



*Maggie Rodman, "Generations," Mixed Media (relief), 200 x 164 x 12cm.*

*Maggie's sculptures and reliefs are composed of exaggerated fragments of the female body. She has experimented with various combinations of materials including cement, wire, clay, resins, and fabric in order to develop a richness of textures. Although a literal understanding of her work is immediate, the female forms are symbolic, creating many layers of meaning in each piece. Maggie's work is an expression from a feminist's point of view of a search for one's inner being. Please see pages 58, 108, and 158 for more of Maggie's work.*

# The Women's Health Movement in Canada

## Looking Back and Moving Forward

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*Cet article fait un survol de l'histoire du mouvement pour la santé des femmes au Canada. Il décrit brièvement les luttes et les victoires des dernières quarante-cinq années qui ont transformé le système de santé. Il fait aussi le sommaire des problèmes qui restent à régler mettant au défi les activistes à continuer de travailler pour le bien-être des femmes, à se joindre à d'autres groupes pour apporter des changements systémiques qui doivent éradiquer la pauvreté, pour protéger les travaux de recherche sur les services orientés sur les femmes, pour maintenir une direction ferme chez les groupes de la base et enfin pour accorder une voix aux citoyens.*

You would be hard-pressed to find any one who works in, or thinks about health in Canada today who did not agree, at least publicly, on the importance of social and economic conditions such as education, housing, environment, and gender on a person's health status. This broadened approach to health reflects a profound change in thinking and can be credited, in part, to the work of the women's health movement. This social movement was the first to bring together women's own experiences with health services, and their own opinions about their health concerns, with new visions, new information, and new methods of research and outcome evaluations.

The publication of this edition of *Canadian Woman Studies* devoted to women's health and well-being provides us at the Canadian Women's Health Network (CWHN) with an opportunity to share our reflections on the past, our comments on the present, and our speculations on the future of women's health in Canada.

### In the Beginning

The 1960s, 1970s and 1980s saw the rebirth of the women's movement and directly associated with it, the women's health movement in Canada and around the world. Women came together to share experiences and knowledge. We looked at our cervixes, fit diaphragms,

helped get each other off mood-altering drugs, and "caught" babies. We shared stories about our interactions with the medical system. We started asking questions. We understood that knowledge was power and sought information. Through debate and sharing, we developed new approaches. We realized that we could understand medical information if it was presented in an accessible form. We came to recognize the impact of issues such as violence and racism on our health. We realized that those who formulated the research questions controlled the answers. We understood that women's health is a political, social, and economic matter. We were, as Sue Sherwin wrote, "Patient No More" and would be, to quote Sharon Batt (1994), "No Longer Patient."

Women gathered in discussion groups, educational forums, and consciousness-raising sessions. We created new avenues to develop our concerns and our ideas that broke down isolation and allowed for individual and group action. No one was just a "patient" or a doctor, or a nurse, or a therapist, or an academic. Health was something that mattered to all women.

The women's health movement made links and formed partnerships with other groups who shared our issues:

- consumer groups and self-help movements dealing with issues such as cancer, mental health, and addictions;
- anti-racism groups and those working on equity and access issues including First Nations and rural communities;
- those providing alternative and traditional healing;
- environmental and anti-nuclear groups;
- disability rights activists;
- medical reform groups, including those interested in health promotion and community development;
- the legal community, who helped us push companies and providers to be more responsive and responsible.

In part, the strength and endurance of the women's health movement has been a result of this network.

### Shaping Our Issues

Over the years, the women's health movement has focused on three main issues: the health care delivery system, the development and analysis of the social determinants of health, and a commitment to increase the participation of women in all aspects of health care.

The movement's critique of a health care system domi-

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nated by white, male health professionals began with exposing how lack of information prevented women from making informed decisions; how the power dynamics between health professionals (doctors [usually male] and nurses [female]) and between physicians and patients made it hard to question professional expertise or refuse treatment; how sexism, racism, paternalism, and other power oppressions within the system led to our priorities not being addressed; how the growing pervasiveness of drugs and other technologies distorted the treatment and prevention programs women really needed (Cohen and Sinding; Beck; Status of Women Canada; Batt 2002).

Women also learned that some institutions had interests in conflict with ours. For example, the commercial push to market a drug and increase profits could supersede the obligation to make safe and effective medicines available and to do follow-up on a drug's safety.

The emphasis was on a woman-centred vision of health and wellness. We knew that improving the health status of women meant paying attention to education, economic and social policies, housing, and the environment. Gender was put up front and centre as a critical determinant of health. The analyses recognized and respected the diverse needs and realities of women's lives and the impact of these on their health status.

Women worked for the increased presence of women throughout the health care system. We looked at the research used to rationalize the existing approaches to our health concerns. We saw that women's issues and voices were absent in both asking the questions and seeking the answers and that none of it was "neutral." We saw that women were often excluded from clinical trials for new drugs and couldn't know if the medicine we were given was safe for us.

We fought for greater participation of women in all levels of the health care system including policy making. We pressed for and finally got Women's Health Bureaus or Departments in provincial governments, women's health committees in research and professional groups such as the Medical Research Council, a Women's Health Bureau inside Health Canada, women's health research centres in Ontario, and the establishment of the Centres of Excellence in Women's Health.

### Creating Woman-centred Programs and Services

Not satisfied with just offering critiques, women's health advocates also developed programs that reflected our vision of woman-centred care (Barnett, White and Horne). When we found existing services unresponsive or unyielding to our issues, we founded new, creative ones where all women would have opportunities to learn and freely discuss their concerns. We developed more equitable, non-hierarchical ways for health service providers to work with each other—and to work with women.

These activities fuelled a new approach to women's health and health services, one that required much more than pink walls or even "nicer" female doctors. We called for providers to listen to women's voices, putting women, not care providers, centre stage in the healthcare system. This approach, which we called a *woman-centred model*, had several themes or principles. These included:

- user control of health care delivery systems;
- establishing innovative services
- creating resource centres;
- emphasising self-help and peer support;
- obtaining appropriate and effective health promotion and education;
- deprofessionalizing medical knowledge and health service jobs;
- developing programs examining health issues in their social context;
- demanding equity in hiring practices;
- understanding that women are experts in their own needs and issues;
- providing continuity of care and care providers;
- having access to female practitioners.

From these principles came activities, programs, and services. One of the earliest was *Side-effects*, a play and popular education campaign about women and pharmaceuticals that made a remarkable cross-country tour in the early 1980s (Tudiver and Hall). Other examples included the formation of home birth and midwifery coalitions, the launching of the still-published *A Friend Indeed* newsletter on women and menopause, women-centred tobacco programs, the Montreal Health Press, environmental action groups, women and AIDS activities, endometriosis and breast cancer action groups, the disability rights

organization DAWN, feminist counselling programs, women's shelters, traditional healing study groups, *HealthSharing* magazine, sexual assault support and action groups, anti-racism work, and community-based women's services such as Le Regroupement des centres de santé des femmes du Québec, Winnipeg's Women's Health Clinic or the Immigrant Women's Health Centre in Toronto to name a few.

These organizations, programs, and services were characterized by innovation and social action. Their work recognized that women's health and well-being are deeply affected by poverty and class and by experiences of abuse and racism. Women who sought services in woman-centred programs experienced group-learning methods, peer support, or new types of care providers, such as nurse practitioners. Women experienced alternative delivery models, which increased their knowledge and sense of autonomy and competence. The programs provided examples of outreach to those women whom conventional medical service providers considered "hard-to-reach."

The development and evolution of these programs and services is the "happy" part of the story. Sadder, if not tragic, is that, despite women's best efforts, most of these programs and services, no matter their effectiveness, remained marginalized within the mainstream health delivery sector and/or have had their funding severely if not completely cut. Those that survive are the exception to the rule and even these have never received the funding that would make them universally accessible.

### **Building the Canadian Women's Health Network**

In the 1970s and '80s, groups of women across the country began talking about creating a formal women's health network to create a national presence and strengthen ties among women working in women's health. They saw a need for a network of networks that would encourage dialogue and discussion about strategies and policies and empower women to make informed choices about health (Tudiver).

Networking is a challenging task in Canada with its vast geographic distances and its linguistic, cultural, and regional diversities. But women across the country rose to the task. It was a time of severe cutbacks in government spending on health and social services and far-reaching attacks on Medicare and medical care as a right in Canada. The cutbacks were targeted to the poor and the poorest of the poor—women on welfare, persons with disabilities requiring home care services, shelters, and other services for abused women and children. Women's health activists knew how severely these cuts would affect women's health.

In 1993, after a decade of consultation and discussion with women across the country, the Canadian Women's Health Network was created. Eleven years later, the Canadian Women's Health Network continues to build

and strengthen the women's health movement in Canada through information sharing, education, and advocacy with the goal of changing inequitable health policies, and practices for women and girls.

Many of the visions expressed when the CWHN was born have become realities. The CWHN has established a national presence for women's health issues and is on the "consultation" list of the federal government and national organizations when health issues are being discussed. Our bilingual information centre now has over 2,500 organizations listed in its database and over 5,000 resources on

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women's health; and we are a major source for media seeking information on women's health. Our website and *Network* magazine are popular sources of knowledge. Our electronic newsletter and email discussion lists are busy and well subscribed. CWHN has links with a variety of research and policy networks.

### **Moving Forward**

Women's health concerns have become very popular and "acknowledged" in the mainstream. This has proved to be both a blessing and a curse. Women's health advocates have achieved a certain level of recognition, but are always in danger of being co-opted or used by those who control the health system. The language of the women's movement has been taken on by governments and media, but too often without a deep commitment to giving women a real voice in health care policy and planning.

We in the CWHN know that there is still much to be accomplished. Today we can identify five broad challenges ahead for women's health in Canada.

#### ***1. Health Reform and Health Service Restructuring***

The erosion of our publicly-funded, not-for-profit health insurance system and the accelerating growth of a two-tiered health system is a significant women's health issue. Though women and men are both affected by government cutbacks and rising health care expenditures, they do not have the same financial resources to cope with them and the impacts are different. Women, on average, earn less than men, are less likely to have supplementary health insurance coverage through their paid employment, and are more likely to live in poverty (Donner, Busch and Fontaine). As a result, women face a greater burden when health care costs are privatized.

And it is women who bare the burden when health care services are off-loaded from the institution to the home. Women provide 80 per cent of both paid and unpaid health care (Armstrong *et al.*; National Coordinating Group on Health Care Reform and Women). This inequitable situation results in increased stress, poverty, and social exclusion for these female caregivers.

Despite a 2002 Royal Commission on Health Care that clearly demonstrated the support for and superiority of the Canadian Medicare system (Romanow), action is missing. The Commission report itself was also lacking in almost any mention of women's health issues and concerns (National Coordinating Group on Health Care Reform and Women, 2003). The movements toward national home care and pharmacare programs seem to be fading. Primary care discussions make little if any mention of community health centres. Midwifery and feminist counselling services remain small and under-funded. Through the establishment of the Canadian Institutes for Health Research (CIHR) there has been an increase in support for academic research in gender health. But there is little funding for innovation or demonstration projects such as support for women's second stage housing, women centred smoking cessation or addiction treatment, or mothering support.

The federal government, as well some provinces, has a commitment to undertake gender sensitive policy and program development, with, at the very least, uneven results. Provincial governments may have identified women as a priority population, produced a women's health plan or set up Women's Health departments but without much effect on care. The hopes and requests for women-centred models of care remain.

There have been and continue to be huge cuts to the groups and ad hoc organizations that have provided much of the infrastructure for the women's health movement. Women's centres, community health centres, national and regional organizations such as DES Action, *HealthSharing*, women's centres, the Vancouver Women's Health Collective, and innovative demonstration projects have all had their funding dramatically reduced or disappear altogether. Burn-out is common as staff members grow exhausted from unrealistic workloads to which are added the need to write seemingly endless funding proposals and reports (Scott, 2003). The loss of these groups and programs is a "double-whammy" women lose services and programs providing practical examples of women-centred approaches, and also lose their work in promoting a health determinants approach in all service and policy areas.

## **2. The Continuing Medicalization of Women's Health**

The biomedical-corporate model continues to dominate our health care system. Institutions, professional groups, and corporations in the medical field have signifi-

cant built-in inertia, if not conflicts of interest, with the reforms envisioned by the women's health movement and the Beijing *Platform for Action* (United Nations), and indeed, Canadian government policy statements such as "Health For All" (Epp). For most, it is business as usual.

Despite years of mobilization and analysis, women's bodies and women's health issues continue to be over-medicalized, with women seen as incompetent and *all* our health issues in need of medical intervention. Among the latest examples are the widespread prescribing of hormone replacement for all menopausal women and the increasing use of epidural anesthesia for birthing women (O'Grady; *Giving Birth in Canada*).

This biomedical focus on the treatment of acute medical problems continues to colour the approach of health care providers as well as the media, and politicians. In this reactive role the health system continually allocates resources that result in questionable policy "choices" such as:

- Paying for breast cancer screening by mammography, but not for breast cancer support groups or smoking awareness and cessation programs, or for research into possible environmental causes (O'Leary Cobb).
- Directing some \$100 million in federal/provincial "economic development" funds to drug companies to produce hormonal drugs for older women, with little or no support allocated to health education, menopause research, or ensuring streets are safe enough to encourage women to prevent osteoporosis through exercise (Batt 2002).
- Investing large amounts of public and private funds into "new" reproductive technologies while midwifery continues to struggle for recognition and resources to support mothering and to address environmental contaminants that may lead to infertility are basically non-existent (Hawkins and Knox).
- Over-prescribing of Benzodiazepines. Women are not only more likely to be prescribed benzodiazepines compared to men, but are also more likely to be prescribed benzodiazepines for longer periods of time (Currie 2003).
- Over-prescribing selective serotonin uptake inhibitors (SSRIs) to treat depression and other mental health conditions while other effective interventions such as counselling or exercise remain unfunded and under utilized—and systemic changes in workplaces and elsewhere that lead to stress and depression are ignored (Currie forthcoming).

It took two decades of lobbying by women's health advocates before legislation to regulate the new reproductive technologies was introduced and passed into law (*An Act Respecting Assisted Human Reproduction and Related Research*) The *Act* is just one step towards an overall strategy to improve the reproductive and sexual health of

Canadians, a commitment made by the government several years ago in yet one more “green” paper. This strategy must include increasing access to emergency contraception and ensuring reliable, accessible information on sex education for women and girls across their life spans.

### **3. Quality Health Information for Women**

For women to make informed choices, we must have access to accurate, timely, women-sensitive health information. But programs that used to fund groups creating

failure to protect citizens and increases ill health, not just for the impoverished, but for everyone. Poverty is increasingly becoming feminized. The dismantling of social programs such as housing and income support are felt everywhere in Canada, but this has a particular impact on the lives and health of women and children. Poverty is hazardous to women’s health.

### **5. Changes in the Women’s Health Movement**

Women’s health activists continue to struggle with whether or not to put our energies into modifying existing

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information tools no longer exist. And while the explosive growth of the Internet seems to have created access to an enormous amount of information, it is not necessarily the knowledge women need or can access. In addition, most health research continues to lack an analysis of the differences between men and women or between women (Health Canada).

Community-based health providers have responded to the demand for health information by creating material, but have been constrained by limited funding and time. By contrast, advertising by the pharmaceutical industry has continued to permeate our media, not only to promote new products to professionals with expensive sophisticated techniques, but to produce health “information” brochures and other material that really should come from impartial, trusted, non-commercial sources. These same companies push their products to women—often flouting laws that prohibit direct-to-consumer advertising (Mintzes and Baraldi, 2001).

### **4. Public Policy—Is it Going to be Healthy or Not?**

While the federal government takes pride in its progressive health policy statements, we need actions not words.

Those government policy frameworks that emphasize a broad range of health determinants and have goals to achieve population health (Federal/Provincial/Territorial Advisory Committee on Population Health) overlap with a woman-centred holistic approach. However, many of the government’s actions appear to ignore these commitments. No action has ever been taken to build in health impact assessments that would evaluate new policies or programs as possible causes of inequities in women’s health.

The growing gap between the rich and the poor, both within Canada and internationally, points to a societal

institutions or building new ones. Funding restraints makes it more difficult for *all* the services envisioned by grassroots groups to be developed. When they are (under) funded they immediately develop long waiting lists and meeting needs becomes difficult if not impossible.

We are grappling with a sisterhood made up of women who live at different levels of power and privilege. Our sisterhood’s members have many different issues, priorities, and perspectives. How to prioritize issues and resource allocation is far from clear.

Midwifery is an example of this potential stress—in effect, a competition for services between rich and poor women. Midwifery, fought for by a broad coalition of consumers, midwives, and public health staff, has finally been implemented in most provinces and territories. How can equal access for all women be ensured? Will midwifery services, in short supply at the present, be “overused” by women who have resources, while women who would most profit from midwifery services (adolescents, women with multiple problems, rural and northern women who have to leave their communities to birth) have the least chance of getting access to them? It is clear that many women would seek to improve their birth experience if they had the opportunity. What happens to the women most in need, whose voices are often absent?

### **Protecting Our Vision**

The women’s health movement has broadened and matured. Some of the coalitions created long ago remain, but even those that have come apart have continuing ties that have created an underlying network of individuals and groups who remain active and connected. And women need this network: the issues we have fought for remain as current and as real today as they were three decades ago.

New problems have an all too familiar ring. The task is clearly not an easy one.

The changes that have been won have been the result of persistence and, at times, anger and pain. Not only has the health care system resisted us, but frequently women's wishes and concerns have been disregarded, no matter how clearly they were articulated, while at other times they have been co-opted. Gender parity in medical schools and the recognition of nurse practitioners are wonderful, but this is only a small step toward our vision. Having women in positions of power as physicians, health administrators, and politicians will continue to have some positive effect. But this is not the only mechanism that we can rely on. As we all know, women frequently experience "glass ceilings" and "sticky floors." We also know that one's values cannot be automatically assumed because of gender.

We need to move from the *personal is the political to the communal good is in everyone's interest*. Individual health cannot exist without social justice. As individuals, we need to work on issues that are best for the community of women, even when these are not necessarily our personal priorities. Those of us working in the health service sector will need to join other groups to advocate for the systemic changes that will remove inequities such as poverty and racism that so strongly affect health. We need to ensure that whatever changes are made are not merely superficial or cosmetic changes laid over a biomedical service model, with no attention paid to the broader social determinants of health.

Women's health activists need not only to continue to lobby to reform and adapt existing institutions and professions, but we need to be sure this work doesn't lead to losing what has been achieved with the creation of alternative and new women-centred services and service providers. We must stay on guard to protect woman-centred research. We also need to consider creating a long-term demonstration fund for community-based, consumer-controlled services, particularly for women. We are, after all, retooling an industry.

We need mechanisms throughout the system to ensure that this dynamic process continues. Grassroots groups and a diverse range of citizen voices must maintain a strong leadership role as we move forward. We know that in times of confusion and constraint, dissent and critiques can be hard to hear. We will need to continue to build new alliances and new coalitions.

The women's health movement has provided a dynamic environment for some of the most creative debates and positive visions for a better, healthier future. Given the opportunity, there is no reason why we can't take on the challenges ahead.

*This paper is adapted and updated from a presentation by Madeline Boscoe, Executive Director of the Canadian Women's Health Network, to the delegates of the Canada-U.S.A. Women's Health Forum in 1996 and was edited by Ghislaine*

*Alleyne, Gwynne Basen, Madeline Boscoe, Barbara Bourrier-LaCroix and Susan White and reviewed by the Executive Members of the CWHN's Board of Directors.*

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## ANNE DUKE JUDD

### Fast Bones

The doctor said  
my femurs equal eighty years old.  
Someday, I joked, the rest  
of my fifty-five-year-old body  
will catch up.

Meantime I resist  
hormone pills,  
synthetic bone-builders,  
eat cheddar and broccoli,  
crunch salmon spines  
while the covetous dog  
drools.

The density decline flattens:  
bones holding,  
body reaches sixty-two.

Backpack replacing  
shoulder-straining purse,  
I cycle to town,  
absorbing Vitamin D  
with every push  
of the pedals.  
From shed to stove,  
carry firewood  
morning workouts  
weight-bearing  
without a health club.

Stretched on the scanning table  
while the densitometer looks again,  
my mind finds poetry  
therapeutic.  
Doctor's amazement:  
density increasing  
against the odds.

Strong words my medicine.  
Not just getting older  
getting denser.  
Words outlive bones.

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