

Simmering Outrage During an “Epidemic” of Fetal Alcohol Syndrome

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Ce texte est issu d'un colloque national tenu à Vancouver, Colombie Britannique en 2002 où on tentait de sexualiser la recherche sur la prévention du syndrome de l'alcoolisme foetal. L'article illustre le développement de "l'épidémie" de ce syndrome dans la communauté autochtone qui a conduit à une surveillance accrue et à un contrôle de la fertilité des femmes, cela sans aide ni services pour elles. Un exemple démontre que la perception de la classe dominante au Canada sur la reproduction chez les femmes autochtones est basée sur des données combinées de la science, de la médecine, de la santé publique et des services de première ligne qui encouragent certaines catégories de gens à se reproduire alors qu'on décourage la reproduction future chez d'autres, voire même empêchée.

In this paper I critique understanding held by dominant Canadian society about the reproductive lives of Indigenous women. Specifically I explore how local reproductive relations are constituted by intersecting discourses emerging out of arenas of science, medicine, public health, and front-line service provision that empower certain categories of people to nurture and reproduce, while the reproductive futures of others are discouraged and if at all possible, avoided (Ginsburg and Rapp 3). I examine how portrayals of an “epidemic” of fetal alcohol syndrome

(FAS) unfolding in Indigenous communities has been invoked to support increased surveillance and control of Indigenous women’s fertility, without meaningful supports and services being put in place for them. Supporting the image of a “FAS epidemic,” is the practice of non-medical labelling of Indigenous women as having fetal alcohol-related brain damage. The paper examines how, with the creation of this new population of “FAS persons,” FAS prevention strategies targeting Indigenous women have expanded beyond simply preventing pregnant women from drinking alcohol, but now include as an equal focus, pregnancy prevention with approaches ranging from increased use of chemical contraception¹ to permanent sterilization. As a micro example of this larger phenomenon, the events of the workshop described in this paper help to illustrate that apart from serving as a medical diagnosis, the category FAS simultaneously exists in Canada as a means by which negative stereotypes about Indigenous women and the place of their reproductive futures in the nation’s body are reinforced. This is an image that allows for certain actions to be mobilized while others are not.

Garden Therapy

Looking out of the plane window, I felt relieved to be coming home.

Even though I had only been away a week it felt much longer and I looked forward to seeing my son, Skender. I also hoped that returning home would lessen the unease that I felt as a result of the meeting I had just attended in Vancouver, which aimed to provide direction in areas of fetal alcohol syndrome prevention research to the newly formed Canadian Institute for Gender and Health Research. This latest trip also marked the end of my doctoral field research and I felt a sense of urgency in light of the past few days to reexamine some of my writing, and to produce a critique of what I now saw to be a blanket acceptance across Canada that FAS is a health and social problem of epidemic proportions in many Indigenous communities. It was with this in mind that I arrived at Dorval airport, hopped in a taxi, and headed home.

The next morning, still feeling the effects of the Vancouver meeting, I decided to retreat to the garden to see if this would help me to reconcile my thoughts on what had transpired during the workshop. However, unlike other days where digging and pulling weeds had a therapeutic effect, today I felt increasingly worried, concerned, and even alone. Why was I the only one at the workshop who felt outraged by the federal government’s lack of critical reflection in portraying the “FAS problem” as an “Indigenous

problem,” when very few individuals, Indigenous or not, have actually been assessed or diagnosed with the illness and so much uncertainty remains over the actual rates of effected individuals? Why was it that my apparent outrage was met, at best, with limited concern, and at worst, dismissed out of hand by other participants? How was I to interpret the silence of other participants whom I knew shared my concerns about the gaps and numerous methodological problems with the research literature on FAS? Why did they not at least support my call for critical evaluation of government policy and programming, and for an examination of non-medical labelling by service providers of Indigenous mothers and their offspring as being alcohol-affected?³

As these questions occupied my thoughts, I could not help but think how fortunate it was that Lucille Bruce had attended the meeting. Lucille, a fellow Métis, and the only other Indigenous person present at the workshop, is someone I had met during my field research in Manitoba, and she had been sent to the workshop to represent the Canadian Women’s Health Network.⁴ My assumption was that Madeline Boscoe, the network’s Executive Director, had specifically chosen Lucille because of her community activism and work with impoverished Indigenous women.

Reflecting back on the workshop, I admitted that Lucille’s presence had made the experience more bearable as we worked together to push the group toward developing a critical perspective that challenged, rather than reinforced, entrenched stereotypes of Indigenous women and their children. Lucille drew upon her experiences working at a transition house for Indigenous women in Winnipeg, illustrating the barriers and gaps in programming that hinder these women to seek and comply with service demands. In turn, I put forward critiques of the current direction of FAS research, prevention, and intervention services, pointing

toward racial and gender biases characteristic of these interrelated arenas of knowledge and practice. Thinking of Lucille’s support, I reconsidered that maybe it had not been as bad as I first remembered. Maybe I was just feeling tired from the week of travelling and meetings. However, as I surveyed the garden for weeds, the feeling of outrage left from the meeting continued to simmer in my thoughts.

The Workshop

The workshop, “FAS and Women’s Health: Setting a Women-Centered Research Agenda,” was organized by the British Columbia Centre of Excellence for Women’s Health. My role was as a “discussion starter” for a session focusing on FAS prevention among Indigenous women. As I sat in the garden, reflecting on the session, I was certain that the workshop organizers were less than satisfied with my decision to critique the negative stereotypes of Indigenous women that characterized FAS research literature, including the ways these images have come to shape social service and public health responses. While I felt they recognized the logic of my presentation, I was also aware that a few of the participants identified me more as an “angry Indian” than a productive “discussion starter.” This, however, was not the reason I was feeling such unease; I have known many “angry Indians” who, because of their anger and determination to hold their ground on important issues, have individually and collectively transformed Indigenous and non-Indigenous relations in Canada in productive and positive ways. Rather, the unshakeable unease that followed me to my garden was the overwhelming presence of the “white man’s burden,” which had hung like a thick cloud over the workshop.

In Canada, the companion of “the white man’s burden” is the “Indian problem”—terminology that best

describes the ways in which federal and provincial governments have approached, in the past and the present, the socioeconomic, historical, and cultural/traditional realities of First Nations, Inuit, and Métis peoples. If looked at from a historical perspective, one could readily argue that Canadian governments, with support from the broader society, have ideologically framed Indigenous and non-Indigenous relations using the dichotomy that Indigenous peoples have problems, and the dominant society carries the burden of identifying, describing, and intervening in their lives in order to “fix” those problems.

A case in point is the residential school system, which theoretically was created to address the “burden” held by the colonialist government to “civilize,” “Christianize,” and “assimilate” Indigenous children. The government argued that the removal of Indigenous children from the care of their parents—or the supposed “immorality” of Indigenous traditions and cultures—was a proper method by which to indoctrinate them with European values and culture in order that they become productive members of society. Although stated much more subtly, the sentiments at the Vancouver workshop clearly indicated that “the white man’s burden” and the “Indian problem” were central players in the twenty-first century’s understanding of Indigenous persons. However, the “problem” here was not one of assimilation but of biological deficit whereby large numbers of Indigenous women believed to suffer from fetal alcohol-related brain damage give birth to “epidemic” numbers of similarly affected children. It was the “white man’s burden” to come up with solutions in the form of research, interventions, and services to address this “preventable tragedy,” and essentially save Indigenous peoples from themselves.

Approximately 25 people who work in FAS prevention attended the workshop. The day started with a presentation by one of the organizers

who outlined the ways in which FAS prevention research, interventions, and services overwhelmingly focus on the fetus. The goal of the workshop, she stated, was to shift away from what could be described as the “uterine tradition” by advancing a “women-centered approach,” that addressed the mother and fetus as a single unit. By mid-morning, it seemed evident that the workshop would prove to be

they are ignorant of the public health message, on this particular occasion she used the example to illustrate that the women who give birth to children with FAS are not similar, but different from her in important ways.

Based upon my knowledge of the research literature, I expected the difference she referred to would be to socioeconomic status, because risk factors associated with pov-

As the physician passionately lamented that years of work on FAS had not made a significant difference to women and children, I became increasingly agitated by the unstated implications of her account. By suggesting that women who give birth to children with FAS are themselves alcohol affected and that most are First Nations, she characterized the “problem” within a larger discourse of

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productive and informative, and that the final outcome would be a positive contribution toward ensuring gender-sensitive research on pregnancy and substance abuse.

My optimism, however, was short-lived as increasingly participants struggled with the shift in focus outlined by the organizers, and much of the discussion remained focused on risk to the developing fetus posed by substance abuse. When the discussion did turn to women at risk for having children with FAS, it was mainly a discussion about Indigenous women, and there appeared to be an uncritical perception by most that Indigenous women were not only at higher risk, but that they nearly constituted the entire risk group itself.⁵

A local Vancouver pediatrician known to be an expert in FAS diagnosis was the first to make a direct link between risk, maternal FAS, and Indigenous women. During an open discussion she described her own pregnancy several years ago and how, even though she was a medical graduate, she had unwittingly placed her unborn child at risk because she was unaware of the dangers of prenatal alcohol exposure. While in previous meetings, I had heard her make reference to her own pregnancy as a way to illustrate that *all* women are at risk if

erty—particularly food insecurities, vulnerability to violence, tobacco addiction, and lack of prenatal care—in conjunction with chronic alcohol abuse are known to impact negatively upon the physiological processes of pregnancy and fetal development (Abel). Much to my surprise, however, she stated that pregnant women who give birth to children with FAS are most often women who themselves suffer from fetal alcohol brain damage and most in Canada are First Nations. While she did acknowledge poverty as a contributing factor, she emphasized that risk significantly increased because of the inability of this group of women to make “good lifestyle choices,” evident, she stated, by the “common occurrence” among impoverished First Nations women of alcohol and drug abuse, and unprotected sex that fails to prevent either sexually transmitted diseases or pregnancy. I knew, however, from my research that few if any of the women the pediatrician referred to would be medically assessed for FAS because of the associated costs of obtaining a diagnosis and the inherent ambiguity within the diagnostic criteria to determine if prenatal alcohol effects are present and if so, whether they are either a primary or secondary cause of “behavioural problems.”

“intergenerational trauma,” that has been adopted by Indigenous peoples to explain the negative health and social impacts of colonization. However, in doing so, she recast “intergenerational trauma” not as collective suffering that at an individual level manifests itself as psychological and emotional distress, but one grounded in biology, and specifically a cognitive deficit that exists beyond the bounds of Indigenous healing.

Important to note in this context is that generally researcher-identified “risk factors” for FAS specific to Indigenous women and their children emphasize, rightly or wrongly, Indigenous ancestry, cultural practices, and collective history (Aase; Asante; Asante and Nelms-Matzke; Asante and Robinson; May). However, the pediatrician’s claims effectively usurped these arguments by making the primary and overarching risk factor, widespread maternal FAS. This shift in discourse further implied that, despite First Nations women being a very high-risk group, their Indigenous identity is relatively unimportant apart from helping to identify them. This is an argument that reminded me of one made a few years earlier by a leading FAS researcher, Anne Streissguth, who suggested that if the frequency of FAS

is high enough, it becomes a “community catastrophe that threatens to wipe out any culture in just a few generations” (9). Consequently, the focus is no longer on “risk factors” present in Indigenous communities and neighbourhoods, but rather the argument contends that in certain local contexts, such as reserves or urban Indigenous ghettos, a culture of pathology has arisen, whereupon perceived widespread maternal FAS places the next generation at risk of being similarly affected.

Following her remarks, the pediatrician announced that she would not be staying at the workshop because she had to teach a class on the effects of prenatal substance use to a group of medical students, among whom I knew there would be few, if any, Indigenous students. After she left I felt a growing unease, thinking about how she had interrupted and redefined our task and legitimized references to the “Indian problem” and the “white man’s burden,” which would spill into the second half of our meeting.

The “Making” of an Epidemic of FAS

Agitation is often difficult to deal with in a setting where a certain amount of decorum is required if one is to be heard. However, as I listened to a presentation later that day by a front-line worker employed by a government-funded FAS prevention program in the Burns Lake region of northern British Columbia, I found myself thinking that too much decorum was stifling in such an ill-conceived meeting. The presentation was described as “bringing a women-centered approach to broad publicly focused FAS prevention strategies.” In her introduction, she stated that Burns Lake⁶ is located near several First Nation reserve communities and that even though the program targets all women, the large majority of women that her program serves are Indigenous.

The Burns Lake program provides

public health education on FAS and from the presenter’s account, it appears to bring a level of support and outreach services to women, their children, and the community that is generally welcomed by the people of Burns Lake, and, to a lesser degree by the surrounding reserves. The presenter began her talk by stating, “most of the moms [that the program provides services to] have had prenatal exposure to alcohol.” She also referred at different times in her presentation to FAS being a serious health problem in the area, suggesting to the workshop participants that government funding and focus on FAS prevention and intervention services had hit its mark in the case of the Burns Lake area.

The Burns Lake *Healthier Babies, Brighter Futures* program was featured in a February 2001 report entitled *Fetal Alcohol Syndrome: A Call for Action in B.C.*, which was published by the Children’s Commission of the B.C. Ministry for Children and Families. Under the subtitle “Innovation,” the program in Burns Lake is described as a “successful prevention project” that “clearly shows that spending money on prevention and early intervention more than pays off” (24). Our presenter had written the feature piece on Burns Lake in the document, describing the program as follows:

The program has managed to connect with very hard-to-reach families. Client profiles at intake show that 83 percent of women display FAS characteristics and behaviours. When the program began, 100 percent of the clients who came to the program were not on birth control, as it is difficult for people with FAS to remember to take a daily pill (The Children’s Commission 25)⁷

The report discusses the program’s success in relation to increased birth control and pregnancy prevention, “healthier” pregnancies (abstinence or

decrease in maternal substance use), birth outcomes such as “healthy birth weights,” and women maintaining custody of their children. Notably, the success of the program is not measured in terms of improved health and wellness of women (clients), and instead the emphasis on birth control and pregnancy prevention suggests that success is measured, at least partially, on making the alcohol abuse of “at-risk” women less visible. More simply stated, when the women are not pregnant, their substance use/abuse and all of the problems associated with it lie outside of the range of “prevention” provided by this and other similar programs. Furthermore, increased use of contraception means that fewer babies will be born, which is perceived as a desirable “preventive” measure.

When I queried the presenter about how she knew that so many Indigenous women in the Burns Lake region had FAS, and subsequently commented that I was unclear about the intentions of her claim that “most of the moms have had prenatal exposure to alcohol,” she looked surprised. However, the surprise quickly shifted back to me when she announced that to the best of her knowledge, she knew of no medical diagnoses of FAS or FAE of the mothers and their offspring in the Burns Lake region. I was further surprised that the presenter was untroubled by this fact in relation to her earlier statements.

In my determination to fully understand her claims, I pressed her for information on how she and her colleagues determined that certain individuals had FAS by asking, “was it their facial features, height or weight, or did they exhibit cognitive problems? If their lay diagnosis was not based upon assessment of physical and behavioural characteristics, how then did they know that prenatal alcohol exposure had a role to play in a woman’s particular situation?” With this questioning, the presenter became defensive, arguing that high rates of FAS were present because there was so much alcohol abuse within

Indigenous communities in the Burns Lake area. She added that neither her nor her colleagues labelled people based upon physical or behavioural characteristics because the problem of FAS in the area was self-evident. As indicated in the written profile of the program, which provides percentages of FAS characteristics and behaviours among the women (The Children's Commission 25), some form of in-

given Depo-Provera® also end up falling outside of the scope of many FAS prevention programs and support services because they are not "at risk" of becoming pregnant.

My fieldwork experience suggests First Nations persons are most commonly labelled as having FAS in the absence of a medical assessment. Generally, non-medical labelling involves an "assessment" based on

of FAS and the "typical" person with FAS. Those who have attended training sessions about FAS for community and front-line workers, report coming away with the impression that prevalence rates of FAS/FAE are very high, especially among Indigenous peoples. They also report that persons with FAS/FAE are easy to identify, and some felt that after their training they were able to identify at least some

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take screening does occur. However, given the presenter's response to my questioning, it is unclear how formalized and organized this process is.

The presenter's over-emphasis on maternal FAS being a causal factor of her clients' behaviour is even more troublesome when considered in relation to her claim that it is "difficult for people with FAS to remember to take a daily pill" (The Children's Commission 25). During my field research, I found that physicians and community clinics that have high concentrations of First Nations or Métis clients commonly prescribe contraception such as DepoProvera®,⁸ sometimes to girls as young as 13 years of age, under the auspices that this contributes to the prevention of pregnancy *and* FAS. According to some outreach and social workers, DepoProvera® eliminates the need for women and girls to remember to take a pill every day or to negotiate condom use with male partners (Tait 14-15). However, public health nurses that I interviewed pointed out that DepoProvera® is not designed for adolescent girls whose bodies are still developing, nor does it address the negative health and wellness consequences of alcohol addiction/abuse or the problem of sexually-transmitted diseases. Women and girls who are

the opinion of one or more persons, and involves consideration of the person's body, specifically their facial characteristics, possibly consideration of their height and weight, and an "assessment" of their intelligence, cognitive abilities, and behaviour. For example, perceived memory problems of clients are interpreted as symptomatic of FAS. However, as revealed by the Burns Lake presenter's statement about birth control pills and FAS, certain actions, or in this case non-actions (not taking birth control pills), may be interpreted as pathology (poor memory) resulting from prenatal alcohol exposure, regardless of whether or not the person reports having experienced such a memory problem. The question remains as to whether or not the client population of the Burns Lake program may refrain from using birth control pills for a whole range of reasons other than poor memory, such as an exercise of personal choice, a desire to become pregnant, cultural beliefs about contraception, or concerns about health risks and side effects of different forms of contraception.

In training sessions for community workers in prevention and intervention programs, the information given to trainees is often over-simplified, offering only a basic understanding

persons with FAS/FAE. Trainees also perceived themselves as having a core understanding of the "typical" person with FAS, including a perception about the "FAS behavioural profile." In this stereotypical profile, persons with FAS generally are described as being unable to distinguish between right and wrong, as having no clear understanding of the consequences that can result from their actions, trouble following instructions and rules, and poor short and long-term memory. They are also believed to be hyperactive, gullible, and easily victimized.

In Canada, medical assessment for FAS involves long waiting lists, and expensive and lengthy travel arrangements for people living in rural settings. It is also difficult to diagnose adolescents and adults, and diagnosis, if it occurs at all, commonly occurs in childhood years; therefore, front-line workers commonly employ non-medical labelling or "screening" to identify adults they believe have FAS. Furthermore, despite scientific evidence to the contrary, the public health message claims that all levels of alcohol exposure are dangerous to the developing fetus, which suggests high prevalence rates of FAS/FAE exist despite a lack of medical confirmation. In the example of the Burns Lake pro-

gram, assumed elevated prevalence rates of FAS are determined by some form of client in-take “screening,” and the program’s activities are then provided based upon this process.

Returning to the presenter’s response to my questioning the identification of persons with FAS, she suggested that “seeing” FAS is simply a matter of “seeing,” or at least perceiving, widespread alcohol use.¹⁰

including sterilization, because they and others perceive of them as being ill-equipped to parent a child.

Important to the representation developed by the presenter is the identification of the Indigenous population of Burns Lake region as a “population in crisis,” an image that was further reinforced during the workshop by the Chief of Pediatrics from the Prince George Regional

their children, with a perceived widespread epidemic of FAS and addiction. I was equally concerned that hardly any of the workshop participants were trained as researchers and that few appeared to have a solid knowledge base of the research literature on FAS, despite the meeting’s intention to influence the direction of gender-based research in this area.

Over dinner that evening Lucille

The assertion reinforced an image of Indigenous communities existing in a perpetual state of chaos with adults being drunkards and sexual predators, and parents—in this case mothers—affected by alcohol-related pathology.

Her response also suggested that she is “seeing” particular cohorts of First Nations and Métis people with FAS, as indicated in her statement that “most of the moms have had prenatal exposure to alcohol.” This claim reinforces an image of an “epidemic” as it implies that Indigenous women with FAS intergenerationally compound the “FAS problem” by giving birth to similarly affected children.

The presenter’s response further indicates that community workers are conditioned by their training to consider most women who attend their programs to have FAS/FAE, particularly if they are Indigenous. Because of this, one can speculate that these women are generally treated as having a chronic brain dysfunction, which could be used to justify actions such as increased social service surveillance, apprehension of their children, and pressure not to have children. In concert, the women themselves may adopt some form of identity associated with FAS that will influence their self-perception both positively and negatively, including the ways in which they engage in, and are perceived by the communities in which they live. This can lead to women, particularly those struggling with substance abuse, to more readily comply with contraceptive options,

Hospital. She stated that many contemporary Indigenous communities in northern British Columbia experience a 100 percent rate of childhood sexual abuse, which clearly indicates the level of dysfunction present in these communities. While she gave no evidence to support her claim, the assertion reinforced an image of Indigenous communities existing in a perpetual state of chaos with adults being drunkards and sexual predators, parents—in this case mothers—affected by alcohol-related pathology rendering them incapable of caring for their children or for themselves, and thus, epidemic numbers of children with FAS being victimized and neglected. Once again, Streissguth’s image of the culture-less society of pathology emerged in our discussions, as the physician explained to the workshop participants how hard it was for her as a medical doctor to watch Indigenous children growing up in such circumstances. She stated that it was difficult for her to focus on the needs of the mothers when the damage they were causing to the children was so obvious and preventable.

By the end of the day I was significantly concerned with the pervasive association of Indigenous peoples, particularly First Nations women and

Bruce and I discussed some of the implications of the day’s discussion. We were both disturbed by the negative representation of Indigenous mothers and their children, especially in the Burns Lake region. Of equal concern was the workshop participants’ inability to stay focused on women, such that time and time again the discussion shifted toward “protection” of the fetus. A further concern was the lack of attention paid to the inadequacies that exist in substance abuse treatment services for women, which in most regions of the country have only been modified slightly despite thirty years of knowledge about the dangers of prenatal alcohol exposure and the negative impact substance abuse has on women’s health in general.

Retrospective Garden Thoughts

In my spring garden, I concluded that the Vancouver workshop reflected much of what my field research had already illustrated about the knowledge production and practices associated with the diagnostic category FAS.¹¹ However, an important question to ask is whether representation of Indigenous front-line workers and leaders at the workshop would have resulted in increased support for my concerns. My research indi-

cates that while Indigenous groups are generally concerned about the difficulties involved in obtaining diagnostic assessments, they have only limited interest in whether the scope of the “FAS problem” in their communities is being overstated by the federal and provincial governments. This I interpret as reflecting less the acceptance of an “epidemic” of FAS in their communities and more a pragmatic response to the pressures brought on by chronic under-resourcing of local and regional health care services. If a label such as FAS results in extra funding being provided to overburdened health and social services than it is unlikely that community leaders will argue against the label attached to those added resources.

Elevated fertility rates among Indigenous populations imply to many Canadians that the “Indian problem” will increase exponentially if solutions are not found. The added dimension of a serious illness such as FAS further fuels this sense of urgency, particularly when maternal FAS is perceived to be a widespread problem. As illustrated by the workshop discussions, the response to alcohol and pregnancy in Canada has resulted in increased surveillance by medical, public health, and social service agencies of the bodies and behaviours of Indigenous women, particularly during child-bearing years. This has, as argued in this paper, reinvigorated enduring government strategies that historically have sought to stigmatize and control the future of Indigenous reproduction, parenting, and family life, while offering limited meaningful supports for impoverished Indigenous women and their children.

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¹Chemical contraception includes, for example, Depo Provera® and Norplant.

²The workshop organizers announced that for the purposes of the workshop the use of the term FAS would refer to both FAS, fetal alcohol effects (FAE) and other alcohol related birth defects.

³This chapter was written immediately after returning from the workshop. In later conversations with

other workshop participants they expressed similar concerns, but said they were afraid or reluctant for various reasons to express them at the workshop.

⁴In an e-mail to the organizing committee later that week, I expressed my concern about the lack of Indigenous representation at the meeting. I was told that two participants who were First Nations had been invited but declined to attend the meeting. The organizers were unsure as to why these individuals had decided to decline the invitation.

⁵Some of the participants in the workshop did not contribute to the discussion during the two-day workshop except to submit written suggestions at the end of the workshop to the organizers. It is unclear why they did not verbalize their opinions, as there was sufficient opportunity for them to do so. Therefore, it is unclear if their silence meant that they concurred with the identification of Aboriginal women as basically defining the risk group.

⁶Approximately 40 per cent of the total population of 6,000 living in Burns Lake are Indigenous. Several First Nation reserve communities are located nearby.

⁷The exact number of women in the program is not given in the publication.

⁸A prescription of DepoProvera® lasts for three months and is given to women through injection.

⁹Presently FAS screening tools for adults are limited and are likely to produce high rates of false positives. This is specifically the case for Indigenous groups where the facial features may show up naturally in the population apart from maternal alcohol exposure (Abel) and behavioral characteristics may result from socio-environmental factors that impact negatively on the person. In other cases, screening occurs as a result of local in-take tools being developed by front-line workers.

¹⁰Known or perceived in-utero alcohol exposure is sometimes enough for a person to be labeled as having

FAS/FAE, and alcohol abuse by the mother is not seen to be necessary. In some cases, just the fact that the child is Indigenous is enough for non-medical persons to perceive prenatal alcohol exposure had occurred, especially if the child has been in foster or adoptive care, or is from certain urban or reserve communities where alcohol abuse is perceived to be high.

¹¹In the weeks following the workshop, a report was produced and delivered to the IGH and to the workshop participants (Greaves, Poole and Cormier). While I gave a small amount of feedback to the organizers, at the time I could not imagine how any kind of meaningful research recommendations could come out of what felt like a very disjointed debate and discussion. However, much to my surprise and appreciation, I received a report in which the authors carefully describe and analyze the information given, producing a set of research recommendations that challenge the assumptions and questionable practices attached to the category FAS and the treatment of pregnant women. After having reviewed the report I not only feel that it signifies a successful representation of the ideas expressed and debated at the workshop, but it also attempts to redefine, at least to some degree, the ways in which research questions attached to alcohol use by pregnant women should be framed and researched in the Canadian context.

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JANICE CAMERON

The Blue Ribbon

horses that prance at the starting line
with eyes that devour the distance to the finish

his eyes eat the floor between us
my eyes consume the length to the door

I'm the faster runner but it is the bang
of the signal that always freezes me

I'm used to it now
and I'll run like I'm meant to

whether there are green fields or brown grass
past the door the blue sky will be above my head

the blue sky will be above my head

Janice Cameron's poetry appears earlier in this volume.