizational structures and process. The tensions inherent in defining collective feminist identities and praxis are highlighted.

This thesis is based on primary and secondary sources including individual interviews and a focus group with twelve women who participated in women's health organizing during this time frame; and the historical records and documents of the four women's groups who made up the women's health movement in northwestern Ontario from 1980 until 1992.

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I also thank my mom and dad for their unwavering love, support and encouragement throughout the process of writing this thesis. My sister and brother, although not living in Thunder Bay were always only a phone call away for inspiring words, laughter and tears and for this I am grateful. I must also thank my friends, both inside and outside of the program for always making themselves available to me for conversation which at times provided insight and questions which were useful to shaping this thesis.

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CHAPTER 1 - INTRODUCTION

1.1 INTRODUCTION

The women's health movement in Canada has been evolving since the 1970s. This social movement has taken various shapes and forms over the past three decades (Tudiver 1994). Changes have occurred in the focus and thrust of national women's health policy, characterized by a growing emphasis on lifestyle and health promotion[1] and grassroots organizing around national and local women's health needs.

The grassroots women's health movement has been instrumental in producing change at the individual and the social levels in several key areas including: the development of women's health clinics; the fostering of research and the dissemination of information and knowledge specific to women's health and women's bodies; and transforming the clinical relationship between physicians and their female clients (Clarke 2000; Ruzek et al. 1997). In particular, women health activists have emphasized the importance of attending to women's physical, emotional, social, and psychological health as well drawing attention to women's roles as health care providers and educators in our society.

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These new policy directions were signalled by the 1974 Lalonde Report and Jake Epp's Report of 1986, "Achieving Health For All: A Framework for Health Promotion." Further, there were various health reports produced by Health and Welfare Canada, ie. "Issues and Priorities for Women's Health in Canada: A Key Informant Survey," (1981) which focussed specifically on women's health issues.

In 1985, the Women's Health Information Network (WHIN) was formed in northwestern Ontario and a voluntary board of women interested in regional women's health issues was established. Organizing around women's health in this region had begun five years earlier with the Women and Health Sub-committee (1980-1983), the Women's Health Action Group (WHAG) in 1983 and the Women's Health Education Project (WHEP), a three year demonstration project (1982-1985) initiated by regional women and funded through the Health Promotion Directorate, Health and Welfare Canada. The northwestern Ontario women's health movement from 1980 -1992 is one successful example of grassroots women's health organizing. Local women educated and provided health information to countless others in their communities and the surrounding region.

1.2 AIM OF THE THESIS

The primary aim of this thesis is to document the social history of women's efforts organizing around health in northwestern Ontario from 1980 -1992. I discuss how and through what means women's health activism developed and sustained itself as a grassroots network in northwestern Ontario. This includes a critical examination of the social, medical and political environment of women's health in the isolated communities of this region. I argue that the regional women's health organizations WHIN, WHEP, WHAG and the Women and Health Sub-committee were instrumental in providing health education and resources to regional women. I explore how the regional context shaped the processes and identities of the women

who shaped these organizations. I examine the specific health issues that the women's health groups addressed over the twelve years of their mandate. Further, I analyse how these organizations structured and organized themselves, looking specifically at the emphasis on consensus decision making. This focus on organization will illuminate how the regional women's health groups aligned themselves with the larger women's health movement and the strengths and tensions of regional feminist identities.

While there has been some documentation of national women's health organizing efforts to date (Tudiver 1994; Dua et *al.* 1994; Gottlieb 1994; Griffen Cohen 1993; Doucette 1991; Stone and Doucette 1988; Adamson, Briskin and McPhail 1988; McDonnell 1986), there has been minimal documentation of women's health organizing efforts in this hinterland region despite a significant hub of regional activity (Pitblado and Pong 1996; Suschnigg 1996). This thesis will present a social history of women's health organizing efforts in northwestern Ontario and make connections between the regional aspects of the women's health organizing and that of the wider Canadian women's health movement.

1.3 THE WOMEN'S HEALTH MOVEMENT

Evolving out of the second-wave feminist movement, the women's health movement in North America gained momentum in the 1970s as women began organizing around shared experiences of dissatisfaction with the existing structure and practices of the formal medical system (Clarke 2000; Ruzek et al. 1997; Lupton

1994; Maleskey 1984; Sandelowski 1981; Ruzek 1978; Marieskind 1975). In particular, women were unhappy with conventional biomedical practices which unnecessarily medicalized women's reproductive and sexual lives (Clarke 2000; Love 1994; Clement 1987; Ruzek 1978). Initially, women met in small, consciousness-raising groups. There, they would share and discuss their own personal experiences of the medical system and the negative encounters many had faced with their physicians. Most often, the shared stories of medical experiences revolved around women's reproductive health issues. Specifically, women were frustrated with the lack of choices available to them regarding access to birth control and abortion, and they were concerned with the lack of control they experienced in pregnancy and childbirth (Pauly Morgan 1998; Doyal 1994). Grassroots women's health groups were formed out of these consciousness-raising sessions and women began providing information and alternative services, lobbying governments for change, acting as advocates, and empowering themselves through self-help practices and health education.

The women who became involved with women's health organizing were middle and working-class housewives and mothers, students, working women, nurses, midwives and women working as service providers in the formal health care system. These women identified with the politics of the second-wave feminist movement and sought to eliminate the male dominance of physicians and the medical system which largely defined and controlled women's sexual and

reproductive lives (Clarke 2000; Love 1994; Ruzek 1978).

From the beginning, the women's health movement focussed on shifting ideas about women's bodies and health from the traditional discourses and hierarchal structure of bio-medicine to women and women-centred definitions. This focus was a result of the consciousness-raising experiences of women, and the collective realization that power relations were unequal in society. In the first published edition of *Our Bodies Ourselves* (1971), the Boston Women's Health Book Collective stated,

> ...power is unequally distributed in our society; men, having the power, are considered superior and we; having less power are considered inferior. What we have to change are the power relationships between the sexes, so that each sex has equal power and people's qualities can be judged on their merits rather than in terms of power (7).

By supporting and providing women with health information and the right to choices, feminists working as women's health activists in the United States and Canada organized and developed women's health clinics[2] and collectives[3] to inform

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The first women's health clinics were established in California. Known as the Feminist Women's Health Centres, these centres offered participatory gynaecology clinics where women could come together and learn about their vaginas and cervixes under the supervision of a skilled health worker. This learning involved identifying anatomy, learning about physiology, detection of infections, checking IUD placements, pregnancy testing and nutrition counselling (Sandelowski 1981).

3

Working out of Boston in 1971, the Boston Women's Health Book Collective published the first edition of *Our Bodies Ourselves*. These women were seen as radical and revolutionary as they "encouraged women to take a pro-active role in their own health care, to be their own advocates and to speak up and question the medical profession"

and empower women of their choices and to educate women about their bodies and their health.

Women health activists often began their organizing efforts around issues which were directly relevant to their own life histories. Central concerns were birth control options, access to legal abortion, the harmful effects of diethylstilbestrol (DES)[4], childbirth options, lesbian health issues, over-prescription of psychotropic drugs including tranquillizers, barbiturates, and sedatives, and changing the clinical relationship between doctors and women.

Women's health collectives, including women's health clinics and women's consciousness-raising groups began to spring up across Canada early on in the 1970s (Tudiver 1994). Some of the earliest women's health collectives and clinics in Canada were established in Vancouver, Montreal, Nova Scotia, Toronto and Winnipeg (Tudiver 1994). Many of these women initiated health collectives were based on the notion of self help, the sharing of educational resources and the provision of alternative health care services. These alternative health care provisions and services stood in stark contrast to contemporary Canadian medical practices rooted firmly in bio-medicine. A pamphlet put out by The Vancouver Women's

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(Vann 1998). Since that time there have been numerous reprintings and several revised editions of this text including several special editions which focus on aging, pregnancy and young women.

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Diethylstilbestrol was a synthetic hormone given to women from 1941 until 1971 to prevent miscarriages. It has since been discovered that the children of women who took this hormone have extremely high cases of cervical and ovarian cancer.

Health Collective in 1976 stated, "We are opposed to the traditional health care model where one person is the expert and the other receives advice or treatment with no opportunity for discussion or decision around alternatives."

Along with the many urban women's health collectives formed in the 1970s, a variety of smaller women's health groups began to appear across Canada. Some of these were support groups for women living with specific conditions or in similar situations, some were more loosely defined seeing themselves primarily as sharing information and knowledge on health and related issues and some of the groups were directly involved as service providers, or political activists (Clement 1987). Yet, all were part of the larger women's health movement in Canada and as Clement (1987) comments, they all "shared a common vision of what health could be, and a common dissatisfaction with the existing health care system" (6).

Women were organizing and providing health information not only through grassroots women's groups and women's health clinics at the local level but also through national print media. In Canada, the Healthsharing Collective, working out of Toronto, Ontario produced and distributed a Canadian women's health journal, *Healthsharing: A Canadian Women's Health Quarterly* from 1979 through to February of 1994. This collective was committed to bringing women's health issues to the forefront and presented feminist perspectives on issues from both medical and alternative models of health (Dua et al. 1994). *Healthsharing* connected women's health groups by providing a national forum where women from across the

country could voice and discuss health issues and concerns (Tudiver 1994).

The women's health movement, as part of the larger women's movement has always worked to push the boundaries of traditional social thought and practice and for this reason, has been subject to criticism (Griffen Cohen 1993). Within women's health organizing efforts women have attempted to challenge not only women's place within bio-medical thought but the traditional structures and processes involved with running organizations. Successfully and with challenges, women's health groups have used non-hierarchal structures and consensus for decision making (Ristock 1991). Although not without tensions, these organizational distinctions have led women's health groups to provide health information and empower women in ways which reach beyond the boundaries and scope of conventional medical models.

1.4 THE WOMEN'S HEALTH MOVEMENT IN NORTHWESTERN ONTARIO

At the same time as women were organizing nationally, women in northwestern Ontario were in the process of developing a regional group of women health activists. Northwestern Ontario women were pushing the confines of traditional medicine and medical practice through their organizing efforts. Beginning in 1980 with the Women and Health Sub-committee, an off-shoot of the Northwestern Ontario International Women's Decade Council, women expressed concerns about the lack of health information and services available to women living in the relatively isolated communities of northwestern Ontario (Chumway

1981).

When activists in the regional women's movement became aware of funds available to initiate a project on women's health a voluntary Board, the Women's Health Action Group (WHAG) was formed to support the Women's Health Education Project (WHEP), a three year demonstration project aimed at providing health information to women living in the region of northwestern Ontario (Karlstedt 1987). Initially, these groups determined the health needs and concerns of regional women through a survey conducted during the fall of 1982 and the spring of 1983 (WHEP Final Report 1986). Issues identified by the survey respondents included stress, isolation, lack of information, lack of services and the health impact of the environment. The WHEP project's goal was to provide consumers with the specific health information asked for in the survey through a number of workshops and conferences held in the regional communities and Thunder Bay. Upon completion of the generously funded three year project, the women involved wished to continue organizing and providing health information to regional women. Thus, in 1985 the Women's Health Information Network (WHIN) was formed with a voluntary working Board committed to carrying out the tasks of providing women's health information to regional women as initiated by WHEP.

WHIN was a non-profit organization committed to providing resources and information to women across the region. WHIN's philosophy was to, "promote an

awareness of health issues; respect the realities of women's lives in Northwestern Ontario; and encourage and support women to take responsibility for their own health" (WHIN Pamphlet 1986). Over a period of seven years, this regional network organized and produced women's health resource kits, activities, workshops, conferences, the newsletter *Health Network News*, the theatrical production of the play Crane Dance, and in collaboration with the Red Lake Women's Group the publication of the book, *Long Distance Delivery: A Guide to Travelling Away From Home to Give Birth* (1990). The membership of WHIN fluctuated extensively yet this women's health network reached hundreds of women through their organizing efforts in the many communities they serviced. In 1992, WHIN dissolved for several reasons despite ongoing commitment to women's health.

Over the eleven years that women organized around women's health in northwestern Ontario regional women's lives were changed. Whether in the form of acquiring health information previously unknown, recognizing the choices available to women through the work of women's efforts, gaining skills and knowledge that were transferable to other areas of their lives or simply acknowledging that women have specific health needs and view health differently from bio-medicine, regional women were affirmed through their organizing efforts.

1.5 WHAT IS HEALTH?

Feminist definitions of health speak in terms of physical, mental, spiritual and social well-being so that political, social, economic and environmental

conditions are seen as health issues (Dua et al. 1994; McDonnell 1986). This holistic definition of health which was adopted by the women's health movement shifts the focus from disease and treatment of acute illnesses to prevention and education. Further, it factors in the social influences affecting health rather than maintaining a strictly biological basis for determining health. Women health activists recognize that there are numerous factors influencing the health of women such as economic status, living conditions, race, educational level, and sexuality. A central goal of the women's health movement has been to educate women that biological understandings of illness do not fully encapsulate the meanings of health.

Studies have shown that women are the primary consumers of health care services[5] and they are often considered family 'health guardians' (McDonnell 1986). Because health is a central feature of women's lives, feminist health researchers and activists have invested considerable time in critiquing and understanding how traditional understandings of health have worked to control and influence women's definitions of health and their experience with the health care system. Through comprehensive analyses of traditional medical practices and the dominant medical system, women health activists and feminists have critiqued the unnecessary

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For further discussion of women's high use of health services see Sheryl Burt Ruzek, *The Women's Health Movement: Feminist Alternatives to Medical Control*, New York: Prager Publishers, 1979: 13. Also, Pitblado and Pong's article "Women's Health In Northwestern Ontario: An Introductory Geographical Appraisal" in *Changing Lives: Women in Northwestern Ontario*. Edited by Margaret Kechnie and Marge Reitsma-Street, Toronto: Dundern Press, 1996 : 239-250.

medicalization of women lives and women's bodies within bio-medicine (Pauly Morgan 1998; Lupton 1997; Findlay and Miller 1994; Doyal 1979).

Bio-medicine, specifically the bio-medical model has existed as a dominant theoretical perspective in medicine, culture and the economy. This model attempts and claims to explain disease through four assumptions. Mishler (1981) explains how these assumptions function to maintain hegemonic medical discourse on health and illness. The bio-medical model is based on the premises that:

> 1. Disease can be defined as being a deviation from normal biological functioning.
> 2. Disease can be accounted for in terms of a specific etiology (the cause of the disease can be found within the body).
> 3. Disease is manifested the same way in all humans (gender and cross-cultural differences are ignored).
> 4. Scientific medicine is neutral.

This model provides both the medical profession and the lay population with the dominant discourse on health and illness. By asserting that disease and illness are primarily biological in nature as understood through elite scientific discourses, control of health is effectively taken out of the lay realm of understanding. Furthermore, the model and its practices unnecessarily medicalize experiences and conditions.

Medicalization refers to the process whereby an object or life experience becomes defined through dominant societal discourses as an illness and the focus shifts into the sphere of bio-medicine and under the power of the medical profession (Findlay and Miller 1994). By medicalizing experiences and conditions physicians

are able to exercise and increase their control over women's normative life cycle in areas which previously would not have been viewed as medical. Some examples of medicalization which have greatly impacted on women's lives are the labelling of pre-menstrual syndrome (PMS), childbirthing, and menopause (Doyal 1979). As aspects of everyday life are increasingly brought under the scrutiny of medicine, critics contend that we have the 'medicalization of everyday life' (Doyal 1979; Lupton 1994). Women and women's bodies in particular, because of their frequent contact with physicians and the medical system are a continual site for medicalization.

1.6 FOCUS OF THE THESIS

The focus of this thesis is to document a detailed case study of women's health organizing efforts in northwestern Ontario. This social history will be examined within the context of the women's health movement. I explore how the region affected both the organizing efforts of the women involved, and contributed to the experiences of building a collective feminist identity for the women. Further, I explore the strengths and tensions uncovered in this particular history of women's health organizing. Specifically, I look to the politics of organizing and group decision-making through consensus, what health issues were defined as women's health issues, and how the groups aligned themselves with the larger women's health movement in Canada. The organizing efforts of the women living in northwestern Ontario are one example of how the women's health movement

developed within a certain time frame, in a specific region, with distinctive regional health issues while at the same time contributing to the larger efforts of the women's health movement.

1.7 METHODOLOGY

> Methodology is itself a theory. It is a theory of methods which informs a range of issues from who to study, how to study, which institutional practices to adopt (such as interpretative practices), how to write and which knowledge to use (Skeggs 1997: 17).

This thesis is guided by, and framed within current discussions of feminist theory, epistemology, methodology and methods. Because the theoretical and methodological positions are overlapping, mutually-influencing and informing each other throughout all stages of the research process it is necessary to briefly examine and outline each in relation to one another (Stanley and Wise 1990).

Feminist theorizing relies on women's experiences and material realities to inform the conceptual framework from which to build theory. This differs from other traditional disciplines whereby experience and subjectivity are thought to undermine theorizing and the research process. Although there are many current academic debates surrounding the fragility of subjective positioning in the research process, feminist research acknowledges and relies on researcher/participant subjectivity to understand how the process of interpreting events and experiences contributes to the development of knowledge(s). Feminist research seeks to create knowledge(s) about women and women's lives as interpreted through the

examination and telling of women's experiences.

Analyses of power are central to feminist theory, methodology and epistemology. Epistemology theorizes knowledge and power and problematizes the notion of who can be a 'knower', what gets to be known and why? Further, feminist epistemology examines previously established knowledge and asks why certain kinds of knowledge have been validated (Stanley and Wise: 26). This attention to "the social relations of research and knowledge production" is what sets feminist research apart from other disciplines (Ironstone-Catterall et al. 1998). Ultimately, methodology is both theory and epistemology or "a perspective, or a very broad theoretically informed framework" (Stanley and Wise: 26).

Methods are the techniques or practices, such as interviews and focus groups which can be used to carry out the methodology. Recent critiques of knowledge and epistemology contend that social scientists need to be hyper-vigilant to the subjective position they, as researchers occupy while conducting research and creating knowledge (Stanley and Wise 1990; Harding 1986). Therefore, an important part of this research process has been situating myself within the research context.

My interest in the topic of women's organizing around health in northwestern Ontario evolved for several reasons. First, because I was born and raised in Thunder Bay and then spent the better portion of a decade living away only to return again, I became keenly aware of the lack of women's health services

in the area. Though my involvement with local women, I became aware of a group of women who had organized in the region around women's health issues in the recent past. The WHIN women had accomplished a great deal in the area of women's health and undertaking a social history of their activities is important as local women's history is for the most part untold. Further, because of my own involvement with women's organizing and women's organizations I was interested in uncovering the specifics of how and why these women organized. Finally, the broad range of women's health issues affecting not only myself, but my mother, sister, aunts, friends and co-workers is important and understanding the history of how women in northwestern Ontario have talked about, and understood women's health issues contributes to this understanding. For these reasons, I was and continue to be invested in understanding how women's health issues are understood in the region.

Another piece of the methodology guiding this research process has been an attentiveness to what feminist researchers term "reflexivity" (Ironstone-Catterall et al. 1998). As part of the epistemological questioning within the research process it is critical that researchers attend to their own subjective reflexivity. This process refers to the attention which the feminist researcher must focus on her own social location, including the privileges and biases which may influence the research process. Being reflexive throughout the research process including asking myself why this particular research project was undertaken, how my participants were

chosen, how I collected my data, why certain themes seemed more critical than others in writing the final thesis and reflecting on, and asking the participants how the thesis should be made available to the wider women's community upon completion.

One final reflection on my methodology concerns how the research evolved as the process and information available revealed itself. At the beginning of this project, my intent was to document the efforts of the Women's Health Information Network (WHIN) from the time period of 1985 through to 1992. However, as I collected my interview and focus group data it became apparent that the history I was being told dated back further than the efforts of WHIN. I was hearing recollections of the Women and Health Sub-committee (1980-1983), the Women's Health Action Group (WHAG) from 1983 until 1985 and the Women's Health Education Project (WHEP) which took place from 1982 until 1985. Further, in examining the WHIN documents I uncovered reports, minutes and records dating back to 1980 which included the activities of all the above mentioned groups. It became evident to me that in recording a social history of WHIN I could not separate out the history of WHIN from the histories of the Women and Health Sub-committee, WHAG, and WHEP. In order to have a clear picture of how WHIN had evolved, who had been involved and what health issues were facing the WHIN organization I had to understand chronologically how the women's health organizing had unravelled in northwestern Ontario. For this reason, the project

unfolded itself as a more complete history of women's health organizing efforts in northwestern Ontario.

I. Methods

I have used three methods in this project and the research is based on both primary and secondary sources. Primary sources include thirteen semi-structured interviews using open-ended questions with twelve of the women who were actively involved with women's health organizing in northwestern Ontario between the years of 1980 -1992, as well as a semi-structured focus group attended by five of the women. Two of the women interviewed chose to be interviewed together over a period of three one and a half hour long interviews. These two women informed me at the first interview that they preferred being interviewed together because their memories could be 'jogged' by one another in the telling and remembering of their collective involvement and I also sensed they enjoyed sharing the memories together. In using the two methods of interviewing and a focus group and through the open-ended questions in both these methods I have been able to "maximize discovery and description" (Reinharz 1992). The focus group was held upon completion of the interviews with five of the women who participated in the interviews. The interviews took place in October and November of 1999. The focus group was held on December 15, 1999[6].

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Prior to undertaking the interviews and focus group, I was granted ethical approval on my research instruments [See Appendix A and E], cover letters [See

Primary source data was analyzed through a documentary analysis of the Women and Health Sub-committee, WHAG, WHEP and WHIN files and resource kits [See Appendix I] available which included 19 banker boxes of historical records and information. The documentary analysis was an ongoing process from September 1999 to February 2001. In conducting the documentary analysis I immersed myself in reading and making notes on the information found in the boxes. The records were laden with historical information through which I was able to piece together a historical look at women's organizing efforts around health in northwestern Ontario. By using the multiple methods of individual interviewing, a focus group and documentary analysis, I have obtained a more 'multi-faceted information' which has provided greater historical detail and a more collective sense of the organization and processes of the Women and Health Sub-committee, WHAG, WHEP and WHIN. This thoroughness may have been missed if I had only used one of these methods.

The participants, some of whom had been WHAG or WHEP and WHIN members, were identified through word-of-mouth, beginning with the two original WHIN members who were interviewed together. As well, I was introduced to three members of WHEP and WHIN at the Northwestern Ontario Women's Decade Council Conference, "Women of Yesterday, Today & Tomorrow" held in Thunder

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Appendix B and F], and consent forms [See Appendix C and G] from the Lakehead University Ethics Advisory Committee on April 7, 1999.

Bay on October 1-3, 1999. Initially, one of the women introduced to me at the conference was hesitant to agree to an interview. She told me that there was conflict within WHEP and WHIN and she felt uncomfortable because the tensions had never been resolved. I encouraged her by telling her that all of the women's voices needed to be heard in the telling of this social history and that I hoped she would participate because I felt that there was definitely room for differences of opinion in the research project. I was encouraged when she phoned the next day and agreed to do the interview.

Telephone numbers and addresses were collected by myself and the participants who knew of the research. The majority of the women were initially contacted by telephone. In some cases, after the initial contact, I would mail out a letter of introduction [See Appendix B] and in others, an interview would be set up over the phone and I would bring the letter of introduction and the consent form [See Appendix C] to the interview. Most women immediately expressed interest in the project and were enthusiastic that a social-history of WHIN was being undertaken. This made the process of organizing and arranging the interviews enjoyable and fairly easy.

With almost all of the interviews, throughout the process, each participant would give me names, telephone numbers, addresses, e-mail addresses of other women who were involved with WHIN and who they thought might be interested to be interviewed. Often, when I would make the initial call, the woman participant

would be anticipating my call and was more than happy to set up an interview. After thirteen interviews I felt that I had more than enough information collected for a project of this magnitude.

At the point of initial contact, the purpose of the study would be explained, I would ask about tape-recording the interview, respondents questions were answered and a time and place would be set up for the interview. Before the interview would begin, we would go over the consent form and the study would be explained again in more detail. It was made explicit that the women's participation in the study was voluntary and they could resign at any point. It was explained to the women that they could refuse to answer any question and if they wanted to shut off the tape recorder they could at any time. Moreover, it was explained that all of the information provided in the interview would remain confidential[7]. I also asked all of the women at the end of each interview if they would mind me calling them back to clarify any of the information provided in the interview. In many cases the women themselves would call me back to clarify or add information that they had forgotten at the time of the interview. Thirteen interviews were conducted with women from Thunder Bay, Schreiber, Nipigon, Red Lake, Kenora and Keewatin in order to capture the experiences of women from the broader region.

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Anonymity was offered to the participants however, only one woman chose to remain anonymous.

The semi-structured interview guide [See appendix A] consisted of thirty - eight questions of which the first six questions focussed on demographics. These questions included age of first involvement with WHIN, education level, occupation and questions concerning children and partners. The main body of the interview guide consisted of questions concerning the structure and process of WHIN; WHIN activities; how and why the resource kits were put together and distributed; effects of funding sources; personal involvement with WHIN; and perceived effects of WHIN on the region.

The interviews lasted between one and one half and two hours with a few exceptions. The first exception was with the two original participants who chose to do the interview together. These women decided that there would be three interviews over a period of three weeks. This worked extremely well as they were able to confer with one another during the interview and respond with shared recollections of WHIN and their own involvement.

One interesting feature of many of the interviews was how the women chose to remember their involvement with WHIN. In many instances, women would recall their involvement with WHIN by remembering the birth of their children or other women's child birth experiences or use the ages of their children as specific points of reference. This is an interesting dynamic as it shows how women's lives are layered with roles and experiences which overlap and inform women's ways of knowing. Moreover, the women would often speak of how their children were a

central part of WHIN in that WHIN promoted child-friendly spaces and at most every WHIN function, children were present. Some of the participants would laugh and say that they were sure that their children would know how to organize and write funding proposals through osmosis by the time they were adults.

All of the interviews were tape recorded and transcribed in full. This enabled me to read over the transcripts several times looking for common themes, tensions and shared recollections. Some of the common themes that came through in the interviews were structure and process issues, identity including regional and feminist identities, issues around funding, what the health issues were that were focussed on, empowerment of women through popular education, resistance to medicalization, issues around the lack of technology (computers, internet, and e-mail), tensions and conflict within the organizations, and reflection on the successes of the women's efforts.

Many of these themes repeated themselves in the focus group. All of the women who had participated in the interviews were invited to attend the focus group held on December 15, 1999 however, only five women participated. Upon completion of the interviews, I informed the women of the upcoming focus group. A letter [See appendix F] was mailed out to each of the twelve women approximately three weeks prior to the date of the focus group. As was explained to me by the women calling to confirm their participation in the focus group the time of year made it difficult for many of the women to attend because of

unpredictable weather and the resulting road conditions. The focus group took place in a neutral location in Thunder Bay. On the evening of the focus group, the research was explained once again and the consent form [See Appendix G] was reviewed and signed by the participants. The framework for the focus group evolved from the individual interviews and consisted of three general thematic questions [See Appendix E]. The focus group interview was tape-recorded and detailed notes were transcribed upon completion.

The focus group was important as it enabled the women to sit together and recall a collective memory of women's efforts organizing around health in the region. It was the first time that some of the women had been able to meet, discuss and resolve some of the tensions which had occurred when they were organizing. All of the women expressed gratitude for the unique opportunity it provided.

The focus group also permitted a discussion of the thesis research process including suggestions of where to house the documents upon completion of the research and how the social history should be distributed to the participants and the wider women's community. After a short discussion, it was decided that the documents would go the Thunder Bay Historical Museum Archives along with a copy of the thesis to provide a context for the records. Further, I agreed to produce and distribute a booklet documenting the history of the women's health organizing efforts upon completion of the academic portion of the research. In part, this is my way of giving a part of the research back to the participants and the community.

This research would have been impossible to conduct without them freely giving of the documents and their time in the form of interviews and the focus group.

The documentary analysis was a long and tedious process but provided a picture through which I was able to interpret the history of WHIN and a history of women's health organizing efforts from 1980 through to 1992. There were 18 banker boxes and 18 resource kits. The boxes were given to me by two of the original members of WHIN. The boxes had been previously stored at these women's homes. For the most part, the boxes were neatly organized and the majority of the files were labelled and colour coded which assisted the analysis.

The process of conducting the documentary analysis consisted of first going through each of the files and creating a card catalogue system which listed the contents of each of the files. By using index cards and an index card filing box I was able to colour code the index cards to represent each of the eighteen file boxes.

All of the files were reviewed and notes were made as the filing system was constructed. Certain files were highlighted as I believed that particular information uncovered might be more useful for constructing the social history. Some examples of the information found in the files included: women's health reports and studies done by other Canadian women's groups, Health Canada, or researchers; membership lists; reports on each of the workshops done in the region including numbers of women who attended; correspondence files; meeting minutes; files on various topics of women's health information; a copy of the eighteen workshops;

copies of the newsletter *Health Network News*; annual reports; and numerous other files containing similar information for the Women and Health Sub-committee, WHAG and WHEP.

By organizing the documents in an index file card system I was able to re-visit the documents on numerous occasions simply by looking up on the index cards the specific information I needed and then going directly to the box, to the specific file and pulling out the information. In this way, the documentary analysis was ongoing throughout the entire research process as I returned to the boxes repeatedly throughout the writing stages of the thesis.

On the whole, all of the participants were enthused that the history of women's efforts organizing around health was being documented. As many of the women explained to me, a great deal of effort, time and energy had gone into these organizations and to have that history recorded was an important step to bringing some closure to that period of their lives. Further, some of the women explained that the research project affirmed the work that they had invested so much of their time and personal spirit in. For these reasons, I have felt a keen sense of responsibility in capturing as fully as possible the history of these efforts. Yet I am also attentive to the fact that the social history found in these pages reflects my own interpretation of the documents and interview/focus group data. It is, as with all research, a partial account.

1.8 SIGNIFICANCE OF THE RESEARCH

This thesis documents and analyses women's health organizing in northwestern Ontario. This is important because it highlights the value of women's participation at a grassroots level in the women's health movement. Critical insight into the Canadian women's health movement is both useful and necessary in order to understand how women's roles in health and health related activities have evolved over the last two decades and to understand and be critical of how and through what means women have worked to gain autonomy over their bodies and their health. This research documents and provides a critical analysis of women's history and women's organizing around health in northwestern Ontario.

Through this regional case study of the Women and Health Sub-committee, WHAG, WHEP and WHIN, I am able to examine how women in northwestern Ontario contributed to the larger, national women's health movement. Although there is a developing literature which examines women's health in northwestern Ontario (Pitblado and Pong 1996; Suschnigg 1996; Southcott 1993), there is an obvious gap in documenting how regional women themselves, view health (Wakewich 2000). Further, there have been several analyses which have focussed on the politics of feminist organizing in Canada (Tudiver 1994; Pierson et *al.* 1993; Adamson, Briskin and McPhail 1988) however, there has been no analysis of regional women' s organizing and the health movement in northwestern Ontario. It is my hope that this thesis will contribute to the growing body of regional historical literature documenting one aspect of the larger Canadian women's health

movement, in all its complexity, and as told through a Northern feminist perspective.

1.9 PLAN OF THE THESIS

In Chapter Two I describe the geographical and socio-cultural contexts of northwestern Ontario in which the women's health movement evolved. I examine its relationship to the broader women's movement in northwestern Ontario. I give a chronological account of the roots of women's health organizing efforts beginning with the Women and Health Sub-committee and the Women's Health Action Group (WHAG). In turn, I examine the Women's Health Education Project (WHEP) which ran from 1982 through to 1985. Finally, I describe the Women's Health Information Network (WHIN) which existed as a non-profit women's organization from 1985 until 1992. In constructing this social history I draw on my primary and secondary source data as discussed earlier in this chapter.

In Chapter Three, I focus on the politics of women's organizing. I look at how the structure and process of the groups evolution, how they used consensus for decision-making, how women's health issues were defined for women living in northwestern Ontario and why funding issues were critical to these particular initiatives. Further, I demonstrate how this regional case study is related to the context of the wider women's health movement. This analysis lays a framework for a discussion of how the women perceived their collective identity (as discussed in Chapter Four) as linked to their praxis and the politics of their practice. Finally, I

touch on some of the particularly unique features of WHIN including the women's working environment and how the women's roles as mothers influenced their organizing efforts.

Chapter Four lays out how the women who participated in the women's health organizing efforts constructed regional and feminist discourses around identity. Using Fraser's (1992) pragmatic model of discourse theory, I examine how regional identity intersected with feminist identity for this particular women's health organization. This chapter provides an analytical look at the tensions and contradictions experienced by the women in attempting to define a collective feminist and regional identity for their organization. Detailed excerpts from the interviews are used to illustrate how the women's identities were shaped in relation to the specific contexts through which identities were being negotiated.

Finally, in Chapter Five I summarize and draw together the analyses on regional and feminist identity, both individual and collective and how the groups identities intersected with the politics of their practice. I make some concluding comments on the significance of women's health organizations in northwestern Ontario from 1980 - 1992. Further, I will suggest recommendations for future research which would be beneficial to understanding the complexities of feminist identity as connected to women's health activism.

I argue that by examining this case study through a feminist postmodern lens it is possible to understand the complexities of the women's groups praxis and

identity as contingent on the multiple discourses which were contextual to the time and place in which the women organized.

CHAPTER 2 - THE HISTORY OF WOMEN'S HEALTH ORGANIZING IN NORTHWESTERN ONTARIO

2.1 INTRODUCTION

In this chapter I describe both the geographical and socio-cultural contexts of the thesis, the region of northwestern Ontario, and the grassroots women's health organizing efforts from 1980 until 1992 in the region. I begin this chapter by examining the region of northwestern Ontario. I begin by describing the regional characteristics of the social, political and economic landscape. I discuss the nature of single-industry towns, and the isolation which accompanies living in the region and highlight the ways in which women's social and economic well-being is experienced in this context. In addition, I demonstrate how regional identity was central to the shape and development of women's health organizing in northwestern Ontario.

Subsequently, I discuss the development of women's health activism in northwestern Ontario. I examine what regional women considered as primary health concerns and how the women came together in a grassroots movement to organize around specific women's health issues. Primarily descriptive, this chapter looks specifically at the chronological events of women's organizing efforts and establishes a context for my analysis (in Chapter Three and Chapter Four) of the women's collective and individual identities and the structure, process and tensions inherent in women's health organizing from 1980 -1992 in the region.

2.2 THE REGION OF NORTHWESTERN ONTARIO

Northern Ontario is a large, geographically isolated region constituting ninety percent of the province's land mass (Dunk 1991). Northwestern Ontario is one part of this larger region stretching from the Manitoba-Ontario border to, and including the district of Thunder Bay (Pitblado and Pong 1996). In northwestern Ontario, the largest city is Thunder Bay with a population of 113,662 (Statistics Canada 1996). Although an urban centre, it continues to be geographically and culturally isolated in that it is a minimum of a day's drive to either Sault Ste. Marie in the East or Winnipeg, Manitoba to the West. Kenora, in the Kenora-Rainy River District and close to the Manitoba-Ontario border is the second largest city in the region with a population of 10, 063 (Statistics Canada 1996).

Numerous smaller towns and communities are scattered throughout the region both east and west of Thunder Bay. Many of these communities were originally established as a result of primary industry resource-based employment in mills or mines. Residents of these communities rely on Thunder Bay as the nearest urban centre and travel lengthy distances on secondary roads for necessary urban amenities and access to health care services.

Necessities such as hospital and dental services (including birthing options[8]),

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In some of the communities women are not allowed to give birth in their local clinics, hospitals or at home and must travel to Thunder Bay or Winnipeg, Manitoba to deliver their babies (Northwestern Ontario Women's Health Information Network and Red Lake Women's Information Group, 1990).

legal services, shopping and entertainment, business opportunities, and national air transportation are but a few of the reasons one might have to travel to Thunder Bay. Travel to and from Thunder Bay can be at certain times, precarious as weather dictates road conditions with the winter months lasting on average six months (from November through to April) of the year. North of Thunder Bay and west to the Manitoba border there are several reserves where First Nations people live around James Bay that are even further isolated as there is no road access to these communities (Pitblado and Pong 1996). Residents must either fly or boat between these communities.

In the past, northwestern Ontario was primarily viewed as a resource hinterland with forestry and mining as its staples. As well, the position of Thunder Bay as the furthest west community on Lake Superior allowed for the development of an important port for the shipment of grain from the West to the East. Traditionally, numerous employment opportunities existed in the resource related mills, mines and grain elevators and it was the robust male population who were hired to fill these positions. Women would often follow their husbands to the smaller communities outside of Thunder Bay where secure employment in one of the local mills or mines could be found. There was little secondary or tertiary employment, thus women could not find work in paid positions and instead, carried sole or primary responsibility for the home and children.

Today, employment opportunities in the region have changed. Areas of

employment have shifted away from resource based jobs to positions focussed in the health, social and service sectors. Some of these positions are secure and pay well however, many of the jobs found in the service sector are low paying, temporary or part-time and without benefits. Yet, there exists in the public imagination the belief that the region prospers as a result of the jobs found in the resource driven economy. This firmly embedded notion remains strongly entrenched in the hearts of its inhabitants. As one respondent explained in Dunk's research on working-class culture in Thunder Bay, "It's a working man's town. Everybody carries a lunch bucket here" (Dunk 1994: 45). The notion that Thunder Bay and northwestern Ontario are dependent on primary resource industries and the traditional male employment that accompanies them contributes to a strong collective regional masculinist identity found within the population.

Traditionally and presently, there exists a substantial North-South regional disparity in health care between the northern and southern parts of the province. This disparity greatly affects "the northern quality of life and consequently, alters the perspectives on northern women's health needs" (Ramsay 1984). Within the region itself, the extensive geography further isolates communities from one another and there is 'isolation within isolation' (Ramsay 1984). Communities and towns are separated from one another by great distances and in many cases it is a minimum four to eight hour drive between communities.

As previously noted, many of these smaller communities are single-industry

towns which limit women's participation in the labour market. One woman I interviewed explained that although she was formally educated and experienced in marketing and advertising, when she moved to Nipigon (80 kilometres from Thunder Bay), her choice of employment opportunities was either working as a checkout cashier at the local hardware store or as a waitress in the local coffee shop. Discouraged, she chose to stay at home busying herself with volunteer work until her children were born. As was explained by the Women and Health Sub-committee in the original proposal for the Women's Health Education Project,

> Women are not employed in significant numbers by the major employers in the resource sector of the region as the majority of jobs offered have been traditionally defined as male work.
> (Original WHEP proposal 1981: 7)

The lack of employment opportunities in many of the smaller communities in the region lead to boredom and frustration for many of the women. For those who have been educated and experienced in a particular employment field, being unable to work increases their sense of isolation. Further, most of these communities have minimal health care facilities and few recreational and entertainment amenities. Because they lack the social and cultural offerings available in larger communities and the means to access them readily, opportunities for women are few and the experience of continuous isolation is always present.

The ratio of healthcare services and providers in northwestern Ontario to population is about half that of the rest of the province and studies have shown that

the health status of the population is inferior to the provincial norms (Southcott 1993; Ramsay 1984). Although the Ontario Ministry of Health has initiated programs to recruit and retain physicians and allied health care professionals (Underserviced Area Program) to the region since 1969, northwestern Ontario continues to face significant physician and other healthcare professional shortages (Anderson and Rosenberg 1990: 35). In addition, there are other neglected factors which are equally important in determining the health status of the population such as socio-economic status, gender, and geography[9] (Southcott 1993) similar to other parts of the province. Women consume healthcare services more often than men (Pitblado and Pong 1996).

Lack of services affect how women are able to control their own health and the health of their families. Because health care professionals working in northwestern Ontario are burdened by heavy workloads and minimal health care services there are limited choices for women which adds to the stress level when trying to meet their own health needs and those of their families (WHEP Final Report 1986). Women are also likely to lack assertiveness or to be equally heard

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In many provincial government studies and reports of health in Northwestern Ontario, the focus tends to revolve around the recruitment and retention of physicians to the region. This suggests that when defining health, and healthcare issues, the problems of health status in a population could be improved if sufficient physicians were employed in the region. This provincial focus is in part, problematic in that it denies the complexity of issues in defining health for a given population.

when dealing with their doctors which increases their sense of frustration (WHEP Final Report 1986). All of these healthcare issues overlap to increase the isolation and stress experienced by women living in these northern communities. The healthcare that does exist is not something that is taken for granted by its population, particularly women.

The realities and experiences of those living in the region reflect a geographically and socially divergent picture when attempting to envision health or healthy communities in the Northwest region. Consequently, when women began conceptualizing and initiating discussion around women's health in the late 1970s and early 1980s there was much excitement and enthusiasm. The large domain of women's health was new and yet to be explored. Direction for development in this vast realm of opportunity was wide open and in 1980, regional women began to come together to talk about women's health (Women and Health Sub-committee Minutes 1980).

2.3 THE WOMEN'S MOVEMENT IN NORTHWESTERN ONTARIO

The women's movement in northwestern Ontario began to take shape in the late 60's with women's liberation meetings bringing women of all backgrounds together to discuss current women's issues and plan the first northwestern Ontario women's conference[10] (Karlstedt 1987). Soon after the conference, several smaller

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10 The first northwestern Ontario women's conference was held at Confederation College on April 6-8, 1973. Conference organizer's expected 100 women and

consciousness-raising groups were formed, each working on specific issues (single parenting, older women, lack of subsidized childcare, abortion reform, and such) important to their members. A regional women's centre was formed in 1974, with funding from the Secretary of State to hire six women to deliver counselling and referral, crisis housing and rape crisis, drop-in and information centre and services to women in Thunder Bay (Karlstedt 1987). The *Northern Woman Journal* began publishing a feminist newspaper in 1973 as a means of providing women with a forum to promote feminist awareness and action in the region (Karlstedt 1987). Women's studies classes at the local college, the Northern Women's Credit Union, and the Northwestern Ontario International Women's Decade Council among several other initiatives[11] took hold in the region as part of the larger women's movement. (Karlstedt 1987).

The women's movement in northwestern Ontario was developing at a similar pace to other cities, towns and regions across Canada with many of the same national issues facing women in the North. However, there were also issues facing

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were shocked and thrilled when 600 women attended. Themes discussed at the conference included: day care, sex-role stereotyping, working women, welfare rights, abortion, women in politics, high school women, single parents, women and the media, women's centres, older women, native women and women in the arts. The key note address was delivered by Canada's then most visible radical feminist, Bonnie Kreps (Karlstedt 1987).

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For a more comprehensive overview of women's organizing efforts in northwestern Ontario see *Northwestern Ontario Status of Women Initiatives 1973-1987* by Fiona Karlstedt, 1987.

regional women which were specific to the isolation and lack of opportunities (employment, recreational, service, educational) of hinterland life.

2.4 THE WOMEN'S HEALTH MOVEMENT IN NORTHWESTERN ONTARIO

Women's health organizing in northwestern Ontario has parallelled and progressed at much the same pace as some of the more urban places in Canada. Although there has never been a women's health clinic in northwestern Ontario, women's health collectives and groups have existed in various forms. Some have been fairly small and loosely organized such as the Women and Health Sub-committee in 1980, which had functioned as one dimension of the Northwestern Ontario Women's Decade Council[12]. (Women and Health Sub-committee Minutes 1980). There have been consciousness-raising groups and women's health projects which have predominantly organized with the intent to share women's health information in a region where health information was sparse. In part, the women's health movement in northwestern Ontario has developed in this way because of the regional context and the distinctly isolated nature of the hinterland area. However,

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The Northwestern Ontario Women's Decade Council (NWOWDC) evolved out of the Northwestern Ontario International Women's Decade Coordinating Council (NWOIWDCC) in 1982 when funding became available to hire a full time coordinator. The NWOIWDCC was originally formed in 1976 "to serve as a resource for, and liaison between, area women's groups and services working to improve the economic, social and political status of Northwestern Ontario women" (Karlstedt 1987). Since 1982, the Women's Decade Council has continued to work on promoting "non-partisan interest in and action on status of women issues in Northwestern Ontario" (Karlstedt 1987).

there have been over time, groups of women and feminists in northwestern Ontario who have been politically vocal, and have successfully organized around women's health.

The Women's Health Action Group (WHAG) evolved in 1983 from the work of the Women and Health Sub-committee. WHAG was formed because women saw a need and desired to initiate change in the area of women's health. It began in 1981 when two members of the Women and Health Sub-committee participated in the first provincial conference on women's health held in Toronto on March 27-29, 1981 at the Ryerson Polytechnical Institute[13] (Strategies for Well Being Conference Proceedings 1981).

At that conference, women from across northwestern Ontario were able to meet and discuss northern women's health issues. Collectively they recognized that there was a shortage of doctors and services because of the isolation and distance between Northern communities; and that the health needs of women living in northwestern Ontario were different from those of women living in urban centres in part, because of the transient nature of the population (including health care

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The conference, initiated and funded by the Health Promotion Directorate, Health and Welfare Canada, was called the *Strategies for Well-Being: a conference for action on women's health.* The conference was attended by two hundred and fifty women representing five regions in Ontario (Toronto, Southwestern Ontario, Southeastern Ontario, Northwestern Ontario and Northeastern Ontario). Several out-of province women attended as well (Strategies for Well-Being Conference Proceedings 1981).

professionals) (Strategies for Well-Being Conference Proceedings 1981). Upon their return to Thunder Bay, the women involved with the Women and Health Sub-committee wanted to do something to improve women's access to health information. They had some information on specific women's health issues such as child birthing, birth control, and abortion and believed that there was a need to share this information and make it available to all women in the community (Interview 6 Women and Health Sub-committee Member, WHAG Member). In order to obtain funds from the Health Promotion Directorate, Health and Welfare Canada they formed the Women's Health Information Group (WHAG) creating an organizational structure with a Board of Directors to oversee projects. The creation of WHAG allowed them to be autonomous from NWOWDC, and be fully engaged with women's health issues (Interview 11 Women and Health Sub-committee Member, WHAG Member, WHEP Coordinator). WHAG members would meet on a regular basis at the Women's Centre on Bay Street in Thunder Bay to share information, compile resources[14] in an accessible way and think of ways that the information could be passed on to others (Interview 6 Women and Health Sub-committee Member, WHAG Member).

The WHAG women resided in Thunder Bay and worked out of the Women's Centre as a feminist collective. WHAG organized consciousness-raising and self-

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WHAG had in its possession a rare and difficult find in Northwestern Ontario - *Our Bodies Ourselves* (1971) published by the Boston Women's Health Book Collective.

help groups for women living in Thunder Bay (Interview 6 Women and Health Sub-committee Member, WHAG Member). The work done by the health collective members overlapped with several other women's organizing efforts in Thunder Bay as many of the members were involved with the local women's movement in a variety of capacities (Interview 3 WHEP Coordinator). WHAG members continued to sit on the Northwestern Ontario Women's Decade Council, belonged to the Women's Centre, and worked on the *Northern Woman Journal*[15] (Interview 11 Women and Health Sub-committee Member, WHAG member, WHEP Coordinator). The journal was an important instrument for sharing all sorts of information pertinent to women across the vast distances of northwestern Ontario. Importantly, this feminist journal devoted some of its space to covering pertinent women's health issues and at times, would publish an entire edition featuring wide-ranging issues around women's health[16].

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The *Northern Woman Journal* was also run as a feminist collective (Interview 3 WHEP Coordinator). It had begun as a newsletter or bulletin informing women about the first northwestern Ontario women's conference, the *Northern Women's Conference* held in Thunder Bay on April 6-8, 1973 (Karlstedt 1987). Because of the conference's success (organizers had hoped that 100 women would attend and recorded attendance was 600), the women formed a collective and began to publish a feminist journal for women living in the northwest region of Ontario in 1973 (Karlstedt 1987). The journal was published through to 1997.

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The *Northern Woman Journal.* "Health" Vol. 6. Issue , January/February 1980. Topics covered included: childbirth, DES, birth control, mastectomy, hormones, abortion.

2.5 THE WOMEN'S HEALTH EDUCATION PROJECT (WHEP): 1982-1985

In 1982, the Women's Health Education Project (WHEP) was birthed from the local grassroots women's health organizing of WHAG in Thunder Bay. In this phase, the organizing became more formalized and structured (Interview 11 Women and Health Sub-committee Member, WHAG Member, WHEP Coordinator). The idea for WHEP originated at a second regional *Strategies for Well Being* Conference held in Dryden, Ontario in 1981 (Women and Health Sub-committee Minutes 1981). The overarching concern expressed was that women in northwestern Ontario had specific health needs which were not being met. Upon learning of possible funding through the provincial Health Promotion Directorate, Health and Welfare Canada, two WHAG members wrote a proposal to secure funding for a pilot project concerned with women's health needs in northwestern Ontario. The proposal written by the WHAG women was accepted in 1982, and the group was awarded funding of $325,000.00 for a three year demonstration project. The aim of the project was to survey the health needs of women living in the isolated Northern region of Ontario and then compose and deliver various workshops to meet the identified needs (Sparkes 1983). The project's goal was to connect women across the region in fourteen target communities[17], spread over an area of

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The target communities were: Red Lake, Sioux Lookout, Dryden, Pickle Lake, Kenora, Fort Frances, Atikokan, Geraldton, Nipigon, Marathon, Terrace Bay, Manitouwadge and Thunder Bay (WHEP Final Report 1986).

approximately 151,000 square kilometres[18], by providing health education in the form of workshops and information about health issues and health services that were of concern for regional women (Karlstedt 1987).

Initially, four project coordinators, each working part-time, were hired to fill the two full-time positions (Interview 1 WHEP Coordinator). It was the WHAG members who were responsible for advertising and selecting the coordinators (Interview 11 Women and Health Sub-committee Member, WHAG Member, WHEP Coordinator). While there were several qualities the hiring committee was looking for, each coordinator was primarily chosen because she had "a positive philosophical orientation to women's roles, an awareness of women's health issues, and a strong feminist perspective with a belief that everyone has something to offer" (WHEP Final Report 1986). Once hired, it was decided by the WHAG members and the newly hired coordinators that the Women's Health Education Project would be non-hierarchical in organization and consensus would be strived for when making project decisions (Interview 3 WHEP Coordinator).

The project began in its first year by undertaking a major survey[19] of

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The project area extended west to Kenora, north to Pickle Lake, east to Manitouwadge and south to the Canadian/U.S. border (WHEP Final Report 1986).

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See "A Survey of Women's Health Needs in Northwestern Ontario" by Jane Ramsay for the Northwestern Ontario Women's Health Education Project (WHEP). Submitted to the Ontario Health Promotion Directorate, Health and Welfare Canada, February 1984.

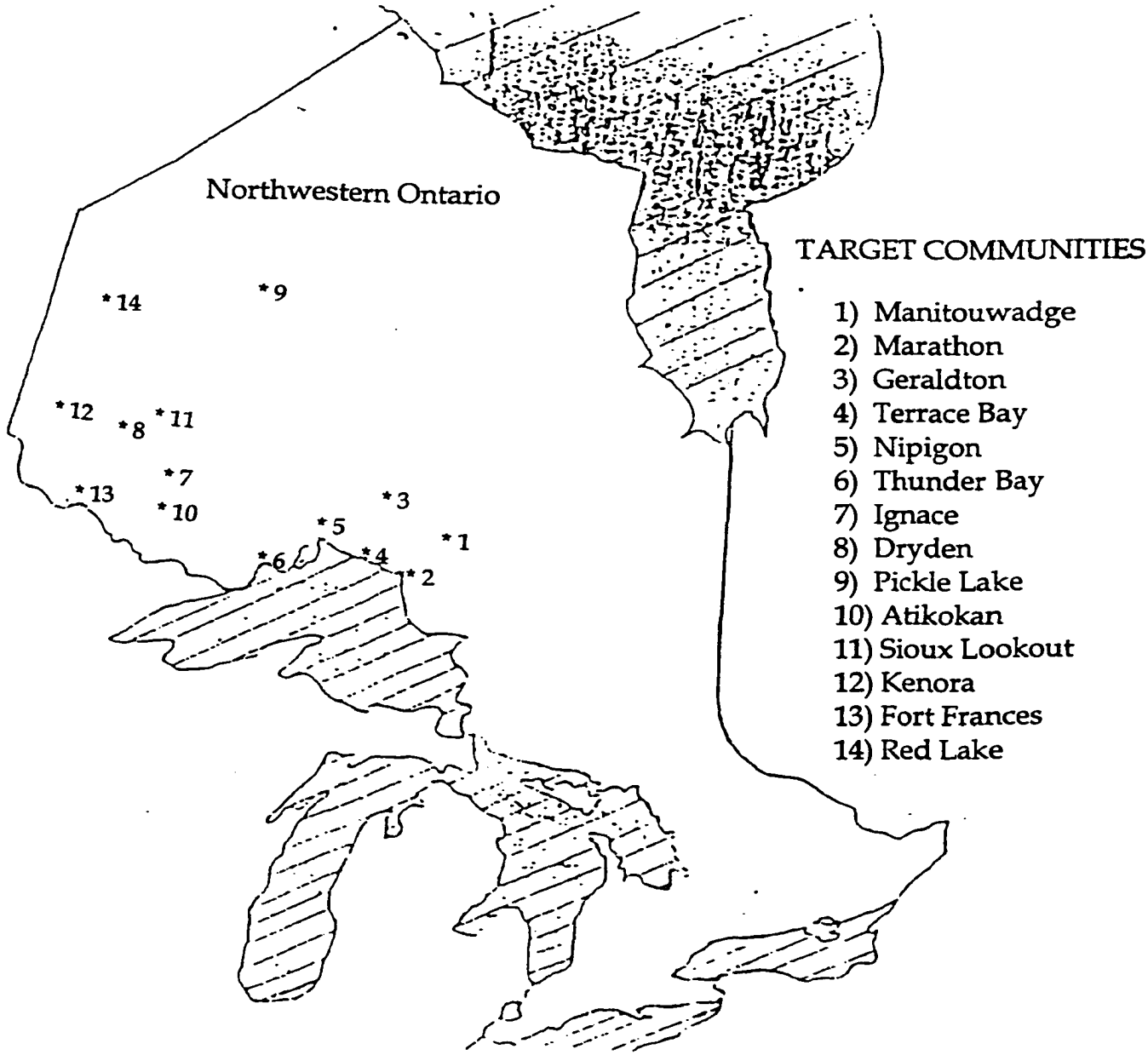


Figure A

Taken from the WHEP Final Report, 1986: 5.

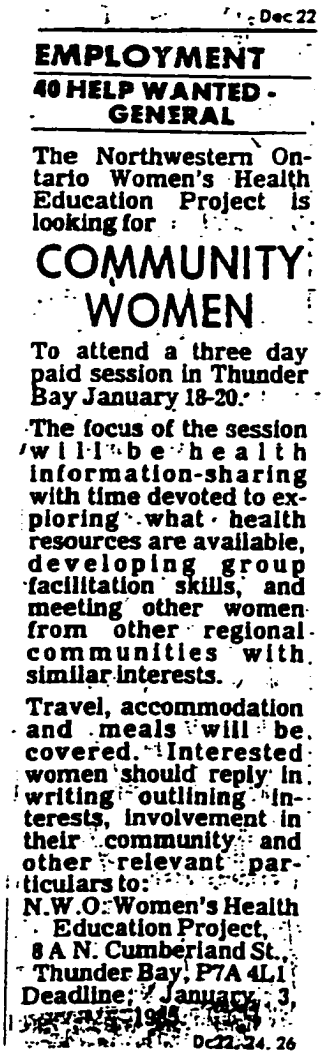
women's health needs. The survey was distributed to eight hundred women throughout the Northwest region (WHEP Final Report 1986). Although the survey development, implementation and analysis was demanding and difficult, the coordinators persevered and in that same year of the project, they developed a workshop and kit entitled *Cabin Fever* (Interview 1 WHEP Coordinator). This first workshop kit dealt with identifying the various health stressors for women that could be associated with Northern living and isolation (WHEP Final Report 1986). These *Cabin Fever* workshops were important as they confirmed to those involved what the survey had been showing about women's health needs and concerns in the region; that women felt isolated and that they wanted and needed health information and resources (Interview 8 WHEP Coordinator). The workshop, once completed was taken out into all of the fourteen communities by the coordinators.

Over the second and third years of the women's health project, the coordinators developed a further nine workshop kits (WHEP Final Report 1986). The themes of the WHEP popular education workshops were varied but all shared the specific goal of addressing the women's health issues which had been documented through the regional survey (Interview 8 WHEP Coordinator). Similarly, additional workshop themes were identified through the initial *Cabin Fever* workshops as women participating vocalized other health concerns which they felt to be pertinent (WHEP Final Report 1986). Because of the growing demand for workshop delivery in the target communities, the WHEP coordinators decided

that regional women should be trained in the delivery of the kits and paid honorariums to facilitate (Interview 1 WHEP Coordinator, WHIN Board Member). Consequently, one of the jobs of the WHEP coordinators became training community representatives in the delivery and facilitation of these workshops (WHEP Final Report 1986).

Fourteen volunteer community representatives were chosen by the coordinators through contact with the initial workshop as well as advertisements posted in local newspapers (Interview 8 WHEP Coordinator). Although, the honorariums to be paid for facilitating the workshops were limited, WHEP coordinators believed that by offering training in facilitation skills, public speaking, making effective use of the media, and community development women would be interested in working as regional representatives (WHEP Final Report 1986). Also, because there were so few employment opportunities for women in many of these communities, women were excited to have paid positions on the Women's Health Education Project (Interview 12 WHEP Regional Representative, WHIN Board Member; WHEP Final Report 1986).

The response to the ads for WHEP community representatives from women living in the target communities was impressive (Interview 1 WHEP Coordinator, WHIN Board Member). The women who were hired were eager to begin working, organizing and setting up workshops around the important women's health issues,



Dec 22

EMPLOYMENT

40 HELP WANTED - GENERAL

The Northwestern Ontario Women's Health Education Project is looking for

COMMUNITY WOMEN

To attend a three day paid session in Thunder Bay January 18-20.

The focus of the session will be health information-sharing with time devoted to exploring what health resources are available, developing group facilitation skills, and meeting other women from other regional communities with similar interests.

Travel, accommodation and meals will be covered. Interested women should reply in writing outlining interests, involvement in their community and other relevant particulars to:

N.W.O. Women's Health Education Project, 8 A N. Cumberland St., Thunder Bay, P7A 4L1

Deadline: January 3, 1985

Dec 22, 24, 26

Figure C

Taken from the Chronicle Journal (Thunder Bay) December 22, 1984

Figure B

Taken from The Dryden Observer, Wednesday, December 26, 1984

Wanted

ATTENTION TRAPPERS! D & M Raw Fur Co. buyer will be at the LenVer Inn Motel from 8 a.m.-10 a.m. January 4, 1985. For further information call 983-2712. j2

"THE NORTHWESTERN Ontario Women's Health Education Project is looking for community women to attend a three day paid session in Thunder Bay January 18-20. The focus of the session will be health information-sharing with time devoted to exploring what health resources are available, developing group facilitation skills, and meeting other women from other regional communities with similar interests. Travel, accommodation and meals will be covered. Interested women should reply in writing outlining interests, involvement in their community, and other relevant particulars to: NWO Women's Health Education Project, 8A N. Cumberland St., Thunder Bay, Ont. P7A 4L1. Deadline: January 3, 1985.d26

Employment Opportunities

stress, nutrition and birthing as identified through the survey (WHEP Final Report 1986). One woman I interviewed told me how excited and honoured she was to be chosen as her community's representative.

> I think that what attracted me to it was women's health... and it was women. A lot of the volunteer work I had been doing was with men and men's organizations... not necessarily men but men's organizations... and I wanted something with women... and women's health... I was really interested in women's health. I had just taken a Sociology of Medicine course and was really interested in it... and the training they offered... they offered to train me as a representative and I just thought it would be really interesting and I remember when I first applied I wanted... I really wanted to be chosen... and when they actually phoned me I was really honoured... I thought that you know, that this was a real honour to be chosen as a representative (Interview 12 WHEP Community Representative, WHIN Board Member).

She was honoured to become a community representative and excited that she would be trained in facilitation skills. She explained how she felt nervous to have such a public position and really gained confidence through the WHEP training sessions.

> My experience with WHEP was ... tremendous... It really was... I was at a point in my life where I was a little mouse, that's a good description of it... I don't know how else to say it. Although I was involved with a lot of organizations... I was very quiet... very timid... rarely would I speak to people... definitely wouldn't speak to someone unless they spoke to me... and WHEP and WHIN really helped me get over that and feel more confident... In fact it really... when we went to the training sessions when it came time... I remember the first time when it came my turn to speak... I swear my

> heart was just pounding out of my chest... and then afterwards when we talked everyone was saying... yeah, I feel the same... and I came to realize that ... that I'm not alone ...
>
> **Yeah...**
>
> But you know... in fact that is what really attracted me to it... that they would train me in facilitation skills and now...
>
> **And now you teach and stand in front of a room of people everyday...**
>
> I do... and I do workshops at the drop of a hat... I don't even think about it anymore.. (haha)... And they did that for us... they gave us a lot of skills and then forced us to use them... to go out and use them and try them out.. And it was great....

Through the experiences and skills gained working with WHEP and WHIN this woman's life was changed. All of the women interviewed who had begun as community representatives expressed similar sentiments when reflecting back over their experiences with WHEP. They were positive life-changing experiences, particularly the training sessions, which in turn led the women into continued work around women's health, many eventually becoming WHIN Board members.

The first of the community representative training sessions, a conference called *Shared Perspectives* was held in Thunder Bay during the winter of third year (1985) (WHEP Final Report 1986). It was attended by thirty-two women from fourteen communities (WHEP Final Report 1986). As was explained by one of the coordinators, "there was a heightened awareness within the region of health issues

and community needs. On a personal level, women had the opportunity to develop new skills and build on their self-esteem" (WHIN Files 1989).

In all, there were three "Shared Perspectives" training sessions in the third year of the WHEP project (WHEP Final Report 1986). All of the training sessions focussed on facilitation skills, using the media, public speaking and community development (WHEP Final Report 1986). If a community representative was unable to attend one of the sessions it was her responsibility to find a replacement from the community. As was explained in the WHEP final report, "regardless of their age, education, or economic background, the women shared the conviction that women in their communities needed health information" (WHEP Final Report 1986). The training sessions not only brought regional women together to discuss women's health issues in northwestern Ontario; they also provided women with practical skills, confidence and a desire to be involved and active in their communities.

The WHEP workshop kits were in demand. There were requests for them both in the region and from other women's health organizations across Canada (Interview 1 WHEP Coordinators, WHIN Board Members). Early in the project, the coordinators worked on putting the kits together. The coordinators decided to use an adult education model of popular education techniques to formulate the workshop kits[20] (Interview 3 WHEP Coordinator). In utilising this method the

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The formula for the kits and the workshops followed several principles as outlined in the WHEP Final Report (1986). First, the workshop facilitator would

coordinators were able to de-emphasize the notion of 'expert' (Interview 1 WHEP Coordinator, WHIN Board Member). It encouraged women to participate in their own learning about health, and acknowledged that women in their own communities had knowledge and understanding about health issues which could be drawn on as a resource. Finally, the kits encouraged women to take an active role in initiating change both individually and as a community (Interview 3 WHEP Coordinator).

As the project progressed and the coordinators became busy with recruiting and training volunteers/facilitators and managing the various day-to-day tasks of the project, women were hired as project workers to develop the workshop kits (Interview 4 WHEP Coordinator, WHIN Board Member). All of the kits followed the popular education formula which was refined by the coordinators and the project workers as the project progressed. The facilitators and coordinators learned from their experiences of holding workshops where there were gaps in the kits (Interview 8 WHEP Coordinator). By adding further resources and information and

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initiate a process of sharing personal experiences relating to the specific issue or topic of the kit. Symptoms or experiences would be listed and in so doing, the women participating in the workshop would have their experiences validated. The facilitator would then add some basic information or facts about the issue taken from the resource kit. The group participating would then work together on formulating or identifying possible solutions. The facilitator would assist the group in developing and setting goals to make the desired changes. The coordinators would then encourage the group to follow through with their plan of action. As well, the coordinators and the community representatives would then be available to provide on-going support and resources to the women.

Figure D
Taken from The Echo (Manitouwadge)
Thursday, October 13, 1983

FINAL NUTRITION WORKSHOP

'Why Eat Brown Rice?' is the title of the final workshop in the Women and Nutrition Series sponsored by the Northwestern Ontario Women's Health Education Project.

The first half of the workshop will provide women with an opportunity to take and in-depth look at the gross factors which effect the nutritional value of food. These include some of the techniques through food is changed from its raw natural form to the processed products with which we are familiar. Also, ways in which these products are displayed and advertised to encourage us to buy will be discussed.

In the second part of the workshop, women will examine personal and social factors which could prevent them from getting high quality food. Some of the topics in this part are lack of time and/or money and resistance by other members of the family.

The session will end with a discussion of realistic ways to improve the nutrition of yourself and your family.

In Manitouwadge the workshop takes place on October 18 at 7:30 p.m. at the Recreation Centre. Call 826-3847 for further details.

Figure E
Taken from The Regional (Red Lake)
April 25, 1984

"Eploring Life Changes" workshop deals with mythes about menopause and aging

EAR FALLS — Separating the facts from the myths that surround menopause and aging is the focus of a workshop entitled "Exploring Life Changes", to be sponsored by the Northwestern Ontario Women's Health Project in 14 communities.

If you have ever heard someone attribute the behavior of a woman over forty to the fact that she is "going through the change", you have been exposed to an attitude that many people have toward menopause and aging. Women in mid life are accused of irrational behavior, raging hormones, fits of anger and emotion all classed as the symptoms of menopause.

In fact, the effects of menopause are not all that established. Until a very recent surge of medical and scientific research on the subject, (no doubt related to the current age of the bulk of the North American population), very little concrete research existed. Very often the myths and negative attitudes are a result of a lack of information and understanding.

This workshop has been designed for women of all ages to explore the attitudes, mysteries and myths surrounding menopause and aging. The 2½ hour workshop looks at the actual physiological changes that occur at this time, as well as some of the changes in roles and relationships that are prevalent during mid life. Prevention of mid life health risks, surgical menopause and the controversial Estrogen Replacement Therapy will be dealt with during the workshop.

Menopause and aging are natural processes in a woman's life. Supportive group activities where there is sharing of information and experience among those involved have been demonstrated as the most effective way for women to gain a better understanding of these subjects.

"Exploring Life Changes" will aim to inspire and motivate participants towards this process.

In Ear Falls, the workshop will be held April 25 from 7-9:30 p.m. in Room one of the Spruce Street School. For further information please contact Carol at 222-2493.

constantly updating the kits, the workshop kits were kept current and responsive to the diversity found within the various northern communities (Interview 4 WHEP Coordinator, WHIN Board Member). The titles of the original workshops included:

1. Cabin Fever
2. Women and Nutrition
3. Women and Stress: Coping with Northern Living
4. Exploring Life Changes: A Workshop on Menopause and Aging
5. Breaking the Diet Habit: A Positive Approach to Body Image
6. Patient's Rights and Responsibilities: Active Consumer Awareness
7. Preventing Menstrual Stress: Demystifying the Menstrual Cycle
8. Family Centred Childbirth: Pro, Cons, Options in Northwestern Ontario
9. Birth Control: Being in Control

The workshops were organized and advertised within the various communities by the community representatives (Interview 8 WHEP Coordinator). Those interested in participating in the workshops did not have to confirm their attendance thus, the facilitators were never sure of how many women would show up to a particular workshop (Interview 12 WHEP Regional Representative, WHIN Board Member). It was important that the kits and activities planned were flexible and could be adapted to smaller or larger groups of women (WHEP Final Report 1986). Some of the workshop topics were more popular than others. The workshop on *Women and Stress* was particularly successful (Interview 8 WHEP Coordinator). In Manitouwadge, fifty-three women attended and in Kenora, fifty-six women attended (WHEP Final Report 1986). However, the Nutrition workshop advertised

as *Why Eat Brown Rice?*, was not as successful and few women participated (Interview 8 WHEP Coordinator). Similarly, the level of individual participation varied by community (WHEP Final Report 1986). In some, women were very open to discussion and exploring their experiences and feelings towards a particular issue. In others, the women were more comfortable with a lecture style format (Interview 1 WHEP Coordinator, WHIN Board Member).

Because of the flexible structure of the kits, the community representatives could gear the workshops to the needs of the women participating and to the time frame available (WHEP Final Report 1986). Upon evaluation of the project the coordinators felt that the workshops were one of the most positive aspects of the project in part because they were flexible for different groups of women and because they were adaptable to varying time frames (WHEP Final Report 1986).

The development of each of the workshop kits involved extensive research. The coordinators were in contact with other women's health groups across Canada and would exchange resources including books and articles (both academic and lay). As well, there was an exchange of newsletters among the groups (the Vancouver Women's Health Collective, the Toronto Women's Health Network, the Women's Health Education Project in Nova Scotia, the Winnipeg Women's Health Clinic, the Regina Women's Health Collective) through which further information and knowledge of both national and regional services was shared and could be accessed through the WHEP office. An extensive filing system documenting

resources and information on pertinent women's health issues ranging from childbirthing options, effects of pharmaceuticals, endometriosis, menopause and patient rights to information on how to form support groups was collected by the coordinators and made available through WHEP. These resources were supplemented by materials put out through the Health Promotion Directorate, Health and Welfare Canada and the local District Health Units. The WHEP workshop kits were detailed and complete with extensive bibliographies which enabled women to access several choices (either information or service) on each specific topic. Further, if the information available was not specific enough to what was needed, the WHEP coordinators would work at finding further information until the individual woman could be satisfied (Interview 1 WHEP Coordinator, WHIN Board Member).

The coordinators and the community representatives worked enthusiastically to provide health information to women in the target communities and all were committed to the idea of improving women's health in northwestern Ontario. Through the workshops, WHEP reached over three thousand women in northwestern Ontario (WHEP Final Report 1986). Over the three years, the group produced a total of nine workshop kits, and performed dozens of workshops and regional conferences in the target communities (WHEP Final Report 1986). As well,

WHEP coordinators held three well-attended training sessions[21] for the volunteer representatives.

One particularly important feature of WHEP that set it somewhat apart[22] from other women's health collectives and clinics in Canada[23] was its funding base (Interview 1 WHEP Coordinator, WHIN Board Member). In part, some of the success of this three year Women's Health Education Project was due to the significant seed dollars awarded from the Health Promotion Directorate, Health and Welfare Canada (Interview 1 and 4 WHEP Coordinators, WHIN Board Members). This money provided not only the budget to employ four part-time coordinators but it also enabled the group to set up an office; employ researchers periodically to develop the workshop kits; print numerous copies of the workshop kits; hold regional conferences, facilitate training sessions for the community representatives; reimburse the community representatives for their travel costs to and from their

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The training sessions were called Shared Perspectives I, II, and III. These sessions were each held over a weekend and guest speakers from other women's health organizations, clinics and collectives were brought in to speak about relevant topics (WHEP Final Report 1986).

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WHEP was not completely unique in the way that it evolved, or was structured partially around significant funding dollars from the Health Promotion Directorate, Health and Welfare Canada. In Nova Scotia, the Women's Health Education Network ran a similar project from1980-81 until 1983-84. Both projects emphasized women's health in rural or isolated regions of Canada (WHEP Correspondence Files).

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ie. WHEP was structured, run and funded differently from the Vancouver's Women's Health Collective and the Winnipeg Women's Health Clinic.

home communities to Thunder Bay for meetings and training; and to purchase necessary office equipment for maintaining a regional office on women's health issues in northwestern Ontario. The benefits gained through the funding had enormous effects on the sharing of information and education of women's health in the region. Further, the coordinators were able to gain numerous skills in learning how to manage such a large scale project (Interview 4 WHEP Coordinators, WHIN Board Members).

Yet, for the women managing the WHEP project there was a downside to the Health Promotion Directorate funding. WHEP was highly accountable in that they were required to provide four quarterly reports per year, monthly budget statements and year end reports. Project evaluations had to be submitted on a regular basis (Focus Group December 15, 1999). The first year of the project was mainly spent on the production, dissemination and analysis of a major survey on women's health needs in northwestern Ontario as laid out in the original proposal (Interview 8 WHEP Coordinator). Executing this survey took considerable time particularly because none of the coordinators hired had much experience in survey construction, distribution or analysis (Interview 1 WHEP Coordinator, WHIN Board Member; Interview 8 WHEP Coordinator).

The administrative tasks and the bureaucracy of working under the umbrella of Health and Welfare Canada consumed a significant amount of time and energy from the four coordinators (Interview 4 WHEP Coordinators, WHIN Board

Members). This led to frustration on the part of the coordinators as they could not devote as much time to the goal of actually educating and providing information to women in the region about women's health concerns (Interview 1 WHEP Coordinator, WHIN Board Member).

WHEP was able to secure funding for an additional ten months following the three year demonstration project which carried the project through until June of 1986 (Interview 1 WHEP Coordinator, WHIN Board Member; WHEP Final Report 1986). The four coordinators stepped down from their paid positions with WHEP and a new coordinator was hired for the ten month extension project (Interview 1 WHEP Coordinator, WHIN Board Member). In part, she was hired to finish up work on the workshop kits and begin distributing them to the local regional libraries and public health offices (Interview 1 WHEP Coordinator, WHIN Board Member). Further, she was responsible for writing and submitting the final WHEP report (1986) to the Health Promotion Directorate (Interview 12 WHEP Regional Representative, WHIN Board Member).

2.6 THE WOMEN'S HEALTH INFORMATION NETWORK (WHIN): 1985 - 1992

Within the WHEP time frame, it became evident to the past and present WHEP coordinators, the WHAG members and the many community representatives that it was necessary to continue providing resources and information on health issues relevant to women in northwestern Ontario. Early on in the women's health education project, the WHAG Board had filed an application

requesting non-profit organization status for a women's health network (WHAG Minutes 1983). In part, this decision evolved from the provincial and regional *Strategies for Well-Being* conferences as regional women wanted to see a regional network for women's health. Although the Women's Health Education Project had more or less functioned on their own with project decisions and running the project, it was only funded as a three year demonstration project. Ultimately, the WHAG Board was responsible to not only the Health Promotion funders but to women living in the region. In this light, the women from WHAG also applied to receive their charitable status registration. This process had dragged on throughout the duration of WHEP's existence but in the fall of 1985, charitable status was finally received (WHEP Annual Report 1985-86).

This recognition partly affirmed for the WHEP coordinators and community representatives that working on women's health issues in the region was important. Having outside recognition for the work that the women had been dedicated to for the past three years was inspiring (Interview 1 WHEP Coordinator). The WHEP women also realized that their structure would have to change without baseline funding (WHIN Board Meeting Minutes October, 1985). Thus, by receiving charitable, non-profit status the women working on the health education project were in a position where they could continue to work as a women's organization providing women's health information in the region (WHIN Board Meeting Minutes October, 1985).

Although unsure of the direction they would take, the women involved wanted to continue the work they were doing (Interview 1 WHEP Coordinator, WHIN Board Member). Ultimately, it came down to the fact that the women could not stop what they had started. As one interview participant explained when asked why WHIN had developed, "there was a momentum, and we just couldn't stop when the funding ended... we had to keep going ... for women" (Interview 1 WHEP Coordinator, WHIN Board Member).

On October 19, 1985 it was decided that an active voluntary Board be formed and at the WHEP's final training session for community representatives, *Shared Perspectives: Future Directions*[24] conference held in Thunder Bay, the Women's Health Information Network (WHIN) was born (WHEP Annual Report 1984-85). Their mission was "to enable women to take responsibility for their health and actively participate in their health care and healthy decisions" (taken from a WHIN Pamphlet 1986). In part, forming the women's health network met one of the goals that the Women's Health Education Project had persevered towards; seeing the project become completely community based (WHEP Final Report 1986). Importantly, WHIN resolved that they would function as a regionally based Board (WHIN Board Minutes October, 1985). This was no small task given the great

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This conference was held at the Avila Centre in Thunder Bay on October 18, 19 and 20th,1985. It was the third and final training session of the Women's Health Education Project, attended by the community representatives and coordinators involved with WHEP.

distances between communities in the Northwest region.

The twelve Board members were women from across the region and all had previously been involved with women's organizing around health through either WHAG or WHEP (WHIN Annual Report 1984-85). These women were experienced and knowledgeable about women's health issues in northwestern Ontario. They understood the diversity of the region and what would work to bring women together to talk about health (Interview 1 WHEP Coordinator, WHIN Board Member). Moreover, they were enthusiastic and determined to continue providing health information and resources to women who were living in the isolated communities of the region.

WHIN began without the significant seed dollars that the WHEP project had possessed. However, beginning in the fall of 1985 through until 1992, the Women's Health Information Network continued to pursue similar goals to those of WHEP. In many ways, WHIN began where WHEP had ended. Women on the Board began to organize activities, workshops, conferences and maintain regional networking (WHIN Annual Report 1984-85). They continued producing the quarterly newsletter - *Health Network News* that WHEP had begun three years previously (Interview 1 WHEP Coordinator, WHIN Board Member).

At the first WHIN Board meeting, held in conjunction with its inauguration, WHIN addressed a considerable range of organizational details necessary to running this particular women's non-profit organization (WHIN Board Minutes

October, 1985). The Board members decided to continue working in a similar fashion to the Women's Health Education Project. This meant that the Women's Health Information Network Board would function in a non-hierarchical manner and that members would aim for consensus when making decisions regarding all aspects of the organization (WHIN Minutes Board Minutes October 1985). Ironically, the women also decided that they would have four elected positions on the Board including a president, vice-president, secretary and treasurer (WHIN Annual Report 1984-85). Because the organization had no paid staff (extension funding WHEP coordinator was finishing up her position), the Board would be active and busy in running the network. It was therefore decided that all of the Board members would have to make a one year minimum commitment to their role (WHIN Annual Report 1984-85). Finally, the members decided to maintain the WHEP office space in Thunder Bay (WHIN Annual Report 1984-85).

The philosophy and goals of WHIN, as determined at the initial consolidation of the regional Board were outlined as follows;

> Statement of Philosophy
>
> As a non-profit charitable organization, WHIN promotes an awareness of health issues stemming from the realities of women's lives in Northwestern Ontario. Through an evolving network of regional women WHIN operates with a flexible alternative structure, emphasizing decision making by consensus. Using innovative and creative methods of information sharing, WHIN strives to be non-judgmental and supportive to women taking responsibility for their own well-being.

Goals

1. To identify and respond to the health needs of Northwestern Ontario women through the development of resources and the dissemination of information.

2. To foster an ongoing health information network among women and groups of Northwestern Ontario.

3. To advocate for positive changes in women's health care services in Northwestern Ontario.
(Taken from the original WHIN Board Meeting files October 1985).

Developing the philosophy and goals was in part, possible because of the women's previous commitment to WHEP and the time they had spent on developing their regional framework for women's health. Both knowledge and experience had been gained through WHEP.

Further, the newly formed Board set out to work immediately and began to draft a collective definition of health and core WHIN principles [See Appendix J]. The specifics of how exactly the draft evolved for the network's definition of health and principles are unclear however, it is evident that the women were working from the World Health Organizations broad view of health. Their adoption of this definition illustrates that the women were conscious of an analysis of the systemic nature of sexism, racism, classism and heterosexism, particularly as these institutions related to narrowly defining women's health(WHIN Annual Report 1984-85). Further, the network women saw the importance of clearly outlining their goals of empowering and being accessible to all women; and supporting and

encouraging women to take responsibility for their own health (WHIN Annual Report 1984-85). WHIN defined health as,

> Health is the complete state of physical, mental and social well being, influenced by the social, economic and political environment. In order to achieve this state of well being, it is essential to recognize that women must and will have to attain individual and collective power over the definition of well being and over the life and health that are part of that definition. (WHIN Annual Report 1984-85).

The WHIN members saw health as being much more than the absence of disease and access to a hierarchical structured health care system. Rather, WHIN members envisioned a holistic approach to health which was evident in the work that they did as WHEP, and would be seen in the projects that they would undertake and support. The women established at the beginning how they would work within a non-hierarchical structure and have respect for the autonomy of any future groups that they would work with (WHIN Annual Report 1984-85). These principles would guide the women on their journey of organizing around women's health in northwestern Ontario.

At that initial meeting, the Board also decided to apply to have all of the WHEP workshop kits copyrighted (WHIN Annual Report 1984-85). In part, this was because WHIN saw the kits as a resource to be sold; a way in which they could make money to further the network. The original WHEP workshop kits were being updated and edited with additional modules being added, which ultimately resulted in a doubling of the number of kits available (WHIN Annual Report 1985-

86). In all, there were eighteen kits that were used extensively in the communities involved with WHIN [See Appendix I].

The WHIN members decided that they would apply for funding from the Secretary of State to organize their first conference, *Healthy Herizons* (WHIN Annual Report 1984-85). If the funds could be found, it was determined that the conference planning session would be held in Dryden with the conference happening in October of 1986, one year from WHIN's formation (WHIN Annual Report 1984-85). By having the organizing session in one of the smaller regional communities, the WHIN Board was able to act on their commitment to being in the region and operating as a regional Board. This was an important step for the women involved in WHIN as most regional activities, Boards and organizations operated out of the largest centre in the region, Thunder Bay. Typically, this meant that if you lived in one of the smaller communities and were involved with a regional organization, travel to and from Thunder Bay was expected, and the norm (Interview 12 WHEP Regional Representative, WHIN Board Member). All of the women that I interviewed stressed how important it was that WHIN made the commitment of being a regional Board. In particular, for the women it was meaningful as most of those involved were mothers of young children and thought it only fair, that all of the Board members take turns travelling to meetings.

Over the course of WHIN's first year, the women accomplished a number of things. First, the Board held a total of three full day Board meetings, two of which

took place in Thunder Bay, and one in Dryden (WHIN Annual Report 1985-86). Three editions of the *Health Network News* were sent out to over two thousand women (WHIN Annual Report 1985-86). Half of the workshop kits were fully completed and donated to all of the regional libraries (WHIN Annual Report 1985-86). Finally, the *Healthy Herizons*[25] conference, focussing on reproductive health, was planned, organized and held in Thunder Bay, exactly one year to the date of the network's inception (WHIN Annual Report 1985-86). Many of these activities were accomplished with the help of WHEP's part-time coordinator (Interview 1 WHEP Coordinator, WHIN Board Member).

Year two saw the WHIN members functioning without the help of a paid coordinator to deliver more workshops and regional networking (WHIN Annual Report 1985-86). Talks were initiated[26] with other women's health groups across

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Healthy Herizons, WHIN's First Annual Health Conference took place in October of 1986. The focus of the conference was on women's reproductive health issues and conference workshops included: Birthing Options in Northwestern Ontario, Starting and Maintaining Self-Help Groups, Nutrition, Exploring Life Changes: a workshop on menopause and aging, Breast Health, DES Action, Demystifying PMS, and Speaking Out: Facilitation Skills Expanded. Highlighted key note speakers were a midwife from Toronto and a woman from the Northern Vancouver Women's Self-Help Network. Funding was provided for by the Secretary of State (WHIN Annual Report 1986-87).

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One of the Board Members attended a conference sponsored by Health and Welfare Canada in Geneva Park, Ontario. From this consultation process, a group of women evolved who were interested in starting a Canadian women's health network. WHIN consulted on, and was involved with this process throughout 1986-87. The Canadian Women's Health Network eventually formed in 1989 (Tudiver 1994).

Canada about the possibility of starting a national women's health network (Health Network News Newsletter Summer 1986). However, regional women's health remained the top priority and three mini-conferences[27] were planned and held in the spring of 1987 (WHIN Annual Report 1987-88). A second *Healthy Herizons* conference, focussing on the impact of technology on women's health, was held in the fall, once again in Thunder Bay (WHIN Annual Report 1987-88). The success of both the mini-conferences and the regional conference was overwhelming. One interview participant explained to me that up until recently, women continued to stop her on the street to talk about how the mini-conference in Nipigon had changed their lives by encouraging the women to be responsible for their health, be assertive and ask questions in their encounters with health care professionals and ultimately, had given the women a higher level of self-confidence generally (Interview 5 WHIN Board Member).

The success of the workshops and the conferences cannot be underestimated when attempting to understand how regional women's lives were influenced by WHIN. Women learned about their own health, their communities, and the region by listening and talking with one another. They learned that the problems and isolation they felt to be their own individual difficulties were shared, and that many of the women who lived close to them experienced similar situations (Health

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The mini-conferences took place in Nipigon, Kenora and Marathon (WHIN Annual Report 1986-87).

Network News Newsletter Winter 1987). Through this sharing and learning women were able to understand that women's health issues were a collective problem.

The women involved with the Board were refining their skills with consensus for decision making and the network was becoming strongly independent (WHIN Annual Report 1987-88). Board development began in year two, and long range planning was also done (WHIN Annual Report 1987-88). Committees were established to oversee membership, workshop production and fundraising (WHIN Annual Report 1987-88). The diversification of the Board on committee work ensured that all regional members were able to contribute in ways with which they felt comfortable and skilled. As well, through funding from Employment Development and the Ontario Women's Directorate, three students were hired to work on summer contracts (Health Network News Newsletter Spring & Summer 1988).

In this same year, WHIN began to collaborate with the Red Lake Women's Information Group on the production of a book about giving birth away from home. Funding for this book, *Long Distance Delivery: A Guide to Travelling Away from Home to Give Birth*[28], was applied for, and received from the Health Promotion Directorate (WHIN Annual Report 1987-88). Coordinators working out of two locations, Red

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The book was published in Rexdale, Ontario: Helmsman Press, 1990. Requests for this book were significant and to this day, requests for the book continue to come in from across North America. An article about the issue of birthing away from home was published in *Healthsharing*, a Canadian women's health journal entitled, *Long Distance Delivery* by the coordinators, Holly Rupert and Dianne Lai in the winter edition, 1988.

Lake and Thunder Bay with a distance of six hundred kilometres between them, were hired to research and write the book (Interview 7 WHIN Board Member, WHIN Project Worker; Interview 10 WHIN Project Worker). The process involved several focus groups in the region where women shared their experiences, such as the horrors of having to leave their communities and homes to travel while in labour to a larger centre in order to deliver their babies. A regional survey of women and health care providers; and workshops to prepare women who would be travelling away from home to give birth was conducted (WHIN Annual Report 1987-88).

This project was important as it was the first initiative in which WHIN collaborated directly with another regional women's group. The book took three years to complete with several drafts necessary before printing (WHIN Annual Report 1989-90). Through the process the women involved learned a number of skills both in the actual involvement of writing and editing a book of this nature as well as the process of working collectively together and at a distance (Interview 10 WHIN Project Worker; Interview 1 WHEP Coordinator, WHIN Board Member). When the book was finally published in August of 1990, over two thousand copies were distributed to regional hospitals, centres, health clinics, and to women in the isolated communities of northwestern Ontario (WHIN Annual Report 1989-90).

In year three of WHIN the women involved were continuing to work with great intensity. Several smaller groups (self-help, lobby, information, support) had

grown out of WHIN's regional networking, all sharing the common thread of providing information and resources to regional women about various women's health needs (Interview 2 WHEP Coordinators, WHIN Board Members). The project on out-of-town-birth continued and funding was received from the Ontario Women's Directorate and the Secretary of State to put together what would be the final workshop kit, *What Can I Do: Making Changes in Health Care* (WHIN Annual Report 1987-88). This kit encouraged women to sit on their local hospital boards, the District Health Council, and lobby the government for specific health care changes (Interview 3 WHEP Coordinator, WHIN Project Worker). In all, the women worked efficiently over the distance and the kit was ready for distribution in the spring of 1989 (WHIN Annual Report 1989-90). As one of the original WHEP coordinators explained to me, "women did it, they went out and they got involved with various boards in the region" (Interview 1 WHEP Coordinator, WHIN Board Member).

Nearing the end of 1989, the WHIN Board realized that the past couple of years had been extremely busy working on the two major projects, the publication of *Long Distance Delivery* and the *What Can I Do* kit and the numerous other smaller projects including the newsletter, workshops and conferences (Interview 2 WHEP Coordinators, WHIN Board Members). They realized that very little time had been spent on Board Development (WHIN Annual Report 1989-90). The core of the regional organization had been neglected and long term planning had fallen to the wayside. A proposal was submitted to the Secretary of State to fund Board

Women must get involved politically to bring about changes in health field

Women must take ownership and get their feet into politics if they want to see changes in the health care system, say members of the Thunder Bay District Health Coalition.

"We have to make a lot more waves than what we are," said Prue Morton of the coalition.

Morton was one of several participants who attended a Northwestern Ontario Women's Health Information Network workshop Tuesday night. The workshop focused on the structures that exist in the health care system in the North as they pertain to women.

Sponsored in conjunction with the Health Coalition, the workshop titled, What Can I Do? Making Changes in the Health Care System, also included a discussion and analysis of barriers as well as a breakdown of key players in the health care system.

Doctors need to play a key role in health promotion and education and not just as healers, said participants, adding that nurses have been more effective in teaching. Morton said Thunder Bay needs a community health centre for those who don't use doctors.

Societal changes in attitude and education pertaining to health such as schizophrenia need to be addressed. Coalition president Helen Schumacher said more emphasis should be placed on preventive medicine and less on relying on the practitioner for a cure.

"We have to spend more time on what we should be doing to stay healthy. It's just common sense," she said.

One participant scoffed, "I don't think there is enough mental health care. I would love to see a women's health clinic."

Coalition member Celia Gibbs said there is a "definite shortage" of health professionals in the North and a "big shortage" of homemakers who tend to the elderly.

"The reason for that is because they are poorly paid," she said.

There should be more interest in native health care and wholistic medicine, said Naomi Abotossaway. Natural hygiene is another health care alternative. Morton added the concept of good health should be termed the "illness system" as opposed to the "health system."

Project co ordinators [redacted] and [redacted] said their goal is to produce a resource kit with video component to enable women to actively particpate in policy and decision-making in health care organizations in N.W.O. Special emphasis will be placed on district health councils, hospital and agency boards, the ministry of health and non-profit advocacy groups. Target distribution date is 1989.

Figure F

Taken from the Chronicle Journal (Thunder Bay) Thursday, June 2, 1988

Development in December of 1989 and funding was received in February of 1990 (WHIN Annual Report 1989-90).

Through Board development, the goals of the WHIN Board were to generate both short and long-range planning (three to five years); develop financial strategies for increasing their self-sufficiency; and evaluate the organization to date (WHIN Annual Report 1989-90). With successful funding, WHIN was able to hire a part-time coordinator and three Board development planning sessions were planned and completed throughout the year (WHIN Annual Report 1989-90). The sessions were held throughout the region including one in Thunder Bay, one in Kenora and the final meeting was held at Quetico Centre, west of Thunder Bay (WHIN Annual Report 1989-90).

These sessions were valuable to the WHIN members as the women who had been involved for many years were able to look back and reflect on where they had begun women' s organizing around health, their accomplishments and from that, decide on where they would like to see WHIN go in the future. This planning led the Board to thinking about funds, and how WHIN could sustain itself as a regional non-profit organization (WHIN Annual Report 1989-90). Until this point, WHIN had relied on project funding for all of the work that they had accomplished (Focus Group December 15, 1999). This had been very difficult as it meant that various funding proposals were constantly being pursued and often, decisions for projects would evolve out of what funding was available rather than self-defined needs

(Focus Group December 15, 1999). The WHIN members felt that there needed to be either base-line funding, which did not seem available, or a detailed fundraising plan that would provide the financial resources needed to run the regional organization (WHIN Annual Report 1989-90).

It was at this time that the WHIN Board decided to submit a proposal to the Trillium Foundation (WHIN Annual Report 1989-90). The success with Trillium funding enabled WHIN to move to a larger office space in Thunder Bay, purchase office equipment, and hire a part-time coordinator (WHIN Annual Report 1989-90). The Trillium funds provided base-line funding for a two year period (1990-92), during which time the WHIN Board was to work towards financial self-sufficiency (WHIN Annual Report 1989-90). In order to achieve self-sufficiency, WHIN members undertook to learn fundraising techniques and further Board development. Most of the women interviewed discussed how hopeful they were that this enormous step would secure WHIN's position as a regionally-based women's health network (Interview 12 WHEP Regional Representative, WHIN Board Member). However, in many of the interviews the women shared with me how they felt that in the end, the Trillium funding eventually led to the demise of WHIN.

The final project that WHIN was to complete began in 1990. The *Body Image Project* addressed the problems of women's, particularly young women's obsession with body image, including eating disorders and self-esteem (WHIN Annual Report

1989-90). The project was jointly funded by the Ontario Women's Directorate, the Ministry of Northern Development and Mines, The Ontario Arts Council, The Canada Council, and the Secretary of State (WHIN Annual Report 1990-91). A playwright was hired to write and direct a play[29] focussing on the health consequences of negative body image. A workshop and resources were compiled over the next two years, on raising the awareness for the need that young women develop a positive and healthy self image. Completed in 1991, the play toured across northwestern Ontario during the spring of 1992, visiting all of the regional high schools (Health Network News Newsletter January-June, Volume 21).

During this period, WHIN underwent several major changes. Through them all, the members remained committed to their original goal of providing information and resources to women in northwestern Ontario. They provided local women's health resources and support for thousands of women living in the Northwest region of the province; and they advocated for changes to the health care system at the municipal, provincial[30] and federal levels[31].

29

The play was written by Thunder Bay writer, Eleanor Albanese and first titled The Crane Dance. Since that time, it has been performed across Canada and is now titled The Body Image Project.

30

An example of their advocating efforts at the provincial level took place in Ignace where they had the water treatment centre updated by the Municipal Government at the request of the Ministry of the Environment because of the poor water quality in their community.

31

One national endeavour which WHIN worked on was participating in a national

One example of their advocating efforts included working with a small grassroots group in Schreiber to take on the municipal government, a large mining company and the Canadian Pacific Railway (CPR) (Northwestern Ontario's Women's Health Information Project 1989). As detailed in the "What Can I Do" video, women living in the community were concerned because the gold mining company was housing its dumping grounds in their communities downtown area, close to the railroad tracks, and using uncovered trucks to re-locate the waste from the mining site. The heavy arsenic composition in the mining waste was causing environmental deformities in the surrounding plant and fish life. They believed that the waste was harmful to however, they could not get anyone in a position of power to listen to their concerns. Through petitions, and hundreds of letters and telephone calls to the Town Council, the Ministry of Environment, the Ministry of Health, the mining company and the CPR Company they were, after much frustration and expense, able to have by-laws changed and a protocol established whereby the dumping grounds were moved outside of the town, and the trucks carrying the waste had to be covered when transporting the dangerous goods.

WHIN's accomplishments were immense for working without baseline funding and relying on volunteers to accomplish the goals of the network. The

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coalition supporting the Canadian women's group which wrote and performed *Side Effects*, a play about women and pharmaceuticals (Interview 4 WHEP Coordinator, WHIN Board Member). This play toured in 1985-86 and has since been performed world-wide (Tudiver 1986).

actual daily work involved in both providing information and resources to women in the region, the running of an office in Thunder Bay, and later on in Kenora, and the writing of the various funding proposals was accomplished by women volunteers from around the region (Interview 2 WHIN Board Members).

WHIN's demise was not abrupt but a long drawn out process of Board members recognizing that the enormous workload of WHIN was physically and mentally exhausting (Interview 2 WHIN Board Members). In short, the few dedicated Board members were burnt out (Focus Group December 15, 1999). As the project on Body Image was concluding, WHIN's Board membership was also waning. Typically, it was explained that two to three new Board members would be recruited through work on a project (Interview 2 WHIN Board Members). However, with the Body Image Project, no new Board Members were recruited (Interview 12 WHIN Board Member). Fundraising efforts had been for the most part, unsuccessful in terms of self-sufficiency (Interview 2 WHIN Board Members; Interview 12 WHIN Board Member). Because there was little money, communication efforts with women in the region had dwindled. The Board members who were living in Thunder Bay, volunteering their time in the WHIN office eventually had to find paid work which left less time to volunteer with WHIN(Interview 2 WHIN Board Members). In part, the taking on of paid work happened as the women's small children reached school age. Prior to this, many of the women had been 'stay-at-home' moms, raising their children and working with

the WHEP and WHIN projects (Interview 2 WHIN Board Members).

There was never an official Board meeting to decide that the efforts organizing around women's health would end (Interview 12 WHIN Board Member). Rather, the few members living in Thunder Bay sought legal advice as to what to do with the non-profit women's organization (Interview 2 WHIN Board Members). It was suggested to them that they let the women's organization die out slowly on its own (Interview 2 WHIN Board Members). As difficult a decision as it was, the women decided to let WHIN dissolve. The remaining WHIN women managed to get out of their leased office space, and donate the office equipment and supplies to other non-profit organizations in the city (Interview 2 WHIN Board Members).

As was mentioned earlier, it was suggested by some of the participants that the Trillium funding had led to WHIN's demise. In part, this funding had brought about major changes in the women's organization as the women's efforts turned from their primary concern of women's health organizing to fundraising as a non-profit organization (Interview 12 WHIN Board Member). Because there were so few volunteers at the point of receiving the funding, the energy required to actively engage in fundraising consumed the women's time (Interview 2 WHIN Board Members). This was disheartening as they were no longer engaged in what they wanted to be doing - sharing women's health information in the region (Interview 2 WHIN Board Members). However, the women believed that if they could learn

how to be financially self-sufficient, they would be able to once again, resume their efforts organizing around regional women's health issues (Interview 12 WHIN Board Member).

Yet, in the process of attempting to gain financial self-sufficiency through fundraising, acquiring paid work, and having no money to communicate with women in the region, WHIN eventually dissolved. For those women who were still actively involved with WHIN in the summer and fall of 1992, the interviews brought up shared feelings of sadness and defeat (Interview 2 WHIN Board Members; Interview 12 WHIN Board Member; Interview 13 WHIN Board Member). However, these women also shared a sense of accomplishment and joy in reflecting back over their experiences with women's organizing in northwestern Ontario (Interview 2 WHIN Board Members; Interview 12 WHIN Board Member; Interview 13 WHIN Board Member).

2.7 SUMMARY

The strength of women's health organizing efforts in northwestern Ontario was found in the commitment of several women to providing information and resources on women's health needs in the region. The Women and Health Sub-committee, WHAG, WHEP and WHIN reached thousands of women and were instrumental in providing consciousness raising, health education, information and resources to women in the isolated communities of the northwestern Ontario region. Moreover, the history of these women health advocates and women's groups

demonstrates how women's grassroots organizing encouraged, inspired and empowered ordinary women to successfully take up the roles of community leader and women's health activist, both of which promoted social change in the areas of health and healthy communities.

The women's health issues that were being addressed by the women living in northwestern Ontario were similar to the women's health issues being taken up by women health advocates across the country. Attention to reproductive choices for childbirth, contraception, and access to abortion, stress, nutrition, menopause, and changing the clinical relationship between women and their physicians were critical issues for women across Canada and the United States. However, there was specific attention and focus on the Northwest region and how living in this particular location influenced the interpretation and health experiences of regional women. The regional flare of the Women and Health Sub-committee, WHAG, WHEP and WHIN demonstrates how the location where one lives influences perceptions of health and the organizing activities that are possible within a specific context.

In Chapter Three, issues around structure, process and the tensions surrounding these themes will be addressed. Selected interview and focus group quotes will be used to illustrate the politics of the women's efforts including how the women organized themselves. I will examine the women's perceptions of their efforts, their identified health issues and the tensions which arose over the course

of their organizing. In part, this will demonstrate that there were specific features of their efforts which were explicitly feminist and that a feminist identity, either collective or individual is framed by the social context (including the geographic location), in which it is negotiated.

CHAPTER 3 : THE POLITICS OF WOMEN'S HEALTH ORGANIZING IN NORTHWESTERN ONTARIO

3.1 INTRODUCTION

> The feminist movement is not coherent, singular or unified. It does not and cannot pursue a single strategic course. It is a multi-faceted mobilization that has taken different forms at different times, in different areas of the country, in different socioeconomic and political contexts and among women of diverse racial, ethnic, class and age groups (Marx, Ferree and Yancey Martin 1995).

This chapter examines the respondents comments and reflections on the politics of northwestern Ontario women's organizing. The notion of politics here is understood in the period of second-wave feminism's emphasis on, 'the personal as political'. Heavily critiqued for being a time period where the women's movement predominantly relied on a feminist essentialism grounded in the perspectives of white, middle-class women; the politics of grassroots organizing were rooted in a non-patriarchal alternative model, with the popular ideal of consensus as a model for decision-making and participatory work practices whereby women took turns job-sharing the roles and responsibilities necessary to the functioning of the group (Ristock 1991).

As stated by Ackelsberg (1988), "Political life *is* the community, and politics is attending to the quality of life in households, communities and workplaces" (308). In examining this particular social history of women's organizing efforts in northwestern Ontario, the politics discussed include: how the women were

organizing (structure and process); what issues were being identified as women's health issues; why these particular health issues were germane to the women; and the tensions which were inherent within this political movement.

I begin by outlining Beagan's (1996) conceptual model in an effort to demonstrate the utility of a postmodern approach to praxis and identity. What then follows is a description of several of the core themes linked to the politics of women's organizing which illustrate how day-to-day processes shaped the women's notions of collective identity. One theme which surfaced repeatedly in the interviews was the contradictory notions of feminist and alternative structure and process, particularly the model of consensus decision-making popular at this time. The women involved wanted to use a 'feminist model' or alternative structure however, they did not necessarily share a collective understanding of what that meant. Because the groups were not static but evolving over the twelve year period their definitions of structure and process were in constant flux. In part, tensions among the women arose as the groups experienced contradictions in their identity and a lack of clarity about alternative organizational and process related goals.

In this chapter I will elaborate on the theme of a collective understanding of identities paying specific attention to how these affected the women's efforts to define and practise their alternative structure and process. Understanding the complex social aspects of the northwest region including issues of distance, difficulties in communication and the isolation faced by many of the women

involved as well as the women's multiple and shifting identities is critical to this analysis of organizing as a regional women's issue. In many of the interviews, the importance of understanding how the region influenced organizing efforts was presented as central to a social history of women's organizing. Further, the women's identities, both individual and collective shaped the praxis of the groups. Issues of power relating to identity politics were implicitly central in the discourses around organizing, alternative structure, process and tensions.

Many of the tensions and difficulties which arose are linked with notions of power and 'powerlessness'. Conflicting understandings of power within the group of the women involved, or as the group of women worked towards change in a larger context are integral to this case study. Further, funding issues became more and more complex as the groups evolved, and particularly with WHIN, lack of core funding became one of the main sources of tension experienced by the women. By detailing the women's experiences as relayed through the interviews, the many facets of the politics of women's organizing around health in the northwest region will be revealed.

3.2 POLITICS: PRAXIS VS. IDENTITY

Beagan (1996) has outlined three approaches she found useful in her 1993 case study examination of identity and praxis within the Nova Scotia Advisory Council on the Status of Women. Beagan was interested in analysing the processes women's groups use to build collective feminist identity. She suggests that some

women's groups begin with a shared identity when undertaking the practice of their work (75). This shared identity is unifying. However, it is problematic in that differences (identity and power) among women are often overlooked to present cohesiveness among the group. Beagan argues that in this type of politics, "feminism becomes a matter of being rather than doing" (78). This type of organizing is characteristic of the early days of the second-wave feminist movement when the notion of 'sisterhood' was preeminent.

Second, she notes that some women's groups focus on diversity and difference as their starting point for praxis (75). This approach to women's organizing efforts took hold with women's groups during the late 1980s and early 1990's. It evolved out of criticisms from women of colour, lesbian women, and disabled women that differences were not being adequately addressed by the largely white, middleclass movement (79). For women's groups, the move to centre difference and power accompanying the multiple subject positions women occupy was of critical importance as it shifted the discourses of the feminist movement to be attentive to women's multiple social locations. However, this approach is not without tensions as individual women, in the process, often become labelled by their (typically) most oppressed social location thus, denying their commonalities with other women.

Finally, Beagan contends that it is useful to examine women's praxis from a feminist postmodern stance (1996: 76). She argues that this allows the first two

approaches can be merged in a meaningful way because postmodernism accounts for a fluidity of 'multiple and fragmented, constantly shifting, and internally contradictory' identities (80). Further, it permits the possibility of understanding how as individuals, we can experience 'oppression and privilege at the same time' (81). A postmodernism approach to understanding identity is valuable because it allows for attention to the contradictions women experience in their praxis - or organizing efforts.

3.3 ORGANIZING EFFORTS: STRUCTURE AND PROCESS

> Women were finding their voice at that time... it probably began in the sixties... when people were beginning to accept that there were inequalities gender wise... I don't know how to put it better but the time was right. I mean... I think the money was important... but it probably would have happened without the money. It might have taken longer or fewer people might have been involved... but it would have happened (Interview 9 WHIN Board Member, WHIN Project Worker).

To situate my analysis of how the women of northwestern Ontario structured and organized themselves in the various women's health organizations it is necessary to begin in 1980, with the Women and Health Sub-committee and then discuss the subsequent genesis of WHAG, WHEP and WHIN. In part, this is important because it allows the reader to understand how ideas about feminism, feminist structure, collectivity and consensus were learned and adapted to meet the evolving needs of northwestern Ontario women's health groups. Because each group existed within a specific regional and socio-cultural time frame, concepts of

feminist structure and organizing varied according to the diverse regional identities and needs of the women involved.

WHAG, WHEP and WHIN assumed varying degrees of a similar non-traditional structure. In part, the evolution of this alternative non-hierarchical form came about through a process of experiential learning of how to organize and work together. A common goal which unified the collective identity of the groups was sharing health information to empower women to take responsibility for their own health by learning about choices regarding health care and body issues. The goal of learning to work with an alternative structure based on collectivity and consensus had been identified early on in the development of the women's health group when the Women and Health Sub-committee had decided to work with an explicit feminist orientation (Women and Health Subcommittee Minutes September 21, 1980). The significance of this decision is important as it marks how women's health organizing efforts in northwestern Ontario became rooted in using an alternative structure and process. In part, this was carried over from the women's efforts organizing and working as feminist collectives on the *Northern Woman Journal* and in the Women's Centre in Thunder Bay. The decision for the Women and Health Sub-committee to work with an alternative orientation and structure grew out of the values of the larger northwestern Ontario women's movement.

The decision to work with an alternative form and process was characteristic of grassroots women's groups at this time. Women focussed on using alternative

structures because they either did not have experience with traditional organizations or the experiences they had were largely negative (Adamson, Briskin and McPhail 2000). Radical feminists had developed a critique of earlier social movement organizations which contended that traditional organizations were patriarchal and deprived women of leadership roles and opportunities (Vickers 1991).

As noted by Ristock (1991) the choice to use alternative, non hierarchal forms was also influenced by women's often negative experiences with traditional models of organizing and organizations, where women often worked in positions with minimal power and influence in decision-making (Adamson, Briskin and McPhail 2000). By choosing to work in egalitarian relationships with consensus decision-making each woman involved could exercise equal power in decision-making for the group (Ristock 1991; Vickers 1991). Women modelled their organizing after the consciousness-raising groups of the 1970s which had proven empowering while defying traditional organizing techniques and processes (Ristock 1991; Vickers 1991). However, one of the problems with this ideology was that power relations did not entirely disappear but often became less visible. Individual women's voices would be lost in the process of deciding how the collective should move forward. Although women involved were aware that there were contradictions in this collective process, there was little critique at this time of this alternative feminist form (Adamson, Briskin and McPhail 2000). During the late 1980s and into the

1990's, this 'ideal' feminist alternative came to be heavily criticized by feminists and women 's community groups because the differences and power relations which accompanied consensus and job-sharing were often denied in favour of maintaining a unified collective identity or the notion of sisterhood (Ristock 1991).

I. **The Women and Health Sub-committee**

As elaborated in Chapter Two, WHAG grew out of the Women and Health Sub-committee of the larger Northwestern Ontario International Women's Decade Council. Decade was a feminist body working on women's social, economic and political issues in northwestern Ontario as part of the broader provincial Status of Women initiative of the 1970s (Karlstedt 1987). As a sub-committee of Decade, the Women and Health Sub-committee identified concerns that women in the region had limited access to health information. The committee members organized as a feminist collective, in a similar fashion to their parent organization (Interview 6 Original WHAG member). As was explained by one of the original members, "It was an alternative structure for women by women" (Focus Group December 15, 1999). This loosely structured group was interested in consciousness-raising as a means of sharing health related experiences. As noted in their self-identified mandate:

> We would like to spend time initially establishing who we are as individuals and what our attitudes to Women's health are. Self-education is a high priority for the committee in order that we may operate effectively in this complex and technical field (Women and Health Sub-committee Minutes September 21, 1980).

Consciousness-raising was, and is considered basic to feminist organizing (Adamson, Briskin and McPhail 2000). Once formed, women's groups in the 1970s and early 1980s began to practice consciousness-raising as a means of organizing themselves. Both the Women and Health sub-committee and the WHAG membership were small, with usually no more than eight to ten women meeting on a monthly basis (See WHAG Minutes 1980-1983). This enabled group members to share personal experiences, learn and grow together and to work as a cohesive feminist collective. Commonly, these small somewhat structureless groups became the model for feminist organizing and organizational structures and processes (Adamson, Briskin and McPhail 2000).

The Women and Health Sub-committee structured themselves as a collective with non-hierarchical principles and employed a model of consensus decision-making. Their philosophical orientation was explicitly feminist and their primary concern was with articulating and following feminist process (Interview 6 Women and Health Sub-committee Member, WHAG Member). This group of women based their collective identity on their shared feminist orientation and identity. Many of the women also volunteered their time at the local Women's Centre, *Northern Woman* Journal Collective and the Decade Council (Interview 6 Women and Health Sub-committee Member, WHAG Member). In Thunder Bay, the women's community was tightly interconnected with women routinely active in more than one group. Typical of this time, the local women's groups worked with a distinctly

feminist collective structure (Interview 3 WHEP Coordinator; Interview 6 WHAG Member; Interview 11 WHEP Coordinator).

The Women and Health Sub-committee and WHAG were initiated without funding. As WHAG matured and new members joined, it was decided that a three dollar membership fee per year would be collected (WHAG Minutes March 14, 1983). Materials and resources were collected by donation or were borrowed and photocopied (ie. one woman knew another woman who had information on a particular topic) (Interview 6 Original WHAG Member). The women's groups supported one another and in the case of the two WHAG representatives going to Toronto for the first provincial women's health conference, *Strategies for Well-Being*, one hundred and fifty dollars was received from the Decade Council to cover the travel and accommodation costs (The Women and Health Sub-committee Minutes April 5, 1980).

The Women and Health Sub-committee members were interested in compiling health resources and information which they thought could be of use to women living in Thunder Bay. Some of the specific areas which they identified as needing attention were: women's general lack of knowledge about health, unnecessary surgeries (ie. caesarians and hysterectomies), women's relationship to the medical establishment; women's reproductive health issues such as childbirth, breastfeeding and fertility; and abortion (The Women and Health Sub-committee Minutes, September 21, 1980). These regional health concerns were echoed by

women's health groups across the province and nationally (McDonnell 1986).

Health resources for some of these issues could be accessed through the local Women's Centre (The Women and Health Sub-committee Minutes April 5, 1981). However, the Women and Health Sub-committee members were aware that the location of health resources was problematic because some women would not go the Women's Centre for health information. In part, this was because of the negative community perception of the Women's Centre and its explicit feminist orientation. As was explained by one of the participants,

> ... hardly anyone went to the Women's Centre because you know... it was a bad word... that's where those terrible bra-burning, horrible, man hating.... lesbian feminists were... so they would stay away from the Women's Centre because that was the terrible word remember (feminist)... so women weren't or some women weren't going to the Women's Centre for women's health information... and we knew that (Interview 6 Original WHAG member).

Reflecting on why the WHEP project was proposed for the region, one of the original WHEP coordinators commented further,

> It was... it was funny, you know... that's the bitter reality... in so far as I think you know... having been involved in the Women's Centre and I'm not criticizing it because I think that there is a role for a range but that's something that we never had at the Women's Centre... necessarily... where just your average woman... who didn't necessarily... but probably could have benefited from a lot that was there... but they didn't go there... they didn't associate with it (Interview 8 WHEP Coordinator).

In recognition of the fact that only certain women were benefiting from the women's

health resources which were being collected, it was decided by the Women and Health Sub-committee that they should seek to change their organizing efforts to enable more women (including regional women) access to the resources. However, by choosing to expand into a more service oriented group WHAG was to undergo change. In part, the changes were a result of the Health Promotion funding received to accomplish their goal of reaching regional women. As well, by opening their membership to any regional women interested in organizing around women's health their collective identity would also undergo changes as not all of the women who were to become involved would share a collective feminist identity.

The funding resulted in the grassroots organizing efforts becoming further defined and more structured (WHAG Minutes March 14, 1983). After organizing for three years, in 1983 the Women and Health Sub-committee officially incorporated into WHAG, the Women's Health Action Group (WHAG Minutes 1983; Karlstedt 1987). The purpose of the incorporation was a result of the WHEP proposal which had designed a project with a Board of Directors to oversee the Women's Health Education Project for the three year duration of the funding (Original WHEP proposal 1981).

II. The Women and Health Action Group (WHAG)

The WHAG Board was made up of eight to ten women, some in the health care field, and structured with executive positions including a president, vice-president, secretary and treasurer (WHAG Constitution 1983). In part, this structure

evolved to meet the Health Promotion Directorate funding requirements. As one participant explained,

> You had to have this kind of structure (a Board of Directors) to get the money from the government... and they had to be not seen as a feminist organization to get the money from the government (Interview 6 Women and Health Sub-committee Member, WHAG Member).

In receiving the large project funding (approximately $320,000.00) and requiring a Board of Directors to oversee the pilot project on women's health in northwestern Ontario women's health organizing activities were transformed.

First, it was necessary for the WHAG Board be accountable to the Health Promotion Directorate in a way which was unfamiliar and not necessarily desired by all of the members. It became the responsibility of the coordinators, once hired to both organize the project and be accountable to the funders. The WHAG Board would meet four times a year to discuss initiatives however, their involvement in the project's day-to-day activities was minimal (WHAG Minutes March 14, 1983). Some of the original Sub-committee members continued to organize the resources which had been collected and compiled in filing cabinets at the Women's Centre (WHAG Minutes March 14, 1983). Thus, there was a sort of division in the women's health organizing efforts where organizing was taking place on both a smaller, local scale and in a larger, regional context.

This split can also be viewed in terms of the ways the groups collective

identities were being developed. WHAG was interested in concentrating on their collective identity and process - both strongly feminist. The WHEP coordinators primary focus was reaching regional women and providing them with health information and resources. Further, this difference in the way the groups were structuring themselves can be viewed by acknowledging that the WHEP coordinators were hired and being paid to carry out a task while the WHAG women were ordinary women coming together to not only share women's health information but develop their feminist identities, both individual and as a collective.

Second, because the structure had changed from that of a sub-committee or working group to a formalized, incorporated Board, the process of using consensus was modified to include voting. This structural change was formalized in a policy however, using the process of rounds whereby every woman present would have the opportunity to speak without interruption until all women had spoken, and coming to decisions through consensus was practised informally (WHAG Constitution 1983; Interview 11 WHAG Member, WHEP Coordinator). This formal/informal arrangement for decision-making became problematic for some of the WHEP coordinators (Interview 1 WHEP Coordinator; Interview 8 WHEP Coordinator; Interview 11 Women and Health Sub-committee Member, WHEP Coordinator).

WHAG members prioritoes lay in the process whereas for the WHEP coordinators the focus was on delivering a service to regional women. Some of the

WHEP coordinators felt that more direction for the project was needed from the WHAG Board (Interview 1 WHEP Coordinator). However, the WHAG Board although fully supportive of WHEP was not entirely interested in running a project the size of WHEP because of the loss of feminist intimacy and process that had been part of the Women and Health Sub-committee (Interview 6 WHAG Member).

III. The Women's Health Education Project (WHEP)

As was detailed in Chapter Two, the WHEP project began in 1982 with a structure consisting of four paid coordinator positions with the WHAG Board overseeing their work and the progress of the project. As revealed through the early WHAG/WHEP minutes, all of the coordinators had been hired based on their knowledge of women's health issues, their feminist orientation and their willingness to work using a model of consensus decision-making (Original WHEP proposal 1981; WHEP Minutes 1982). Although some of the coordinators brought with them a knowledge of working collectively and experience with consensus decision-making, not all had that particular knowledge base or experience. One participant explained why she had applied for the position of WHEP Coordinator,

> Women's health and health in general was always an interest of mine.... and I really liked the idea of going out into the Northern communities... I thought that was great, and the concept of working collectively... I had been involved with the *Northen Woman* Journal for quite a while before I joined WHEP so I liked that idea because as a collective... the *Northern Woman* Journal worked very well, so I had these expectations that we

> would work more or less in a similar kind of fashion (Interview 3 WHEP Coordinator).

Once hired, it became one of the first decisions that the four coordinators agreed on: to work collectively using consensus within an alternative (not male) structure (Interview 11 WHEP Coordinator). Although the decision was supported by the four women, not all of the women based their decision on a commitment to shared feminist ideals.

All of the coordinators understood that working as a collective implied that there was no hierarchy and all of the positions were equal - power and responsibility over the project was to be shared (Interview 3 WHEP Coordinator). Job sharing had been a strongly iterated guideline outlined in the original WHAG proposal. It stated,

> The Women and Health Sub-committee feel very strongly on this point. We are looking at two full-time jobs that are job-shared. We have thought about job-sharing just one of the full time jobs and having the other as a regular one. However, we realize that this very easily could lead to hierarchy. The full-time person taking over as co-ordinator and the two job sharers as assistants. We then ruled out this alternative. (Original WHEP Proposal 1981: 28)

All of the duties, as determined by the coordinators were shared including the bookkeeping for the project. As explained by one of the original coordinators,

> The way it was structured was there were basically no job definitions, so what happened was that everybody job shared... the way that we implemented the idea of a collective was to share absolutely everything... and rotate tasks... even to the point of the books and the

financial accounting (Interview 8 WHEP Coordinator).

Ideally, the job sharing of tasks and roles was an important part of working collectively as a WHEP coordinator. However, after about a year of working in this manner the job sharing and ill-defined positions became problematic and had to be re-evaluated (Interview 11 WHEP Coordinator). As the above quoted WHEP coordinator explained further,

> We determined at that point that this rotating jobs was really a burden... that it wasn't accomplishing what it was supposed to because people have different abilities and skills... (Interview 8 WHEP Coordinator).

In the first couple of years job sharing was one area where tensions abounded. Characteristic of women's organizations at this time was a commitment to sharing and rotating jobs (Vickers 1991). As Ristock (1991) explains, "the ideal is that responsibility, knowledge and accountability will be shared equally by all members" (53). Certain coordinators felt that if one was better at a particular job or role, such as bookkeeping or media relations, then that woman should be the one responsible to carry it out. However, other coordinators held firmly the notion that no one coordinator should be the 'expert' in any particular job, rather all should share the responsibility of the tasks and ultimately, the project. Long, drawn out meetings took place in which the coordinators attempted to sort out the particulars of what it meant to work collectively, share jobs and use consensus and how specifically, the project design would be accomplished within the specified time frame. Unacknowledged was the fact that by denying individual women's

strengths and weaknesses in particular jobs women's differences, and power relations between women were being overlooked. In the quest for sameness (ie. equality among the coordinators) power struggles among the women emerged.

The workload expectations were great and in deciding to use consensus and practice job sharing, the coordinators had unwittingly initiated a difficult process which would require a significant amount of time to work through.

> That wasn't there at the start, that really developed, you know... I characterize the first year as trying to get up and running, getting really bogged down in the process... of who does what... and we really didn't use the Advisory Group (WHAG Board) in that capacity... and it might have helped...
>
> **Do you know why you didn't?**
>
> No, I don't. But it probably would have helped.. We might have been able to resolve some of those things because there was a bit of conflict... (Interview 8 WHEP Coordinator).

The WHEP coordinators needed time to learn how to work together, who was skilled in the specific tasks which needed to be done, and to understand why each of them was committed to providing women's health information in the region. Inevitably, there were tensions and power struggles. These tensions were exacerbated in part, because the WHEP coordinators were not able to go the WHAG Board to discuss emerging problems. Because many of WHAG Board members had full time work outside of their membership and only chose to meet formally four times a year, physically, the WHAG Board was not available to the coordinators .

As was explained by one of the original WHEP coordinators,

> And it was upsetting because we didn't ... we had a Board but it was like a straw Board... and that's not to say anything against anybody... it was really hard to try to figure out how to integrate the organizations... but at that front line level... you know... (Interview 11 WHEP Coordinator).

Overwhelmingly, as was explained by the original WHEP coordinators it felt as if the four coordinators were responsible for the entire project (Interview 11 WHEP Coordinator; Interview 8 WHEP Coordinator; Focus Group December 15, 1999). Being responsible for the project meant that there were internal problems with their structure and process as well the additional weight of being responsible to their service goals. The initial coordinators explained that there was no one to ask for expertise on either the internal or external problems facing the WHEP coordinators as the WHAG Board, when available, was not familiar or experienced with running a project the size of WHEP (Focus Group December 15, 1999). The internal problems facing the women including how they had chosen to structure themselves and make decisions were such that only they could choose to work them out. For the coordinators, the tension over the amount of time which should be spent on their organizational process and the time spent on delivering the service of providing health information and resources to women in the region was one which pervaded their meetings and drained their energy.

Project decisions would only result when all of the coordinators could come to an agreement (Interview 1 WHEP Coordinator; Interview 3 WHEP Coordinator).

As mentioned earlier, in making a decision, they employed the process of 'rounds' with each of the coordinators going around in a circle discussing and voicing ideas and concerns until an agreement on the decision could be made (Interview 1 WHEP Coordinator). Ideologically, using consensus and working collectively made sense to the coordinators (Interview 11 WHEP Coordinator). Because all of the coordinators shared some understanding of working in an alternative structure where the women were sharing equal positions and equal working hours, it seemed important and necessary that decisions concerning the project were made in collaboration and equally with one another. However, the process of working collectively and putting consensus into practice was time-consuming and difficult. Further, there was no collective analysis of the implicit power relations which accompanied these organizational processes and goals. As was explained by each of the original WHEP coordinators;

> 1. The coordinators made the decisions and we attempted to work with consensus and you would think that with only the four of us it would be possible... but it wasn't because someone would always change their mind... which was extremely frustrating because you know, we would have these long, long, headache type meetings where we would be going over something, trying to make a decision about something... (Interview 3 WHEP Coordinator).

> 2. I remember spending a lot of time in meetings and that became a real source of frustration because it was the collective piece... I think people started feeling that process ... and product were always difficult to balance and it seemed that we spent a lot of time around a

> meeting table because everyone had to agree with everything... and certain people felt that consensus meant that we all had to see eye to eye... (Interview 8 WHEP Coordinator).

> 3. It was supposed to be a collective and we had lots of meetings about structure and process... we spent a lot of time on process... (Interview 11 WHEP Coordinator).

One of the concerns for the WHEP coordinators over the course of the three years was the time required in consensus decision-making. Because the coordinators had varying schedules, they typically would only work together on limited days. It was important that when it came time to make a decision, the group of coordinators be available for meetings which often, would end up lasting several hours. Because some of the women were more task rather than process oriented, tensions surfaced (Interview 11 WHEP Coordinator; Interview 1 WHEP Coordinator). For some of the women, not enough time was spent on process while for other women, too much time was spent on process.

Further, it was felt that certain women held more power and influence in the decision-making process (Interview 1 WHEP Coordinator; Interview 3 WHEP Coordinator; Interview 11 WHEP Coordinator). Although attempts were made by some of the women to address these power imbalances there was a denial that power differences existed because ideally all were equal contributors to the project. Tensions existed among the women who were coordinating the project throughout the three year term. Two of the coordinators who had originally been hired left and

were replaced (Interview 3 WHEP Coordinator; Interview 11 WHEP Coordinator). One of the original WHEP coordinators explained,

> It was 'structurelessness' and there were no points of accountability. There was no development of the alternative structure... it was just people's own idea of what it was... and certain people were vying for power.... it wasn't that individuals did not want to develop the structure... they just didn't have the knowledge or the perspective... (Focus Group December 15, 1999 - WHEP Coordinator).

The different perspectives held by the original coordinators may in part reflect their diverse educational and experiential backgrounds. Some of the women had training in the social sciences and education while another woman had a background in nursing. There was no recognition of the multiple social locations and experiences from which the women had come to the project or the different disciplines each had been trained in. Some had been actively involved in the women's community, working collectively and using consensus for decision-making while the others did not share this experience. As one woman commented,

> perhaps I was hired because I was the token nurse... I didn't have a feminist analysis when I began WHEP... and I was task-orientated not focussed on the process... (Focus Group December 15, 1999 - WHEP Coordinator).

During the interviews, it was noted that some of the coordinators were more committed to developing a feminist analysis than others. As will be discussed in Chapter Four, the issue of a collective feminist identity was problematic for the WHEP women and attention to process was also contested. Whether the women

would focus on the tasks necessary to providing health information in the region or building a strong, feminist collective process were debates which the coordinators faced daily. These divergent goals affected how the process could evolve and the women's commitment to maintaining WHEP's explicitly proposed feminist orientation as outlined in the original proposal.

As was discussed in Chapter Two, the proposed objectives for year two of the WHEP project were to formulate and deliver workshops kits on the health issues identified through the survey of regional women. The survey (1984), although methodologically limited, had shown that women in many of the communities in the region were most interested in workshops on mental health issues (ie. stress); nutrition, fitness and weight control; birthing, child care and parenting; alcohol, smoking and drugs; reproductive health; sex education, birth control and abortion; patient rights issues; and relationship problems (marriage, separation and divorce) including issues around communication (Ramsay: 72). Upon learning what issues women were interested in attending workshops for, the coordinators began putting together the workshop kits [See Appendix I]. Initially, it was the coordinators who delivered the workshops to women living in the regional communities (Interview 8 WHEP Coordinator).

However as noted in Chapter Two, it was decided by the coordinators that regional women in each of the target communities should be hired to fulfil the role of community representatives. In part, this was because the coordinators believed

that if the workshops were delivered by women from the community there would be greater 'ownership' of the issues. Another factor which influenced this decision was logistical, specifically, the time available and the time required to deliver the workshops was unbalanced. The fact that there were fourteen communities in which to deliver the numerous workshops which had been developed, or were in the process of being developed and that the coordinators had very full schedules led the women to determine that it would be in the best interests of everyone if community representatives could be hired.

The first year of the project had seen the coordinators focus much of their time and energy on process-related issues. When the coordinators had begun the project, they had not anticipated the time that would be required. Further, the coordinators had not been intimately knowledgeable of the great distances between the target communities and the time that would be involved with travelling to communities to deliver the workshops (Interview 11 WHEP Coordinator). As explained by one coordinator,

> We were driving all over the place... I remember flying to Pickle Lake... And ### broke the axel on her car... we were trying to do everything... so labour intensive and at a tremendous personal cost... and I think that's where you got the stress... what I mean is that it got to be too much... (Interview 8 WHEP Coordinator).

The physical geography of the region played a significant role in shaping how the women could realistically organize and structure the WHEP project. Thus, in year two changes occurred in their organizing process for several reasons. First,

the time-consuming meetings left the coordinators with less time to invest in the construction and delivery of resources. Second, it was decided that regional, community women needed to assume a sense of ownership over the workshops and desired changes in the communities. Finally, physical geography influenced how the WHEP project could structure itself. It was difficult, stressful and time-consuming for the coordinators to travel to all of the target communities delivering workshops (Interview 8 WHEP Coordinator).

WHEP evolved as the coordinators and community representatives learned how to reach the isolated women living in northwestern Ontario. The WHEP structure underwent change as coordinators left and community women became representatives. The process of using consensus to make decisions was modified and personalized to fit the needs of the WHEP organization as it grew in numbers and matured. When the meeting (the final training session) was held in Thunder Bay where it was decided to form an active, regional Board, the Women's Health Information Network (WHIN) in 1985, women's efforts around organizing for women 's health also underwent changes in their structure. Similarly, their collective identity was to undergo changes as the Board became regionally based with more women participating at the decision-making level.

IV. The Women's Health Information Network (WHIN)

> There was no more money after the third year of WHEP and when we had that training session at the Avila Centre with all the community reps ... we made this decision to become... something different... to evolve

> and to look for more funding because the women said you just can't stop this now... this can't end... and together we made this decision to form this new organization WHIN and the first Board was established there (Interview 1 WHEP Coordinator, WHIN Board Member).

WHIN began with non-profit status, as a women's organization with membership across the region. A Board of Directors with an executive, including a president, vice-president, treasurer and secretary was established similar to the form which the WHAG Board had adopted. Annual membership fees were collected (Health Network News Newsletter Fall 1985). The commitment made by the women involved to work as a regional organization with Board representation in many of the smaller communities necessarily changed the structure of women's organizing efforts. Power and decision making was no longer in the hands of a few women living in Thunder Bay, rather, the responsibility and direction for the women's group now came from women who represented the diverse smaller communities of the region.

Despite some tensions, WHIN members decided that they would continue to use consensus as a method for decision making, similar to WHEP. The WHIN Board and membership was organized in a manner different from traditional non-profit organizations. Participants were encouraged to act fully and speak during the rounds, which were a part of the consensus process. One participant explained,

> That's what WHIN did for me personally... It allowed me to become better at speaking my mind... or at least giving my opinion (Interview 13 WHIN Board

> Member).

However, there was also much tension over the issue of equal voice and consensus. As one participant explained,

> People used consensus to get their way because not making a decision was making the decision the way that they wanted to... (Interview 5 WHIN Board Member).

Similar to some of the problems WHEP had encountered, WHIN at times also found itself struggling with the consensus model. As was explained in the focus group, achieving consensus took time and often the Board would have to "let a decision float for a long time" before consensus could be achieved (Focus Group December 15, 1999). WHIN did not develop an analysis as to why there were power struggles among the women. Rather, the group focussed on and maintained their goal of sharing health information and resources with regional women.

In joining Board members had to agree to a three year term. This term could be shared and was in situations where women were either working or raising children (Interview 12 WHIN Board Member; Interview 13 WHIN Board Member). Monthly meetings were held across the region in all of the towns and communities where there was WHIN representation. The WHIN Board would use consensus to determine the direction, decide on a project to undertake, and then hire project workers to carry out the project. Often, the project workers would job share one position over distance (one worker in the West and another in the East) in order for the project to be regionally based. Further, by working collectively on the

development of the project all of the women involved were able to add their input and critique. Project workers would regularly report to the Board on the progress of the projects. In many cases, Board members would also work as volunteers on the project. Hence, there was a strong feeling shared by all of the women interviewed of the importance of working collectively on each and every project that WHIN undertook.

V. The Work Environment

One feature of WHIN that set it apart from traditional organizations was its acceptance of always having children present at Board meetings, work meetings and conferences. In part, the women involved understood that they were mothers and members of WHIN and worked to combine these identities as easily as possible. One participant explained,

> I can't believe how we worked around the kids... I remember trying to work around the kids... like doing things like writing.. I think it was around something like a report for the project on out-of-town birth or something...writing...no..it was something for the directory of services for pre-natal care and umm.. the kids are running around and we were typing at the computers... (Interview 4 WHEP Coordinator and WHIN Board Member).

WHIN meetings and conferences always included plans for the children of the WHIN Board members. One WHIN Board member remembered,

> At Quetico was where we put together the fundraising... we took the kids and everything... somebody had arranged for a young girl about thirteen or so to care for the kids... they had games and stuff...

> my son still remembers that... he had such a good time... (Interview 13 WHIN Board Member).

Not only was a WHIN a child-friendly space for its members but WHIN was also known for providing childcare for the women who were participating in either the workshops or conferences.

> The Women's Health Information Network people... the women who were involved with women's health issues... they provided childcare.. (Interview 6 WHAG member and WHIN volunteer).

Many of the women interviewed mentioned the fact that WHIN provided childcare and there was an acceptance of children being present in a work space. Taking into account the fact that so many of the women involved were mothers, the provision of these types of services enabled many of the women to participate in women's health organizing activities.

VI. Funding Issues

One of the primary factors affecting WHIN's structural shift was a change in the way the women's organization was funded. While WHEP had seed project dollars allotted to not only constructing resources but managing the project, WHIN existed on project funding alone (Interview 1 WHIN Board Member). As was explained in an interview, "with WHIN, we went for funding wherever we could..." (Interview 1 WHIN Board Member).

> Project by project... that's really how we survived once those developmental dollars were gone with WHEP... it was project to project and the funding affected what we did... somewhat... in that funders would be looking for

> certain kinds of projects... that's how you got the projects approved... there was always criteria... so we always tried to be really creative and make our projects fit the criteria.... stretch the imagination a little bit.. so that it did fit... so it did influence what we did.. the project dollars that were available (Interview 12 WHIN Board Member).

All of the Board members were volunteers and the task of seeking out possible funding and then writing proposals to meet the funders's expectations was time consuming and exhausting (Interview 1 WHIN Board Member). Eventually, some of the Board Members experienced burn out as a result of these tasks while other women just left the organization to focus on other activities.

Various tensions surrounded the issue of funding for WHIN. At first, it was difficult for some of the Board members to make the transition from having the security of core funds to having to constantly apply for money (Interview 2 WHIN Board Member). Funding affected, to a degree, what projects could be pursued by the WHIN Board (Focus Group December 15, 1999). Particularly challenging, was the fact that initially, only a few Board Members were skilled in proposal writing. One WHIN Board Member explained,

> I was a part of that... I mean I didn't sit down and write out the proposal but the Board was a part of that... because we needed the money to survive... and that was always one of the big problems... from 1985 when WHIN formed... it was from grant to grant and you just never knew what was going to be around the corner... so you would just kind of cross your fingers and hope that the money would come through (Interview 7 WHIN Board Member, WHIN Project Worker).

Not only was the uncertainty around funding stressful for Board membership and project workers but the lack of core funding affected how the women could logistically organize themselves. One participant explained,

> WHIN didn't have a lot of money so the whole organization... these women had to drive incredible amounts of hours to get to a meeting and we didn't have money to make long distance calls... I mean....WHIN ... it was a function of finances (Interview 5 WHIN Board Member).

Throughout the interviews funding issues were commented on by WHIN members. However, there were also prosperous WHIN times from 1987 through to 1990 when more than one project was funded and project workers were employed at various tasks (Health Network News Newsletter Winter 1987; Fall 1988; Spring 1989). While not having core funding meant that project workers and volunteers often had to assume some of the tasks of running the WHIN office, there was project money for Board development (WHIN Annual Report 1987-88). With the opportunity for Board development, the WHIN women were able to strategize both short and long term goals while developing their techniques for using consensus (Interview 1 WHIN Board Member).

Lack of core funds did affect how the women could communicate with one another, particularly as project funds were drying up (Focus Group December 15, 1999). Because of the great distances between communities, and the high cost of long distance telephone communication in the 1980s, regional women were not able to spend time as much time as they would have liked to developing their organization.

When remembering back to that time, one participant explained,

> The way that I recall it... the way that WHIN operated as far as funding and all that stuff... was they were always operating on a shoestring budget... they were always just trying to keep the doors open and it was the Board and the staff who were constantly looking for something else to bring money in... to keep the office open and the staff on... and then I remember that there was no more money for staff and then it was manned [sic] by volunteers (Interview 5 WHIN Board Member).

The women who were interviewed constantly reminded me that there was no technology as is known today. There was no e-mail and setting up a conference call was costly and challenging (Interview 2 WHIN Board Members). WHIN members were innovative in figuring out ways to communicate with one another. One Board member explained how chain letters were used, with the WHIN information being typed up and then mailed out to one Member, who upon receipt would sign her name and mail to the next woman on the list (Interview 4 WHIN Board Member). From this point of view, WHIN members saw themselves as "being ahead of their time" (Focus Group December 15, 1999).

When the opportunity to apply for Trillium[32] funding, where the goal was

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As explained in the1990-91Annual Report for The Trillium Foundation, the goal is "to help fund those voluntary social service organizations assisting the men, women and children in Ontario whose lives have been affected by adverse social circumstances or disabling conditions". The purpose of the Ontario Trillium Foundation is to "provide funds in an equitable, efficient and socially acceptable manner to private non-governmental social service agencies which provide services to the public throughout Ontario" (Annual Report 1990-91: 31).

sustainable, long term development through the use of fundraising came along, the WHIN Board was faced with perhaps, what could have been their most difficult decision (Interview 12 WHIN Board Member). The Board membership was at an all time low and the women who were still active were experiencing volunteer fatigue from their activities. The women were hopeful that with a strong funding base, a regional coordinator could be hired to manage the day-to-day affairs of the network which in turn, would alleviate some of their volunteer time. Unclear however, was the amount of time which would be required by the Board to successfully fundraise the dollars necessary to maintain the network.

> I think Trillium is what killed us... to be honest... really, I think that is what put us under... those Trillium dollars... that's what did it... that was another decision that I remember sitting in the Thunder Bay office deciding about that... we had a representative from Trillium come and make a presentation about the Trillium dollars and that was a big decision for us.. And it took us a while to make it... (Interview 12 WHIN Board Member).

However, once the decision was made the Board moved full force into developing a fundraising campaign[33].

It was at this time, 1990, that WHIN began to believe that they might possibly have a long-term future in the region of northwestern Ontario (Health Network News Spring 1990). They had done Board development, they had a successful

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In June of 1990, WHIN received $32,800 from The Trillium Foundation.

history of organizing in the region, and they knew how to reach the women living in the isolated communities. Further, their collective identity was cohesive in that the primary goal of providing women with health information was central to their organizing efforts. However, the women were to learn that fundraising was a difficult task, particularly because "women's health was not easy to sell" (Focus Group December 15, 1999). As one WHIN Board member stated,

> We just saw the dollars and an opportunity to keep WHIN alive and going... but it sucked the life right out of us because we all... all of our resources went into fundraising... and we couldn't do anything... any projects... all we were doing was fundraising and we weren't fund raisers... as an organization we were pitiful at fundraising... absolutely pitiful... I remember we organized a car rally in Kenora... we were excited about it... but it took major work to set it up... but it wasn't our expertise... the workshop kits... that was our expertise.. (Interview 12 WHIN Board Member).

The decision to work with the Trillium dollars meant that the actual work of sharing health information with women in the region was, in a way, put on hold while the Board members could fundraise. There was tension among the Board members over this decision. Although the Board agreed that funds were necessary to the survival of WHIN, compromising the goals of WHIN to achieve this was problematic for some of the women. The Board started to dissolve shortly after this decision because there were no funds to bring the regional women together for Board Meetings (Focus Group December 15, 1999). Eventually, as was discussed in Chapter Two, WHIN dissolved without formally deciding as a Board to end its

organizing efforts (Interview 2 WHIN Board Member; Focus Group December 15, 1999).

3.4 UNDERLYING POWER: TENSIONS

> There are politics everywhere... and when people come together to do work there will always be conflict... (Interview 5 WHIN Board Member).

Ristock (1991) contends that when women come together to work collectively to provide a service, they can have a difficult time acknowledging the power relations at work within their organization and will "let power issues fester rather than articulating them and work on solutions" (1991: 46). In part, she attributes this avoidance to women's commitment to empowering women through their work and women's assumption that power is bad or always negative. This view of power as negative denies the fact that power exists at both the micro and macro levels and that women are not always powerless. Rather, dependent on the various multiple social locations that a woman occupies she may hold power in certain situations while in other situations, she may in fact have less power.

Within WHEP there existed internal conflicts among the four coordinators and the WHAG Board (Interview 1 WHEP Coordinator, WHIN Board Member; Interview 3 WHEP Coordinator). For the coordinators, differences arose over issues of organizational process as WHEP had chosen to work from a model of consensus (Interview 3 WHEP Coordinator). Further, the four coordinators held differing feminist philosophies which caused some internal struggle and conflict (Interview

1, 2, 3, 8, 11, WHEP Coordinators, WHIN Board Members). It was felt by all of the coordinators that they did not have the support that they needed from WHAG (Interviews 1, 3, 8, 11 WHEP Coordinators). All of the coordinators had been hired because of their commitment to women's health and their belief in feminist principles. Once involved in the project however, the problem of defining and agreeing upon a feminism they all could be comfortable with became an issue (Interview 3 WHEP Coordinator; Interview 11 WHEP Coordinator). Power issues both among the coordinators and between the two women's groups remained unaddressed throughout their duration.

Although the Women's Health Action Group (WHAG) had been instrumental in writing the original proposal and securing this funding, soon after the project began, WHAG continued to function as a 'paper Board' for WHEP (Interview 1 WHEP Coordinator, WHIN Board Member; Interview 8 WHEP Coordinator; Interview 11 WHEP Coordinator). The reasons for this are unclear, however, it appears that WHAG functioned as a feminist collective and actively chose not to participate in the structured, heavily funded WHEP organization (Interview 6 WHAG Member). WHAG members did not want to be held to the high level of accountability required by the Health Promotion Directorate, Health and Welfare Canada (Interview 6 WHAG Member). Many of the WHAG members did volunteer work for WHEP either in the form of providing them with files of collected information on different women's health issues or they would organize

and facilitate different health workshops, produced by WHEP, for women in Thunder Bay (Interview 6 WHAG Member). As well, there was individual support around shared feminist philosophies for the WHEP coordinators from some of the WHAG members (Interview 3 WHEP Coordinator).

In addition, there was always a degree of tension among the regional women over the choice of Thunder Bay as the head office of WHEP (Interview 1 WHEP Coordinator, WHIN Board Member). As was described earlier, northwestern Ontario is a large region made up of several small communities with Thunder Bay as the largest city in the area. Because of the urban nature of the city it is often viewed by many in the region as the 'Toronto of the North' (Interview 5 WHIN Board Member). In fact, WHEP's office was located in Thunder Bay because of the original funding proposal (Interview 11 WHAG Member, WHEP Coordinator). WHAG was a Thunder Bay collective, and although the proposal set out to work with women in the region, the group believed that Thunder Bay was a logical place for the project to work from.

The WHIN women did not speak of a collective analysis of the micro power relations which were part of their organization. They did articulate a fully developed analysis of the power of dominant discourses on health and how these played themselves out in the larger context. This was evidenced through their philosophy, definition of health [See Appendix J], and their goals. However, in terms of the day-to-day relations between Board members and project workers

when tensions arose and consensus was lodged, there was never an analysis of power. Sometimes the tensions arose because of the perceived differences between the regional women and the women living in Thunder Bay. At other times, tensions arose over decisions concerning individual projects, the way decisions were being made, and over who was determining the vision for the projects. In some cases, efforts were made to come together as a Board and discuss problems however, most often attempts to smooth over the difficulties were superficial in that the women were unable to break down the underlying power relations. For some women, the tensions within WHIN were never resolved while participating in the organization (Interview 9 WHIN Project Worker).

Attempting to use the process of consensus and the practice of job-sharing both which de-emphasize the notion of 'expert', the women's groups in northwestern Ontario were exploring an alternative form of organizing based in a feminist orientation. As came through in the interviews, this collective structure was empowering for most women, at least some of the time. However, because there was never any checkpoint or analysis by the women of the internal power relations which existed within this alternative frame, WHEP and WHIN were not fully able to understand and transfer their macro analysis of power (health care system against women) to the micro level of individual power relations. This lack of internal reflection of power on the part of the women's group may have resulted because the women's collective identity was not explicitly feminist. Rather, WHIN

was focussed on delivering health information and resources to women living in the Northwest region.

3.5 SUMMARY

Women's health organizing in the northwestern Ontario region began with a generous opportunity for core, seed funding from the Health Promotion Directorate in the early 1980s. This evolved into a continuous struggle for monies on a project-to-project basis. Finally, after pursuing the possibility of fundraising as a means of generating enough funds to sustain itself, the women's efforts were defeated with much dismay. Similarly, and as with many women's organizations, funding issues were critical and discussion of them overlapped in complex ways throughout the interviews.

The women involved with WHEP and WHIN understood that they were working in a women's organization that was structured differently from a traditional 'male' organization although there was much disagreement as to what their structure was. This was problematic over the three years and some of the women left the organization only to return again at a later time. Further, although all of the women's health groups shared the philosophy of using consensus for decision-making the process became unique to each group.

In light of Beagan's (1996) conceptual frame of praxis and identity, it is useful to think about the tensions experienced by WHIN members with reference to the feminist postmodern stand for this analysis. Throughout this chapter I have been

highlighting the tensions involved with the politics of the organizing experiences by the Women and Health Sub-committee, WHAG, WHEP and WHIN. It is apparent that contradictions abounded both with the individual and the collective women's identities. Further, the tensions around identity, both individual and collective affected how the women could organize themselves and the larger project. As was demonstrated throughout this chapter, the women's identities were fluid and multiple affecting what issues were defined as northwestern Ontario women's health issues, the logistics of their structure and the contradictions felt in using the process of consensus for their decision-making. Moreover, there was little analysis of the power built into the organizational form and the power relations which individual women possessed or lacked because of the various social locations they occupied.

Within the socio-historical context of women's health organizing efforts in northwestern Ontario, Chapter Four will lay out how the women who participated in these specific efforts constructed regional and feminist discourses around identity. I will describe the women who participated in these health organizing activities and why it was possible for them to be involved. I will outline Fraser's (1992) pragmatic model of discourse theory as a means for understanding the complexities inherent to understanding identities, both individual and collective. Regional identity intersected and was juxtaposed with feminist identity for this particular initiative in women's health organizing. I will provide an analytical look

at the tensions and contradictions experienced by the women in attempting to define a collective identity for their organization. I will draw on excerpts from the interviews to illustrate how the women's identities were shifting and overlapped depending on the specific context through which their identity was being negotiated.

CHAPTER 4 - WOMEN'S IDENTITY IN NORTHWESTERN ONTARIO: FEMINISM AND REGIONALITY

4.1 INTRODUCTION

> Social identities are discursively constructed in historically specific social contexts, they are complex and plural; and they shift over time (Fraser 1992: 178).

Identity, both collective and individual is the focus of this chapter. Specifically, I examine how the women involved with women's health organizing in northwestern Ontario constructed regional and feminist identities. I will illustrate how these individual identity discourses were partially shaped by the participants experiences with the regional women's health organizing efforts, and the women's perceptions of the larger women's movement, which included their understanding of feminism.

Varying notions of regional and feminist identity surfaced in complex and overlapping ways throughout the interviews. This analysis will demonstrate how both the region and the women's multiple, sometimes conflicting understandings of feminism co-existed in formulating their collective and individual identities. Excerpts from the interviews illustrate how notions of regionalism and feminism both influenced and facilitated the construction of collective and individual identities and demonstrates the multi-layered nature of identity construction.

Social identity is constituted through a plurality of discourses which are intertwined and overlapping. Identity becomes partially constructed as an

individual presents herself in the discourse in which she is participating at a specific time (Fraser 1992). Understanding and knowing how an individual constructs her identity is thus, always partial and dependent on the present context. Furthermore, as explained by Riley (1997) the category, " 'women' is historically, discursively constructed, and always relatively to other categories which themselves change..." (241). The contradictions which Riley speaks of surrounding women's individual and the collective identity were always present to some degree in my research interviews.

Within the larger women's movement, identity politics are central. From the mid-eighties onward, the category 'women' has been problematized. The equality-difference debate exists as a substantially contentious issue in both theory and practice (Riley 1997; Stanley 1997; Marx Ferree and Yancey Martin 1995; Delmar 1994). Women's groups now, and in the past have grappled with collective definitions of feminism which all women in the group could unify around (Beagan 1996; Pierson 1993). In my examination of feminist identity, I demonstrate how the women's groups in northwestern Ontario were not unique in their struggles for collective feminist identities.

Nancy Fraser's (1992) pragmatic model of discourse theory for individual and collective identity is useful in this case study as it provides a framework for understanding how identity is linked to feminist politics (185). This model illuminates the process of how individuals come together to build collective

identities (Kaufert 1998). The threads of how and why tensions were experienced by the women in building a collective identity are significant and central to this analysis.

I begin by outlining some of the specific demographic details of the women who participated as health activists in northwestern Ontario. This follows with a conceptual map of Fraser's (1992) pragmatic model of discourse theory. I explain how it is heuristic for this case study of women coming together to form women's health groups and in the process, build collective identities. I link this work with Beagan's (1996) argument which argues that by utilizing a postmodern approach we are able to situate and understand women's identity and praxis.

Regionalism, and a meaningful sense of 'Northernness' as prominent discourses in the interviews shaped how the women understood their individual and collective identities (as well, it influenced the women's praxis, as was discussed in Chapter Three). Moreover, these discourses framed how the women were able to forge through, and resist the regional gendered discourses. Finally, I examine how feminist ideologies and orientation influenced both the women's individual and collective identities. Although contested, these identities shifted to varying degrees over the years reflecting diverse understandings of feminist orientations.

4.2 NORTHWESTERN ONTARIO HEALTH ACTIVISTS: The Participants

Hundreds of women were involved with the women's health organizing from all of the many communities that made up northwestern Ontario in the 1980s

and early 1990s. Women's involvement varied depending on their stage of life (age; place of residence; and personal experiences with specific health issues) and the opportunities available. At times, there were paid positions as project workers on the workshop kits or as coordinators; and at other times, the women's work providing health information and resources was strictly volunteer. Many of the participants interviewed worked for the duration of the women's efforts from the Women's Health Action Group (WHAG) through to the end of the Women's Health Information Network (WHIN).

As noted in Chapter One, twelve women were interviewed and of those twelve, five participated in a focus group upon completion of the individual interviews. The women had lived in six different communities (both rural and urban) in the region at the time of their involvement. The information gathered from the interviews was to some degree representative of the women's experiences within the regional context as the women who participated in the interviews were from five of the smaller regional communities and from both rural and urban Thunder Bay. At the time of the women's involvement, the women ranged in age from twenty-three to thirty-nine. All but one of the women interviewed, were mothers of young or school age children at the time of their involvement. The women's roles as mothers was central to their discussions of identity, both individual and collective, and their praxis as a women's group as I discussed in Chapter Three.

The interview respondents were largely a group of educated women. Of the twelve interviewed, one had a Master's degree in journalism, five held university degrees in various disciplines (nursing, science, humanities, and two in the social sciences), three had some university training, one had a heavy mechanics certificate and an athletic therapy certificate, one held a diploma in nursing specializing in occupational health and safety, and one woman had her grade twelve diploma. Interestingly, all but three have furthered their education since the time of their involvement with women's health, many in health-related fields.

From the work of the Women and Health Sub-committee, WHAG, WHEP and WHIN there evolved numerous other smaller support and self-help groups which functioned independently from the Northwestern Ontario Women's Health Information Network. Some of these smaller self-help and advocacy groups included: the Childbirth and Education Support Group, the Committee to Re-Instate Birthing Systems (CRIBS) in Nipigon, and the La Leche League (breastfeeding support group).

Finally, all of the women had been extensively involved in their communities in various other volunteer and community organizing capacities at the time of their involvement with women's health[34]. A strong commitment to community was one

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Some of the women's activities included: local school boards, library and hospital trustee's, consumer panels, the Ontario Midwifery Task Force, the Lakehead Social Planning Council, the Canadian Abortion Rights League, the Ontario Coalition of Daycare Centres, the District Health Council, Women of the Moose

characteristic they all shared. The act of being socially conscious and committed to community through active volunteer work is a central feature of the women's collective regional identity. This in part, evolved from the work of the women's health groups and women finding their 'voices' through the consciousness-raising experiences and understanding that the socio-material realities of their lives was something facing all regional women, not just themselves as individuals. The women's health groups empowered women to be vocal in their communities. In addition there was, and remains a gendered discourse of who is responsible for looking after and creating community.

4.3 NOTIONS OF IDENTITY

I. Collective/Individual Identity Building: A Pragmatic Model of Discourse Theory

Similar to Beagan's (1996) model as discussed in Chapter Three, Fraser's (1992) pragmatic model of discourse theory is useful for understanding how women form social identities, come together to build collective identities and form social movements. Fraser explains that, "discourses are historically specific, socially situated, signifying practices" (1992: 185). Further, she suggests that discourses unify language with social practices. Utilizing discourse theory and the pragmatic model is valuable because it provides a framework for examining how women come together to build collective identities and provide services to other women.

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and the Professional Women's Business Club in Kenora.

This model begins by explaining how discourses evolve in specific times, locations and social contexts. Discourse theory recognizes the fluidity and flexibility of the discourses, none of which are static (185). In Fraser's words, "the model lends itself to historical contextualization, and it allows us to thematize change" (1992: 185). This is important for contextualizing this case study of women's organizing over twelve years in northwestern Ontario, as the women's collective identities were shifting in relation to the growing complexity of the regional and feminist discourses found within the groups as they evolved.

The second point which Fraser makes is one which positions individuals as "socially situated agents" (1992: 185). In this case study, the women, both as individuals and as groups were not only reacting to the social, political and economic situations of the times but were also constituting these discourses. Fraser notes that discourses are relational to one another formulating and reformulating each other in the specific social situations as they occurred.

Third, the pragmatic model situates discourses as plural (1992: 185). Thus, I can establish that the individual women and the groups of women in northwestern Ontario were operating in a myriad of discourses. Both individual and collective identities are not monolithic but shifting in relation to the specific discourses through which they operate (1992: 186). So for example, when the women were negotiating their collective identity in relation to the larger women's movement, it was important for them to speak with a collective regional identity; however, when

the regional women were locating themselves as community women in relation to the Thunder Bay women, it was important that the women identify with a discourse which centrally located their individual communities.

Fourth, Fraser points out that the pragmatic model "rejects the assumption that the totality of social meanings in circulation constitutes a single, coherent, self-reproducing 'symbolic system' " (1992: 186). In other words, discourse theory and analysis allow for the tensions and conflicts which are implicitly and explicitly part of negotiating social identities. This is important because it demonstrates that understanding identity, either individual or collective, is not neat and tidy. Identities shift depending on the context through which they are experienced. As will be discussed later this was evident in this case study when the women were attempting to explain their own understanding of gendered realities.

Finally, because the pragmatic model connects social relations and society with the study of discourses, we are able analyse the power relations which are played out in these shifting experiences (1992: 186). As noted in the introduction of this chapter, power is relational (Sawicki 1991) and shifts as individuals deploy various identity discourses available to them in given situations and contexts.

Because the pragmatic model presented by Fraser is complex it offers us a tool for understanding the subtleties involved in the formation of identities. Fraser's pragmatic model corroborates with Beagan's assertion for a feminist postmodern approach to understanding women's collective identity and praxis.

4.4 REGIONAL IDENTITY

> Identification with a geographic region can be a positive force, giving meaning, identity, community... However, region also determines difference, and difference is most often understood as disadvantage. (Heald 1991)

The region is central to the constructions of the participants' identities both individual and collective. Notions of identity and the discourses available to women and men are inextricably bound up with the prevailing ideologies of the region (Wakewich 2000). In the case of northwestern Ontario, a hinterland in relation to the southern part of the province, identities are often formed with the understanding that power and decision making are mostly in the hands of southern counterparts who have little if any understanding of the region and its specific character or needs (Southcott 1993). In relation to the political power held by those in southern Ontario, individuals governing and living in northwestern Ontario often project discourses of resistance in their Northern identities.

Generally, this collective understanding of a hinterland identity evolves through a collective yet fragmented and individual process of self-definition. Often, this process occurs as individuals define themselves and their communities in relation to others in the southern part of the province though explanations of difference (We are... what they are not) and similarities. The explanations however, are not static but continually shifting dependent on the specific time and context. Further, the culturally significant differences and similarities which are ascribed to

Southerners and Northerners by those living in northwestern Ontario take place at an everyday discursive level[35] (Dunk 1991). In this process, the cultural characteristics which are ascribed to Northerners and Southerners are negotiated into several collective regional discourses.

Although each individual community in northwestern Ontario varies, the differences and uniqueness of the individual communities and towns in the region become insignificant when discussing and maintaining a regional identity within the larger province. Consistent with the North-South distinction made by those living in northwestern Ontario, there is an assumed discursively constructed power imbalance between Thunder Bay and the smaller towns and communities in the region.

Because of the relative size (largest city in northwestern Ontario) and cultural diversity found in Thunder Bay in comparison to the smaller communities, regional identity becomes further negotiated and understood by its inhabitants. The common perception held by many living in northwestern Ontario, including many of the women interviewed who lived in the smaller communities in the region, is that Thunder Bay is the "Toronto of the North". This notion of the metropolis-hinterland difference was repeated several times throughout the interviews. One

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Examples of Southerner being weak while Northerners are hearty and strong are prevalent. Northerners assume themselves to be strong because they live in a region which experiences harsh fluctuations in the climate whereas Southerners are identified as weak because they live in a relatively mild climate.

participant explained,

> They sometimes call Thunder Bay the "Toronto of the North"...that we have that big city mentality like we know where its at...and people in the boonies and... people in Thunder Bay are very condescending to that...first...they don't understand that experience...that way of life...and they think people must be nuts to live in the boonies... (Interview 10 WHIN Project Worker).

This participant had lived in the region while she was involved with WHIN but at the time of the interview, was residing in Thunder Bay. She explained that she felt she had an advantage to understanding the various perceptions (including power relations)of individuals living both in Thunder Bay and out in the region because she had experienced both locales. Similarly, these sometimes shared and sometimes distinctive regional discourses of identity were also replicated in the experiences of the women's health movement.

It is important to distinguish between the shared regional identity felt by the women involved in women's health organizing as understood in relation to that of the rest of the province; and the specific community identities in relation to Thunder Bay as understood by the women. Depending on the context in which the women were negotiating their identity, distinguishing between the regional identity and community identity discourses became central for them. Sometimes, it was necessary to be seen representing the various communities they lived in and at other times, it was important to be seen as a regional women's network with a regional identity. One example where it was important to present a collective regional

identity was when a group of Northern women were working as part of the national steering committee overseeing the implementation of the Canadian Women's Health Network (Interview 7 WHEP Community Representative, WHIN Board Member). In this specific national context, it was critical that northwestern Ontario women's concerns be voiced.

Because of the transient nature of the populations living in the region there is a strong need to develop a community identity within the smaller towns. As was explained by one participant, many of the women living in the smaller communities were not originally from those areas. She referred to these women as 'transplants' and stressed how vital and important their community commitment was to life in the small community. She says,

> We were kind of drawn together by that (transplanted identity)...and to me there was a real psychological factor because Red Lake is at the end of the world...highway 105 stops in Red Lake and there isn't anything beyond that.. bush roads...First Nations Communities...so once you are there...you are at home in your town but you feel incredibly isolated...it's a two hour drive just to get back to the trans-Canada...you have to get ideas flowing and get things going... (Interview 10 WHIN Project Worker).

She emphasized how community organizing and establishing a collective identity was essential to building a life in a small, isolated community. Hence, her involvement with women's organizing around health and other community issues was an important link for her to her community. Through participation in her own community, she is able to foster wider participation in the region.

Another WHIN member explained how it was for the exact opposite reason she became involved with the regional women's health network.

> I was a newcomer to this community...and I wasn't really out there..it was a really difficult transition to make...coming from #*#*# to this small, very insulated community.. You know, I was an outsider...I'm still an outsider...I think in a lot of people's eyes because I'm not from here..you know, I've lived here for ten years and its still, "what's she doing that for? She's not from here.." And you know... can't I embrace this community as mine? (Interview 5 WHIN Board Member).

In her situation, a collective identity based in her community is difficult to find. She explains that even though she has lived in the community for a number of years, she continues to be seen as an outsider. As a result, she builds and maintains a community identity by participating in the regional organizing efforts of the Women's Health Information Network (WHIN). She was able to nurture a regional identity more strongly than a community identity although she was the community representative for WHIN. The impact of her regional WHIN identity was felt in her community because of the work she did around women's health. In this case and in contrast to the woman mentioned above, it was through her regional identity that she was able to build a community identity.

Building a community identity for this woman follows her commitment to the region. With the skills and knowledge gained through her involvement with WHIN she is able to initiate a separate identity from WHIN within her community. For example, she started a community group that began to lobby for changes in the

area of childbirth[36] as well, as establishing a community drop-in centre for teens[37].

From the beginning, the women who organized around health in northwestern Ontario saw the importance of having a presence in the region. They did this by working with the target communities as laid out in the original WHEP proposal. They went even further than was expected by hiring regional community representatives. As time progressed, the importance of sharing the decision making process across the region became even more clear. This was achieved through a strong regional Board of women, all working towards the same goal of providing information and resources to women across northwestern Ontario. In maintaining both the WHEP and the WHIN projects, a collective regional identity was reinforced through their commitment to women's health.

> There was a Board and it had representation from all over northwestern Ontario...like a woman from Nipigon, a woman from Schreiber, a woman from Manitouwadge, a women from Red Lake, Pickle Lake...all those places.. Atikokan, Kenora... (Interview 3 WHEP Coordinator, WHIN Project Worker).

The importance that the women placed on the regional representation on WHIN's Board was strong. This sense of regionalism and commitment to

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This participant initiated CRIBS - the Committee to Re-Instate a Birthing System in Nipigon, Ontario because of her involvement with WHIN.

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She also applied for and was granted three year pilot project funding from the Health Promotion Branch, Health and Welfare Canada for a teen drop in centre in Nipigon. The funding was not renewed after the three year period and the teen centre was closed.

community possessed by the women bound them together and gave them a sense of a collective identity. One participant explained,

> WHIN was really regional and to be honest, I think it was the only regional Board that I was on.. they made a commitment to being in the region...you know... it wasn't always in Thunder Bay... our meetings could be anywhere.. And they were... (Interview 12 WHEP Community Representative and WHIN Board Member).

The dedication by the women to existing as a regional Board meant that the women had to travel throughout the region to attend meetings, mini-conferences and workshops. For the most part, this was described as positive because it gave the women an opportunity to see the various communities and meet with new women who were interested in some aspect of women's health. There were also negative aspects to the travel. Dangerous roads, the lengthy distances between communities, added car mileage and time away from families were all factors that the women had to consider when travelling for WHIN. Childcare issues also arose and for some of the women, travelling to meetings meant bringing small babies with them (the women were breastfeeding) or leaving their older children at home with partners or other caregivers. When discussing these constraints, it was possible to see how overlapping individual identities and roles such as mother and WHIN member intertwined themselves and in some cases, caused conflicting notions about individual identity for some of the women.

The commitment to regional representation evolved from the experiences of

the women involved with WHEP and a shared understanding that the communities across northwestern Ontario were distinct. There was also the understanding that individual communities would have specific community health issues which required solutions that would need to come from within the community. One WHIN Board member explained,

> Every community is unique with their own needs and that's why it was so important to have inside representation instead of having the outside coming in and saying this is the way it is..... (Interview 7 WHIN Board Member and WHIN Project Worker).

The women were aware of the differences among the communities and from experience, knew that ultimately, if change was to occur, it had to come from within. This commitment to the region developed as the women's groups evolved from WHEP to WHIN. With WHIN however, it was of utmost importance and solidified the women's collective identity.

WHIN members had a concrete understanding and analysis of women' s health issues in relation to living in the region. As noted in Chapter Two, the isolation and the distance between communities and towns was significant and it affected the health information and services available. This isolation from information and services inspired WHIN's regional commitment to ensuring that any woman living in the hinterland could have access to both initiating change through WHIN membership, or by participating in workshops and conferences. This strong commitment to the region fostered the strong sense of a collective

identity felt by WHIN members.

I. Gendered Regional Identity

As noted in Chapter Two, northwestern Ontario has in the past relied on resource extraction as its primary source of economic well-being. Although the majority of jobs are now found in the service sector of the economy there remains a strong masculinist identity for men living in northwestern Ontario because many of the better paying jobs are found in the mills, mines and elevators (Dunk: 45). In turn, women's identities in northwestern Ontario have largely been defined in relation to their roles as supporters, caregivers and nurturers to men working in industry (Wall 1993). This in part, has been a reflection of the lack of satisfactory employment opportunities for women. As well, it indicates a gendered discourse which reinforces and regulates male and female roles.

In many instances, industry directed when, where and how communities were established (Wall 1993). Simultaneously, the ideology of the nuclear family was reinforced. This was advantageous to industry because it was assumed that company men would be more content in their jobs with their families living close by and there would be less need to travel into the larger towns and cities (Wall 1993). However, there was little consideration of how women living in the single-industry towns would experience their life. As was explained to me by one of the women who was working as a social worker in a small community,

> ... I was a single mom and everybody else was married... and this is what you did... you got married,

> you lived in a bungalow and you had four kids... and if you didn't you were weird... It was like going back to the 1950's and I remember one day, the mining company was celebrating the mining family and on the front page of the paper... guess what... the family - mom, dad and the four kids with the little bungalow in the back (Interview 3 Original WHEP Coordinator).

Women assumed the traditional roles of housewife and mother and the male identity of worker or 'breadwinner' was reinforced. This strong sense of a sexual division of labour was the norm, and often continues to be in many of the smaller communities (Wall 1993). Being different was difficult because then you were viewed as abnormal or 'weird' as was explained by this participant.

Such strongly ingrained "traditional" values have developed over the course of several generations (Wall 1993). As Fraser (1992) suggests, it is possible in these analytical instances to witness the multiple social discourses which developed in regard to, and reflect the specific values authorizing such a gendered division of labour and social life. These gendered regional values are often difficult to comprehend for those who make the transition to small community from a larger urban centre. One participant explained how she felt upon moving from a large urban centre into a smaller community,

> I look back now and I don't know how I did it... because I am a feminist... I moved into a small town with a bunch of *rednecks* you know... really... I mean really old fashioned values... I said that when I stepped off the plane I felt like I had stepped back in time forty years... and I was doing nothing... I mean there was nothing here that I could do... It wasn't like I could say well, I'll just apply for all these jobs... what jobs? I could be a

> clerk at Canadian Tire or a check out cashier as Zeckner's... and that wasn't really for me, so... I basically became this housewife... waiting for my husband to come home... (Interview 5 WHIN Board Member)

This excerpt shows how gendered discourses are dependent on the specific socio-cultural context. Further, this woman is clearly able to articulate how her identity shifts and is fluid in the two situational locations she finds herself.

A lack of employment opportunities for women in these communities is typical (Heald 1991), and in many cases, women have no choice but to become dependent on men for their economic well-being (Wall 1993). Continually reinforced, these gendered economic roles for men and women contribute to the construction of individual identities and collective regional identities. To live outside these boundaries can be reflected upon in a negative sense. For the woman who was a single mother, this difference impacted on her individual identity and how she was perceived by others in her community.

Although women were confined to the roles of wives and mothers in the regional single industry towns, women in northwestern Ontario actively resisted these narrow prescriptions by participating in endeavours which made their communities a better place to live. By instigating changes in the social landscape they were able to assume and assert some control over their individual and collective situations. The WHEP project and the workshop kits were developed in an effort to empower regional women to instigate change both at the individual

level and the community/regional level. To do so, the kits were structured to present a broader context for situating women's lives in an effort to show women that there were choices available to them. One WHEP coordinator explained,

> We wanted to look at the big picture, and the whole context in which women were situated in northwestern Ontario... and then work from there as a community that women needed to get together and start to identify what they needed in their own communities, to help them be healthy, to help their families to be healthy... you know, so the kits were there to give them a broader context... to give them a sense that this is what I can do... this is what my community can do, this is what my neighbours and friends can do...
> (Interview 3 WHEP Coordinator, WHIN Project Worker).

The WHEP coordinators began the process of educating and empowering regional women through information. They also were able to experience northwestern Ontario as a region. As follows,

> Validating women's experiences and women's lives.. And getting to know northwestern Ontario...getting to see how women in northwestern Ontario lived, getting to know the geography... especially with WHEP, we got to travel all over and with WHIN... we also did... and learning how women really live and what they do and validating all that time that went into their experiences... (Interview 1 WHEP Coordinator, WHIN Board Member).

This approach to building community and empowering women affected how the women perceived and constructed their own identities. As stated by Fraser (1992), "group formation involves shifts in peoples social identities and therefore also in their relation to discourse" (179). Another coordinator commented,

> Women really didn't have choices and we were like this breath of fresh air... you know... you can do something here... I still remember those *Cabin Fever* workshops... women just flocked to those you know... there were dozens of women around here who were very bright and they didn't have jobs... and they were at home with their kids going nuts... and so we rang the bell in women's minds...
> (Interview 1 WHEP Coordinator, WHIN Board Member).

As regional women became involved with the activities of the women's health groups, and as WHEP evolved into WHIN, individual identities were transformed from those of passive actors content with their situation to women creating active forms of resistance through the new knowledge and information acquired. Resistance by the women shifted the prevailing gendered regional identities so that women could construct new identity discourses, both individual and collective. As described by one WHIN Board Member,

> I think of myself in that time and it was exciting... when I think about the group of women that came together and the commonalities between us and what we were able to do as a group... the power of working together and we were able to make change... and work together and lobby... and empower each other and make our communities better places to live... including ourselves... we are much better people because of it... It was a pretty powerful experience... fighting things like a lack of good jobs, and good housing and isolation... all those lacks... working together we can initiate a lot of change...
> (Interview 7 WHEP Community Representative, WHIN Board Member).

Individual women's identities shifted in relation to their roles as housewives and

mothers and resistance to the conventional gender roles evolved as the women became more involved with the health organizing. These individual discursive changes in turn, impacted on the collective identity of the groups.

The regional element in this case study is an important link in understanding how both the women's individual and collective identities were shaped and re-shaped over the course of the twelve years. The women expressed their perceptions of regionalism as being essential to how they could define themselves and how they were able to organize as discussed in Chapter Three. Furthermore, the multiple regional discourses influencing how the women defined themselves demonstrate how power shifted and was relational to the specific contexts in which identities were negotiated (Fraser 1992).

4.5 FEMINIST IDENTITY

> The content of the terms like 'feminism' and 'feminist' seems self-evident, something that can be taken for granted. By now, it seems to me, the assumption that the meaning of feminism is 'obvious' needs to be challenged. It has become an obstacle to understanding feminism, in its diversity and in its differences, and in its specificity as well (Delmar 1994).

From the beginning, WHAG members, WHEP coordinators and community representatives and WHIN members aimed to empower all women through the provision of health information and resources in northwestern Ontario. While these women were actively resisting traditional medical discourses and forming alternative discourses around health and health care, the women were also

developing collective discourses around their evolving groups' identities. In many ways it seems fairly obvious that all three of the women's groups - WHAG, WHEP, and WHIN were feminist. WHAG members explicitly labelled themselves as a feminist collective and all were directly tied to an alternative women's community/movement in Thunder Bay through various capacities. WHEP began in 1982 with fairly explicit feminist ideals and coordinators were hired on the basis of their feminist orientation and perspective (Ramsey 1984).

To the extent that WHIN saw women's health as both a social and political issue and then strove to advocate for change in the specific area of women's health they too, can be viewed as feminist. However, as WHIN progressed there was a great deal of tension and conflict among the women as to whether their collective identity was feminist. As was explained in one of the interviews with two of the WHIN Board members, "WHEP had been feminist but with WHIN, feminism had become a bad word" (Interview 1 WHEP Coordinators, WHIN Board Members). These two WHIN members thought that it was because women from the smaller communities did not want to be associated with anything feminist which could then be interpreted as pro-choice (Interview 1 WHEP Coordinators, WHIN Board Members). The pro-life/pro-choice debate[38] was a contested issue for many in the

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The pro-life/pro-choice debate is one which comes up continuously when northwestern Ontario women meet to discuss women's health in the region. Recently, I participated in an Ontario Women's Health Network (OWhN) Regional Meeting and the issue arose again with similar sentiments being echoed

region of northwestern Ontario. This most likely resulted from the strong family values held by those living in the region and the validation of motherhood as the primary contribution of northwestern Ontario women.

Questions attempting to deal with the difficulty of defining feminism both in terms of an individual identity and a collective identity involved with the day to day task of running the women's organization were multi-layered and complex. This complexity arose from the women's multiple feminist orientations and the discourses which were in circulation in northwestern Ontario on radical, liberal and humanist standpoints.

In the interviews, I challenged the participants to define feminism. Several of the women had a fairly definitive explanation of feminism and spoke without hesitation. The responses varied around common themes: a feminist is someone (could be male) who tries to improve women's lives; a feminist is someone who is concerned with process; and a feminist is aware that the personal is political. These multiple feminist discourses in which the women were operating illustrate how individual identities were being constructed through a plurality of discourses as outlined in Fraser's (1992) model. Specific quotes demonstrating these themes are as follows,

1. A feminist I think is a woman, although there may be

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as to those heard in the interviews. Women once again, were suggesting that women living in the region do not want to participate in women's organizing efforts if a pro-choice stand is being taken (February, 2001).

> men with feminist inclinations, but I think that a feminist is a woman who works towards the betterment of women in society (Interview 3 Original WHEP Coordinator).
>
> 2. You find out what kind of feminist you are when you are working with other feminists (Interview 6 Original WHAG member).
>
> 3. I think that feminism is a very personal decision. I am a feminist because as a woman there are issues that affect me because I am a woman... because of my sex... and that's why I was interested in WHIN... I feel that as a woman there are a lot of things that could be done to improve women's lives (Interview 7 WHEP Community Representative and WHIN Board Member).

It is fair to assume that each of the women had different underlying reasons for choosing to define feminism in her own specific way. The more radical orientations were expressed by those who were interested in process, as highlighted in the second quote. Liberal feminist concerns in the first excerpt were centred around equality. Not all coming at their feminism(s) from the same place however, each had in her past experiences which led them to her own personal definition. For the third woman quoted above, there was an blending of both the radical and liberal orientations. Only one woman chose not to define feminism. Common threads while not expressed identically, surfaced throughout the interviews.

In terms of the women's collective identities, there was a degree of shared understanding that a feminist worked towards bettering women's position in society and further, that women experienced oppression (that word was not used) because of their sex. Further, there was agreement that not only women could be

feminists. Finally, it was also explained that women's issues needing attention would surface from personal experiences. For all of the women, the act of sharing personal stories and experiences (consciousness-raising through the workshop kits) led to some kind of action, at least, that was the purpose of the kits.

All of the women interviewed discussed the negative connotations associated with the word feminist. One participant explained outright that she did not want to discuss it at all during the interview. As was explained earlier by two of the original WHEP coordinators, for women living in the smaller communities talking about feminism was something that many women were just not open too. This aversion to discussion of feminism may have resulted from the strong, stereotypical notions of what a feminist personified (radicalism). In one woman's explanation of why WHIN had formed, she touched on the development of feminism in the sixties and talked about how *those* women, who believed in gender inequities, were perceived.

> It was the really early days, and you were accused of being a bra burner or a woman's libber... you know... all those things that if you tried to voice anything... I mean, I certainly did not want to be on the receiving end of that... Being painted with that brush...
>
> **Yes...**
>
> But when this organization happened and we as women came to realize that when you organize as a group, when you put those things in writing... when you don't give up... when you focus your energy even though you might have personal differences with the woman sitting beside you... it was a very empowering time (Interview

8 WHIN Board Member and Project Worker).

This woman was conscious of the stereotypical view of feminism however, she also recognized that when women came together to do work, as through her own personal experience with WHIN, there was an overwhelming feeling of being empowered both as individuals and as a group of women. Through her own experiences of being actively involved she witnessed changes in herself and chose to wholeheartedly embrace a feminist identity. Later on in the interview she explained this personal evolution and as follows,

> I was a flaming feminist... and now I think I am a humanist...
>
> **What do you mean by humanist?**
>
> What I mean by that is just recognizing people... doesn't matter male, female, religion, race, colour, whatever... that there's the ability in each of us to work together towards common goals... to be good to one another... but there are also weaknesses in all of us and so I mean I don't see it as one particular group being any better in any way than another particular group... I guess... I mean that if you would have asked me this ten years ago I would have said that women are smarter... they're kinder... and now I see us all in a pot and we've all got some of those traits in each of us... and in general you can find as wonderful a male feminist as a female feminist... so I guess that's what I mean by humanist.

In the course of her involvement, she recognized that the concept of feminism and the act of being a feminist is about more than gender. Although she came to her feminist identity through her work on women's health issues she was aware that other social locations influence one's position in the cultural matrix of life. Similar

to many women who lived through the second wave of feminism in the late sixties and seventies, she initially followed a radical feminist orientation which contended gender oppression was solely to blame for women's inferior status. It was only after being involved with women's organizing for a number of years that she began to understand the complexity surrounding feminism and identity. She explains,

> I think that feminism started out as a way of women asserting themselves but also included in that was a lot of anger towards men... and now I think that feminism is a way of respecting human beings for their place in this world or for whatever their situation is... and so, I still call myself a feminist... because I am so proud of the word and I'm so proud to be a feminist... and I want to use that word because I think it's very strong, inclusionary word... But at the same time because of its past it can be very misunderstood... but I also think that for every feminist there's probably a different definition (Interview 8 WHIN Board Member).

This participant was astutely aware of the politics of feminist identity and recognized that her own notion of feminism was constantly shifting.

The concept of humanism versus feminism which she mentions is a tension which still remains in identity politics (Soper 1997). One of the tensions for feminist theory with a humanist standpoint is that it collapses the category of women, and the differences of women from men into a single group. In my own experiences of organizing around women's issues in Thunder Bay I have often been confronted with the debate between humanism and feminism. Often, this tension appears upon identifying as a feminist. Typically, I am resisted by others with negative stereotypes of what a 'feminist' is (or is imagined to be) with an argument which

contends the label of 'humanist' is more inclusive rather than restrictive. It seems that the label of feminist continues to be a contested notion for women in northwestern Ontario.

An additional theme which emerged when discussing definitions of feminism was the assertion of an essential element to womanhood. This notion of an essential feminine has been challenged extensively in feminist theory and literature (Spelman 1988). In northwestern Ontario where conventional gender values abound, it is not surprising that women feel an essential connection to other women. One participant, a mother of four children explained with some tension her feelings around a feminist identity,

> I believe that I am a feminist, I believe that I do feminist work... have always done feminist work... I do it with my children, my sons, my daughters... I do it in the community... I carry that perspective with me... so feminism I think is a perspective... an approach to life for understanding women in a patriarchal culture... it's a position of hyper-vigilance where you are always looking at things with a different, critical eye...
>
> **Ok...**
>
> But I do believe that there is an essential... an essential quality to being a woman and I think that its something that can't be spoken... like when you meet another woman... it is something that is understood... and I feel connected to women in that way..... (Interview 11 Original WHEP Coordinator).

This participant was firmly grounded both personally and politically in her radical feminist identity and she approached the world with a "critical lens", while

maintaining her belief in an essential woman. This essentialism was a strong feature of women's organizing in northwestern Ontario as will be demonstrated later on in this chapter when discussions of difference will be addressed in the women's health organizing. As was characteristic of most women's organizing at that time (Pierson 1993), there was little discussion among the women involved with health organizing about issues of race, class and other areas of difference among the women living in northwestern Ontario.

Arguably, white, middle-class women of the early second wave movement assumed that women should unite over gender inequalities unaware that differences among women including class and race were also substantial factors in oppression (Pierson 1993). Criticism from black women, lesbian women, older women, francophone and first nations women in the early eighties challenged the white, middleclass women of the second wave on their privilege and biases in determining a feminist agenda (Pierson 1993). To assume that gender was the one category of analysis in determining women's oppression was a result of race and class privilege on the part of women organizing during this period of the second wave. The argument was that there was nothing essential to being a woman. Rather, all social locations overlapped and contributed to the various forms of oppression experienced by women (Pierson 1993).

The idea of an essential woman connects women (in particular, white women) for various reasons (Spelman 1988). Often, the notion of women's essential

being is bound up with women's reproductive capabilities: women's 'natural' or biological purpose (Spelman 1988). Powerful, romantic imagery is conjured up to characterize women's experiences with reproduction. In northwestern Ontario women's groups, reproductive issues were central with a strong focus on options surrounding childbirth. These discourses facilitated the women's collective identities.

Many of the women involved with women's health organizing recognized that women became empowered through information sharing or consciousness-raising, a uniquely feminist process (Griffin Cohen 1993). WHIN was in correspondence with several other women's groups across Canada including the Vancouver Women's Health Collective; the Women's Self-Help Network in Campbell River, B.C.; the Women's Health Clinic's in Saskatoon, Saskatchewan and Winnipeg, Manitoba; the Healthsharing Collective in Toronto, Ontario; the Women's Health Project in Kingston, Ontario; and the Women's Health Education Project in Newfoundland and Labrador to name a few. Exchanges with these groups varied in scope and nature. In some instances, resources around particular health issues were shared, in others organizational information regarding structure and process were exchanged, and in others women belonging to these various groups were formally invited to participate as key note speakers at the regional conferences held in northwestern Ontario.

There was a strong commitment on the part of the WHIN Board to network

not only within the region but on a broader, national scale. This was further evidenced by WHIN's involvement with the Canadian Women's Health Network initiative begun in 1987, formally funded in 1989 through Health and Welfare Canada (Tudiver 1994). WHIN Board members wanted to know what other Canadian women were doing in the area of women's health. Being connected to other women's groups outside of the region lessened the regional isolation felt by the women involved and gave the women a broader context for situating their collective identities.

The notion of feminist identity is ultimately complex and overlaps with issues around feminist organizing as discussed in Chapter Three. A number of the women interviewed remained hesitant upon being asked to contemplate how WHIN was as a feminist organization. Understanding why some of the women were opposed to the label and others were not is important, particularly when factoring in the specific regional identity of northwestern Ontario. When asked about a collective feminist identity one WHIN member commented,

> We tried to be... it wasn't operating from top-down..everybody was sort of equal in their opinion... they empowered women to fully participate and be equal...the women who were involved celebrated everything that they did.. and that was important and empowering for women and for a lot of women that was great because that just doesn't happen in their own communities and for some women that doesn't happen in their work because they are housewives and not working... so the philosophy was there
> (Interview 5 WHIN Board Member).

This woman recognizes certain themes, such as empowerment and celebration of women in WHIN's collective identity which she attributes to a feminist philosophy. She acknowledges the importance that WHIN placed on understanding the specificities of women's lives and experiences. Later on in the interview however, she comments on the tensions which arose from those experiences. She explains,

> But it wasn't always... we are all fallible... and there were times when people would get in the way...the utopia was that everyone was equal and everybody's working together, one is empowering the other, but in reality that's hard to do...all the time... so there was tension
> (Interview 5 WHIN Board Member).

The specific mandate of providing health information and resources to women in the region also caused a degree of tension for many of the members. The WHIN Board was not without its philosophical questioning, and as was explained in the interviews, two questions came up repeatedly: was the group anything more than an information service? Was WHIN a feminist organization?

Some of the women preferred to see themselves as lobbyists while others saw themselves more in terms of educators. Some of the women claimed early on in the interview that they were feminist. The view that the women were educators and information providers is an important concept because many of the women firmly believed that information was an empowerment tool for women. When asked about what WHIN was one participant explained,

> There was always an ongoing debate about what we were... we were an advocating group...or what we

> were...and the whole idea behind being seen as an upfront feminist organization...and we said, no we are not..what we are is small peas and we just go off of information... the most... the easiest way to empower any woman is to give them more information...whatever level they are at in their development and understanding... so we went with information (Interview 1 WHEP Coordinator, WHIN Board Member).

Interestingly, the notion of feminism and the tension experienced with the wider collective identity of seeing themselves or the organization as feminist surfaces almost immediately when asked about the origins of WHIN. There is an underlying assumption that empowering women through education and consciousness-raising experiences is important however, for some of the women there is an almost explicit denial that the notion of empowerment is bound up with any type of feminist ideology. This collective understanding of the powerfulness of consciousness-raising experiences is demonstrated later on in the interview when the participant says,

> And then once we started training women in this very basic concept (popular education) and they started doing it and then they said, the fun is over...well then... you could see that they would be angry and they would say, this is changing my life..I'm different than I was... (Interview 1 WHEP Coordinator, WHIN Board Member).

She indicates that providing women with health information and skills in popular education was affecting substantial individual change with regard to health as experienced by the WHIN Board members and community representatives. Yet, the

tensions surrounding the notion of WHIN as having a collective feminist identity were equally as strong. One woman explained when asked if WHIN was a feminist organization,

> Oh definitely! I think so... maybe some of the women didn't feel comfortable with that term but the whole concept of what they were doing was feminist (Interview 7 WHEP Community Representative, WHIN Board Member).

Yet another participant spoke in frustration and disbelief when I mentioned some of the negative responses I had received in asking about WHIN's feminist identity in northwestern Ontario. She says,

> Like what is this about... It's about women's health, working to make better communities and better lives for women... What's the problem here? It's not feminist... come on.. you know it is! (Interview 3 WHEP Coordinator)

A large part of the difficulty experienced by some of the women involved with the organizing efforts of WHIN was the constant denial of it not being seen as feminist. WHIN had evolved from WHEP and WHAG. Both of these groups had begun as distinctly grassroots, feminist women organizing as a small group of women from the women's community in Thunder Bay. Some of these women had experience working collectively and using a feminist process through their involvement with the *Northern Woman Journal* and the Women's Centre in Thunder Bay. When the original four coordinators had been hired for the WHEP project by WHAG members, it had been explicitly stated that a feminist orientation was

necessary. At first, this strong collective feminist identity was possible. However, the desire to hold on to the feminist identity slowly evolved into something else which led to tensions and struggles over the collective identity of WHIN. This was explained by one of the original WHEP coordinators,

> Not everybody was coming at it from the same place...because I think a lot about feminism is understanding things like classism..and sexism, racism, heterosexism.... and there wasn't that understanding....so I don't think that everybody had that political analysis on the Board or the front line workers.... (Interview 11 WHEP Coordinator).

Essential to theorizing feminist identity whether individual or collective, is understanding how the multiple locations that make up a woman's identity are overlapping and multi-layered (Fraser 1992). These layers include, although not exclusively: race, ethnicity, class, sexuality, age and ablism. With each of these multiplicities of identity there are layers of power which are played out in interaction with others, within the organization and in the various communities (Fraser 1992). Although not forthcoming in the interviews when asked about diversity and difference both within the organization and in the communities some of the women recognized that WHIN was not, and did not actively make many attempts to conceptualize and discuss differences. As, one woman stated quite matter of factly,

> I think in the work that they were doing I don't think that it really made much difference that we didn't have someone... I don't know... maybe the native concerns... weren't addressed.. I think cultural differences might

> not have been addressed with WHIN... we were all white, middleclass women you know... (Interview 5 WHIN Board Member).

Further, there were unacknowledged issues of power that evolved throughout the women's experiences organizing WHIN. However, as one participant explained,

> We weren't thinking about it as issues of power, we were thinking of it as issues of poor women against the system... (Interview 9 WHIN Board Member and Project Worker).

Characteristic of women's organizations in the 1980s, understanding how power played itself out was commonly thought to be that power was held by a certain few individuals or the state and that women or women's organizations were powerless (Ristock 1991). For the most part, notions of privilege and power that result from occupying certain social locations at a micro level were not conceptualized in the same terms as those power relations existing at the macro level. Later on in the interview the same participant explained how through her experiences her understanding of power relations had shifted. She said,

> We probably had more power than we knew we had...we didn't know that we had any power... we thought we were underprivileged, under whatever... and now that I've lived a few years, taken a few courses, seen people from other countries... I'm just realizing how much power I've always had but didn't even know it... (Interview 9 WHIN Board Member and Project Worker).

Many facets of identity including power relations were constantly shifting as the women organized themselves around various projects over the course of the twelve

years. In part, the feminist collective identity of WHIN was implicitly understood as all of the women who participated had a common goal of helping women in northwestern Ontario access and understand health information specific to women's needs. Also, acknowledged and understood was the fact that the women were working with an alternative structure of organizing different from traditional organizing practices. However, unresolved tensions surfaced when asked if the women would collectively identify themselves as feminist. Thus, the collective identity of WHIN was not clearly defined which led to tensions for many of the women who were working within this structure.

4.6 SUMMARY

All of the women involved with the WHIN Board had a strong shared sense of a regional identity. The women who had been involved with WHEP understood the importance of sharing health information and resources with women living in the isolated communities of the northwest region. This commitment to the region was promoted as WHEP evolved into WHIN. The regional Board and working within the region was an important part of the success of mobilizing women to press for health changes in the individual communities as well, in maintaining a presence of health conscious women in northwestern Ontario. However, the notion that WHIN may have had a feminist identity was more difficult to conceive.

All of the women who were involved in health organizing activities were coming to WHIN with different definitions of feminism and from different starting

points. Some of the women (those who had been involved with the Women and Health Sub-committee and the WHAG members) had been actively involved with other types of feminist organizing in Thunder Bay and had a strong sense of feminist identity. Other women had come to their feminism through their involvement with the work of WHEP and WHIN, and for some of the women, identifying as a feminist or accepting feminist values was never achieved. These women were simply providing women with health information and resources through a very successful model of popular education. Throughout this chapter I have illustrated the complexities inherent to understanding individual and collective identity. The multiple, shifting and overlapping discourses on the region, gender and feminism were fluid and plural and affected how the women were able to understand and experience their own identities and the groups collective identities.

CHAPTER 5 - CONCLUSION

5.1 CONCLUDING COMMENTS

Through this case study I have been able to document a social history of Northern women's experiences as regional women health activists and how those efforts contributed to the larger Canadian women's health movement. Women in Canada have been organizing around women's health issues since the 1970s. This case study with its focus on regionalism and how it impacted on feminist identity and the women's health work undertaken adds a new dimension to the picture of the larger women's health movement. I have argued a feminist postmodern analysis allows us to understand the complexities of the women's groups' praxis and identities as being contingent on the multiple discourses which were contextual to the time and place in which the women organized.

As part of this social history of the Women and Health Sub-committee, WHAG, WHEP and WHIN, I undertook an analysis of women's organizing efforts paying specific attention to how regional identity and concerns shaped the northwestern Ontario women's health movement. Among the themes which were explored in this context were the regional and feminist discourses on identity, both individual and collective, the politics of women's organizing and how these intersected with individual and collective identity. I examined how the groups developed an evolving alternative structure and process; how the groups used consensus for decision-making; how health issues became defined as Northern

women's health issues; and how funding issues affected the groups organizing goals and outcomes. Moreover, throughout the thesis I have maintained a critical stance in examining the tensions and power struggles which were central to both understanding the collective identity of the women's groups as well as their women's organizing efforts.

The women and the women's groups experienced their identities in multiple, shifting and overlapping ways as was evidenced through the detailed comments from the interviews and focus group. Women experienced contradictions in their identity when situating themselves in the regional context, when attempting to understand their feminist identities (both in the individual and collective sense), and in their politics, or day-to-day experiences of organizing in northwestern Ontario. This fluidity of identity confirms that it is useful to use a postmodern analysis as both Beagan (1996) and Fraser (1992) suggest for understanding the complexities at work as women define their praxis in these women's groups.

All of the women involved shared a strong sense of a collective regional identity. There was a strong commitment on behalf of each of the groups to share, provide and learn about women's health issues as specific to the region as well as in the broader context of the larger women's health project. As Fraser (1992) contends, identity discourses are plural and dependent on the specific location, time and context through which they are being negotiated. A collective feminist identity was contradictory for the women as the interviews reveal. Each of the women who

were involved with the women's health organizing efforts had come to their commitment on women's health from a different starting point. Notions of feminist identity were not always shared and a commitment to building a collective feminist identity was only witnessed in the work of WHAG. In all probability, this was because the group began as grassroots and were able to operate within the political and individual constraints of no external funding. They were small and tightly cohesive because of their shared feminist analysis and attention to process. For WHEP and WHIN, a collective feminist identity was more difficult to achieve. The groups were large, with regional membership spanning several hundreds of kilometers. Further, they were caught up in the funding game which required that they be highly attentive to the service they were providing to regional women. Although there was a commitment on the part of all groups to an alternative structure and process, contradictory and undefined boundaries led to tensions over these alternatives forms for the women involved.

Tensions having to do with funding were continuous as the groups evolved. This in part reflects how the groups matured and grew in number and required significant funds to reach the many communities of northwestern Ontario. The region was always presented as central to this particular case study because of the distance between communities, the isolation experienced by women living in the regional communities, and the social and economic implications of living and organizing in a hinterland region. Power relations were most astutely understood

by the women in terms of their regional identity. However, it was most difficult for the women to understand and conceptualize the micro power relations which existed within their organizing efforts as a result of the multiple social locations they occupied.

Common to women's groups organizing in this particular time frame, little analysis was done by the women on the internal functioning and power relations as experienced both by and within the groups. The general understanding of the women was one which focused on the 'generic' or 'essential' woman who was taken to be powerless in relation to the larger, in this case, medical system. Differences among and between women were overlooked in favor of promoting woman as a single unifying category for analysis except when the issue of regionalism was central. When the groups defined themselves by their regional identity, it was clear which differences (including power relations) a hinterland identity evoked. Although acknowledged in terms of their regional collective identity, one problem which faced the northwestern Ontario women's groups was their narrow consideration of differences or the power relations which accompany them in the complex web of social relations. As a result, tensions existed between some of the women which came out in their experiences with using consensus a decision-making model.

In terms of the successes of the women's organizing efforts, all of the women's groups were notable in their achievement of providing thousands of

women across northwestern Ontario with health information, resources and choices. The women involved were empowered to make individual and community based changes which resulted from their improved understanding of the social determinants of women's health. Further, the women who were active at the Board level learned to work with alternative frames for organizing and use consensus for decision-making, to work collectively, to lobby and make changes in their communities, region, and province, and to effectively organize women and share women's health resources across the vast distances of the Northwest. Moreover, this case study illustrates how these regional women's health groups constructed alternative and complementary discourses on health and women's organizing which both fed into, and evolved from the discourses of the larger women's health movement.

Finally, by documenting this social history of northwestern Ontario women's health organizing efforts it is my hope that I have highlighted the significant social, political and medical impacts that the four women's health groups had on the region. In addition to the definitive social impacts of the women's groups on the region it is essential to recognize and celebrate the profound personal gains and successes that the women experienced throughout their involvement with women's health organizing. All of the women stressed the important role the women's groups had on their individual lives in terms of personal learning, growth, persistence and strength and they were certain that their involvement with regional

women's health organizing had positively influenced and changed their lives. This was further demonstrated in their continued commitment to women's health issues in northwestern Ontario as many continue to organize and work towards educating and empowering regional women through various contemporary women's health initiatives[39]. This thesis is in part, a celebration of the women's health organizing efforts in northwestern Ontario.

5.2 DIRECTIONS FOR FUTURE RESEARCH

This thesis points to a number of directions in which future research would be valuable. First, I was unable considering the scope of this project to look at the specific ways in which these women's groups actively resisted the dominant medical discourses of medicine and science. This would be an important area for future study as women health activists have produced a vast literature on women's resistance to medicalization. It would be insightful to examine how this particular case study of women's health organizing in northwestern Ontario was actively resisting traditional discourses on health and medicine by undertaking a discourse analysis of the eighteen workshop kits produced by WHEP and WHIN from 1982 until 1992. It would be interesting to analyze how the alternative discourses on women's health issues evolved as the women's groups matured and refined their

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Some of the women are currently involved (or have been since their involvement with WHIN) with the Ontario Women's Health Network (OWhN), the Northwestern Ontario Breast Screening Program and various other regional women's health initiatives.

analysis of women' s health.

Further, I was unable to address the ways in which women have worked to construct alternative discourses around health, health promotion and education. The primary aim of the women's groups looked at in this particular case study was to provide women with information, resources and ultimately, choices for women's health. The development of these groups took place in a specific social and cultural time frame where health promotion discourses were experiencing changes in their approach to understanding the social determinants of health. These alternative health promotion approaches stand in contrast to the traditional biomedical discourses of health. How did these alternative discourses affect the women's groups, health activists and feminists in defining an alternative women's health discourse? Further, how have the health promotion and women's health discourses overlapped to shift dominant understandings of health?

It would also be useful given the limited analysis on the women's health movement in Canada, to examine other regional women's health groups across the country in order to make comparisons between this specific case study and other women's health groups. To date, there are no comprehensive examinations of the women's health movement in Canada.

Finally, it is important that current women's health organizing efforts be examined in light of the historical context from which the women's movement has grown up from in Canada. Women continue to organize, provide women with

specific health information, network, and lobby government for change in the area of women's health. It would be beneficial to document women's current experiences with health organizing and analyze how these efforts have evolved over the course of the last several decades and whether technological interventions have helped transcend the exigencies of distance and isolation.

Appendix A

A Socio-historical Examination of Women's Health Organizing: The Women's Health Information Network (WHIN) in Northwestern Ontario
Semi-Structured Interview Guide

Demographics:

1. How old were you when you were involved with WHIN?

2. Did you have a partner or any children at that point?

3. Were you a paid employee or volunteer of WHIN?

4. What other types of work did you do while with WHIN? (Mothering, working outside the home..)

5. At that point, what was the highest level of education you had achieved?

6. Now, what is your highest level of education achieved?

Interview Questions:

1. How did you become involved with WHIN?

2. Why did you become involved?

3. What was your position within WHIN?

4. Why do you think WHIN developed?

5. How do you see WHIN's development? (ie. positive, negative, other)

6.Who were the initial organizers of WHIN?

7. How was WHIN structured?

8. How were decisions made?

9. How do you define feminism?

10. Was WHIN a feminist organization?

11. Was there tension either between Board members, or between the Board and the other volunteers?

12. How were these tensions dealt with?

13.Why were the resource kits developed (WHEP)?

14. Were there changes made to the kits over the course of WHIN?

15.How were decisions made about the resource kits?

16.Who put the resource kits together?

17. Due to the large Northwestern region, how were the kits distributed?

18. Were there any problems with the kits?

19. Were the kits beneficial?
How?

20. How did WHIN meet the demands of the diverse women's population?

21. How did the regional context shape the processes and experiences of the women actively involved with WHIN?

22.Were the health issues facing NW Ont. distinct from the health issues in larger urban centres?

23. How were they different?

24. How were they similar?

25. How did the medical community respond to WHIN?

26. How was WHIN affected by the Health Promotion Directorate and its mandates?

27. How was WHIN funded?

28. Did the funding affect what you did?

29. Did WHIN work with other regional groups?

30. Did WHIN see themselves as fitting into the larger context of the Canadian Women's Health Movement?

31.When did WHIN dissolve?

32. Why did WHIN dissolve?

Appendix B

Cover Letter - Interview

A Socio-historical Examination of Women's Health Organizing: The Women's Health Information Network (WHIN) in Northwestern Ontario

Dear Participant

For my Master of Arts degree I am examining the history of women's organizing around health in Northwestern Ontario. Specifically, my aim is to document and analyze the Women's Health Information Network (WHIN) as a women's group who provided health information and resources to the isolated communities of Northwestern Ontario during the 1980's.

A central feature of this research project is the collection of semi-structured interviews with some of the women who founded and participated with WHIN. The aim of these interviews is to gather information on how and why WHIN developed and some of the specific features of WHIN evolving in the context of Northwestern Ontario and the women's health movement. The interviews will be followed up with a focus group, in which you will have the opportunity to participate if you so choose. Details around the focus group will follow the interviews. The interviews collected will assist me in establishing a social history of WHIN. With your permission, the interview will be tape recorded.

All of the information provided will remain confidential. Your anonymity will be protected. Personal names will only be used in the written materials with written consent from the individual concerned. All notes and interview material when not being used for analysis will be stored in a safe, secure place. Upon completion of the analysis, the material obtained from the interviews will be stored in the office of Pam Wakewich, my thesis supervisor. You may change your mind at any time during the research project and all interview materials will be returned to you. Following the completion of this research, the final thesis will be made available to you upon request from myself or through the Chancellor-Patterson Library at Lakehead University. Furthermore upon completion, a booklet outlining the efforts of WHIN will be given to those who participated in the study.

If you agree to participate please sign the attached consent form. Thank you for your assistance.

Sincerely,

Barbara Parker

Appendix C

Consent Form - Interview

My signature on this form indicates that I agree to participate in the research project entitled: "A Socio-historical Examination of Women's Health Organizing: The Women's Health Information Network (WHIN) in Northwestern Ontario" conducted by Barbara Parker, MA Candidate, Department of Sociology, Lakehead University. My signature also indicates that I understand the following:

1) I may withdraw from the project at any time and all interview materials will be returned to me.

2) My anonymity will be protected. YES [ ]
NO [ ]

3) There is no risk of harm to myself by participating.

4) All verbal information provided by me will be held in confidence for at least seven years. The written documents and materials provided by me will be returned upon completion of the research project.

5) Upon completion of the study, I will receive a booklet about the efforts of WHIN compiled by Barbara Parker. As well, I may access the final thesis through the library at Lakehead University.

_____
Participant's Name

_____ _____
Participant's Signature Date

Appendix D

List of Open-ended Interviews Quoted in the Text

The following is a list of the open-ended interviews quoted in the text. Basic chronological data on the participants organizing involvement is provided after each entry to assist the reader in contextualizing the participants comments in the text.

Interview #1 - WHEP project worker, WHEP Extension Coordinator, WHIN Board Member - Involved for nine years

WHAG Board Member, WHEP Coordinator, WHIN Board Member - Involved for ten years

Interview #2 - WHEP project worker, WHEP Extension Coordinator, WHIN Board Member - Involved for nine years

WHAG Board Member, WHEP Coordinator, WHIN Board Member - Involved for ten years

Interview #3 - WHEP Coordinator, WHIN project worker
Involved off and on for five years

Interview #4 - WHEP project worker, WHEP Extension Coordinator, WHIN Board Member - Involved for nine years

WHAG Board Member, WHEP Coordinator, WHIN Board Member - Involved for ten years

Interview #5 - WHIN Board Member *
Involved for seven years

Interview #6 - the Women and Health Sub-committee, WHAG Board Member, WHIN volunteer - Involved for five years

Interview #7 - WHEP Community Representative, WHIN Board Member, WHIN project worker * - Involved for nine years

Interview #8 - WHEP Coordinator, WHIN volunteer
Involved for three years

Interview #9 - WHEP volunteer, WHIN Board Member, WHIN project worker
Involved for six years

Interview #10 - WHIN project worker *
Involved for three years

Interview #11 - the Women and Health Sub-committee, WHAG Board Member, WHEP Coordinator
Involved for four years

Interview #12- WHEP Community Representative, WHIN Board Member *
Involved for nine years

Interview #13- WHEP Community Representative, WHIN Board Member *
Involved for nine years

* denotes as a woman who was living in the region while involved with women's health organizing

Appendix E

Focus Group - Semi-structured Guide

1. I would like to begin with talking about both the positive and negative aspects of your experiences working together with WHIN.... or WHEP/WHAG.

2. Where did your experiences with organizing around women's health lead you?

3. What were the concrete things that came out of WHIN/WHEP/WHAG?

   -personal level
   -policy level
   -programming level

4. What are the positive things that can be taken from these experiences?

Appendix F

Cover Letter - Focus Group

A Socio-historical Examination of Women's Health Organizing: The Women's Health Information Network (WHIN) in Northwestern Ontario

Dear Participant

As you are aware, for my Master of Arts degree thesis I am examining the history of women's organizing around health in Northwestern Ontario. The aim of this project is to describe and analyze the Women's Health Information Network (WHIN) as a women's group who provided health information and resources to the isolated communities of Northwestern Ontario.

At this point, I have interviewed several women about WHIN. I have collected a rich source of information about WHIN from you. I would like to thank you for your participation and help thus far. However, I would also like to hold a focus group with all the interview participants. The aim of the focus group would be to elicit further collective information and comments on the research process, including additional individual comments about the interview. With your permission, the focus group will be tape recorded. If at any time during the focus group you wish to avoid participating in the conversations you may remove yourself from the focus group. You may also shut off the recorder at any time during the focus group.

All of the information will remain confidential. Your anonymity will be protected. Personal names will only be used in the written materials with written consent from the individual concerned. All notes, recordings and focus group material when not being used by myself for analysis will be stored in a safe, secure place. Upon completion of the analysis, the material obtained from the focus group will be stored in the office of Pam Wakewich, my thesis supervisor. You may change your mind at any time during the research project and the focus group material contributed by you will not be used. Following the completion of this research, the final thesis will be made available to you upon request through the Chancellor-Patterson Library at Lakehead University. Furthermore, upon completion, a booklet outlining the efforts of WHIN will be given to those who participated in the study.

If you agree to participate, please sign the attached consent form. Thank you for your assistance and interest in this project.

Sincerely,

Barbara Parker

Appendix G

Consent Form - Focus Group

My signature on this form indicates that I agree to participate in the research project entitled "A Socio-historical Examination of Women's Health Organizing: The Women's Health Information Network (WHIN) in Northwestern Ontario" conducted by Barbara Parker, MA Candidate, Department of Sociology, Lakehead University. My signature also indicates that I understand the following:

1) I may withdraw from the project at any time and all interview materials will be returned to me.

2) My anonymity will be protected. YES [ ]
NO [ ]

3) There is no risk of harm to myself by participating.

4) All verbal information provided by me will be held in confidence for at least seven years. The written documents and materials provided by me will be returned upon completion of the research project.

5) Upon completion of the study, I will receive a booklet about the efforts of WHIN compiled by Barbara Parker. As well, I may access the final thesis through the library at Lakehead University.

_____
Participants Name

_____ _____
Participants Signature Date

Appendix H

List of Participants who took part in the Focus Group

1. WHEP project worker, WHEP Extension Coordinator, WHIN Board Member
   Involved for nine years

2. WHAG Board Member, WHEP Coordinator, WHIN Board Member
   Involved for ten years

3. WHEP Coordinator, WHIN project worker
   Involved off and on for five years

4. The Women and Health Sub-committee, WHAG Board Member, WHIN volunteer
   Involved for five years

5. WHIN project worker *
   Involved for three years

List of Resource Kits Compiled by WHEP and WHIN
taken from Health Network News Newsletter, Spring/Summer 1990, Number 16

1. Women and Stress: Coping with Northern Living

Module 1. Cabin Fever Deals with Cabin Fever and the long wait for spring. This workshop explores the individual feelings and frustrations with the stress of cabin fever.

Module 2. Personal Stress Deals with personal stress, defining stress and dealing with stress by realizing the sources and causes.

Module 3. Tackling Community Stress Deals with tacking community stress. Focuses on coming to terms with environmental stress and relationships.

Module 4. Stress and Your Job Concentrates on stress and your job and looks at the symptoms of job stress and burn-out.

2. Breaking the Diet Habit: A Positive Approach to Body Image

This workshop was developed in response to the North American pre-occupation with weight and the impulse towards fad diets. This kit looks at the problem of dieting and helps participants get to the root of the problem.

3. Exploring Life Changes: A Workshop on Menopause and Aging

This workshop attempts to look at the psychological changes experienced by women in menopause and explores the attitudes of society towards these women. Controversial subjects such as Estrogen Replacement Therapy and surgery are discussed.

4. Preventing Menstrual Stress: Demystifying the Menstrual Cycle

Module 1. PMS: Preventing Menstrual Stress Is an introduction to the topic of premenstrual syndrome. The objectives of the kit are to - explain the menstrual cycle

-introduce P.M.S. and its symtoms
-discuss methods of alleviating P.M.S.

Module 2. PMS: The Social Implications Examines the social implications of the label P.M.S. Job problems and legal questions are addressed.

5. Patients' Rights and Responsibilities: Active Consumer Awareness

Module 1. The Right to be Informed about Drugs & How to use Them Focuses on the intelligent use of medication.

Module 2. Patient's Rights & Responsibilities Takes an in-depth view of the legal and moral rights of the patient.

Module 3. Assertive Use of the Health Care Services Explores ways people typically react when using health care services. Information and Assertiveness are stressed.

Module 4. An Introduction to Alternatives Covers alternative Health Care Practices.

6. Childbirth Issues: Becoming Informed

Helping to assist parents to wade through the available information and realize that pregnancy and childbirth are not an illness.

Module 1. Childbirth Options Covers childbirth options such as natural childbirth, caesarean section, episiotomy, etc.

Module 2. A Practical Guide to Planning a Birth Is a practical guide to planning a birth. The object is to make people feel more in control.

7. Birth Control: Being in Control

Safety and side effects of birth control are discussed as well as the cultural and social values surrounding the issue.

Module 1. Birth Control: The Social Pressures Focuses on the social pressures surrounding the topic.

Module 2. Birth Control: A Personal Choice Focuses on personal choice and explores the various options presently available in birth control.

8. Women and Nutrition: Personal Needs/Consumer Choices

This kit looks at personal nutrition needs and how we fulfill those needs.

Module 1. Women and Nutrition: Personal Needs Covers women's needs under a broad range of topics titled "Women's Nutrition".

Module 2. Nutrition: A Consumer's Approach Looks at consumer awareness and choices. Food is political. Underlying issues are discussed and consumer roles are discussed.

9. What Can I Do: A Resource Kit on Making Changes in Health Care

Appendix I

Definition of Health and Set Of Principles
taken from WHIN Annual Report 1984-85

Preamble

We define women's health from the feminist perspective that has shown that sexism has created a separate class in all societies.

Through this analysis, the specific oppression of women is based in large part on the concept that women's reproductive and sexual capacities are in fact controlled and appropriated by 'men'. Women's health is therefore one of the primary level's of women's oppression, since health has not been defined by women but by the institutions representing men's power: the state, the church, science, medicine, etc.

Health is the complete state of physical, mental and social well being, influenced by the social, economic and political environment. In order to achieve this state of well being, it is essential to recognize that women must and will have to attain individual and collective power over the definition of well being and over the life and health that are part of that definition.

Our definition of health implies a critical look at our cultural, social, economic and political environment and at the system in general in order to encourage autonomy and taking control over their health by women. We endorse a global, preventive and collective approach that regroups women and that identifies their commonalities as well as the power relationships inherent to sexism which maintains women in a system of exploitation and oppression.

Principles of the Network

1. To empower women individually and collectively by:
   -acknowledging women's knowledge and experience
   -validating self-help
   -developing a critical perspective
   -demystifying the medical theories and practices, both the traditional and the 'alternative'

2. To be accessible to all women, acknowledging the specific realities of the following minorities:
   -immigrant and visible minority women
   -native women
   -poor women

-women from rural and remote areas
-lesbians
-older women
-young women
-francophone women

3. To support women to take control, both collective and individual, over our lives and to attain the skills and knowledge to make informed, critical choices about our health;

4. To be bilingual (French and English);

5. To be a non-profit network;

6. To function in a non-hierarchical way, to share responsibilities and be respectful of the autonomy of the participating groups.
NOTE: the right to dissent does not imply the right to sabotage and to hinder the collective decision (practice of solidarity).

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5. WHEP Health Network News Newsletter
   1982-1985

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