

WINTER 1981

\$1.75

Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY



Resisting
Womanhood

Destigmatizing
Herpes

How to Research Medical Topics

**VOICES:
A Survival Manual for
Wimmin**

VOICES focuses on health of body, mind and spirit. It includes natural medicine, coping, poetry, herstory and spiritual expression.

VOICES is produced by lesbians; contributions are welcomed from all women.

4 issues — \$5. (\$6 Cdn in US)
mothers on welfare — \$2.50
womyn in institutions — free
sample issue — \$1.

c/o I. Andrews,
R.R. #2,
Kenora, Ontario,
P9N 3W8

**TORONTO
WOMEN'S**

BOOKSTORE
85 Harbord Street
west of Spadina
922-8744



The Women's Press



**EVERYWOMAN'S
ALMANAC 1982
Appointment Calendar &
Handbook
\$5.95**

"Women and Health" is explored through interviews, graphics and articles.

See review on page 20.

To order send a cheque (include \$.75 for handling costs) to:

Women's Press
280 Bloor St. W., Ste 313,
Toronto, Ontario,
M5S 1W1.

**The Committee for
A Canadian Women's Health Network**

has recently received funds from the Secretary of State Women's Program to carry out the following work:

- to establish a contact network of health activists and organizations
- to assess the felt need for an ongoing national network, and determine priority tasks
- to propose alternative organizational structures for democratic control and decision-making
- to research potential sources of funds
- to report on the overall feasibility of establishing a national network now.

Join in a growing movement. Send us your name and address, and let us know what you can do.



Committee for a Canadian
Women's Health Network
c/o Women Healthsharing
Box 230, Station M
Toronto, Ontario M6S 4T3

Healthsharing

is now accepting paid advertising!

- * Our circulation is growing rapidly
- * Each magazine is shared with other readers
- * Back issues are kept for reference
- * Reduced rates for out-of-Ontario advertisers

Don't miss this opportunity to reach thousands of Canadian women concerned about health!

Call or write us today for our reasonable rates.

Healthsharing,
P.O. Box 230, Station M,
Toronto, Ontario,
M6S 4T3
1-416-968-1363

Desperate for gift ideas?



Surprise Someone:
GIVE HEALTHSHARING

Name: _____
Address: _____

(POSTAL CODE)

- New Individual \$6.75
(out of Canada \$8.00)
- Renew Institution or Library \$13.50
(out of Canada \$15.00)

Gift
 I want to support Healthsharing.
Total amount enclosed is \$ _____

Do you want a gift notice sent? _____

From? _____

Please enclose payment. Make cheque or money order payable to:

Women Healthsharing
Box 230, Station "M"
Toronto, Ontario M6S 4T3

Name: _____
Address: _____

(POSTAL CODE)

- New Individual \$6.75
(out of Canada \$8.00)
- Renew Institution or Library \$13.50
(out of Canada \$15.00)

Gift
 I want to support Healthsharing.
Total amount enclosed is \$ _____

Do you want a gift notice sent? _____

From? _____

Please enclose payment. Make cheque or money order payable to:

Women Healthsharing
Box 230, Station "M"
Toronto, Ontario M6S 4T3

Name: _____
Address: _____

(POSTAL CODE)

- New Individual \$6.75
(out of Canada \$8.00)
- Renew Institution or Library \$13.50
(out of Canada \$15.00)

Gift
 I want to support Healthsharing.
Total amount enclosed is \$ _____

Do you want a gift notice sent? _____

From? _____

Please enclose payment. Make cheque or money order payable to:

Women Healthsharing
Box 230, Station "M"
Toronto, Ontario M6S 4T3

Inside Healthsharing

FEATURES

- 7 **Tapping Medical Knowledge**
Doing your own Medical Research
by *Connie Clement*
- 10 **Resisting Womanhood**
A personal account of growth
by *Barbara Underwood Scharff*
- 15 **Herpes:**
Towards a positive approach
by *Melinda Cuthbert*

NEWS

- 4 **Newsfronts**
- 23 **Regional Reports**

OUR READERS WRITE

- 19 **My Story, Our Story**
Warding off unsolicited advice during pregnancy
by *Kathleen McDonnell*
- 25 **Letters**

ETCETERA

- 3 **Collective Notes**
- 6 **Healthwise**
The ins and outs of laparoscopy
by *Betsy Cuthbertson*
- 20 **Reviews**
- 26 **Resources and Events**

Collective Notes

Herpes is a volatile issue. We discovered just how volatile it is when our discussion for this *Collective Notes* quickly polarized. Is herpes just another viral disease, like the common cold, afflicting increasing numbers of people? Or is herpes an incurable, frightening disease striking at the hearts of our relationships? This was our dilemma — we could not agree. Perhaps, one of us speculated, herpes was neither of these. Perhaps we were choosing sides to an issue which has no sides.

Herpes, the topic of *Herpes: Towards a Positive Approach* by Melinda Cuthbert in this issue, is currently what syphilis was to the 1880's. At the turn of the century antibiotics had not been discovered. There was no cure for syphilis or other bacterial infections. The Victorian woman who caught syphilis was shamed as promiscuous, immoral and, always, personally to blame. Syphilis today is easily cured; herpes has taken its place. The herpes "victim" of the 1980's is reaping her "just deserts" for behaviour which threatens the very fabric of our culture, just as her sister did 100 years ago. She must suffer the incurable, for after all it is her own fault.

Whoa! Whose script is this? It certainly isn't ours! Our intimate sexual feelings and desires and our fear of the unknown are being manipulated. Once again women are pawns in a fight to uphold traditional forces. The trademarks of sensationalism and fear-baiting should be familiar. Right-wing moralists have used these tactics in the fight against abortion, against home birth and against non-marital sex.

But perhaps the right is not the only force weighing, and juggling, the impact of herpes. Are we being open about our responses to herpes or are we playing into the same game of manipulating its impact? Within Women Healthsharing we found that the size of each member's fear about herpes reflected her position about promiscuity as an acceptable choice. Those of us who defended the choice of multiple partners seemed to be least fearful of herpes; those of us who argued that few women freely choose non-monogamous relationships seemed most upset about the possibility of contracting herpes.

Could it be that some of us are downplaying herpes so that the disease cannot be used as a valid argument against multiple relationships? At the same time, might others of us be heightening the horrors of herpes as a justification for, or a protection of, monogamy?

When we hear about herpes we learn that it is not curable. We learn that the virus can spread at any time. We learn that a Caesarean section might be necessary to keep a newborn from catching the herpes. These are all true facts.

But do we also learn that the virus can go into remission? That the virus is less likely to spread when there are no active sores? That a C-section can usually be avoided if delivery is induced as soon as the waters burst? These are also true facts.

Herpes does not present a happy picture, but neither does it have to be a nightmare.

Madeline Boscoe
Betty Burcher
Connie Clement
Diana Majury

Lisa McCaskell
Jennifer Penney
Susan Wortman
Sharon Zigelstein



Raising a collective agreement
to extricate yourself from quicksand

published by
Women Healthsharing

Collective Members

Madeline Boscoe, Betty Burcher
Connie Clement, Diana Majury
Lisa McCaskell, Jennifer Penney

Susan Wortman,
Sharon Zigelstein

Associates

Rona Achilles, Adelyn Bowland
Anne Rochon Ford

Office Manager

Beverley Rodrigue

Promotion

Susan Wortman

Regional Reporters

Lissa Donner, Frances Ennis
Beth Hutchinson, Deborah Kaetz
Susan Moger, Ellen Seaman
Annie Thurlow, Clara Valverde

Thanks This Issue To

Patricia Brown, Katherine Cook,
Sheridan Cooper, Dawna
Gallagher, Ann-Marie Hranka, Ken
Johnson, Colleen Kennelly, Chris
Lawrence, Allie Lehman, Rhonda
Love, Leslie Riley, Holly Rodrigue,
Krista Rodrigue, Ellen Watches.

Ken Wyman

Typesetters

Dumont Press Graphix

Printer

Muskox Press

Healthsharing (ISSN: 0226-1510), Volume III, Number 1. Published quarterly by Women Healthsharing, Inc., A Resource and Writing Collective, Box 230, Station M, Toronto, Ontario M6S 4T3. Phone: 416-968-1363. Women Healthsharing endeavours to print material with which we agree; however not every article or column reflects the opinion of all collective members. Authors and artists retain copyright, 1981. No part of this magazine may be reprinted without prior permission. Unsolicited manuscripts or artwork should include a stamped, self-addressed envelope. Subscription rates are \$6.75/year, individuals; \$13.50/year, institutions and groups; \$25.00/year, sustaining. Foreign subs, including USA, are \$8.00/year, individuals; \$15.00/year, institutions.

Second Class Mail
Registration No. 5327

Newsfronts

Risk Continues Post-Pill

Women in their forties, who at any time have used the birth control pill for more than 10 cumulative years, may be two to three times more likely to have a heart attack than women who were never on the pill. It is well established that women on the pill run a greater risk of having a heart attack but this risk was thought to decrease soon after stopping pill use. This is the first evidence that some increased risk of heart disease may continue for up to 10 years after women stop taking the pill.

The findings published in the *New England Journal of Medicine* by researchers at Boston University, also indicate that shorter past use of the pill also increases risk, although to a lesser degree.

The researchers caution that their results need confirmation by other studies. In addition, most of the women in the study had been taking now out-dated high-estrogen pills.

Nurses Join Euthanasia Society

A recent report published in England by the Royal College of Nurses (RCN) states that approximately 700 working and retired nurses may belong to a British euthanasia society. The society, called Exit, the Society for the Right to Die with Dignity, has 11,000 members and believes that people should be allowed to take their own lives if they wish.

The RCN, the professional body to which most British nurses belong, finds the study results very worrying. A College spokesperson, quoted in *The Globe and Mail* said, "The RCN is strenuously opposed to

euthanasia, and these nurses should not be doing this. They are departing from their nursing principles."

One is led to wonder what principles and morals these nurses have seen violated to lead them to join the Society. With frequent new scientific "breakthroughs" and "discoveries" which make possible the prolongation of life while giving little thought to its quality or costs incurred, this British example may be only the beginning of a growing movement.

Public Health — Ignorance, Poisons, Infections, Poverty

These four themes highlighted the 72nd annual conference of the Canadian Public Health Association held in Saskatoon this summer. Conference attendees passed resolutions to foster the introduction and upgrading of human sexuality programs, to actively lobby for controls on acid rain, to pressure the federal government to ban 2,4-D as an aquatic weed control and to improve facilities and services for Canadians with disabilities.

The keynote speaker, Helen Mussallem, former director of the Canadian Nurses Association, spoke about the underutilization of nurses in community health services. She pointed out that more than 80% of the country's 200,000 nurses work in hospitals "where they have little or no opportunity to change the course of events that brought the patient to the hospital." Further, she added, "we know that over 80% of the highly qualified health personnel, including nurses, are caring for, at this moment, less than 3% of Canada's population."

Another speaker, Gerald

Bonham, British Columbia's senior deputy minister of health, outlined three areas of concern: increasing medical technology, lack of government funding, and the increasing percentage of the population made up of senior citizens. Coverage of the Conference in the *Canadian Medical Association Journal* reported Bonham as saying that it is the cost of high technology, not hospital pay raises, which is increasing health care costs.

Research Misleading

For years we have read and heard that intercourse during pregnancy is safe. But readers of the popular press this summer may have been surprised and frightened by articles indicating that intercourse is dangerous to the fetus.

These media articles were referring to work done by Dr. Richard Naeye, chairman of pathology at Pennsylvania State University. He announced at the Canadian Pediatric Association annual meeting that he had preliminary evidence that 33-40% of premature births could be prevented if couples either abstained or used condoms during the last six months of pregnancy.

The mechanism is thought to work something like this: bacteria, normally found in the vagina, are carried through the protective mucous plug in the cervix by sperm and seminal fluid. Inside the uterus, bacteria cross the fetal membranes into the amniotic fluid where they trigger a bio-chemical reaction causing premature labour, according to the July 4, 1981 *Medical Post*. Key information was omitted from the press coverage: Naeye has been studying African women who are known to have low levels of zinc in their systems. Zinc helps make amniotic fluid anti-bacterial and therefore resistant to infection. Generally North American women have adequate amounts of zinc present in their bodies and so are not at risk. Further research promoting Naeye's opinions must be examined carefully for the same flaw before we are once again frightened into altering our sexual behaviour.



Medical Plastics Leach Poisons

Individuals undergoing surgery are exposed to a potentially carcinogenic compound leaching from the plastic used in transfusion blood bags, according to an article in the June/July issue of

Canadian Research. The compound is a plasticizer called di-2-ethylhexyl phthalate (DEHP), added to plastics to make them flexible.

DEHP is used in assorted household, industrial and medical plastics. In medical products such as blood bags and blood tubing, plasticizers comprise as much as 40% of the end product by weight.

DEHP can cause testicular atrophy, pituitary gland changes and may be carcinogenic according to the National Cancer Institute in the U.S. In general use, DEHP is absorbed through the gastro-intestinal tracts in minute quantities — at most milligrams per day.

Blood bags are another story. A patient who requires five or six bags of blood during surgery may absorb more than 0.1 gram of DEHP directly into her blood stream. A hemodialysis patient can receive approximately 0.05 g of DEHP during each of 100 to 150 treatments per year. Even healthy donors who give a select portion of their blood through plasmapheresis absorb from 5 to 25 mg of DEHP per donation.

Although the Food and Drug Administration is considering regulatory action, there is no indication that the Canadian government will follow suit in the near future. Given the laxness of medical device legislation in Canada it would not be unlikely to begin seeing blood bags on this side of the border which are no longer considered safe in the U.S.

Doctor's Wife — An Unhealthy Profession

A bleak picture was painted to doctors attending the British Medical Association (BMA) congress in San Diego this fall. According to Sir John Walton, president of the BMA, five times as many wives of British doctors commit suicide as do wives of architects or accountants.

Walton quoted a recent study saying that doctors' wives perceived their husbands' practices "as a demanding mistress who always won, and patients were thought always to come first". Depression, feelings of anger and

hostility, alcohol and drug abuse and suicide tend to be the most common reactions of doctors' wives.

A 1974 study estimated there were between 2,000 and 3,000 alcoholic doctors in Britain; a 1976 study gave the figure for U.S. doctors at between 13,000 and 22,000.

What kind of society and health care system leads to such depression and destructive behaviour? Sir John offered few answers.

Preventive Child Abuse Program Axed

Parent Resources, an innovative preventive child abuse program, will bite the dust on November 30, 1981. Along with many other community and women's projects, it has fallen to the axe of Ontario government cutbacks.

Parent Resources was started initially four and a half years ago by a collective of women. It has been funded by the Ontario government for the last three years as a demonstration project to prevent child abuse. The workers have sought out isolated women under stress and "at risk" for abusing their children. They run two drop-in centres for

parents and kids where moms get a break and can chat with other moms about the frustrations and joys of raising children. An independent research team found that mothers involved have benefited and are less likely to abuse their children.

Despite public and media outcry, the Ministry of Community and Social Services has refused to re-fund the project. Child Abuse is no longer the buzz word for funding. It's served its time and despite the positive evaluation showing that this particular project worked, 300 families are losing their centres and support systems.

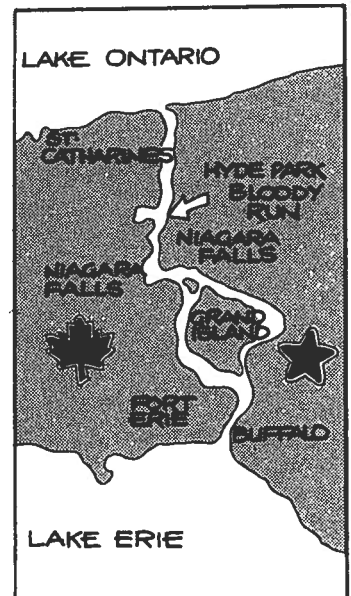
Niagara River is an Industrial Sewer

The Niagara River, famous as a spectacular tourist attraction, is achieving new fame as an industrial sewer threatening the health of over 500 thousand people who drink its water.

In a recent report, entitled *The Ravaged River*, the New York Public Interest Research Group states that the Niagara is overloaded with biological and industrial wastes.

Dioxin, mirex, lindane, phenols, phosphates, lead, arsenic, copper and mercury are found in the 250 million gallons of toxic waste dumped straight into the river by 77 industries on the American side. Another 700 industries pour toxic wastes into municipal sewage treatment plants ill-equipped to handle the waste. One such plant, built specially four years ago to treat industrial waste, broke down six weeks into operation and hasn't been repaired since, according to an Environment Canada official.

Adding further to the deadly brew, toxins from the Hyde Park Chemical dump have been seeping into the walls of the Niagara Gorge, according to the Toronto-based Pollution Probe. Hooker Chemical Company (of Love Canal fame) owns this 80,000 ton landfill site located about a mile south of the Lewiston-Queenston bridge in the Niagara Falls, New York area. Buried in the dump is



an estimated 2,000 pounds of dioxin, the world's most deadly chemical.

"Federal and New York state and local officials have been aware of the contamination for years and are still trying through lies and cover-ups to prevent Canadians from finding out how bad it is," said Donald Ross of the NYPIRG.

After sobering testimony from environmental groups, the Ontario government has threatened legal action against U.S. environmental agencies

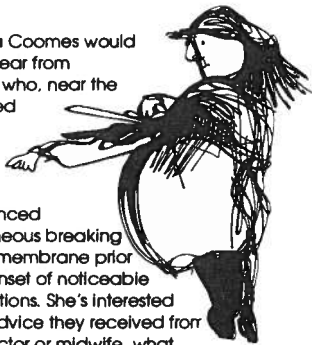


Good, old oatmeal can reduce dangerous blood cholesterol levels, says Dr. James Anderson of the Lexington Veterans Administration Hospital in Kentucky. Anderson uses oatmeal as part of dietary therapy for diabetics, and has been able to take many patients off insulin and other drugs. "Oatmeal fibre," he claims, "not only helps the body get rid of excess cholesterol, but also prevents the body from producing it."

SHARE YOUR ABORTION EXPERIENCES

Do you want to share your experience of abortion? Freelance editor Susan Bagby is compiling and editing a collection of women's accounts of their abortions and invites women of all ages and backgrounds to write her. She asks for direct, honest experiences, following on your feelings about the event. Write under a pen name if you prefer. Send to: 332-B Tescony, Santa Cruz, California 95060

Barbara Coomes would like to hear from women who, near the expected date of birth for their child, experienced spontaneous breaking of their membrane prior to the onset of noticeable contractions. She's interested in the advice they received from their doctor or midwife, what course their labour took, and the way the birth ultimately occurred. Please write to: R.R. 1, Kaministiquia, Ontario



APOLOGIES

- To all the people whose names were spelled incorrectly in the last issue. They are: Joan Barr, Ann-Marie Hranka, Anne Rochon Ford, Bev Rodrigue and Murielle Vachon.
- To the Toronto Women's Health Network for the two typos which resulted in both phone numbers being incorrect! The phone numbers should have read: Anne Rochon Ford (964-9467) and Lyba Spring (635-9467).

Healthwise

Only a Quick Look Around?

by Betsy Cuthbertson

Laparoscopy is a common gynecological procedure used to diagnose and treat different pelvic complaints if standard tests are ineffective or more surgery is contemplated. Endometriosis, pelvic inflammatory disease, cysts, adhesions and tubal pregnancies may be diagnosed and treatments such as drainage of cysts, collection of abdominal fluid, biopsies, removal of adhesions and sterilizations may be performed.

It is minor surgery and has definite advantages over major surgery: anesthesia time is shorter, the length of hospital stay is briefer and post-operative discomfort is much less.

However, there are potential hazards that are not often revealed to patients. Many patients believe the procedure involves only a simple incision and a quick look around. In laparoscopy the patient is given a general anesthetic, her legs are put up in stirrups and the operating table is tilted so that her head is below the level of her hips. A catheter is put in to empty her bladder and an instrument to manipulate the uterus is inserted into the vagina to the cervix. A small incision is made below her umbilicus and a needle is passed in, through which three or four litres of carbon dioxide gas are introduced into the abdominal cavity. These measures are done to separate her intestines from her pelvic organs and to lift her abdominal wall away from the internal structures to create a space for a trocar to be inserted.

The trocar is a sharp, pointed instrument about one quarter inch in diameter contained in a metal sheath. It creates a hole through the layers of the abdominal wall to allow passage of the scope. Once the trocar has pierced the layers it is removed and the laparoscope is passed through the sheath and attached to a light source.

The surgeon can now look at the pelvic structures. Her uterus and attached structures can be elevated for better visibility and access by moving the uterine manipulator.

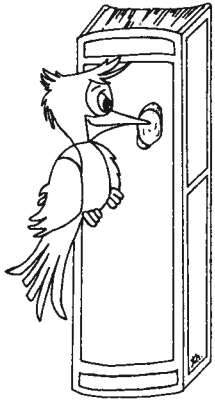
After the procedure is finished, the gas is allowed to escape, the skin incision is stitched and the woman is taken to recovery room.

After the surgery, the woman will probably experience mild to severe pain in her shoulder blades because of retained carbon dioxide gas. She will also have discomfort from the manipulation of her internal organs, vagina or from the urinary catheterization.

The hazards involved are the same as for any surgery — anesthetic complications, hemorrhage, infection and pulmonary embolism. Specific risks include accidental perforation of internal organs or injury to the blood supply of the abdominal wall. Another possibility is that excess gas in the woman's abdomen could compress her heart and surrounding vessels leading to a transient state of shock.

Laparoscopy is a minor operation with only an approximate 1% chance of complications. Yet it involves much more than many women are aware of and the risks are very real. It, like any other operation, should be undergone only after a careful and thorough examination of the benefits and risks.

Betsy Cuthbertson is an operating room nurse working in a downtown Toronto teaching hospital.



TAPPING MEDICAL KNOWLEDGE

by Connie Clement

"I have *what*?" For months Jackie had felt tired, inattentive, feverish and achey. After being shuffled from one doctor to another without telling her what was the matter, Jackie was finally being told the name of her disease. And she couldn't even pronounce it. "Would you write that down for me, please?"

Jackie has Systemic Lupus Erythematosus. One of the problems confounding Jackie as she adjusted to her new knowledge about her disease, was a problem we all at some time or another share: how to find out more about an illness. Jackie was unfortunate in having a difficult to diagnose disease with a myriad of possible symptoms. She did, however, have an easier time finding out about her disease than do many people with better understood diseases. Jackie's physician put her onto the Lupus Foundation and the Foundation in turn provided her with lots of information and support.

But what if your doctor doesn't inform you about an organization to answer your questions? Haven't you sometimes wished that you knew what your doctor was talking about, or that you could read something simple and

basic so you'd know the questions to ask her? How often have you wanted to check out whether or not to believe the advice of your grandmother — or your best friend, or a co-worker, or the plumber you phoned just before you sprained your wrist using the pipe wrench?

Knowing where and how to gain access to health information can be a valuable tool. Occasionally it can be lifesaving. Public libraries, academic and medical libraries and small resource centres housed by specialized organizations can offer you a wealth of information . . . if you know how to find your way around a library.



Public libraries are often the best place to start — sometimes they can be your first and only stop. "The public library has long been one of the few free educational and recreational services in our society. With its stress on equal and unrestricted access to quality information," says Deborah van Wyck, a Montreal health librarian, "it is the ideal start-

ing point for the curious health consumer."

Sometimes you'll want information more detailed than the public library has in its own holdings. In this case you may want to tap medical literature. You can do this by using interlibrary loans, a system whereby your library borrows the material wanted from a technical library and you pick it up at your own branch. Or you can go to a medical library yourself. If you turn to medical literature you'll need to be prepared to struggle through some technical, and sometimes intimidating, jargon. Medical libraries are geared to users versed in medicalese and have only limited experience helping lay people. Patience, doggedness and a good medical dictionary will help.

Whether you stick with your public library branch or use a specialized library, your most useful reference tool and ally will be the reference librarian. Although this article outlines some basic information sources, it is the librarian who will help you locate them and teach you how to use them. Even if you know how to use the card catalogue and find books on the shelves, asking can pay off. Because of high theft rates, health and sexuality books are very often not kept on the open shelves.

Using the card catalogue is your best method to find most books. If you have a title or author look that up; if not, check the subject catalogue under the topic of interest to you.

Even if no book specifically on your topic is listed in the card catalogue, see what's on the shelves. Most libraries use the Dewey decimal numbering system to shelve books, so once you find the right section you can browse. Health subjects are found in the 600s: for instance, nutrition is 641 and public health is 614. Most libraries have signs on the wall to indicate where various subject holdings are shelved; if not, ask.

In recent years a spate of written materials for lay readers has been published. Some of the literature has grown out of the self-care health movement.

photos by Tracy McCall

drawings by Krista Rodrigue

This literature aims to increase the reader's self-reliance and control about health decisions. At the same time, literature has come about because of a move within the medical profession to increase patient education, hoping to increase patient compliance, reduce health care costs and limit the number of malpractice suits. In both cases, although often different in tone and comprehensiveness, we can benefit from the information provided.

Books such as *Our Bodies, Ourselves* by the Boston Women's Health Book Collective and *How to Be Your Own Doctor (Sometimes)* by Keith Sehnert provide extensive health information. These books and many similar books are available at book stores and public libraries. In fact, the problem today is not to find easily understandable health literature, but to know which of the numerous books filling the shelves at your library and book store are the most accurate, unbiased and informative. To sort this out you may need to talk with friends, health practitioners or staff at women's centres. Don't take any information on faith alone — check out whether an author backs up statements with references and whether or not the information provided reflects your experience.

Magazines

Magazine articles also provide wide-ranging health information. Aside from *Healthsharing*, you can find useful information in many magazines: feminist publications such as *Broadside*, *La Vie en Rose* and *Images*; mainstream women's magazines like *Prevention*; *Alternatives*, *Probe Post* and other environmental publications; smaller newsletters such as *The Monthly*, *Voices* and *Planned Parenthood* newsletters; alternative health publications such as *Bodywork* and *Allergy Shot*.

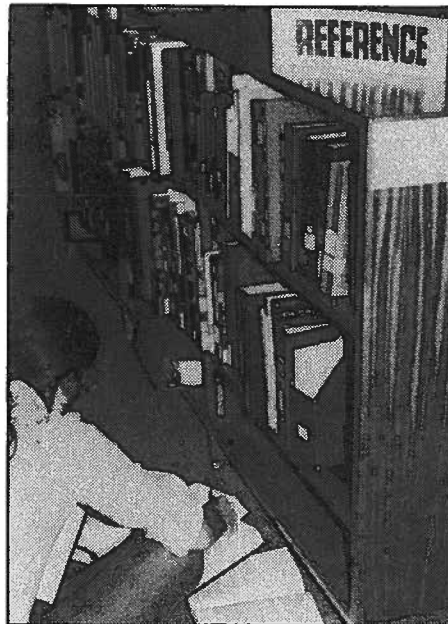
The trick is to find the articles of interest without buying out your corner newsstand. For this purpose *Readers' Guide to Periodical Literature* can be a saviour. *Readers' Guide to Periodical Literature*, the most popular listing or index to mainstream magazines, indexes nearly 160 magazines every two weeks. *The Canadian Periodical Index* is a similar publication which will help you find articles in Canadian magazines. Cumulative indexes of each are published several times throughout the year

so that you can look at several months worth of article listings at once.

If you're researching a topic which is receiving media attention, such as an environmental health issue, then *Canadian News Index*, which accesses newspapers and a few magazines, will make finding coverage across the country much easier. *Canadian News Facts* provides weekly summaries of the news.

Medical Libraries

Sometimes even these indexes at the public library won't be sufficient to find the information you are seeking. Marcie, a community organizer with no medical



training, decided to tackle a medical library to find some answers. Marcie had had copious, and sometimes irritating, vaginal discharge for years. It sometimes lessened, but always returned. She had seen doctor after doctor, received a series of treatments and been told it was nothing to worry about. She decided to discover what the doctors said to one another in their own journals.

She started by talking with friends. "A friend of mine worked at the birth control centre, so I asked her for information. She loaned me some pamphlets and copies of articles. Most important, she reinforced my feeling that recurrent vaginitis was a serious concern," recalls Marcie.

When she felt she had a bit of grounding, she went to her local hospital. She had to persist even to be given directions down the proper hallways to the library. Then she ran head on into an old-time librarian who thought her library was the domain of doctors — non-physician staff were admitted, but had no borrowing privileges; the lay public was not barred access, but was greeted hostilely. "You would have thought I was a criminal," Marcie remembers, "the way she interrogated me!"

Marcie persisted, and discovered, thankfully, that the assistant librarian was cooperative and helpful. She explained to Marcie that the library had three types of holdings — reference, subject books and journals — and that Marcie would probably benefit from using all three.

Reference books, which cannot be taken from the library, include dictionaries, indexes, encyclopedias and basic core texts such as *Gray's Anatomy*. A good reference text, such as *Merck's Manual*, a manual which lists common diseases, symptoms and treatments, may be sufficient to answer your questions.

Some reference books may be borrowed from health practitioners or used in their offices. *Compendium of Pharmaceuticals and Specialties (CPS)*, a manual containing product information about prescription drugs, is acquired each year by all pharmacists and many clinics and doctor's offices. *CPS* will answer questions about drug interactions, dosages and adverse reactions to a drug.

Medical texts are difficult to wade through, however, and very often lay books have been written containing similar information. For instance, instead of using *CPS* you may find it easier to read *The People's Pharmacy* by Joe Graedon. Although not quite as detailed it contains much information written to be understood by people with no training in pharmacology. A nurse friend of mine uses *The People's Pharmacy* as her first source of information, and uses *CPS* only when she needs to check out something unusual.

There are at least two sources to help you find your way to the most useful and readable medical texts. "Medical Books for the Layperson" by Marilyn McLean Philbrook,* is the only bibliography that lists books written especially for non-professionals. Although somewhat dated, it lists many useful references.

"Medical Textbooks I Have Known", an article by Anne Simons in *Medical Self-Care: Access to Health Tools* (edited by Tom Ferguson) pinpoints affordable and understandable text books originally written for medical students and practitioners.

Journal Indexes

Among the reference works, you will find indexes listing articles in medical journals. The most current medical literature is found in journal articles. Because at least one and often many details are out-of-date by the time a medical book can be published, journals are used to share current medical theories and findings. The advantage of turning to journal articles is that you will be able to read the most recent information; the disadvantage is that some of this information will be found, in time, to be full of wrong assumptions. You'll find poorly researched studies and articles by people with vested interests in one or the other side of an ongoing debate. Even if you don't trust everything you read, you'll be able to find valuable information.

When Marcie was researching vaginitis, she was shown how to use *Index Medicus*, an index which lists articles by subject and author from 2,600 medical journals. Marcie hadn't any idea that so many articles about vaginitis could exist. Overwhelmed, she asked for help. The assistant librarian showed her the *Abridged Index Medicus* which lists articles from only the 130 journals judged to be most credible. She was also shown the *Bibliography of Medical Reviews*, which lists only review or summary articles. Sometimes going directly to review articles can save hours: a medical writer has already sifted through the bulk of research findings about a particular subject and written an article comparing various theories and findings.

If Marcie had been at a library designed for non-doctors, she might have been shown other indexes as well. M.S. Averill in an article in *Medical Self-Care* recommends nursing journals because their language tends to be less technical than medical journals. For this purpose, *Cumulated Index to Nursing and Allied Health Literature* is probably the most useful index.

Using indexes to find articles is time consuming and tedious. Once you've made notes of the listings, you still

need to look up each article to discover whether or not the material will be directly pertinent to your area of concern.

Computer Searches

One way to reduce the work, if you have more money than time, is to order a computer search. Vivien, an active member of her union health and safety committee, needed to know more about the potential hazards of video-display terminals (VDTs) after some women complained about eye problems. She had read bits and pieces of the controversy in her local newspaper during the past year, but wasn't



really sure of the ins and outs. The committee wanted information from researchers with many different perspectives and needed the information quickly. They decided a computer search was in order.

Vivien went to the university library in her city and arranged for two searches. The librarian entered her request for information about VDT-related health factors into a computer search programme called Magazine Index, which stores listings from the *Reader's Guide to Periodical Literature* and other general magazine indexes. She also coded the request into the Medical Literature Retrieval System (MEDLARS).

Two days following her request, Vivien picked up two long, annotated bibliographies. Her committee was able to select only the most useful looking references. The two searches cost approximately \$20 and saved several hours of work.

Associations

Vivien might have done as well by contacting a specialized library. For instance, the Canadian Centre for Occupational Health and Safety, a crown corporation located in Hamilton, Ontario, will respond to specific written or telephoned requests for information. Some government libraries, such as provincial ministry of labour libraries, have excellent reference materials which can often be borrowed through inter-library loan.

Many smaller, local or simply private sector organizations can also provide health information. The best ways to find organizations is by word of mouth, the yellow pages of your local phone book or by using *The Directory of Associations in Canada* at your local library. The Directory lists associations alphabetically and by topic. The last edition was published in 1978 and its listings of alternative health organizations and radical feminist organizations is nearly non-existent. It is, however, very useful to find mainstream and technical organizations.

Regardless of the routes you choose to find the information you need, you will learn tools which will retain their value long after you have answered your initial questions. Much medical information is hidden and cloaked in mystery — share what you can unearth.

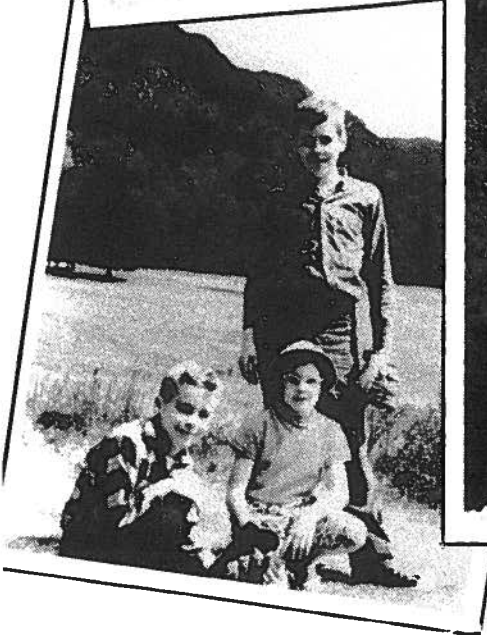
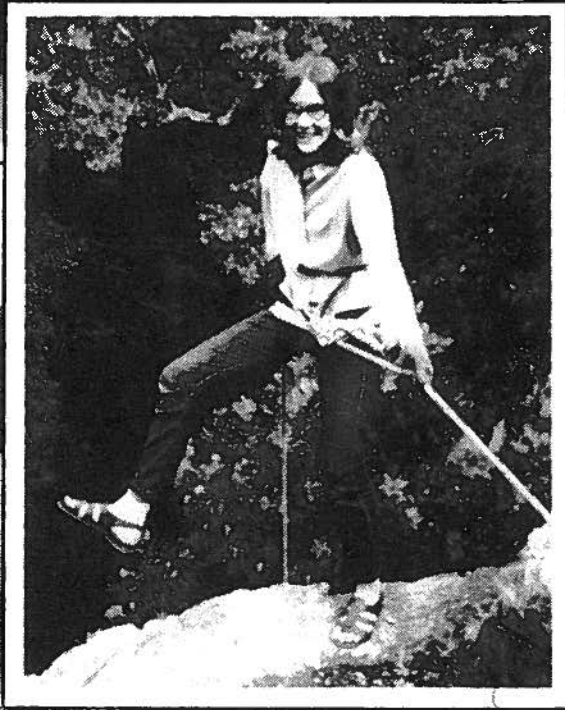
*"Medical Books for the Lay Person" by Marilyn McLean Philbrook is available from the Publication Sales Office, Boston Public Library, P.O. Box 286, Boston, Massachusetts, USA 02117. The 1976 edition costs \$2.00; the 1978 supplement costs \$2.50.

Thanks to Deborah van Wyck, who gathered much of the background information used in preparing this article.

Connie Clement is a member of Women Healthsharing. She is a family planning community worker for the City of Toronto.

Resisting Womanhood

by Barbara Underwood Scharff



Top right — Ethel Todd Anderson, 1912, Barbara's grandmother. Centre right — Barbara at four. Bottom right — Age seven, with her brothers. Top centre — Barbara at twelve, with her mother. Above — Rock climbing at sixteen.

I was born into the skin of a tomboy, swinging from maple trees, hammering together tree-forts and go-carts, waging acorn wars, riding horses at wind-tunnel speeds, breeding a menagerie of albino rats and horned toads. My body felt androgynous. A cluster of stamens and pistils seemed to form one fuse inside me.

During childhood I identified more with the shenanigans and rakish exploits of boys than with the doll-playing world of girls.

I spent my youth sabotaging growing up. As an incipient Peter Pan, I could feel adventuresome, pre-sexual, always believing my full potential hovered off in a future unfolding.

In seventh grade I was the last girl to climb out of a comfortable t-shirt and put on a AAA-cup training bra. I was economically built, my stomach flat, with small efficient muscles. I could pass physical fitness tests at public school with flying colours.

By the age of 15, I still didn't menstruate. I realized I was an oddity and became embarrassed about my barely suggestive breasts. Gym class showers were a torture for me.

My mother took me to a gynecologist one day to determine why I was so late in developing.

We walked into the medical clinic together.

"Mom, is there something wrong with me? What are they going to do to me?"

"Don't worry, Barbo, they're just going to make sure everything is all right. I'm sure nothing will hurt."

"You know, I don't mind not having a period. I mean I wish I never had to get one."

"Oh, someday you'll feel different. You'll want a family and children. I want to make sure you can."

The idea of my having children was a total abstraction, as far from my mind as a snowstorm in summer.

After I had filled out the medical

forms and given a urine sample, the nurse left me in a room with the instructions to undress and put on a thin paper smock. I didn't know whether to put the open end frontwards or backwards. Why hadn't the nurse explained things better before the doctor came in? If I put the smock on wrong the doctor would think me stupid. (I'd just gone through the trauma of not knowing how much urine to collect for the little bottle sample. Maybe I had given way too much and they wouldn't want *all* of it!) I thought, why don't they let my mom come in with me? She'd explain.

After rehearsing "hello" over and over for the impending arrival of the doctor, he walked in, brisk and cool. I forgot to say hello. He asked me why I had come. I said I was 15 and hadn't started my period but I wasn't worried, It was my mother who was worried.

He nodded, glanced up from the medical folder, and told me to turn my smock around. Cast as the fool after all, I didn't want to expose my meagre body to this strange man for judgment. I didn't want him to poke or prod me. His surveying, critical eyes seemed to violate.

"Lie down on your back and put your feet up in these stirrups. Spread your legs apart," he directed.

My feet were used to being in stirrups, but on each side of a horse, not at the end of a table. I felt captive. I had no idea what the doctor would do. My whole body tensed as he touched me. Where was my mom?

"Now we're going to put something inside you that will feel metallic and very cold. It might hurt at first, but just relax," instructed the doctor. He touched my labia.

My mind flayed wildly back and forth between instruction to trust a doctor, and immediate panic that he was a monster about to perform some crippling inner-body experiment.

"O.K. Now you may bleed a little, but that's normal. Here we go."

With sterile plastic gloves, he pressed on my abdomen and pushed metal clamps into my vagina. It was a place that even I had never explored. I held onto the side of the table with all my might. A painful sensation tore me. I wanted to scream, but I thought I'd be cowardly. Maybe the hurt was my fault, from being so nervous and tense. I was embarrassed to ask the doctor

what he was doing to me and he didn't volunteer information. After all, shouldn't I know more about my own body than he did as a man? My ignorance was humiliating.

Without a word, the doctor adjusted the instrument to widen the hole so he could put his fingers inside me. I hated to think that he would be the first person ever inside me there. I couldn't see what was happening, so I just gritted my teeth and closed my eyes. Please hurry, I longed.

Without warning, the doctor put his fingers up my rectum. I tensed my muscles, an automatic private reaction. Feeling violated, I wondered where's my mom? I wished I could go home.

He finally removed the speculum, tore off his sticky gloves, quickly wiped my vagina and told me to get dressed. He said to sit in the waiting room, but he wanted my mother to come in to talk to him.

I brought my legs together and felt a sharp pain inside. I felt poked and stretched and ripped. Sitting hurt me, so I got up from the examining table. There, on the white paper, was my blood. Something inside of me had bled. I wondered if what the doctor had done had started my period. Is that what a period felt like? Is that what it felt when a man came into a woman? Should I even ask my mother? In the meantime, I quickly dressed and walked to the waiting room.

"Mom, the doctor wants to talk to you." I must have looked white.

"Are you all right?"

"That doctor hurt me. I got scared when he put a big metal thing up me. I can't even sit down. And he made me bleed. Was that my period he started? I didn't like him." The protests I'd felt powerless to reveal to the doctor poured out of me. My mom was one liferaft in shark-filled waters.

"I'm sorry they hurt you!" She reacted with alarm, the instinct of the mother I knew. "I never imagined they'd give you a pelvic exam. I wouldn't have let them. I should have stayed with you." She seemed outraged. Her anger helped heal my hurt. She rushed in to speak to the doctor.

That was when I became aware of fearing my sexuality. I feared with the remembrance a body stores in its cells

when hurt or wounded. I feared that having a period would be that painful. I feared that each penetration by a man's penis would feel as horrifying and make me feel as powerless as this first, cold, medical intrusion. The doctor probably also triggered fears that already existed, for I decided I never wanted to grow up, never wanted to be desired by men, never wanted to be at their mercy or within their power. I didn't want to do what other women did sexually. I only wanted to be friends with boys and men. I decided I would be content with fantasy and romance novels. I could skip the rest.

The doctor informed my mother at this visit that all my reproductive organs were intact, though small. He advised that I be put on the "pill" for several months to stimulate a period artificially, to test out my body mechanics.

By the time I was 17 my body had become a testing ground for male gynecologists and endocrinologists, trying out their theories on why my hormones refused to work. Was a brain tumour inhibiting the master hormone trigger — the pituitary gland? I underwent tests on my brain to determine if there was a growth or tumour, I feared I might die. They discovered I didn't have a brain tumour. During that period I discovered I wanted four things in my life before death — to travel in Europe; to try hallucinogenic drugs; to experience romantic "love"; and to discover if God really existed. Not included in this list of "last rites" wishes were yearnings to have sexual intercourse, or to have a baby and be a mother.

Finally my hormonal imbalance and late development was diagnosed as "psychological", related to unhappiness, uncertainty. It didn't help that all around me my female friends seemed to be growing up; most had lost their virginity, and talked about their first *experience*. I wondered if I was just a prude.

The psychological diagnosis had also included the fact that borderline malnutrition had been involved for awhile.

Always a self-tester, I discovered in my teens that I could be a dictator over my own body by limiting my intake of food. A perfectionist, a taskmaster forcing my body to its limit, I could

postpone my female development — a development that somehow threatened me. While lacking an overall sense of control over my life, I was at least certain that I had complete power to determine my weight. That was one absolute formula of cause and effect. By severe dieting, I could rapidly produce weight loss.

Eventually I rejected everything in my diet as fattening except lettuce, celery and lean meat. I was afraid one bite of a cookie, or a piece of bread, or a cracker would cause me to bloat. Even worse, surrendering to that kind of "temptation" would catalyze a chain reaction of uncontrolled gorging. Because I was chronically famished, I had to be careful not to let this happen. When it did, I hated myself. Sometimes I would try to throw the food up, or fast the next day.

My weight slid from 110 pounds to 90 pounds in a few months. Yet I still looked at myself in the mirror and saw a flabby form. I wanted to be more spare, lean, a beautiful and efficient body of sleek muscle and bone.

I found that I was rejecting the nurturing overtures of my parents, especially my mother, as I insisted on acting independent of her strongest wishes to have me eat. But the paradox about this kind of "independence" was that I depended on her concern and worry.

Severe dieting was my way of differentiating myself from everyone else; my decision to practise rigid self-denial and self-sacrifice raised me above the common denominator. There was a kind of purity, a purging in it. I was unique, transcendent, the centre of attention, and superior through my willful overcoming of the need for food.

An image of "beauty" was also involved. Only through repeated acts of denial could I reassure myself of the beauty of my character. Having acquired an older boyfriend my junior year in high school, I was influenced by his preference for a sleek and petite woman.

That my breasts remained small, and that I had no spontaneous periods, didn't upset me. I wanted to forestall or prevent ever having them. Mature womanhood symbolized set roles: maternity, nurturing, sacrifice and duty, answering others' demands for love, caring-for rather than being-cared-for; it meant becoming a grown-up version of the "good-girl" who ful-

filled every one else's expectations about cheerfulness and service. Womanhood symbolized domesticity. Finally, it meant vulnerability to sexual exploitation.

Part of learning to fulfill others' needs was learning how to defer sexually to the needs of the male. I didn't want to get used sexually, or experience the pain I had associated with "sex", a pain I imagined all women constantly suffered.

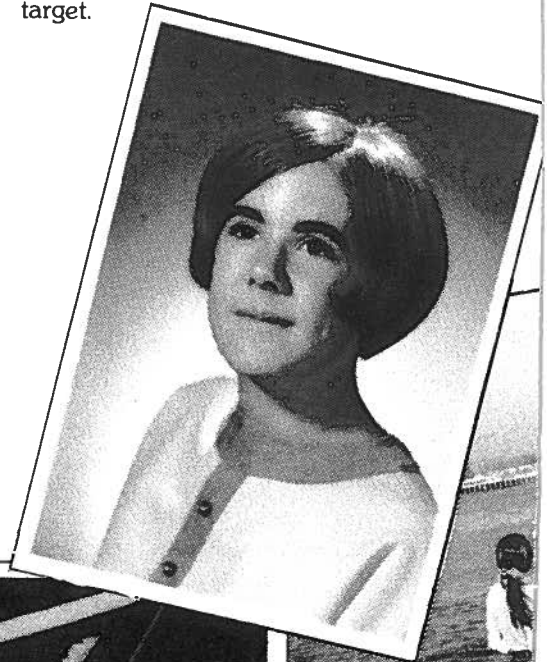
Because womanhood seemed to mean basing my life on others' needs, and because I didn't feel complete in my ability to serve and give, I was unable to envision sacrificing so much of my own self-searching and identity-building for the creating of a family. On the contrary: I was terrified of the responsibility that went with womanhood and mothering. There seemed no limits to the demands placed upon such a being. A kind of "super-woman" image had fit my mother. Could I ever be a duplicate of that? No, I thought. Did I want to be? I didn't know.

One day I came in from hand-mowing my family's lawn in Virginia. It was a hot, gluey summer day. Sweaty, I peeled off all of my clothes, ready to jump in the shower, when I decided to climb on the scale. I wondered how much weight I'd lost in sweat? (I'd only eaten a handful of carrots and celery for breakfast that day.) I weighed 89 pounds! Suddenly I felt frightened. I

realized if I let the incentive of breaking the 90-pound hurdle unleash my obsession to pursue 80 pounds, then 70 pounds, I would have no energy left for the sports and activities I loved. How could I climb up a 150-foot rope from the pit of a cave? Or play soccer or women's basketball? Or carry a 40-pound backpack?

From that moment, my obsession snapped, loosening its hold on me. When I'd consciously weighed the importance of furthering my thinness or supporting my energy, I'd chosen the latter. I remember a physical sensation accompanied the compromise: it was elastic, not metallic.

Standing there, I decided a few pounds wouldn't make me the fat lady in the circus. I wouldn't suddenly become round, defeated, dependent, duty-bound, or a voluptuous sexual target.



Left — Caving, age 19
Top — Barbara at age 19
Centre — Age nine
Right — Age twenty

I began to eat bread occasionally, yogurt, fruit and rice. I gained some weight and finally reached 99 pounds, one pound less than my mother had weighed when she'd gotten married (her rite of passage into womanhood and adulthood). I decided I would permanently stay at a "pre-adult" 99 pounds.

When I left home and journeyed to college at age 18, I was still resisting becoming a woman. To mess with a period every month meant blood and cramps, and that awful fear of pain. The earth-mother mystique familiar on campuses of the time didn't turn me on. I didn't want children.

But the question of sexual experimentation now nipped at my heels. Should I? Shouldn't I? What was I missing? What would I lose? Why was I such a puritan, so uptight? Also, my condition — amenorrhea, when menstruation stops, or in my case, never starts — made it uncertain whether I needed birth control if I did have sexual relations. Leaving the problem unsolved provided a smokescreen for answering "no" to

various come-ons.

When approached sexually by a man, I was socialized not to reject him outright. But in the face of many opportunities to "sleep" with fellow students and teaching assistants, I developed a habit of turning the encounter into a heavy philosophical discussion about sex. Or I would try to defuse the man's sexual energy into affectional energy. After all, my relationships with my two older brothers made it natural to imagine men as close companions without sex. This was my escape hatch. I existed in a state of limbo, lacking confidence in my sexual identity . . . enticed by womanhood, but afraid and angered.

Seeing men's sexual needs as part of a voracious conspiracy, I became involved in the feminist movement of the early 1970's. This movement represented a way for me to recover the choice factor in my life — sexual, political, moral, financial. And I was not alone. The movement signalled independence while allowing the mutual dependence of female support and cohesion.

I began taking women's literature courses, reading Sylvia Plath, Doris Lessing, Simone de Beauvoir, Anais Nin, Lillian Hellman, Adrienne Rich, Virginia Woolf, Margaret Atwood and Maya Angelou.

To my excitement, my mother began to provide me with a continuous flow of biographies of courageous women in history. I grew familiar with Mother Jones, Elizabeth Cady Stanton, Harriet Beecher Stowe, Susan B. Anthony and Prudence Crandall. I

could identify with their defiance, their spirit.

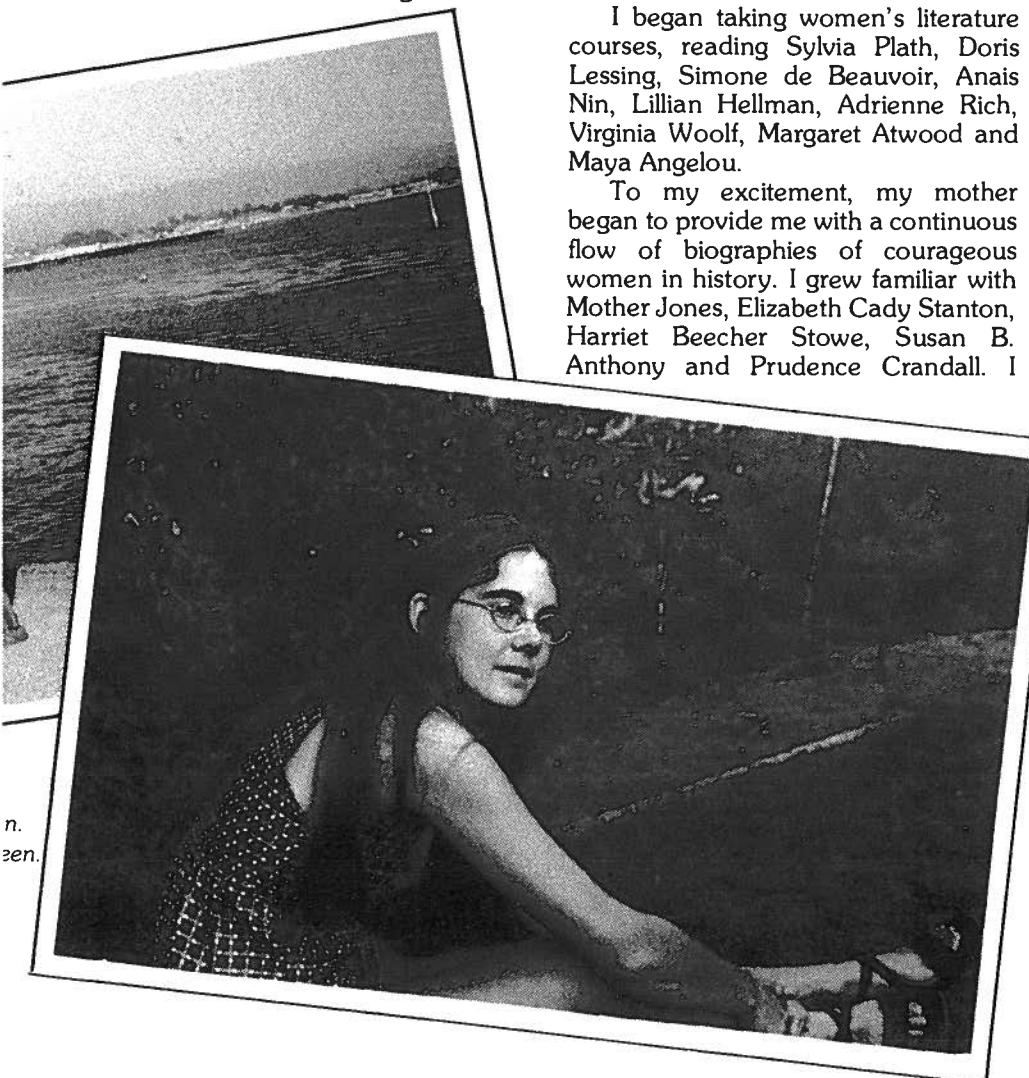
My mother, too, was becoming deeply affected by the feminist movement by this time. As a writer of novels dealing with the injustices and perplexities facing young women in earlier times, she had started research on women when I was a teenager. I remember her spending hours in the Library of Congress, then coming home quietly with notes that eventually filled her clothes closet.

In part because of her concerns for my growth struggles, and in part because of the pain and frustration she found depicted in her research sources, she became more sensitized to her own circumstances. As she began to face the collision of feminism with female duty, obedience, and dependence in a male-powered world, her own "cover story" as the "perfect wife and mother" began peeling away. Her bottled-up anger at being denied independence and self-sufficiency in adulthood began to surface. And my father's flexibility slowly increased as he honestly attended to her transformation.

My mother had struggled throughout my childhood to provide me with a model of an ideal womanhood transcending contradictions. During my later teens, however, she began to display many unaccustomed emotions: uncertainty, confusion, struggle, remorse, pathbreaking. "Bad girl" qualities leaked out. Her limitations became visible as well as her doubts and anxieties. I began to picture myself in her fight for freedom. As long as I didn't have to live up to the perfectionist expectations of a society demanding super-moms and super-women, maybe I could be a woman someday, too. If I could be attentive and concerned about others, but didn't have to hide and deny my own spirit to comply with the demands of others (especially men), then I could afford to be female.

The discovery that being a woman includes growth, trial and error, even defiance, and developing images of myself and my life — images which shift in perspective and focus to account more honestly for the complexities that are important to me — was a liberation to me.

Observing my mother's transformation gave me strength to permit



myself to cultivate the qualities of adventurism, risk and self-searching that characterized my girlhood. I might still be allowed my restlessness and pugnaciousness. Assisted by the example of my mother's pathbreaking, I might find my own paths beyond rigid role requirements at a younger age than she had.

My sensitivity to the humanity and presence of my mother was sharply crystallized for me while I was in college and my mother experienced the death of her mother.

My grandmother had suffered a stroke at the breakfast table while drinking tea with my grandfather. She had been in the hospital a week with little hope of recovery.

It was hard to imagine my grandmother's body inert, her mind clamped shut. Watching my mother face that imminent reality was close to imagining my own mother still and silent forever. I shivered. In the hospital corridor, my mother approached me to try to offer comfort, to protect me with soft words from the harshness of death.

My mother, father and grandfather and I waited for the doctor to emerge from my grandmother's room. Standing there, my mom turned to me suddenly and said, "She's gone."

At that moment the doctor emerged to tell my stoic grandfather that his wife was dead.

"You can come in and see her." The doctor motioned us inside.

"Barbo," my mother said, "I don't want you to go into her room. I want you to remember her as you last saw her." I felt divided. One part of me wanted to bravely accept this loss; another part wanted to let the loss hurt and unsettle me. But I understood my mother's desire to preserve her mother for me, even if only in memory. I waited outside while the others filed in.

In that utterly medicinal, comfortless hallway, I was struck for the first time by the solitariness of my mother, with her vulnerability, her limitations and her loss. She became for the first time truly immediate to me. The loneliness of her loss broke the images I had of her — the images which carried my empathy. She was truly different and

alone and more than my thoughts and feelings of her. She was not simply a giver, a provider, a server, an unquestioned source of strength; she had needed her mother too. What would she especially need from me now? Even with two sons, she had only one daughter — myself. And she had been her mother's only daughter.

The finality of her mother's death, the feeling of rupture which my mother endured and grieved for, brought us together in her search for continuity in life and love. To find that my mother needed me, that she was not always the care-taker, that she took caring for, drew me closer to her. Her vulnerability came alive, and that vulnerability made her womanhood accessible to me.

I remember experiencing within myself, then in the hospital, a primordial echo of life, the thought of giving birth. I hoped for a daughter of my own someday. When? I wasn't sure. But someday, yes.

In the midst of loss at my grandmother's passing, I became aware of a growing desire to add my own link to the chain in which my mom and her mother, and my mother and I were interlocked. I felt myself being tugged at, pulled into womanhood.

In the months following this pivotal episode, I grew more reconciled to my female body. Eventually I had my first spontaneous period. I came to realize over some years something of the conflict between image and reality in being a woman. There had early on slipped into my mind a false romantic image of female identity as a personless commitment to being the constant supporter and nurturer: a proudly but quietly self-sacrificing, virtuous and dutiful embodiment of the idea of caring without needing to be cared for. To this day, my mother and I are both trying to sift out of this image the true from the false, the substance of caring from the requirement and compulsion to serve.

I accepted female adulthood not as a station from which life is carefully controlled and drawn into formulas of propriety, but as a tough and constant movement, a reconciling of opposites: strength and weakness; grace and awkwardness; power and powerlessness. It is limited and limitless, grand and unpredictable, vulnerable and enduring. It is attention to life.

As a 29 year old woman, despite anxieties about bringing a child into a world that hangs in delicate balance, I want to have a child whom I can love as my mother and father loved me, and to be loved as I love my parents. Thinking about getting pregnant, I realize why my mother had been so concerned about my slow adolescent development and my fear of sexuality. She wanted me to embrace the fullness of womanhood — to be empathic, competent and freely female.

I wonder if my husband and I will have a daughter someday? I would wish her success in her struggles, and perhaps less confusion than I had. I know she will have her own share of growing-up battles, self-imposed tests, role-breaking episodes and rites of passage that I may not fully understand, but that will, nonetheless, make her life her own surprising womanhood.

Barbara Underwood Scharff is a public affairs radio show-host and producer in San Francisco, and a free-lance writer. With her mother, she co-authored the book, Hostage to Heaven. She is also organizer of a women's self-help group.



Barbara Underwood Scharff with her mother today.

HERPES:

Towards a Positive Approach

by Melinda Cuthbert

drawings by Elizabeth deGrey

Until very recently, when most of us thought of VD we thought of gonorrhea or syphilis. If we were enlightened, we might also consider trichomonas, yeast or chlamydia as sexually transmitted diseases. Information is finally filtering down to us. There is a growing swell of enthusiasm in our ability, as women, to take responsibility for our health and make responsible decisions regarding our sexuality. For many of us the stigma previously associated with sexually transmitted diseases has all but disappeared, and women suspecting a vaginal infection are presenting themselves for prompt diagnosis and treatment.

Coined the "love bug", "the new sexual leprosy" and "the nightmare that makes sexual lepers out of its victims", herpes genitalis has recently emerged in Canadians' awareness as the "new VD". Herpes, however, has been with us for at least 2,000 years — even the Roman Emperor Tiberius had recognized a type of herpes as a health problem and prohibited kissing at all public ceremonies in an attempt to control its spread.

The manner in which this health issue has been introduced to the Canadian public, and the lack of information among health care workers, has



created problems far beyond those imposed by the nature of the disease itself. The media has highlighted those outdated — or so we thought — notions of shame, guilt, and embarrassment in response to catching this “new” sexually transmitted disease. Comments in the media such as “more people should re-examine the virtues of old-fashioned morality” and “at least . . . Canada’s less inhibited singles . . . will now know the full risks of swinging,” imply that these feelings, and indeed the stigma itself, is just punishment for their sexual practice. It goes beyond blaming people for contracting the disease, to making assumptions about their sexual practice.

To date herpes genitalis has infected approximately one quarter to one half million Canadians, with 40,000 to 50,000 new cases annually. Because there is no known cure for herpes this disease will likely become more prevalent as the years go on.

Herpes is the family name for approximately 70 related viruses that share common characteristics: size, shape, structure and internal composition. The viruses live by attaching themselves to healthy cells in the body, taking over the cell and forcing it to

produce more viruses. In contrast, bacteria which cause many other types of infection kill the host cells, but cannot use these cells to reproduce themselves. Because the cure to a viral infection must get inside the body cell to kill the virus, many potential treatments for viruses are unsuitable because they damage healthy body cells in the process. As well, each virus has a protective protein coat surrounding it.

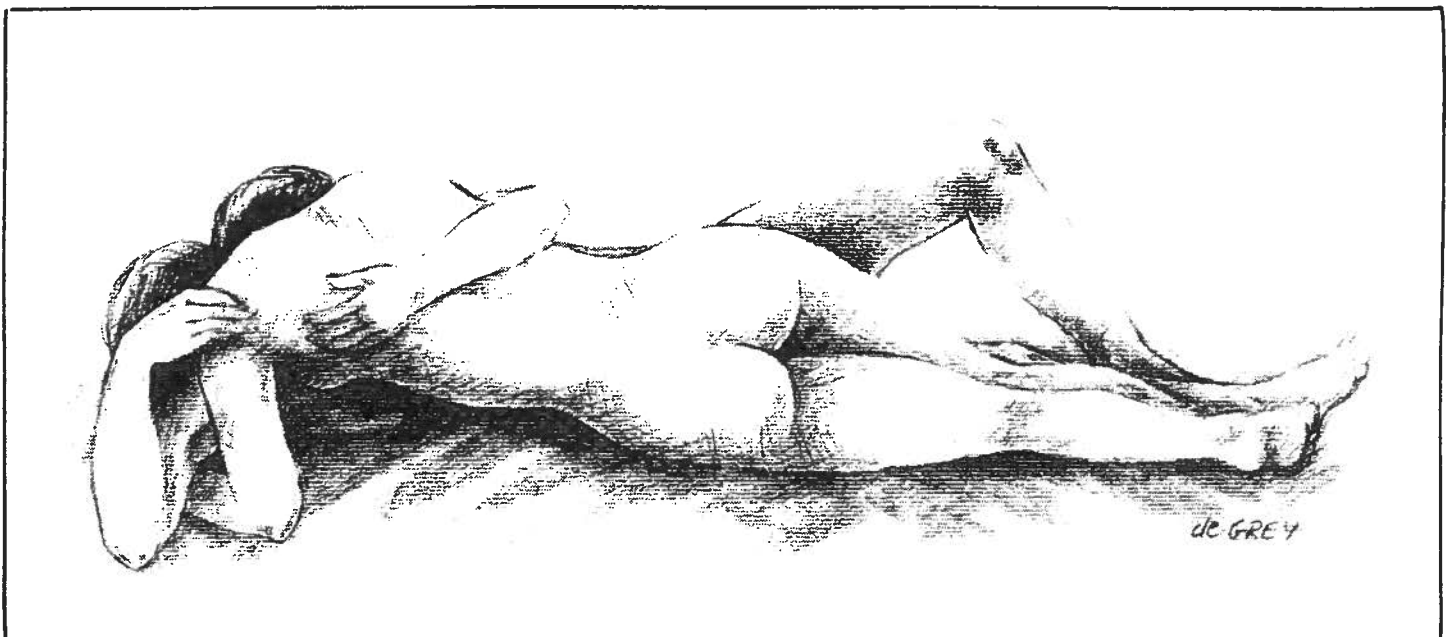
Two of the herpes viruses which are known to infect humans are Herpes Simplex Virus, Type I (HSV I) and Herpes Simplex Virus, Type II (HSV II). Although neither type of virus is confined to a specific area of the body, most herpes infections of the mouth and face (Herpes Labialis) are caused by HSV I (80%); most genital, thigh and buttocks infections (Herpes Genitalis) are caused by HSV II (80%).

It is known that oral-genital sex allows transmission of HSV I, which causes the common coldsore on the mouth, to the genitals and vice versa. In any case, these viruses express themselves identically on any infected area and both travel up the nerves in the area; they remain latent (dormant) in the nerve plexus long after the clinical symptoms have disappeared. This means that the virus stays in the body and may, at a later date, descend down the nerves to create a new case of active herpes.

Although some people never have more than one active case, most experience outbreaks at irregular intervals. The most common symptom of an active case of genital herpes is the development of lesions which look like fever blisters or coldsores. These usually appear about 2 to 10 days after sexual contact, rupturing within the first few days to create shallow ulcers or sores. These usually form scabs and heal over in approximately 1 to 3 weeks, unless they become infected by bacteria. In the case of infection, the bacteria can be cleared up with antibiotics and healing will resume normally.

Herpes lesions commonly cause itching, swelling and pain, especially when discharge or urine passes over the open sores. As well, some people experience headaches, swollen lymph glands in the groin, fever or leg pains, especially with the first (primary) infection. The severity of these symptoms usually diminishes with recurrent episodes.

While we cannot explain why some people have recurrences and others do not, or why recurrences happen when they do, it is noted anecdotally that menstruation, stress, fatigue, poor diet and sunburn can trigger recurrences. Although in most cases recurrences are not predictable, many people have a sense of when an active case will develop several days before lesions appear. A few days prior to the actual



outbreak of active lesions, these people experience warning signals called prodromal symptoms. These include a tingling, burning or itching sensation in the area where lesions will appear or a diffuse pain in the lower back or legs.

Transmission of herpes genitalis generally requires direct intimate contact with the infected area. The majority of people get herpes genitalis by sexual contact — genital-genital or oral-genital. There is also a chance that by touching an active sore, particularly one which is fluid-filled, and then touching another part of your body, or another person's body, the virus can be transmitted to a new site. For example, it is possible to transmit the virus from your genitals to your lips or eyes. This transfer must be almost immediate, as dryness renders the virus inactive. The life of the herpes virus relies on the mucus in which it is transported; you cannot get herpes genitalis from chairs or toilet seats.

It is known that the virus can be transmitted from the onset of the prodromal symptoms until after the lesions have scabbed over and healed. At this time the virus is highly contagious and sexual contact should be avoided. We know that the virus can be transmitted when symptoms are not present, but we are not clear how frequently this occurs in the population or in a specific individual. For this reason, it is recommended that a person with herpes (labialis or genitalis) wash and dry her hands after any intentional or inadvertent touching of the lesions, wash her hands upon waking before rubbing her eyes, and never use saliva as a wetting solution for contact lenses or to remove foreign particles from the eye.

A herpes infection can pass unnoticed if the herpes lesions affect only the cervix or inner two-thirds of a woman's vagina. Most often, however, within several recurrences the virus has spread further down the vaginal canal and the woman becomes aware of it.

Although herpes is not linked with sterility or insanity in its advanced stages, as is the case with syphilis or

gonorrhoea, it does pose certain health risks for women. While no direct causal relationship has been demonstrated, many researchers suspect a link between cervical cancer and a history of herpes genitalis. It has been observed that women with genital herpes have a higher frequency of abnormal cervical tissue and cervical cancer. The screening test for cervical cancer, the Pap smear, can detect minute changes in the cells of the cervix. If caught when cervical cells first begin to look abnormal, management of cervical cancer is straight-forward and the cure rate is almost 100 percent. For this reason, twice yearly Pap smears are recommended for women with a history of herpes genitalis.

Another significant risk posed by herpes genitalis is possible transmission of the virus to a newborn during labor and delivery. If the herpes is latent at the time of delivery there is no risk; if the mother has an active case the baby has more than a 60% chance of catching the disease. Ninety percent of the cases of neonatal herpes are acquired upon passage through the mother's infected birth canal or from viruses which travel through the ruptured fetal membranes. In about two-thirds of the newborns affected the virus produces a disseminated (body-wide) infection of the adrenals, liver, lungs and central nervous system. In the remaining third of the cases the infection is limited to the skin or eyes. While the mortality rate is high for *infected* infants (60%), neonatal herpes is a rare condition.

The risk of transmission to the newborn is greatest when the mother is experiencing her first outbreak of herpes, but caesarean section is strongly recommended for all women who have active herpes, whether primary or recurrent, at the time of delivery. Furthermore, the section should be done within four hours of the membranes rupturing. This precaution nearly guarantees the prevention of transmission at delivery.

Because herpes virus can be transmitted when no visible symptoms are present, a woman whose partner has recently had active herpes should avoid genital contact with him or her past 32 weeks of pregnancy. The American Academy of Pediatrics rec-

ommends that a tissue culture test for the detection of herpes genitalis (or a Pap smear if a tissue culture is not available) be done at least twice during the last six weeks of pregnancy. The last of these tests should be done approximately one week prior to the expected date of delivery. If an active case is suspected a cervical swab for electron microscopy analysis is strongly recommended as soon as birth contractions begin.

The first step in planning for the management of herpes is accurate diagnosis. The best time to go for testing is when lesions are present, because at other times the virus may not occur in high enough concentration to ensure detection. The preferred method of diagnosis is a tissue culture, which involves a swab being passed over the open lesion and then suspended in a special growth medium. The test is quick and painless. Locating a facility to do this method of testing may prove to be more time consuming, especially in rural areas. We recommend that you ask your family doctor, gynecologist, or VD clinic in a local hospital. Most teaching hospitals have virus labs and are capable of administering this test. Outside large cities, this tissue culture test is still available to you through your family doctor who can have the specimen analyzed by a Provincial laboratory and results sent to her or him within two to three weeks.

A Pap smear is also helpful in detecting herpes of the *cervix* (or changes suspected to be caused by herpes) where there are no clinical symptoms. This test will not, however, detect herpes lesions anywhere else in the genital area. As well, a person could have latent herpes, with no changes in the cells of the cervix, in which case the disease would go undetected by a Pap smear.

A very important part of your visit will be the attitude and response of your doctor to the diagnosis. While some doctors are very supportive, offering information and an opportunity for you to discuss your concerns, many women report that this is not the case. An abrupt or alienating response

from a doctor may be due to her/his own lack of comfort with the situation and not necessarily reflect a reaction to you at all.

Each of us have our own values and particular way of viewing the world. It is important that we not take responsibility for values others impose on us. If you are unsure about your response to being diagnosed as having herpes, you are probably more likely to accept a doctor's negative reaction as valid, and to have difficulty sorting out what you really feel about the diagnosis and its implications.

Coupled with this is the need for accurate and accessible information. It may be a good idea to prepare a list of questions or concerns that you want to raise with the doctor and take it along with you. In the past, many people with herpes have found there has been little information available to them upon diagnosis. In a recent Canadian study, more than 75% of the people with herpes surveyed found that the information offered to them was either inaccurate or inadequate. Because much of this information may be new to you, try to take home written information you can review at your leisure.

Of the possible reactions to diagnosis, shock, alienation, anger, guilt, embarrassment and frustration are the most common. Sharing your feelings with someone close to you may help you sort out why you are reacting the way you are and help you resolve feelings. According to people with herpes, gaining a realistic picture of the limitations imposed by herpes — rather than reacting to how you think society will view you — is the key to learning to cope.

Reactions to catching herpes genitalis are influenced not only by accurate and adequate information, but also by the level of control one had over contracting the infection. Most of us don't anticipate contracting a sexually transmitted, and certainly not one for which there is no cure, when we engage in intimate sexual contact with someone. The same study quoted ear-

lier indicated that almost 90% of the people who contracted herpes genitalis had no idea that the risk of transmission existed. In fact, in almost 75% of the cases, the person with the virus was not aware that s/he had it, let alone was capable of transmitting it at that time. Many people who catch herpes feel anger because they did not knowingly accept the risk of transmission — the risk is, in a sense, forced on them. It is easy to see how anger, resentment and frustration of contracting herpes can be directed at the partner who unknowingly and perhaps uncaringly passed it. Guilt, alienation and frustration also easily build up in a person who realises s/he has unknowingly transmitted it.

Embarrassment, fear and isolation are very often the consequences of prevalent social attitudes towards issues with which society is uncomfortable. Such attitudes prevent us from reaching out for information, support and understanding. Many people find that speaking to others with herpes is the least threatening step to take at first. To this end, a group of approximately one thousand Canadians with herpes genitalis have organized Research, Education and Assistance for Canadians with Herpes (REACH). They operate a phoneline, newsletter and self-help groups. (address and phone number follows)

In the newsletter and groups accurate information and strategies for coping are discussed. Given the chance to vent emotions and exchange experiences, many people find that much of their fear and anxiety was created by their isolation and the perception they held of how people would react to them. Perhaps the most important realization is that the general public (with the exception of a few prolific individuals) is not making a conscious effort to alienate or ostracize, but instead is struggling with the same lack of information, misinformation and societal biases as are people with herpes. The issue has appeared to the public, as to the self-help group members, out of the blue, as something which has already affected some half-million Canadians. It is disturbing and confusing to everyone that we had not been informed either of the existence of herpes as a communicable disease which is reported to reaching epidemic

proportions, or of the risks associated with herpes for women and newborns. Until just one year ago, the only information available about herpes in Canada, outside of limited media coverage, was one small paragraph in a government pamphlet.

Herpes genitalis is a very awkward health issue for everyone to address, and one which is easily put aside in favour of more attractive issues. It's too easy to throw our hands in the air and say "There's no cure, so what can we do?"

Better diagnosis, more adequate and accessible information and support services will promote community and professional awareness. But it's the attitude that each of us carries away from this article and similar articles which will influence our sensitivity to herpes in our community.

Melinda Cuthbert is a founding member and Coordinator of REACH. She has recently left a position with Birth Control and VD Information Centre in Toronto to pursue a Sociology of Medicine degree.

R.E.A.C.H. (Research, Education and Assistance for Canadians with Herpes) provides information and support to people with herpes and promotes community and professional awareness and sensitivity about the disease. The organization can be contacted at P.O. Box 70, Station G, Toronto, Ontario M4M 3E8. Their phone is 1-416-698-6225.

My Story, Our Story

My story, our story is every woman's experience — our collective experience — with health.

Unsolicited Advice

by Kathleen McDonnell

Giving advice is a dubious exercise at the best of times. Since becoming pregnant I've noticed that women in this condition attract advice like flies to flypaper. This has always been the case but now, with the information explosion on fetal hazards, it's become a veritable epidemic. Caffeine, alcohol, marijuana, cigarettes, x-rays, pesticides — you name it, and it's dangerous for the baby. Then there's all those grey areas, like sex. Complete the following, based on which "expert" you've read lately: Sex during pregnancy is a) good for the baby; b) bad for the baby; c) good for you but bad for the baby. Don't get me wrong. I'm very glad to have all this information at my disposal. It helps me make some reasonably informed choices, even though I don't always have much control over which particular pollutants go into my body. But one thing I'm quite sure of is that I could go quite happily through the rest of my pregnancy — my life, even — without all this "helpful" advice.

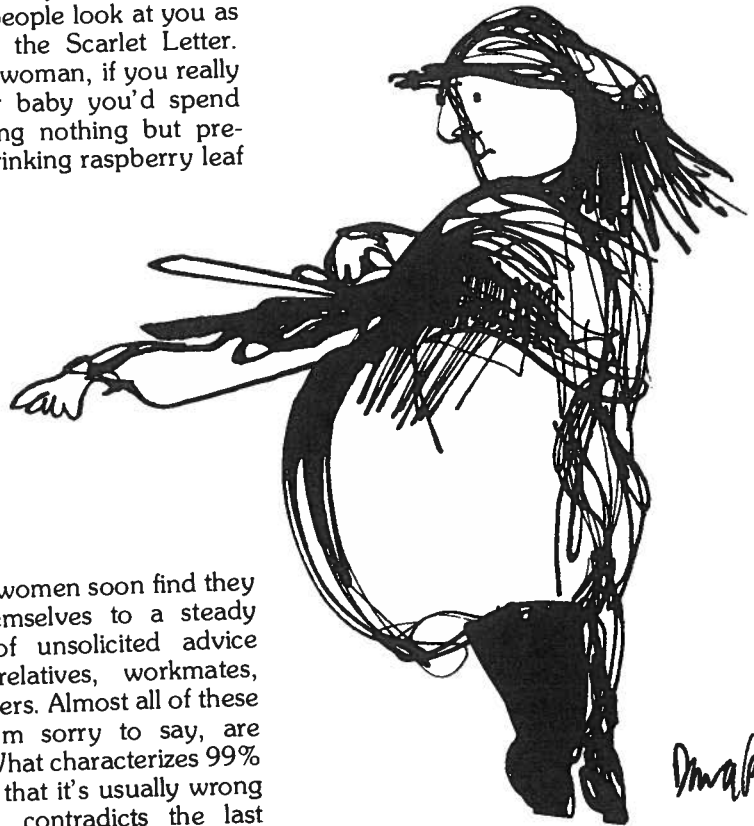
The Advice to the Pregnant Woman Syndrome is based on several premises. One is that pregnant women are rather dim-witted and slow — stupid, really. Perhaps it has something to do with the enlarged state, the slowed-down, ponderous movements. Or it may be the converse of an old-fashioned medical idea that too much mental activity in women causes atrophy of the reproductive organs. Ergo too much reproductive activity causes mental atrophy? Whatever the reason, there's a prevalent feeling,

rarely put into so many words, that such cow-like creatures can't possibly have much going on in their heads. Consequently, most people operate on the assumption that they know more about pregnancy than you do. This belief is almost invariably based on knowledge gleaned from one, maybe two articles on the women's — excuse me, "lifestyle" — section of the newspaper. The details of these articles are remembered only hazily, but that doesn't deter people in the least from quoting you chapter and verse on the latest fetal hazards which you are subjecting your baby to.

Not only does everyone else *know* more about what's good for your baby than you do, they even *care* more about it than you do. Just mention that you're even thinking of a home birth and you're immediately reduced to outlaw status. Ride your bicycle or have a beer and people look at you as if you're wearing the Scarlet Letter. Obviously, selfish woman, if you really cared about your baby you'd spend nine months doing nothing but prenatal yoga and drinking raspberry leaf tea.

So pregnant women soon find they must resign themselves to a steady bombardment of unsolicited advice from friends, relatives, workmates, even total strangers. Almost all of these advice-givers, I'm sorry to say, are other women. What characterizes 99% of this advice is that it's usually wrong and, moreover, contradicts the last piece of advice you got.

Let me present an example: the Great Sauna Debate. A few months ago a poor woman in an advanced state of pregnancy was practically driven out of the sauna at my fitness club by the baleful stare of a helpful know-it-all, who informed her in no uncertain terms that pregnant women weren't supposed to take saunas. Now I knew that this woman was all wet. After all, I read the "lifestyle" section. I'd seen that article, too. What it said was that one study had shown that pregnant women who took *prolonged* saunas tended to have lower birth weight babies. Not exactly a public health hazard on par with thalidomide. With saunas, as with most things during pregnancy, moderation is the key. But somehow the rebuttal stuck in my throat. Guilt, you see. My own pregnancy wasn't visible yet. But I too felt



Donna

like a selfish monster, flagrantly ready to sacrifice the health of my unborn child for a few moments of warmth and comfort.

A couple of months later, now visibly pregnant, I ran into an acquaintance of mine on my way out of the pool. "You should have a sauna after you swim," she said. "All that chlorine is . . ."

"... bad for the baby," I finished.

Just a few weeks ago another acquaintance accosted me on the way out of the sauna. "Do you know you're not supposed to be taking saunas?" I

must have shed at least some of my early pregnancy guilt because I blew up and informed her I didn't appreciate half-baked, unsolicited advice and furthermore, that even though I was pregnant I was still a human being. This time she was the one who got all guilty and apologetic.

The moral of the story is — if you want to be really helpful to your pregnant friends, don't lay the latest media report on them as a moral imperative. They've probably heard it already anyway. Convey information if you must, but in the right spirit. Don't add to their

burdens. Next time you feel the uncontrollable urge to pass on some Helpful Advice, do your pregnant friends a favour. Stifle it.

Kathleen McDonnell is a Toronto journalist and playwright and a founding member of Women Healthsharing. She gave birth to a baby daughter on November 5.

Reviews

Everywoman's Almanac 1982

Reviewed by Victoria Freeman

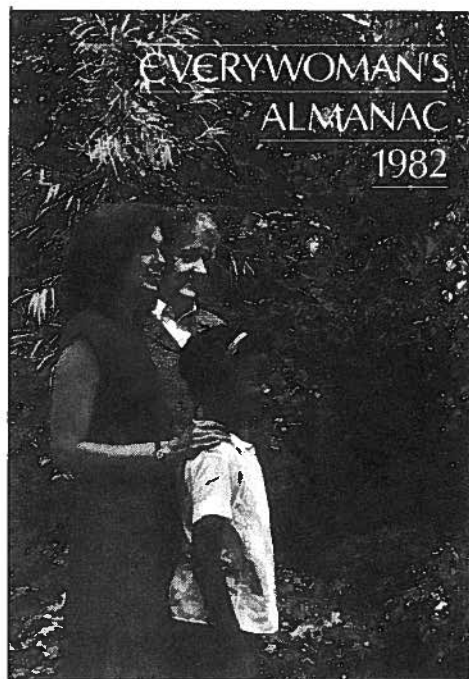
The 1982 *Everywoman's Almanac* is an inspiring little book — not because of the cover, which unfortunately suggests that Women's Press has been converted to Born Again Christianity — but because this edition documents that the women's health care movement is alive and flourishing across Canada.

The format of the *Almanac* is basically the same as in previous years. A brief introduction explains the choice of health as this year's theme and provides a basic critique of the present health care system. Each month's interview focuses on a woman or group of women who have challenged the assumptions of this system. Short quotations and humorous cartoons are

interspersed throughout the calendar for each month. There's also a health information section, a bibliography, and a listing of women's centres and health groups across the country.

The introduction to the *almanac* and to the health information section stress that health is both a personal and political concern. Criticizing the mechanistic, curative approach of modern medicine and the big business aspects of the health care system, the authors warn that more health care is not necessarily better health care, and that the health care system is in some ways a means of social control. Self-help, collective community-based action and a more holistic concept of health are some of the alternatives suggested by the collective.

The interviews offer refreshing examples of real life alternatives, ranging from three women who coached their friend through childbirth despite hospital regulations, to the founding of Canada's first women's running club, to the success of the Vancouver Women's Health Collective in encouraging self-help for women. Occupational health hazards, the status



of nurses, support groups for menopausal women and the struggle against pro-life takeovers of hospital boards are other topics. The geographical range and varying occupations of the interviewees suggest the scope and strength of the women's health care movement.

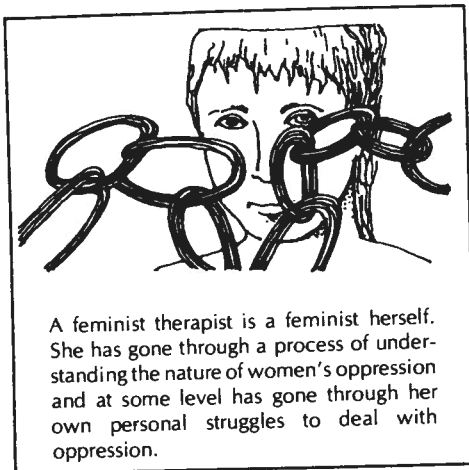
Particularly moving is an interview with Pam, a twenty-five-year-old paraplegic, who struggles to be seen as a complete woman rather than as a person without sexuality. In perhaps the most thought-provoking interview, a native woman who returned to her Indian roots and organized a native women's health conference, suggests

that our consciousness plays a vital role in our physical as well as spiritual well-being.

The health information section at the back of the book discusses such topics as patients' rights, how to choose a therapist, and the recent startling increase in the number of Caesarian births in Canada. In some respects it's quite up to date. There's a section on toxic shock syndrome and another on herpes simplex with an address for information on support groups for herpes sufferers, but surprisingly, and disappointingly, for a book which claims to be interested in alternatives to traditional health care, several important alternatives are not even mentioned, let alone evaluated. There's no mention of the symptothermal method in the discussion of birth control; there's no mention of herbal remedies for vaginal infections; there is no discussion of home births or new birthing rooms in hospitals. And worse, the information section categorically states that diaphragms must be fitted by a doctor, when, in the interview with the Vancouver Women's Health Collective, we learned that they've been successfully fitting diaphragms without the help of doctors for years. Why these discrepancies?

Although these lapses in the information section are disquieting, the Almanac is still a good basic reference. As a day book, it's on the bulky side, but if you're busy, there's lots of space for appointments, notes and phone numbers. And if it's a dull or depressing week, the contents, especially the cartoons, will probably cheer you up.

Victoria Freeman is a Vancouver freelance writer.



A feminist therapist is a feminist herself. She has gone through a process of understanding the nature of women's oppression and at some level has gone through her own personal struggles to deal with oppression.

Invisible Alcoholics

Reviewed by Christine Bois

Invisible Alcoholics is an important book not only because it is comprehensive in content but also because it is carefully written with a compelling style. Marian Sandmaier has achieved a fine balance in producing a book for both health care providers and for women seeking help. It is challenging to those who have a knowledge of alcoholism and useful to those who do not.

Sandmaier explores the social contempt and disgust felt for alcoholic women. Wisely, the book begins with the critical issue of our attitudes. In order to free women to seek help and receive treatment which is helpful, our attitudes must be understood and resolved. Clearly, views are changing, since drinking is often expected of a woman now but still she must never get drunk. Sandmaier analyses historically the moral and social base for these attitudes.

In *Invisible Alcoholics*, American figures show the rapid rise in women's use of alcohol since the Second World War. It has reached a point where almost equal numbers of young males and females are drinking. Canadian studies show this same trend for women, particularly those under 30 years of age. This increased use of alcohol by women "is not so much a sign of equality as it is a cheap substitute for it." The alcohol industry has played its part in the increasing social and economic pressures that women bear. During the 1970's, women were recognized and designated as a "major sales target" by the industry. This is one of the factors that Sandmaier notes when she addresses the question of why women use a powerful drug which has such destructive consequences. More women are now drinking more alcohol and she points out that "no group of women is immune to alcohol problems."

Loneliness, a sense of failure, depression and fears are some of the emotional pain of overdrinking; loss of housing, jobs, status, children, family and money are some of the outwardly concrete problems that accompany alcohol abuse. Interviews with eleven

women bring to life these common feelings and the experience that addicted women share. These interviews also illustrate the differences and special problems of housewives, employed women, minority women, teenage girls, lesbians and skid row women.

Inadequacies of alcoholism treatment for women are numerous. Sandmaier realistically outlines some of these — inaccurate diagnosis, the hazards of cross-addiction to prescribed drugs, lack of facilities and harmful attitudes by health professionals. It is not uncommon to find alcoholism workers who view alcoholic women as more hopeless and helpless than male alcoholics.

The idea prevails that women have a significantly lower rate of recovery and Sandmaier herself references this. Most of the research upon which this conclusion is based is faulty and has often been conducted in settings not designed to meet women's needs.

Sandmaier's presentation of the issues of alcoholism is rooted in an analysis of the feminine sex role. She states, "When the acute powerlessness of the alcoholic condition is crossed with the essential powerlessness of the female condition, the outcome can only be devastating." Her critique includes direction for change in treatment, societal restructuring and psychological changes in the realization of human potentials. Sandmaier sees that these evolving changes will not wipe out alcoholism but that "alcoholism might at last be accepted for the illness that it is, one both women and men could acknowledge in themselves without self-hate or guilt, and be treated for without fear of public scorn."

The book ends on a practical note with a guide for women seeking help. The list of resource groups unfortunately is American, but it still serves as a general guide. In dealing with a painful problem, most often ignored, Sandmaier's approach has not been sensational, but sensitive and hopeful.

Invisible Alcoholics by Marian Sandmaier is published by McGraw Hill, New York, 1981.

Christine Bois is a psychotherapist in private practice in Ottawa. She has research and educational experience in the field of alcoholism.

Two New Resources in Health and Safety

Reviewed by Jennifer Penney

Tradition in the publication of health and safety literature is to produce huge tomes that cost an arm and a leg, are written in an archaic form of scientific gibberish, and are totally useless for quick reference in the workplace. One reference text that is considered a "must" in the occupational health field, Volume I of *Patty's Industrial Hygiene and Toxicology*, is a case in point. The damn thing is 1466 pages in length, costs over \$90, and, as the preface states, is written "to assure that the wealth of information that hygienists in research, industry, and government were accumulating would be of benefit to future men of science".

It would be nice to write off the volume as irrelevant, both to the women of science left out of the preface and to workers of both sexes. Unfortunately, this is not the case. The information is important to all of us.

A Worker's Guide to Health and Safety

Some of that information has recently been made accessible to workers by the Windsor Occupational Safety and Health Council's (WOSH) publication of *A Worker's Guide to Health and Safety*. Unlike the traditional literature in the field, the guide is cheap, easy to read, and a handy resource for the health and safety representative, shop steward, or any other women with occupational health concerns. The attractive 78-page booklet is truly compact, its 3 1/2" by 6" fits snugly into jacket, pants and skirt pockets or purse.

Unhappily, while the size makes the book an easy reference to carry around, the print is so small and condensed that it is difficult to read for an extended period of time. The problem is forgivable if you only want a quick reference, but can be a serious shortcoming for the first-time reader or a worker with poor eyesight. Otherwise, the guide is nicely designed, with a clear use of headings and graphics to make the material more accessible.

Charts are also employed to describe the hazards of certain groups of chemicals and metals, and to ex-

plain some occupational causes for symptoms of illness commonly found in many workplaces. A safety checklist can help workers identify potential hazards from machinery and other equipment.

For workers in Ontario, the booklet has a summary of the elementary rights provided workers by Bill 70, the provincial occupational health and safety legislation. Another chapter provides a guide to establishing a compensation claim in that province. (WOSH will be reprinting the booklet without the Ontario-specific information in the near future.)



Of particular interest to women is the chapter on health and safety problems of clerical workers, which points out that this type of workplace is not the safe and sane haven it is sometimes imagined.

A Worker's Guide to Health and Safety by the Windsor Occupational Safety and Health Council, is available from WOSH, 824 Tecumseh Road East, Windsor, Ontario, N8X 2S3. \$2.00 for single copies, \$1.75 each for orders of 10 or more. Special reductions will be arranged for orders of 100.

Working Women: Factpack/Calendar 1982

If what you're looking for in a calendar is to brighten up the wall in front of your desk, then you should probably ignore this review and head down to your local bookstore. But if you want an inexpensive guide to 1982, jam-packed with information about health and safety hazards faced by women on the job, then dash off a note to the Women's Occupational Health Resource Center in New York for their latest *Factpack/Calendar*.

The calendar itself is marked by

both Canadian and American holidays, a touch which demonstrates the Center's sensitivity to its Canadian audience. And there's plenty of space to mark in important personal dates and upcoming events.

Sombre black-and-white photographs of women at work illustrate each calendar month. The following page details, in a neat and readable format, the health and safety hazards associated with the job illustrated, as well as techniques for prevention and simple checklists to assess the state of your workplace. Among the jobs described are hospital and laboratory workers, retail sales, cleaners, garment workers, meat packers, clerical workers and artists.

The calendar pages can be removed as each month ends, leaving the reader with the factpack sheets intact and useable for some time to come.

Like the *Worker's Guide* reviewed above, the *Factpack/Calendar* is cheap and easy to read. While it can't be tucked into your pocket or purse, it can certainly be tacked up on your wall in your workplace or at home for easy reference.

And a healthy new year to you!

Factpack/Calendar 1982 by the Women's Occupational Health Resource Center is available from



WOHRC, Columbia University School of Public Health, 60 Haven Avenue., B-1, New York, New York 10032, U.S.A. \$5.00 (US) for single copies; \$3.00 each for orders of ten or more.

Jennifer Penney is a freelance writer, researcher and teacher in the field of occupational health. She is presently working on a book, The Struggle for Good Work.

Regional Reports

NEWFOUNDLAND & LABRADOR

Workshop Activities: Barbara Luby of the Women's Health Education Project has sent information on many upcoming projects. Among other activities, women in Newfoundland and Labrador are being trained to use a teaching resource entitled "It's Just Your Nerves." The kit grew out of concern about the pervasive assumption that women's "relatively unimportant and minor" problems can be solved with tranquilizers and alcohol. Through discussion, participants develop a better understanding of the social and psychological factors that contribute to women's addictions. Those trained in using the kit will be conducting educational sessions in their own communities.

NOVA SCOTIA

Deborah Kaetz

Listeriosis Update: A total of 29 cases of listeriosis, a rare bacterial infection which can affect pregnant women, fetuses and newborn infants, were reported in Nova Scotia over the summer months. The last report was made on August 30th. The disease has resulted in 2 adult deaths and 11 perinatal deaths (5 spontaneous abortions, 3 still-births and 3 deaths shortly after birth). Although isolated cases of listeriosis have been reported previously, the outbreak this summer was of alarming magnitude. The cause of the infection is still unknown. To date the only common denominator which has turned up is that all the persons affected had recently eaten cabbage or cole slaw. There is some speculation that the manure spread around the cabbage might have been the source of the bacteria. However, this theory has not yet been substantiated and the investigation continues.

QUEBEC

Clara Valverde

Cutbacks Close Maternity Wards: Huge provincial health care budget cutbacks will probably close the maternity wards of six hospitals in Montreal. The concentration of births in fewer hospitals will be announced in a few months by a special government appointed committee. Dr. Papageorgiou, from the Jewish General Hospital (one of the few hospitals which will not be losing its maternity ward) and member of the special committee, says that these proposed changes will improve the quality of births and lower the mortality

rate. However, many observers feel these cutbacks will mean a further decrease in the quality of what are already inhumane and technically controlled hospital births.

Clinique Des Femmes: A sexual enhancement course is being offered at the Clinique des Femmes this fall. The Clinique des Femmes is affiliated to the CLSC (neighbourhood clinics run by the provincial government) and offers a wide range of services, including general medicine, gynecology, rape crisis, pre-natal, post-natal, and a VD program (in which they are conducting a study on chlamydia).

ONTARIO

Jennifer Penney

Health, Safety and VDT's Conference: "Got the VDT's?" asked the button sported by workers attending a recent conference held in Toronto.

Over 200 workers, the majority of them women, participated in the conference. Bell telephone operators were particularly eloquent in describing the dehumanizing effects of the new technology on their jobs and well-being. Themes of speeches and discussions included: the need to treat new technology as "guilty until proven innocent" with respect to potential health hazards; the manipulation of language by industry and government in order to denigrate health concerns of workers; poor design of VDT equipment, which results in all kinds of "dis-ease" in workers; health effects of ultraviolet, radio frequency and x-radiation given off by VDT's; the use of VDT equipment to control every moment of the workers' day; and strategies to fight the negative effects of VDT technology in the workplace.

MANITOBA

Lissa Donner

Labour Plans Occupational Clinic: At its annual convention the Manitoba Federation of Labour decided to launch a major fundraising drive for money to set up an occupational health clinic to be controlled by workers and run for the benefit of workers. Currently the only physicians specializing in occupational medicine in Manitoba are employed by companies.

The Clinic would provide treatment to workers who believe they have an occupationally induced illness or accident. In addition, the Clinic would offer educational programs about the hazards of substances, occupations and workplaces; computerized access to relevant international data banks; and consultations for other interested health care workers.

Regional Reports

Women's Health Clinic Booming: Nine hundred women have already become clients of the Winnipeg Women's Health Clinic which has been open less than six months. This clearly indicates the support for such a clinic by Winnipeg women. The Clinic is hoping to move to larger premises, to expand their medical staff and reduce the waiting time for appointments.

"Renaissance" Active In Provincial Election: Renaissance Manitoba, a fundamentalist group which once succeeded in having Margaret Lawrence's *The Diviners* banished from several rural Manitoba high school libraries, has announced it will send questionnaires to all candidates in the upcoming provincial election, to be held on Nov. 17. They plan to publish the results, and will be advising voters to support candidates who are anti-abortion, anti sex-education in the schools, pro-capital punishment, and anti-union. This is the first organized move of the new right into Manitoba provincial politics.

ALBERTA

Ellen Seaman

Alberta Leads The Country: Alberta has been accused of being backward in some respects, but in one area we lead the country — in the rate of surgical operations per capita. Surgeons favour rural Albertans more than urbanites; according to the *Edmonton Journal*, the rate of radical mastectomy is three times higher in Medicine Hat than in Edmonton and the rate of open heart surgery three times higher in Fort Vermillion than in Edmonton.

Never fear though, the Alberta Medical Association is sponsoring a study to investigate the situation. According to the registrar of the Alberta College of Physicians and Surgeons, the study will take "several years at least". But what about all those individuals who will suffer unnecessary hysterectomies, mastectomies, heart operations, etc. in the meantime?

One AMA official has speculated that Albertans have become so sophisticated they now view surgery as fashionable. Those of us who are a little more cynical wonder if perhaps the heavy fees (euphemistically referred to as "balanced billing") that surgeons charge over and above Medicare is not the most significant factor encouraging excessive surgery.

Alberta Medical Association Not Always Slow To Act: In the case of Dr. Henry Toupin, an Edmonton neurologist, the AMA moved swiftly to suspend his license to practice for six months. Had the Association found that Dr. Toupin was negligent or had made a serious diagnostic error or had breached confidentiality? No. Dr. Toupin's medical competence was never in

question. He was suspended after Edmonton police raided a gay health club and he was publicly acknowledged to be a major shareholder in the operation.

BRITISH COLUMBIA

Abortion In Jeopardy: Hospital board election fights continue throughout British Columbia with anti-choice forces making considerable gains. They won in Surrey, Richmond, Powell River, Langley and Victoria but were defeated in Prince George and NQORTH Vancouver.

Four thousand people attended the yearly meeting for election of Board members to Victoria General Hospital. Despite strong organizing efforts by pro-choice groups, the three seats up for election, all formerly held by pro-choice supporters, went to anti-choice candidates. This gives the anti-choice faction a majority on the thirteen member board.

There is a need to counter the threat of abortion becoming totally unavailable or illegal. Pro-choice forces organized in two major rallies in September, one in Vancouver and the other in Victoria. Both demonstrations were attended by hundreds of people.

VANCOUVER

Beth Hutchinson

Welfare Cutbacks: The latest in a long list of Socred government cutbacks is the plan to spend less money on welfare. Monthly payments will be decreased by amounts ranging from \$35 to \$55 and "employable" recipients will be cut off welfare. Any person is to be classified as "employable" who is not: (1) 65 years of age or older; (2) suffering from a physical or mental infirmity; (3) a single parent having at least one child under 6 months or 2 children under 12 years; (4) a single parent with a child with a serious physical or mental handicap.

The effect of these cutbacks will be to force more people into the lowest paid jobs, thus increasing competition among unskilled workers. This desperate competition may become a major threat to minimum wage and union bargaining rights.

VICTORIA

Susan Moger

Options For Teens: Victoria is the home of an exciting new program that will address one of today's most pressing problems, teenage pregnancy. Options — an alternative program for pregnant/parent teens — is funded by the Greater Victoria School Board and the Ministry of Human Resources. The program will provide a safe supportive environment where young women can learn about pre- and post-natal care, nutrition and exercise, and receive life skills assessments.

Letters

We reserve the option to print letters to *Healthsharing* with minor editing for length, unless they are marked "not for publication."

Natural Birth Control Not Natural

I am writing to comment on Vicki Van Wagner's article in *Healthsharing* Vol. 2, No. 3 entitled *Controlling Conception — Naturally*.

I object strongly to the nomenclature used in this article, and in the publication of Serena and other organizations promoting periodic abstinence method (PAM) as an effective means of contraception. To propose a schedule of sexual activity, and to then label this as "natural" implies a false view of human nature. Periodic abstinence is no more a "natural" state than is long term celibacy, or regular, frequent intercourse, or regular, frequent masturbation. I make a distinction between my desires and my ovaries, my intellect and my ovaries, and even, on occasion, between my intellect and my desires. By labelling periodic abstinence as "natural", these distinctions are lost, and female nature becomes nothing more than the physiology of ovulation and menstruation.

The teaching of fertility awareness (a necessary precondition for the successful use of PAM) is useful since it makes women more aware of themselves and of how their bodies work. But what the advocates of PAM have done is to turn some of the gains of the feminist self-health movement against us by labelling any other method of contraception as "unnatural".

The feminist movement also insisted on the responsibility of men in conception. Again, the advocates of PAM have turned that against us. In Manitoba, those teaching PAM will only teach "couples". Where does that leave the sexually active single woman?

Women being instructed in PAM should also be given accurate information about back-up barrier contraceptive methods for those times when

their desires may coincide with ovulation. Note that religiously-based groups teaching PAM do not teach back-up birth control methods, and so have used this narrow view of women's "nature" to once again restrict our choices.

One serious side-effect of the use of PAM as contraception is the increased risk of fetal deformity, due to the increased risk of the (unplanned) fertilization of an overripe ovum. (See Berger, Charles J., "Medical Risks Associated with 'Natural' Family Planning".) I feel it is important to stress this risk, since most women assume that anything "natural" is necessarily harmless.

Lissa Donner
Winnipeg, Manitoba

Dysmenorrhea

I found the article on dysmenorrhea helpful and informative. I was pleased that the author discussed the wide variety of therapies in use and recognized that their efficacy varies from woman to woman.

The recent work on anti-prostaglandin drug therapy is interesting and appears hopeful. However, I am concerned with the statement in the article that side effects appear to be quite minimal. According to recent drug studies, there are a wide variety of possible side effects, although their frequency is not documented. Naprosyn may cause prolonged bleeding time, Naprosyn, Ponstan and Motrin all may cause headaches, drowsiness, dizziness, depression and inability to concentrate. Motrin and Naprosyn may cause edema, palpitations and hypertension. All three may cause anorexia, nausea, vomiting, diarrhea, gastrointestinal hemorrhage and blurred vision. None of

these drugs should be used if the person has a history of liver or kidney disease. We are also warned that Ponstan should not be used for more than one week at a time.

Any woman who considers using any of these drugs should be given access to all the information available concerning their side effects and possible drug interactions.
Lisa McCaskell
Toronto, Ontario

Healthsharing Translated

I was very happy with the gift subscription to *Healthsharing*. I had already received some issues this past year and I think it's very good.

It's also very useful to my work. I'm working in a centre for adult education in the field of health, and mostly with women's groups. For this reason I've translated two articles and published them in our own monthly. I realize that you probably won't read Dutch, but it might be nice to your collectige to know what impact your magazine has.

Wil van Gyn
Reigershamp, Holland

Sympto-thermal Method Rewarding

Thank you for publishing the excellent article on natural birth control by Vicki Van Wagner in your summer 1981 issue.

I was introduced to the sympto-thermal method by a friend nine years ago and have used it successfully ever since. I learned the method as a single woman. In the two major relationships I have had since then both men have been supportive but not very involved in my use of sympto-thermal. A physician here once commented that a woman would have to be

extremely obsessive-compulsive to use sympto-thermal; my experience has been that I find it very rewarding to assume control over this aspect of my life.

I have been disappointed in the past that many feminists discounted this method as "a lot of work," though I think many were also turned off by the very couple-oriented approach of organizations that teach it. Articles such as yours encourage women to adopt this intelligent approach to the question of their fertility.

Audrey Hall
Saskatoon, Saskatchewan

Our Bodies, Ourselves

We have just begun a major revision of *Our Bodies, Ourselves*. We need your help to make it speak to and for as many women as possible.

In addition to sections in the current edition, we plan to add sections about women in the workplace, environmental hazards, reproductive technology, alternative forms of health care and growing older. We want to include more experiences from women of color, women with disabilities, midlife and older women.

Your written contributions will help shape our understanding of what needs to be in the book. Please send us your experiences. We will read all the material you send, quoting from some, not all, in the revised *Our Bodies, Ourselves*. We will not use your real name except, if you wish, in the case of poetry. All material you send becomes our property and will not be returned. We will, unless you indicate otherwise, keep your contributions on file for other women to learn from.

When you write, take enough time and space to do justice to what you have to say, but be brief where possible. We won't be able to respond personally, but please know in advance how much we appreciate your help, caring and time.

Boston Women's Health Book Collective, Box 192, W. Somerville, Massachusetts, U.S.A. 02144