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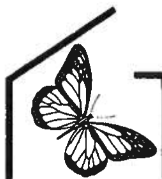

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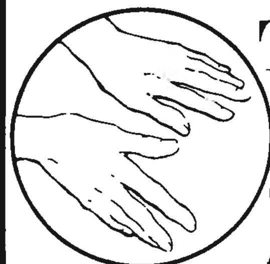

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Collective Notes

The recognition of oppression of women by the medical system was a critical factor in the rise of our present women's movement. It was logical that our first battles rallied around women's need to control our own bodies. And it is in the area of reproductive issues that we have made the greatest strides. Although there are constantly new struggles, unnecessary hysterectomies are on the decline, surgical intervention methods for breast cancer have been improved, spousal consent for sterilization is rarely required and, although we are not making headway, we are, for the most part, holding our own against organized anti-choice efforts.

Through struggles for reproductive rights feminist theory and analysis have grown. Even though we have applied this same feminist perspective to broader concerns — equal pay for work of equal value, occupational health and safety hazards, sexual harrassment and sexual assault — we seem to be most comfortable when dealing with gynecology. We are hesitant when we move beyond our physiology and anatomy.

When we began *Healthsharing* we envisioned a magazine which would address *all* health issues as they affect women's lives. We dreamt of a magazine which would link women, and by linking women help us to develop a feminist perspective of health. We had hoped that *Healthsharing* would share knowledge, pose questions, share personal and collective experiences — joyous and painful, and articulate our visions.

We're thrilled with the growth of *Healthsharing* during the past 2½ years and even more thrilled by your open armed acceptance of the magazine. But we're disappointed in the breadth of issues which have been addressed in *Healthsharing.* We're succeeding at presenting good, informative articles, especially about reproductive concerns. We're not yet going far enough in presenting articles about issues which have not been defined as "women's issues", or in expanding our existing body of feminist health theory.

Sheila Rowbotham, in *Woman's Consciousness, Man's World,* wrote that any oppressed group must at the same time be able to shatter the world image created by the ruling class and create its own new image. As feminists we have done well at seeing the falseness of the female stereotype, but we have not yet created a new vision. We stand in front of a shattered mirror: sections of the mirror have been reconstructed, but other portions remain fragmented. Much feminist activity has been the process of shattering this mirror bit by bit as we confront each specific instance of oppression. Sidney Oliver in *Defining Our Territories* (*Quest*, Vol. IV, No.3) calls this practice "reactionist". Oliver recognizes that we react to existing oppressive situations because these situations do require change. She argues however, that the drawback of a reactionist perspective "is simply that it isn't as affirmative as we require feminism to be. It doesn't go far enough in identifying relevant issues . . . because it limits our ability to envision feminism as a *world view* capable of generating analyses of all issues affecting the quality of life, a reactionist politics limits the issues we accept as ours to those which can be linked anatomically to females."

The question then arises: Can *Healthsharing,* through the joint effort of its editors, writers and readers, assist feminist health activists to move beyond a reactionist approach? Can we develop a feminist analysis . . . of cardiology treatment? of disease distribution? of rolfing? health legislation? chemical proliferation?

We think such analyses can and should be developed. Feminist viewpoints are being applied in some fields of health research. For example, whereas in the past many drug studies excluded women because women's fluctuating hormones would "confound" study results, today it is recognized that women and men absorb and utilize many drugs differently. Marijuana is a case in point. Until the early 1970's marijuana was studied using only male subjects. It took Cannie Stack Adamec to recognize that marijuana might affect women differently and to subsequently discover that not only do women react differently to marijuana but they also exhibit different smoking habits than men. Alcohol is another example — women drink for different reasons than men, develop different drinking habits and absorb alcohol into the liver more rapidly than men.

In other fields feminists are also making extensive inroads in altering scientific thought, not just because of new data, but because we begin with a perspective which leads us to question basic underlying assumptions of most scientific theory. Hence, in behavioral biology and anthropology reinterpretations of old findings are undercutting longstanding beliefs. For instance, the image of the all-dominant male baboon or elephant seal has been tempered recently as the importance and existence of female choice in mating has been recognized in these species. We're not witnessing a sudden emergence of liberated female baboons and seals, simply a change in vision of the scientists watching these animals.

In these fields we're breaking new territory, which is more difficult than expanding theory within the traditional ground of reproduction. During our collective discussion for this *Collective Notes* we admitted that while we believe in the development of a feminist world view we're not sure what a feminist perspective of, say, cardiology would look like. We find it difficult to articulate, once we move into the realm of non-reproductive issues, how a feminist ideology would differ from a humanist perspective or an anarcho-socialist approach. We also find it difficult to move beyond the subject areas with which we are familiar and have personal experience. It's as though we are learning, not simply a new language, but virgin concepts which attend the untried words.

Sidney Oliver suggest we are in a period of transition. "In this phase," she writes, "the old and familiar can at least be articulated and the new and recently-perceived can only be suggested."

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Connie Clement
Diana Majury
Lisa McCaskell
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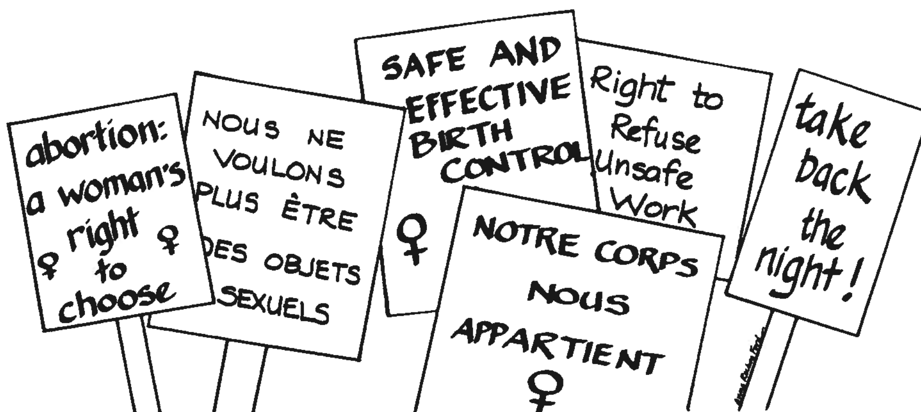

Healthsharing

Reaching a collective aggreement to extridite yourself from quicksand

published by
Women Healthsharing

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Newsfronts

Medical Blackballing

In Pincher Creek, Alberta, a woman and her two daughters **will** be given medical attention — but only under duress.

Pearl Ferland had been informed in a joint letter by all five Pincher Creek doctors that she and her pre-school daughters would be refused medical treatment except in extreme emergency. Why? Because she had the gall not only to sue, but to win a settlement from one of the doctors. The court ruled that Dr. Juan Teran had been negligent in not telling her that she might possibly become pregnant despite her tubal ligation. She did.

According the the Globe and Mail report, the Alberta College of Physicians and Surgeons had a talk with the doctors, and they now say they will provide medical care for the Ferlands. The College will consider disciplinary action if Mrs. Ferland files a formal complaint against the five doctors.

Healing Secrets Found in Evening Primrose Flower

Current research in 13 different countries is showing that the seed oil of the Evening Primrose flower contains properties which may help the body to prevent and treat a variety of conditions, from the Premenstrual Syndrome and benign breast disease to obesity and alcoholism. Dr. David Horrobin, over whom there was much contoversy last year following the connection he made between valium and cancer, recently left his post at the University of Montreal to devote himself exclusively to researching Evening Primrose Oil. The oil of the flower's seed has been found to the only food substance available which is a source of gamma-linoleic acid (GLA). GLA is an essential fatty acid, vital for the body's production of prostaglandin E_1 (PGE_1). Due to a North American diet rich in processed vegetable oils and saturated fats, alcohol consumption and a lack of zinc, magnesium and Vitamin B_6, many of us do not properly formulate GLA, thereby curtailing production of PGE_1. PGE_1 has been shown to be present in either excess or sub-normal amounts in a number of diseased and unhealthy states. Horrobin and his reasearch team in Nova Scotia have found connections between PGE_1 and hyperactivity in children, arthritis, multiple sclerosis, schizophrenia and some human cancers.

The powers of the Evening Primrose plant have been known for hundreds of years and were long used by North American Indians for the treatment of a variety of ailments. In Europe, it was known as "the King's cure-all". The oil from the Evening Primrose flower is currently available in capsule form in Canada, but is quite expensive as it is manufactured in England. Efforts are underway to begin production in Canada.

Birth Control Update

Confused about birth control methods? No wonder. If you have been following the latest developments in the birth control market place covered recently by the Globe and Mail, you will have made the following discoveries:

• **Lower-hormone birth control pill now available:**
"Ortho Pharmaceutical (Canada) Ltd. has received federal approval to market in Canada a "bi-phasic" birth control pill which cuts the over-all intake of progestins . . . Progestin has been implicated in the increased risk of vascular problems, including heart disease and elevated blood pressure among women taking oral contraceptives." (Dec. 18)

• **Progestin may protect lining of uterus:**
"University of North Carolina scientists say they have new evidence that oral contraceptives containing the hormone progestin as well as estrogen can help protect women from cancer of the uterus lining". The paper quotes the Journal of the American Medical Association study as saying "women who don't use combination-product oral contraceptives have at least twice the risk of developing endometrial cancer as those who do." (Jan. 25)

• **Once-a-month birth drug successful scientists say:**
"Scientists in California say they have successfully tested a new birth control drug offering the possiblity of a "once-a-month" contraceptive pill which is unlikely to have any harmful side effects. . . .The drug, a synthetic form of a naturally occuring brain hormone speeds up the delicate changes in the second half of the 28-day menstrual cycle, preventing a fertilized egg from lodging in the womb." (Jan 1)

• **Rubber plug being tested as birth-curb:**
"A flexible threadlike rubber plug is proving to be a safe, effective and perhaps reversible method of sterilization for women, a researcher says. . . .The procedure involves squirting a few drops of liquid silicone rubber into each fallopian tube with a thin instrument inserted through the vagina into the uterus." (Dec. 12)

As one reads these articles more carefully, confidence in the drug companies, scientists and doctors doing this research reaches a new low. Halfway through the article on the low progestin pill, the medical director of Ortho-Pharmaceutical admits that there is still not enough data available to statistically evaluate whether the lowered progestin level actually results in decreased side effects.

Once past the headline of the piece on progestin and cancer of the uterus lining, it is pointed out that actually endometrial cancer is less common than the side effects of oral contraceptives, such as blood clots, so we really shouldn't all go on birth control pills to protect ourselves from cancer. The article concludes by saying that the study is based on information from 79 patients who had endometrial cancer and 203 women who had not.

The exciting headline for the once-a-month pill is followed by the somewhat disturbing revelation that only 5 women have undergone pilot trials of the drug to date. Yet the scientists are willing to say that the drug in unlikely to have any harmful side effects.

The rubber plug method appears to have undergone more extensive testing. We learn that more than 600 women have undergone "tubal occlusion" since 1978 with no serious side effects. Two questions come to mind — first what is considered a serious side effect and second, what is meant by the phrase "perhaps reversible method of sterilization"?

The information contained in these articles is confusing. Two messages come through loud and clear — Women's bodies continue to be used as guinea pigs, and scientists still show no hesitation in releasing information and advocating products for women for which testing has been inadequate and inconclusive.

VDTs and Pregnancy — A Legal Precedent

A precedent was set in Ontario in early February regarding working on VDTs during pregenancy. Helen Barss, a 26 year old data processing technician employed by the provincial government lost pay when she was assigned to a lower-paying job in which she did not have to use a VDT. Mrs. Barss had read the reports of possible health hazards of VDTs to a fetus. She consulted her doctor and on his advice asked to be transferred to another job when she was five months pregnant. She then filed a grievance because of the resulting loss of pay. The Ontario Public Service Arbitration Board ruled in her favour that she should not have lost the money. Sean O'Flynn, president of the government employee's union, OPSEU, predicted that it will have far-reaching effects.

In the decision the Board stressed it could not decide whether exposure to radiation from VDTs during pregnency is dangerous. However it said that it had to take a skeptical view because scientists often change thier minds especially about the health effects of previously undtudied substances.

Abortion Update

Canadian Abortions Level Off — Good or Bad?

Statistics released in December 1980 by Statistics Canada show that the number of therapeutic abortions performed in Canadian hospitals are levelling off.

Since the change in Canadian abortion law in 1969, there has been an increase in the number of abortions from 11,200 in 1970 to 65,855 in 1980. The 1980 figure showed an increase of only one percent over 1979.

The interpretation of these statistics are controversial. Are the numbers levelling off because more women are using contraception resulting in fewer unwanted pregnancies? Or do these statistics mean that right-to-life lobbyists have been elected to hospital boards preventing the establishment of therapeutic abortion committees in those hospitals? Are the costs of travel and paying opted-out physicians becoming too prohibitive?

There were 269 Canadian hospitals with therapeutic abortion committees in 1980, down from 274 in 1975. However in 1980, 76% of the total number of abortions were performed by less than 17% of these hospitals. What is more appalling are the regional disparities which force women to travel out of province and country to obtain an abortion.

The statistics show that Canadian women having therapeutic abortions continue to be mostly young, unmarried and without a previous pregnancy. As well, the figures show that women are getting abortions during earlier stages of pregnancy.

Victoria CARAL

Legal Precedents

On Tuesday Dec. 1, 1981 the Supreme Court of Canada ruled that Joe Borowski may legally challenge the 1969 federal abortion law which permits abortions in hospitals with therapeutic abortion committees.

Borowski's challenge is on the grounds that the abortion law "may violate the rights of the unborn". The federal decision was split 7 to 2 and withheld the decision in which court the battle would proceed, either the Saskatchewan provincial court where the proceedings began or in the federal court since it is a federal law.

Joe Borowski is a former cabinet minister in Ed Shreyer's NDP government in Manitoba. He quit on the abortion issue in 1971. During the last three years he has continually been challenging the abortion law.

It is expected that the court battle will begin in the spring of 1982. The outcome of this battle could seriously affect the rights of women to obtain abortions.

Karen Hammond of CARAL, the Canadian Abortion Rights Action League, said that CARAL is planning to take legal action in the Borowski-initiated battle. Interested individuals or groups who could contribute financially or in other ways can contact CARAL, P.O. Box 935, Station Q, Toronto, Ontario M4T 2T1.

Proposed Changes to Rape Law

After nearly 10 years of work and planning, proposed changes to Canadian rape law may finally come into effect this year. Bill C-53, after receiving approval in principal from Parliament, has gone before the federal justice and legal affairs committee for debate before being given final approval by Parliament.

The changes proposed are radical and the bill has both strong supporters and detractors. The most obvious and dramatic change to present law is the removal of the offense of rape from the Criminal Code. In its place, two new offenses will be created — sexual assault and aggravated sexual assault. As reported in the Globe and Mail, sexual assault could range from a grab at a woman's breast to forced sexual intercourse. The charge of aggravated sexual assault would be used when a victim was injured or a weapon was used. Under these new laws charges could be laid by both men and women, since rape would no longer exist as a crime that can be committed only against women.

Criticisms of the bill are based on the removal of the crime of rape. It is feared that if rape becomes just another assault charge, rather than a unique crime committed against women, that sentences for rapists will become even lighter.

Other sections of the bill have been more easily accepted and praised. A new offence of sexual misconduct has been created for adults who sexually exploit children under 16 years of age. For example, adults who use children for production of pornography — from the developer of the film to the distributor could face a maximum penalty of 5 years in jail and double if a parent or guardian is charged.

Another dramatic change is a new secton to protect women against marital rape. Women will now be able, for the first time, to charge their husbands with sexual or aggravated sexual assault.

It is expected that the new bill will also change some of the rules and procedures of a rape trial, such as removing the requirement of proof of "penetration", and removing questioning of the victim's past sexual behaviour as if she were on trial rather than her attacker.

It is hoped that by removing pressure on the victim to give the bulk of the testimony, complete with all the intimite details of the attack and any other sexual involvements she may have had, that women will be more willing to come forward and lay charges against their attackers.

APOLOGIES

- **to Margaret Laurence for spelling her name incorrectly and to Lyba Spring for once again listing her phone number incorrectly. Her phone number really is 652-3665.**
- **to the Women's Press for failing to list them as the publishers of Everywoman's Almanac.**

My Story, Our Story

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

Taking Care of Myself

by Mǫe Lyons

I've used many methods of birth control in my time — condoms, rhythm, abortion, the pill, the Lippes Loop, the Dalkon Shield, the Copper 7 and again the Lippes Loop. IUDs never worked for me. It's true they were successful as contraception, but they hurt me when I had sex with men. It has been three-and-a-half years since I said goodbye to all that in a way that made me feel I had power over my life.

I was having increasing difficulty with the idea of being an independant woman who always practised contraception. What bothered me was that for almost ten years I had continuously interfered with my body in order to be always sexually available to men. A remark I had read stuck in my mind: "Sex is never an emergency."

I thought about how long it had been since I had felt any sexual urgency in relation to a man. And I knew it was time for me to stop confusing compulsory heterosexuality with sexual revolution.

There I was, this IUD in my body and no further use for it.

The thought of having it removed by a doctor, of being once more tense and alienated in that sterile environment, repelled me. My experience with doctors around insertion and removal of IUDs had been universally unpleasant and painful. I became convinced it didn't have to be that way. The parallel that occurred to me was the difference between hospital birth and home birth. Surely, I thought, if you can have a baby at home you should be able to pull out an IUD.

First I approached a woman friend who was interested in healing about helping me to take the IUD out. Understandably, she didn't want to take the responsibility. She was intrigued by the idea, but she was afraid.

I didn't know what to do next.

One evening I was lying relaxed in a hot bath, thinking about getting rid of my IUD, a matter which seemed to be taking up a considerable amount of my thinking time generally. Finally I said to myself, "Why don't I just do it? Now. If it hurts I can stop, but I'll bet I can take it out myself."

I reached inside myself and found my string and gently tugged on it. A twinge of pain. But I wasn't tight and I wasn't afraid.

I know how to relax myself in a hot bath — I've been doing it for years. I masturbated, slowly, gently, carefully, making myself open up wide to receive myself. I took hold of the string with one hand and pulled, slowly, gently, carefully, while making love with myself with the other.

I was in no hurry and I wanted very much not to hurt myself. Steadily, steadily, I pulled on the string while opening myself up as much as possible. I could feel the IUD sliding through my cervix and suddenly there was no more resistance and it was out. The pain had been less than the mildest period cramp.

I felt so good that it's hard to describe. I had taken care of myself, taken power over myself, and I had made myself free.

****

Having written this, I find myself asking, "Now, what's the point here? Is this just an excuse for rampant exhibitionism? Are you trying to promote a home IUD removal movement, or what?"

One point is, of course, to share the revelation that my liberation did not lie in being available for heterosexual intercourse at a moment's notice.

The point in writing this story for this magazine as opposed to some other, however, is that we have been terrified into believing we have to submit to experiences no one could possibly want because of the expertise we supposedly need to take care of ourselves. Not only that, we have been trained to feel guilty for being irresponsible when what we are doing is assuming responsibility for ourselves. Taking care of oneself is not an irresponsible act, especially if it is done with love for oneself and a willingness to quit if it seems going on might be dangerous.

No doctor who removed an IUD from me ever took care of me, and the situations in which the removals occurred always contained fear, tension, alienation and humiliation that made the experience difficult and painful. Maybe (probably) if there had been a women's clinic available to me I would have been glad to go there, just in case there might have been some complication involved. Given no such option, I knew who the woman was who would best take care of me: myself.

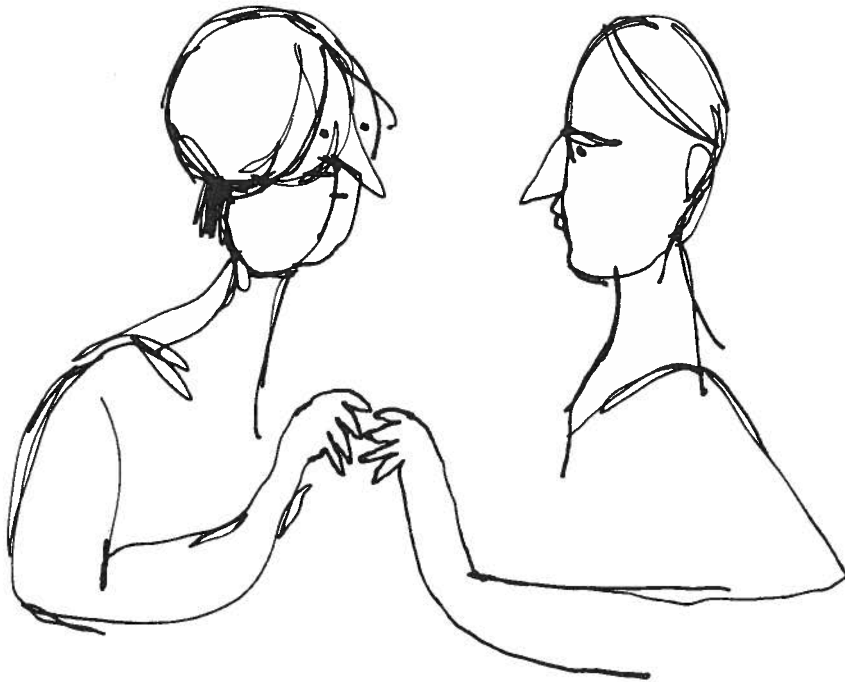
Allopathic medical help is for crisis intervention. Most health needs we have are not crises. We should be prepared to call on professionals if and when we need them. I believe, however, that the more power we take into our own hands, the less power we give an anti-personal medical establishment to make us believe we need to pay them to do anything they define as medical and therefore as being their province.

We are neither stupid nor irresponsible and we have the right to decide for ourselves what we need and how to get it. It's important for every woman to have faith in herself and to remember there is always within her the one person she can be assured will be sensitive to her and who will respect and respond to her wants and needs.

Mǫe Lyons is a lesbian/feminist activist who is involved with Dumont Press Graphix and Hysteria magazine in Kitchener, Ontario.

The Emotional Turmoil of INFERTILITY

by Marlie Manning



"I lead my life with two basic assumptions. One is that everything will turn out to be okay, regardless of how bad things are right now. The other is that I can get almost anything I want, if I really work for it. My infertility shattered both, and I am enraged! How can this be?"

Infertility is a life crisis, occurring at a time when most of us are activating, not shattering, our dreams. It viciously destroys the myth of freedom to choose to be biological parents. It makes a mockery of our adolescent and adult fears of unwanted pregnancy. It cruelly tackles feelings of sexual adequacy by denying the visible results of potency and virility. It denies the achievement of an important developmental milestone, and a common marriage expectation.

As one who has been professionally active in the field of adoption for many years, I am regularly confronted with the subject of infertility. Yet despite such familiarity, I sometimes remain shy to introduce the topic with couples who initiate adoption proceedings. It is no wonder. Infertility is a subject of privacy. It concerns sexuality, intimacy and self esteem. I am acknowledging a reality that is laden with very painful emotions of failure, inadequacy and shame.

Even the word is uncomfortable to most. What does it mean? From a medical perspective, it is generally agreed that primary infertility is the inability to conceive despite one year of regular intercourse without contraception. Secondary infertility is the lack of conception after one birth, or the inability of a woman to carry a pregnancy to a live birth. Research suggests that primary infertility is caused by an absolute male factor in 30 percent of cases, an absolute female factor in 30 percent of cases, two or more female factors in 30 percent of cases, a combination of male and female factors in 5 percent, and unknown factors in 5 percent. Further, 80-85 percent of infertility is primary. Subfertility is a more contemporary term used to indicate that pregnancy is improbable rather than impossible.

It is estimated that one out of every six couples is infertile, and that rate is growing. Several factors are identified for this increase in infertility. First, for many people the decision to bear children is now made at a later date. Because maximum fertility is in the mid-twenties for both women and men, the chances of conception are reduced. Second, venereal disease is increasing throughout all social strata. The effects of such infections are adhesions and scars within the woman's reproductive system, creating obstacles for both the ovum and sperm. Third, it is suggested that many common forms of birth control are precipitating infertility. The use of the birth control pill may cause ovulation to cease forever in some women. The intrauterine device increases the risk of pelvic inflammatory disease, resulting in scar tissue similar to that caused by V.D. Fourth, abortions are also on the increase, and sometimes result in an injured cervix which can no longer support a pregnancy. Fifth, cancer research indicates that the carcinogens of some industrial environments increases the rate of miscarriages, while others decrease the number of healthy sperm.

Additionally, I hypothesize that both the traditional teaching of sexual restraint and the contemporary emphasis on sexual freedom may create psychological barriers to spontaneous discharge of healthy sexual energy. In fact, the collision of these opposites — a collision that we who are of childbearing age often confront — might almost immobilize healthy sexual

drawings by Dawna Gallagher

expression. I need only to think of those women who cease to menstruate following a marriage separation or a traumatic abortion, to realize the intimate relationship between emotions and physiology.

Fertility is a known, confirmed only after the fact. Infertility is experienced as a process, sometimes never with an endpoint. It starts with doubt, and then continues, sometimes for years of physical and psychological pain, before being confirmed by tests and/or the failure to bear a child. Many report that this process of grief is more anguished than any before endured. Undoubtedly, such suffering is intensified by the frequent lack of empathy or compassion from the medical profession. As one woman chronicled in her journal:

"At first I was so grateful to get an appointment that I didn't mind the traffic jam in the waiting room. But, the gratitude sure disappeared quickly. The doctor made me feel like I was just a mess of incompetant reproductive tools, not a person with feelings. It seemed that I had no right to be embarrassed about describing our sex life, or submitting to his physical examination. I was scared to tell him when it hurt, and terrified to ask him for a little time to get used to the idea of surgery. I felt raped and robbed of my adulthood. It was more like I was a bad little girl."

Infertility test and treatment procedures can be humiliating, invading and controlling. Feelings of failure are apt to erupt with specific tasks assigned. A man may experience an inability to achieve erection or to ejaculate in response to a post coital test, or in response to a schedule for intercourse in accordance with basal body temperature chart readings; a couple may "cheat" on their recorded sexual activities, to prevent their physician's rebuke that they aren't "trying hard enough"; a couple may query what social, religious or biological rules they have transgressed when faced with no physical or metabolic reason to explain their infertility.

Like any life crisis, infertility precipitates a process of feelings similar to the stages of dying articulated by Elizabeth Kubler-Ross. Most often the initial response is surprise and denial, feelings which are necessary defense mechanisms until the psyche can tolerate the absorption of such critical information.

Isolation follows; the couple experience their despair and agony as too intense to share outside their partnership and they need protection from inaccurate advice and insensitive

attitudes. Frequently isolation within the partnership happens when one partner thinks he or she has failed the other, or when gender differences prevent full empathy. Isolation explodes into anger. The real target is the situation, but the anger is often projected onto the partner or an authority figure such as a a physician. Guilt, depression and feelings of unworthiness are experienced — and acts of bargaining or atonement frequently result once a "guilty reason" is identified.

Finally, grief is reached:

"I was angry. With the whole world. Somehow that crankiness and bitchiness was tolerable, but my rage towards Tom scared the hell out of me. I couldn't stand him or anything he did — and I especially hated his tolerance of that. After weeks of this, he finally exploded one day when I yelled about the baggy jeans he was wearing. 'When are you finally going to accept that the world is unfair? When are you going to forgive all of us for your hysterectomy?' It was like a bolt of lightning. For a split second I wanted to run away, but nope . . . I looked at that loving man, and the tears came. I cried and cried. For days, weeks. I still do. I cried for the death — of my reproductive abilities that were never used, for the death of life that never happened, for the death of a dream, a fantasy. God, why isn't there a funeral for something like this?"

The resolution of grief is sometimes never attained because of an interrruption at some stage of the process, and there are significant factors in the loss of fertility which appear to increase the risks of interruption. The loss of something that *may have been* is more difficult to grasp than the loss of something that *was*; a plan is more abstract than a person or concrete object. Particularly when the loss of that something is not absolute, i.e. when infertility has no apparent medical base, the uncertainty is even more difficult to grasp.

Because infertility is such a private matter the grief cannot easily be shared and the process sometimes gets stuck at the stage of isolation. Many feel alienated from a society that regards the grief of childlessness as selfish, that regards emotionality with criticism, and regards the irrational with fear. Thus, in order to reduce the feelings of aloneness, emotions are sometimes repressed by rationalization before a full grief process is completed. After all, it is not hard to justify the insignificance of a loss of fertility by proclaiming the merits of decreased population growth, or the joys of childlessness, or the irrelevance of parenthood to self-esteem or the altruism of adoption.

"I am a feminist, and my women friends have always come through for me. When my partner and I found out that he had no sperm count, we all tried to protect him by saying that it didn't matter, that kids weren't everything. But it didn't work. Somehow the reasonableness of all the arguments didn't help him or me. I just felt more guilty about being so angry at him, and at my friends for not understanding how it felt. We split up before I realized that we both were entitled to our feelings regardless of how unwarranted they seemed to be."

Of course we can rationally protest that infertility has no relevance to personal or sexual adequacy and that parenthood is no indication of maturity, but infertility powerfully impacts on the irrational, the emotional. It reminds many of a Judeo-Christian myth that a barren woman is as much valued as barren land and that infertility is punishment to those who have lost favor with God.

Infertility frequently precipitates belief in the myth of "maternal instinct" — the notion that women have a biological need to birth and to mother — despite studies which disclaim it. As importantly, it reveals individualized myths:

"What a shock, what a painful shock it was to acknowledge to myself that my failure to conceive meant to me my failure as a daughter. Mum had often jested that she expected me to give her the first grandchild, and now I couldn't do that. I knew I was being ridiculous, but it didn't seem to matter. It didn't help either when Mum pretended that she didn't care. She *did* care. She wanted to be a grandmother!"

It is difficult not to judge such myths as right or wrong, good or bad. And it is just as difficult not to judge the many motives for wanting biological children, motives that are as highly personal as the meanings of infertility. In addition to the enjoyment of parenthood for its own sake, some want to fulfill a role, to conform to social pressure, or to finally emancipate themselves from parents by this entrance to full adulthood. Some women feel a need to experience total performance of their bodies, to experience pregnancy, labor and delivery and breast feeding. More men than women seek genetic continuity. Infertility is perceived to deny such fulfilments and, for a time, life may appear empty of purpose.

Support systems are rare for those struggling with infertility. Misinformation, misguided assistance, and judgmental attitudes from family and friends are common; social services are almost non-existent. Although fertility clinics are increasing throughout the country, few therapists and counsellors grant much attention to the matter. There is little impetus since the infertile populace tends to remain silent and alienated from one another.

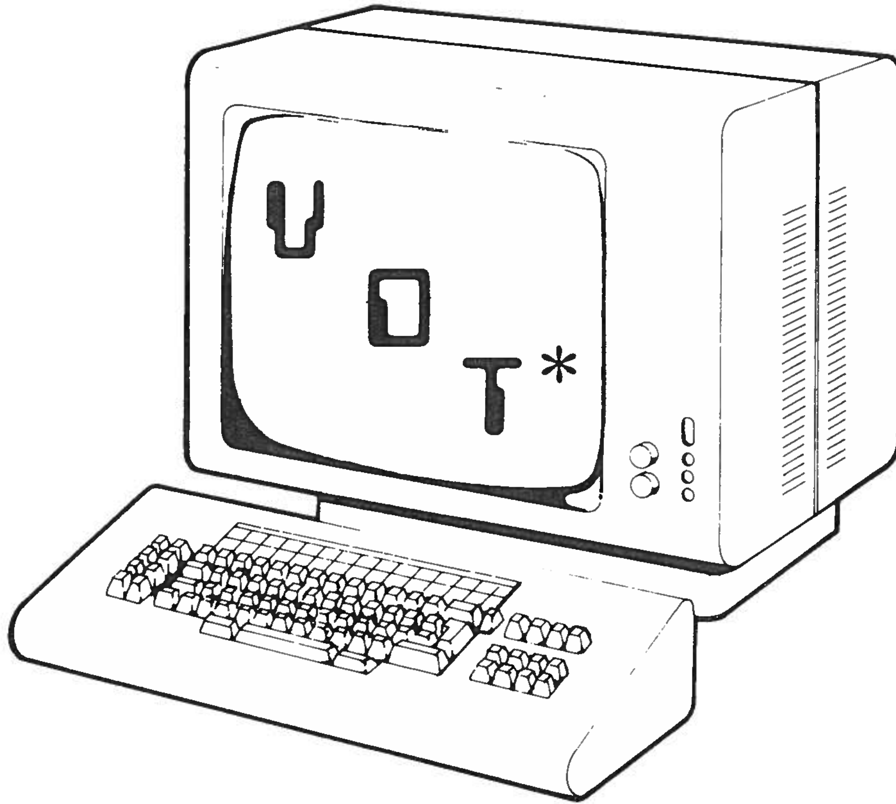
In 1973, a charitable organization, Resolve, was begun in the U.S. to provide education, referral, counselling and support groups for infertile couples. Resolve eagerly shares literature with Canadians, but is restricted by legislation from expanding beyond national boundaries. Using Resolve as a model, a new Toronto collective has begun its own network of support and self-help. As well, a Candian film production company is about to develop a film on infertility to inform the public of the medical and emotional aspects of the subject.

Infertility deserves more public acknowledgment, and those who personally struggle with it require stronger advocacy. The investigation and treatment of this problem, as well as counselling for those involved, should be readily accessible. Almost half of those who seek medical counsel can be helped. As importantly, the painful emotions accompanying infertility can be replaced by a sense of resolution, reward and fulfillment.

Marlie Manning is an adult educator and counsellor in Toronto. Her practice includes individual, family and group work. Her particular areas of interest are adoption, infertility and weight regulation.

Resolve, Inc. can be reached at P.O. Box 474, Belmont, Massachusetts, U.S.A. 02178.

The newly forming Toronto group can be contacted through Jan Silverman at 5 Wilkins Avenue, Toronto, Ontario M5A 3C2.



*Very Damning Testimony

by Melanie Conn

I've been wearing a fluorescent green and black button in my lapel that says, "Got the VDTs?" It's a souvenir from a recent conference on the health hazards of VDTs, (Video Display Terminals), presented by the Labour Council of Metropolitan Toronto and it provokes questions and comments wherever I am.

Some of the people who notice my button are VDT operators. More than 250,000 workers in Canada, mostly women, use VDTs in offices and banks, in insurance and telephone companies and in the printing, newspaper and travel industries. Also called word processors or CRTs, (Cathode Ray Tubes), the machines have radically changed the clerical worker's environment.

Looking innocently like a typewriter attached to a T.V. screen, the VDT is a product of microelectronic technology that stores vast quantities of information which it can reproduce, correct or transmit at the touch of a key. In many workplaces, VDTs have been plunked down on the desks, literally replacing typewriters. Increasingly, VTSs are clustered in groups of 10, 20, or 30, making the office resemble a factory.

Indeed, clerical work is reduced by the VDT to an assembly-line process of repetitive, monotonous routines. Variety and initiative are eliminated and only limited physical movement is required.

In practical terms, this means that the VDT operator spends her workday virtually plugged into the machine, keying in information or scanning the screen for data. Depending on her workplace she may also deal with customers or operate a printer which produces hard copy (printed words on paper). The machines can be programmed to monitor a worker's productivity so that the employer knows exactly how many keystrokes and incorrect entries the worker makes each hour, how her "score" compares with her co-workers or with her own score the previous week; the employer also knows when she takes a break and for how long.

VDTs are creating an array of health problems for workers ranging from stress and vision deterioration to possible radiation injury. Common complaints include headaches, blurred vision, burning and itching eyes, neck and back pain, fatigue, dizziness and nausea. There have also been cases of cataracts in the eyes of operators and reports of birth defects in children of operators; both conditions are thought to be the result of exposure to the low levels of radiation emitted by the machines.

Stress

In a study of VDT operators in 1979-80, NIOSH found that VDT operators in strictly clerical operations (that is, not bank tellers or journalists) showed higher stress ratings than any group of workers the organization had studied, including air traffic controllers. Repetitive, routinized, "de-skilled" work, increased pressure to speed-up, isolation from co-workers, invisible and constant surveillance by supervisors and the sense of being plugged into the machine are major sources of stress for

VDT operators. Stress produces a wide range of physical and emotional problems that can only be reduced by significant alterations in the work process. Some ways to remove sources of stress include the introduction of job variation, the elimination of monitoring and the elimination of the category "VDT Operator".

Radiation

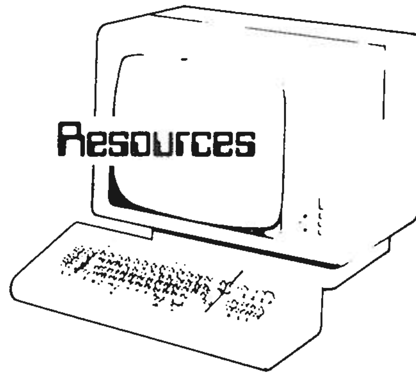
The question is not whether VDTs emit radiation, but at what level exposure is harmful to workers. Most government and industry studies have shown that the machines produce both ionizing radiation (ultra-violet, infra-red and X-radiation) and non-ionizing radiation (radio-frequency and microwaves). Officials are quick to point out that emissions are well below the current North American standards, and that the machines, therefore, are "safe".

Workers have become suspicious of this conclusion. Present standards are being questioned by workers' groups and by scientists who see them as inadequate protection for workers. For one thing, there has been no research done on the particular conditions of the VDT worker who sits 12-14 inches from the screen and is exposed to several kinds of radiation simultaneously 7½ hours a day, five days a week, for months or years. In fact, in recent years information has emerged about the hazard to human beings from accumulative doses of radiation over time.

The cataracts that have appeared in the eyes of VDT operators have the characteristic formation of those which develop in radar workers. This means that VDT operators are being exposed to hazardous levels of non-ionizing radiation, just as radar workers have been.

Exposure to low doses of non-ionizing radiation has also been shown to produce problems of the central nervous system such as irritability, fatigue, insomnia, memory loss, dizziness and black-outs — all symptoms reported by VDT workers.

The birth defects in the children of VDT operators that have been reported with increasing frequency are thought to be related to the exposure of the developing fetus to radiation.



The Hazards of VDTs.
O.P.S.E.U.
1901 Yonge St.
Toronto, Ont.
M4S 2Z5

Health Protection for Operators of VDTs/CRTs. $1.00
NYCOSH
32 Union Square, Rm 404
N.Y., N.Y.
U.S.A. 10003

VDTs, Health Alert. one copy free
Labour Council of Metro Toronto
15 Gervais Drive. No. 407
Don Mills, Ont.
M3C 1Y8

Working With VDTs. free
Ministry of Labour
Occupational Environment
Branch
4946 Canada Way
Burnaby, B.C.

Health Hazards of VDTs
Association of Scientific, Technical & Managerial Staffs (ASTMS)
10-26a Jamestown Road
London, England
NW1 7DT

Chapters on VDTs are included in the following books:

Working in an office is dangerous to your health. free
Women's Action on Occupational Health
1501 West Broadway
Vancouver, B.C.

Clerical Fact Pack. $3.00
Women's Occupational Health Resource Centre
60 Haven Ave, B-1
N.Y., N.Y.
U.S.A. 10032

The Office Worker's Survival Handbook. $5.75
BSSRS
9 Poland St.
London W1, England

Health Hazards for Office Workers. $3.00
Working Women's Education Fund
1224 Huron Rd.
Cleveland, Ohio
U.S.A. 44115

While the hazard of radiation emission is a specific issue, some organizations have recommended that it not be separated from the other issues because of the controversies about government standards. Since reduced time on the machine will also reduce exposure to radiation, adequate rest-breaks away from the machine are an effective way of beginning to deal with the problem.

Other groups such as the Newspaper Guild, have zeroed in on the radiation hazard as a potential cause of birth defects. Their strategy has been to demand that pregnant workers have the option of not working at a VDT, and instead can be transferred to another task without loss of seniority or pay. Other options include a leave without pay, but with a guarantee of returning to the same job without loss of seniority or pay. (See *Newsfronts* for update.)

While these demands seek to protect the pregnancy as well as the woman's job, it is important to keep in mind that damage to the fetus can occur during the first six weeks of development, before the woman knows she is pregnant. Also, men's fertility can be affected by radiation and this issue needs to be addressed as well.

It simply doesn't make sense to assume that these machines are innocent, even though the scientific "proof" of their guilt isn't in yet. Workers need legislation and contract language now to protect them before more damage is done.

Visual Problems

In surveys of offices where VDTs are used, eye problems rank highest. Workers who are stationed at the machine for most or all of the work day are straining their eyes in new and specific ways; over time a wide range of problems emerge having to do with diminished clarity of vision, difficulty in adapting to changes in light and loss of the ability to focus quickly on different things. The muscular strain on the eyes is aggravated by reflected glare on the screen from nearby surroundings or direct overhead lighting. Often the lighting is maintained at the bright level required for conventional clerical work. This creates a problem of contrast glare for the VDT operator who needs dimmer light in order to read the screen effectively. The characteristic "flicker" of the letters and numbers on the screen causes problems for many workers. In addition to obvious visual problems, eyestrain produces headache, fatigue and irritability.

Workers' research has produced a number of ideas for reducing eyestrain. These include anti-glare filters for the screens, appropriate, diffuse lighting, and changes in physical surroundings to reduce glare such as curtains on the windows and use of subdued matte colours on walls, furnishings and keyboards. Another idea is the provision of individual dimmer switches at each work station so that operators can maintain their own level of optimum lighting for their tasks. Regular replacement of the tube will help to prevent excessive flicker. Some contracts include regular eye examinations at the expense of the employer; others have the employer bear the cost of new or special glasses.

Time away from the machine, scheduled at regular intervals and not according to the demands of the work flow, give workers' eyes a chance to recuperate. In fact, time away from the machine — regular breaks or maximum use per day — has become a key issue in collective bargaining on behalf of VDT workers.

The U.S. National Institute of Safety and Health (NIOSH) recommends a 15-minute break following two hours of work with moderate visual demands and, and 15 minutes following one hour of work with high visual demands. These recommendations have provided the guidelines for some union negotiations. Other contracts call for longer breaks, e.g. 30 minutes after two hours, called for by Association of Scientific, Technical and Managerial Staffs in England. Maximum time on the machine per day has been written into some European contracts ranging from 100 minutes per day for postal workers in England to 5 hours for a contract in Nantes, France.

Ergonomic Problems

Ergonomics is the study of the relationship of the worker to the workplace. The goal is to improve that relationship, so that the workplace suits people better. Two examples of ergonomic problems experienced by VDT workers are poor seating and inadequate desk space which cause fatigue and neck and back pain. Another source of skeletal-muscular problems is that the VDT screen is often not detachable from the keyboard. This means that the worker cannot adjust the viewing distance or angle of the screen to suit her own particular needs for long-term work at the machine.

Researchers stress the importance of flexibility in arranging the work station: adjustable seating, swivel chairs, detachable screens, adjustable desks provided with foot-rests, adequate desk surface and copy holders.

Stratagies for Change

Union-inspired research and collective bargaining have been the two crucial elements in successful action around health and safety for VDT workers. Effective health and safety committees continue to play significant roles in this issue.

The vast majority of clerical workers are not in unions, however, and along with encouragement to organize, they can get support and information from the resources that are listed with this article. And, while government agencies are conservative in their assessment of the hazard to operators from radiation, some information they have about ergonomic concerns can be helpful in dealing with employers.

Employers will claim that the machines have been thoroughly tested for safety or will accuse workers of being superstitious and afraid of technology. Media presentations of the miracles of computer technology reinforces our sense that we should accept and adapt to the machine.

Good and accessible information about VDTs has been produced by unions and occupational health groups which can be used to challenge these arguments. Workers can educate themselves and their co-workers and begin to plan strategies.

Another effective tactic is to compile information about the concrete experience of VDT operators in their own specific workplace. A survey should include information on visual problems, general problems such as fatigue and memory loss, and changes in body rhythms such as sleeping patterns and the menstrual cycle. Several of the resources listed here include examples of surveys. The data collected will provide the facts with which to challenge and influence the use of the machines.

Over the Long Term

Ultimately, dealing with the health effects of VDTs means challenging the employers' control of technology. Demands for maximum time per day at the machine, for job rotation and the elimination of monitoring are examples of the workers' struggle to take control of technological change. In their negotiations around the introduction of the machines into the workplace, unions have demanded job security and limited working hours; they have blocked the introduction of shift-work and refused to allow the reclassification of clerical workers as single category VDT operators.

It may be that technology can enhance our lives without crippling our health, but only if we gain control over its use. That workers are taking up this struggle in countries where VDTs are used is an encouragement to us all.

Melanie Conn is a member of Women's Action on Occupational Health, a Vancouver resource group about women's workplace health issues. She is active in a subcommittee which speaks and writes about VDTs.

Why we need a C
Health N

Concern about women's health has always been a vital element of the women's movement. In the sixties, we began to demand the right to control our own bodies. While this notion surfaced in the context of being able to choose safe and legal abortions, it quickly expanded to take in other health-related issues.

The myriad of women's groups that formed and re-formed from the mid-sixties to the present, was the connection between a lack of personal power over our health, and the political organization of health care. During that period, the women's movement developed powerful and comprehensive criticisms of the medical system. We found it to be focussed on disease rather than on health in its fullest sense. We realized that hospitals and physicians rely increasingly on complicated, expensive technology, which forces women to be passive consumers of service rather than active participants in their own well-being.

Millions of women have been pushed into dependence on tranquillizers and other drugs in order to cope individually and alone with social problems. Women confront a health care system which medicalizes our normal biological processes — menstruation, fertility control, pregnancy and birth, menopause — sometimes by unnecessary and mutilating surgical techniques. Little is done to counteract many of the serious environmental and occupational sources of ill health, but the victims of disease are roundly condemned for their "unhealthy lifestyles".

The women's health movement has encouraged women to make our own assessments of our health care needs, to research health and medical topics of importance to women, to learn and de-mystify the languages of science and medicine. We have helped ourselves and each other to identify gynecological problems of infection, prepare for childbirth, deal with disease or handicaps. We have tried to promote our own definitions of health care, with an understanding that health requires a context of clean environments, good work, supportive networks of friends, and relationships free of mind-bending stereotypes.

Working in ones and twos and small groups all over this country, we have tried to create alternatives to the medical system which dominates health care in Canada. Our efforts have taken all sorts of forms. Sometimes we began new organizations; other times we worked within existing groups.

We provided abortion information and referral services, and joined political organizations for repeal of the aboriton laws. We established and operated birth control and venereal disease centres and clinics. We helped force recognition of the need for well-mother, well-baby clinics, and got some started. We organized childbirth education groups, supported midwifery and home birth projects. We staffed rape crisis centres, transition houses and shelters for women in trouble. We formed self-help groups of all kinds for women. We created or joined health collectives. We took part in environmental organizations and occupational health groups. We promoted an orientation toward preventive health care, analyzing, writing and sharing information about nutrition, exercise, alternative perspectives on well-being. We wrote about our concerns in women's publications and eventually formed our own regional and national women's health newsletters and magazines.

Our accomplishments have been impressive, but it is important to take a sober look at the difficulties we have faced and still confront.

Most women who become health activists are volunteers who also have a living to make and have other social or family commitments. Relatively few of us have training in science or medicine, and we must work hard to acquire the knowledge of fundamental concepts in these fields. We must overcome lifetimes of social conditioning to question or challenge authorities in medicine and government.

Because of our dispersal across a very large country, we find ourselves continually reinventing the wheel: duplicating research that has been

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by Jennifer Penney

done painstakingly elsewhere, repeating mistakes which others have painfully learned to avoid, reproducing basic concepts, arguments and analyses rather than developing upon them.

And, while some local women's health groups have had a long and productive existence, others have sprung up, worked very hard for a short period, but then collapsed, victims of burn-out from the grinding effort of taking on powerful medical and political interests. Pockets of women working in isolation and with limited resources will always find it difficult to sustain the ongoing energy and organization necessary to have an impact on overall social policy.

We need to help and support one another in this struggle. A Canadian Women's health network could provide means of doing just that. A national organization could help provide the strength and solidarity for health activists that comes from sharing a common purpose and common goals.

A national network could develop resource guides, or other forms of sharing information so that the careful and time-consuming efforts of gathering, synthesizing and summarizing research materials need not be repeated unnecessarily. It can prepare reports or organize meetings to provide the opportunity to share experiences of different organizational strategies and tactics, and the encouragement of successful efforts in other parts of the country. We also need to share assessments of where things go wrong, of common problems that arise in our work.

We need an organization that can help create and assert a united voice of women on the health issues which concern us all, and in the face of corporate, medical and right-wing political interests who themselves are organized nationally and internationally.

Connecting to the Network

The Committee for a Canadian Women's Health Network was formed in late March, 1981 as a result of preliminary discussions held at the *Health Actions Conference* in Edmonton in October 1980 and a series of meetings at the *Strategies for Well-Being* Conference held in Toronto. We took on the task of doing some of the preliminsry legwork necessary to create the organization.

We applied for funds from the Women's Program at the Secretary of State, and received $5900 in November to begin our work. In the next six months we hope to accomplish the following:

- set up an initial contact network of women's health groups and health activists;
- distribute a questionnaire to women in the health movement to assess the need for and desirability of a national women's health network, and also to determine the priority tasks that might be undertaken by such an organization;
- examine the structures of various existing women's networks and decide which models might most successfully apply to a national health network;
- study the short — and long-term financial basis of a national network;
- make an assessment about the feasibility of establishing a network in the near future. If that assessment is positive, we would begin work to organize a founding convention for the network.

In addition to these tasks, we have been working with other women's organizations on two important projects. The first is to set up a national women's health conference, tentatively planned for April 1983. The second is to research and publish a Canadian Women's health resource guide.

Our committee is presently made up of members living in Ontario and Quebec because we do not have funds to pay the costs of women from other provinces who might want to travel to our monthly meetings. As a result, we have made an arrangement with a number of women's health groups from Vancouver to St. John's to act as advisors on major decisions. We keep in contact by letter and phone.

Please connect with us in any way you can and help make a Canadian Women's Health Network a reality. Send us a note and get on our mailing list. Tell us about your work or interests regarding women's health. Tell us about organizations and activities in your area. Let us know what you think the potential value and pitfalls of a national network might be. Send us any information you have about network organizations. Offer your ideas or services to plan a national conference. Join our committee or become an advisor to it.

The Committee for a Canadian Women's Health Network: *Rhonda Love, Denise McGhie, Nancy Miller Chenice, Barbara Nathan Marcus, Jennifer Penney, Shirley Pettefer, Anne-Marie Smart, Alison Stirling and Janet Torge*

Committee for a Canadian Women's Health Network
Room 108, McMurrich Building
University of Toronto
Toronto, Ontario M5S 1A8
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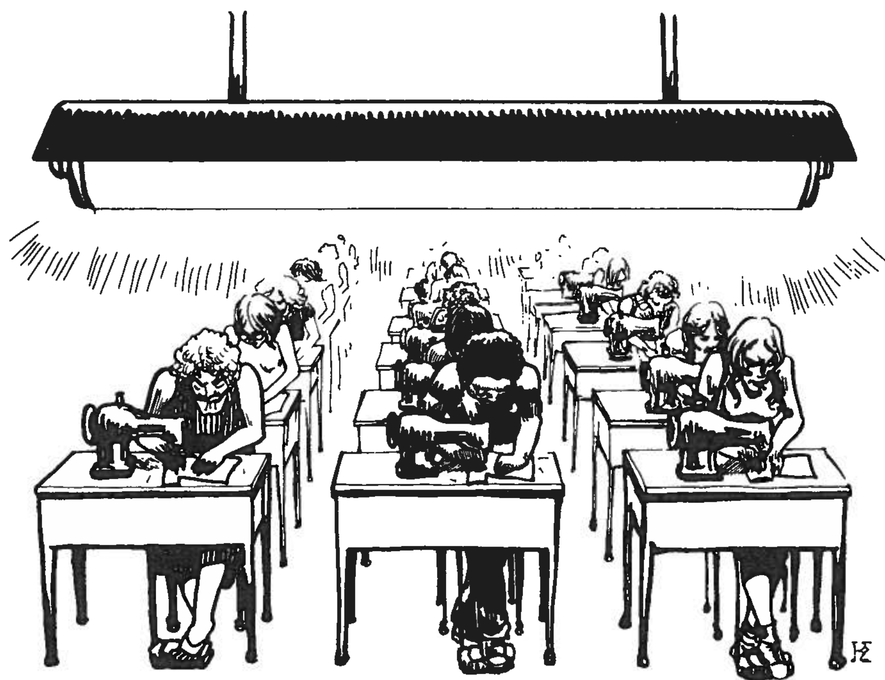


THE POLITICS OF ARTIFICIAL LIGHT

by Roberta Rivers

drawing by Karen Wehrstein

Four floors underground, in a totally sealed office, Mary works as a bank data centre worker five nights a week. In a room the size of a small gym, she and 62 other workers — almost all Filipinas and East Indian women — are crowded behind 62 data encoding machines. They sit in the same position for 6 to 8 hours until their work load is completed. Working under brilliant fluorescent lights, in stale air, with noisy, hot machines these women are all too anxious to escape their stressful working conditions and relax in the quiet sleeping city streets when work is done for the night.

Mary works a "split shift". Driving home she makes it to bed around 3:00 or 4:00 a.m. only to get up by 8:00 a.m. to send her children off to school. She then begins her second job as mother and housewife. The upshot is that Mary spends her days and nights indoors depending almost entirely on artificial light.

Other women I know, be they factory workers, university students, teachers or housewives, share a lifestyle similar to Mary's. Most of their days and nights are spent working under artificial lighting, often fluorescent, and all manage to get little, if any, exposure to direct sunlight. Many of these women complain of headaches and eye-strain, wear eyeglasses, have very pale skin which is sensitive to the sun or shows signs of early aging, and experience menstrual abnormalities such as irregular menstrual cycles or painful periods.

I started to wonder if some of these symptoms might be linked and wondered if artificial light might be involved in some way. After some investigation I found that available studies show there is a definite relationship between these ill effects and artificial light.

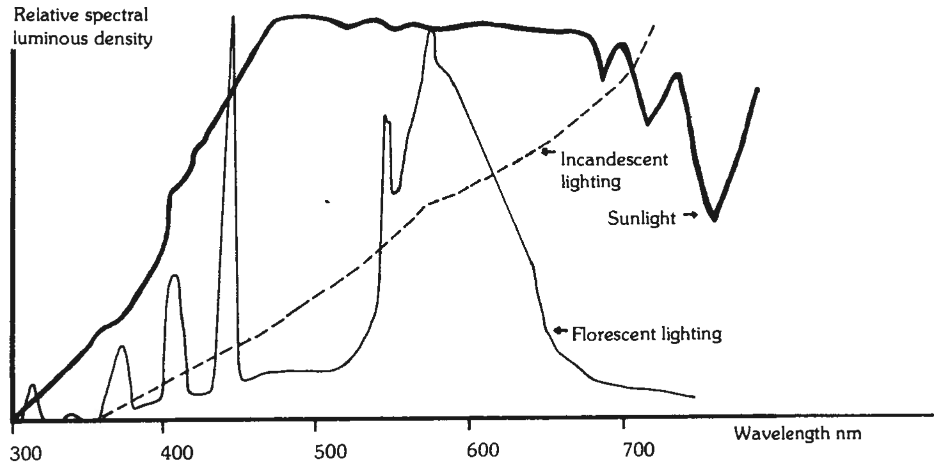
With the trend towards underground walls and more energy efficient, sealed office environments such as Mary's workplace, our dependency on artificial light, specifically fluorescent light, is increasing. Couple this with the fact that we are also tending to spend less and less of our days outdoors exposed to natural light, and it becomes critical to look at the impact this change in our environment is having on our bodies and biological rhythms.

For hundreds of thousands of years, human work and life have been structured around and determined by sunlight and natural day-night rhythms. Person-made or artificial sources of lighting have gradually replaced this natural source of light and subsequently changed the relationship of human life to these natural cycles.

Edison's invention of the carbon filament bulb in 1879 marked the beginning of a new era in lighting technology. When introduced into the workplace,this new light source replaced the inadequate light of oil and gas lamps, allowing work hours to continue far into and often through the night. This dramatic increase in the length of the working day also meant a corresponding increase in productivity which was extremely pleasing to the entrepreneurs of the day.

It was not until the 1930s that commercial fluorescent lights were available on the market. Their development marked a significant leap forward from the use of incandescent technology. The quantity of light produced by fluorescence magnified a hundredfold that produced by previous bulbs.

Replacing incandescence with fluorescence was a definite technological advance for capitalist production. This change increased productivity even further by increasing visibility and therefore worker performance at the same time that it reduced energy costs. Its brilliant illumination allows for an even greater division of labour into more segmented highly specific job tasks, further complementing the segmentation created by Ford's assembly line. The more specific the job task, the more intense the illumination required.Jobs that require focusing on tiny objects such as typewriting, sewing or assembly of parts are examples of work that depend on this brilliant illumination. (Most of these jobs are usually performed by women.) Flourescent lighting is ideal for it can light up a huge factory yet allow each worker to see clearly, allowing for an expansion in teh size of the workplace.



Wavelengths of sunlight, incandescent and fluorescent light (Adapted from F. Hollwich, *The Influence of Ocular Light Perception on Metabolism in Man and Animal,* Springer-Verlag, New York, 1979).

However, Hollwich, in his book *The Influence of Ocular Light on the Metabolism in Man and Animal* (1979), points out that any increase in worker performance results in long term costs to the worker. Although fluorescent light increases visibility and initially speeds up the workers' metabolism, thereby speeding up their capacity to labour, this burst of energy lasts only a few hours after which time performance declines. He attributes this to the stress of over-stimulation to both the eyes and the body of the worker. The rewards of this short-term increase in performance then are short-lived, while the more long-term hazards are borne by the workers. In the end the worker must buy her own eyeglasses out of her wages as well as sustaining the other not yet understood repercussions of this "efficient" form of producing commodities.

Since incandescent and more recently fluorescent forms of lighting have proven to be such valuable assets to production, scientists have sought only to study new ways to produce a brighter light at a lower energy cost rather than research any possible ill effects this simulated sunlight could have on the human body. Clearly scientific investigation until recently has placed concerns over increased production ahead of concerns over human well-being.

Only now, after one hundred years of everyday usage of artificial light and fifty years of fluorescent light are we finally starting to address the question of what affects this dependency shift from natural sun to artificial light may have on our health. And only now are we discovering that artificial lighting has more serious consequences for the human organism than we could have imagined. Along with this realization of the hazards, comes the acknowledgement that natural lighting is essential to our everyday bodily functions in ways modern science is only just beginning to understand.

Research published in the last few years is starting to show how artificial light can disrupt our biological mechanisms. Overall, many of these studies point out how both incandescent and fluorescent lighting can lead to degeneration of deficient cells in and around the eyeball. The average person is exposed to a variety of artificial lighting, incandescent lights at home, intense fluorescent lights at work and high-powered monochromatic lamps in streets and public places. If this is combined with insufficient exposure to natural lighting then a variety of symptoms can begin to manifest themselves.

One such symptom is the degeneration of cells that affect our eyesight. Numerous studies show how artificial light affects blood vessels and muscles in and around the eye causing ocular fatigue and often near-sightedness (myopia) requiring eyeglasses to be worn.

But the effect of artificial lighting moves beyond the specific area of the eye. The rapid degeneration of one specific grouping of retinal receptors (epithelial cells) indirectly affects the production of certain hormones, one of which is melatonin (see box for further details).

Finally, there are psychological effects of artificial light. Degenerating eye cells cause stress with eye fatigue

TURNING ON THE SWITCH

Incandescent light comes from bulbs that contain a filament which glows when electricity flows through it. The heat created produces a continuous light source. This kind of bulb is still very popular in our homes and in some cases larger buildings too.

Fluorescent light most often comes from a long glass tube containing one of many possible forms of gas. When electricity is applied this gas ignites and emits invisible radiation. This radiation then strikes the powder-like phosphorus on the inside of the tube and is changed to visible light. The actual composition of this light depends on the type of gas and phosphorus used in the bulb.

Monochromatic lights are a more sophisticated form of fluorescent light (not shown in the graph) that emit only specific wavelengths of energy. They are usually used to provide more intense illumination for streets, large buildings, signs and advertising. Neon lighting is one form of this.

HOW ARTIFICIAL LIGHT DIFFERS FROM THE SUN

Since fluorescent lighting has supplemented or replaced natural lighting to a large degree in almost all of our lives it becomes important to look at the ways this artificial lighting differs from the "real thing". The major differences can be broken down into three categories: wave-length intensity, intensity pulsations and ficker. Please refer to the graph.

Wave length intensity: the energy intensity of the sun's light occurs in varying wave lengths from 2,000 Angstroms to 7,500 Angstroms (Angstroms being an expression of the length of a particular light wave). The graph shows us the wavelengths of the sun's radiation. What is important to note here is the intensity of each wavelength relative to one another. Notice how the curve increases from shorter to longer wavelengths and then decreases again all in very gradual and even changes of intensity. Sunlight is what we humans have been adapting to for millions of years.

The graph also shows the wavelength distribution of a typical fluorescent bulb. Notice how its wavelengths occur in a series of ragged and sharp intensity peaks. This means that the uniformity in intensity variations found in natural light are lost. Instead fluorescent lighting emits sharp peaks of energy at very selective wavelengths. Visual receptors for these wavelengths become overstimulated and break down. Eye muscles degenerate and often eyeglasses become necessary.

The wavelength intensity curve for incandescent light is also plotted on the graph. Note how it too differs from natural light composition. However, it is more uniform in distribution than fluorescent lighting, and for this reason is perhaps less serious in its effects.

Intensity Pulsations: The graph shows how light from the sun is composed. But remember that this graph only represents sunlight at a particular moment in time. Light from the sun actually throbs from second to second, day to day, season to season, year to year. While the light from the sun constantly represents a complete range in the light spectrum, it never stays exactly the same. When one wavelength increases in intensity others will decrease.

Fluorescent lighting on the other hand is fixed. Its changes regarding wavelength distribution are virtually insignificant. It is a very repetitive source of light that does not stimulate our retinal receptors in the manner they have adapted to. The human eye needs continuous variations in light to properly stimulate and sustain visual functions. Fluorescent light cannot provide this necessary variation. Instead it exerts monotonously consistent pulsations onto very select groupings of retinal receptors, causing them to overtire and degenerate, just as fluorescent wavelength distribution does.

This is also true of incandescent light. There are no throbbing variations in its light source and it is monotonously consistent.

Fluorescent's Flicker: Despite variation in the brightness and colour of light from the sun, for all practical purposes it is continuous. Fluorescent lighting is not: it flickers on and off. This is due to an alternating electrical current. The fluorescent tubes are ignited when the current is positive and then go out when the current becomes negative. This process occurs 60 times per second creating a flicker not directly visible to the human eye. Fluorescent light therefore is not as continuous a source of light as the sun.

We can sometimes catch this flicker out of the corner of our eye through our peripheral vision. As the tubes wear out this flicker becomes more obvious and can disrupt our ability to see objects when they are travelling at approximately the same speed as the flicker's frequency. Such an effort can cause dangerous misjudgements of the speed of rotating machinery. A carpenter friend reported that due to the old fluorescent tubes in their woodworking studio, which have a distinctly visible flicker, their saw blade actually appears to stop when in fact it is still rotating!

This flicker can also lead to a breakdown in our peripheral vision affecting our eye/hand and eye/foot coordination, causing us to fumble and trip more frequently than normal.

In short, fluorescent light can cause overuse of certain retinal receptors in the eye causing them to degenerate. This causes eye strain and fatigue which can lead to overall monotony, boredom and irritability.

Incandescent light is not generated by an ignited gas but by a heated filament. It is a continuous form of light but is generally hotter in its distribution than that from the sun. In fact its degenerative affect on cells results from giving off a light closer to hot infrared rays. These so-called hotter waves may cause eye cells to degenerate.

TURNING OFF THE SUN

The effect of fluorescent light on the body's intricate hormonal system is one of the most important and the least fully understood aspects of the artificial lighting problem to date. Our hormonal system is a very delicate timing mechanism — if you affect one hormone you are likely to affect them all. We know that ultraviolet radiation from the sun absorbed through retinal receptors in the eye, is a critical stimulus to production of specific hormones and hence to the body's metabolic processes.

Recent studies have established an important connection between light and the human body occurring in the process of melanogenisis (the production and distribution of melanin). Ultraviolet radiation is received by epithelial cells found in the retina, neural messages are then sent to the pineal gland which is responsible for the production of many hormones, including melatonin.

When the pineal gland releases melatonin into the blood stream, a whole chain of reactions takes place. One of these reactions is the process of melanogenisis, which controls the production and distribution of melanin granules underneath the top layer of skin. The human skin needs ultraviolet radiation of specific wavelengths to produce Vitamin D. This is why Vitamin D gets its nickname "the sunshine Vitamin". Melanin granules help to regulate the absorption or rejection of ultraviolet radiation depending on the body's need for this vitamin. Among its many uses, Vitamin D is essential for the proper absorption of calcium into the body. Melanogenisis is also believed to be critical in the regulation of ultraviolet radiation during pregnancy. More research needs to be done on the effect of fluorescent lighting on this process.

The epithelial cells in the retina and their stimulation by light are extremely important to human metabolism. The over-stimulation of certain retinal receptors and the under-stimulation of others by fluorescent light can wreck havock on the fine tuning of the body's endocrine system. Studies carried out by Hollwich show that over-stimulation by fluorescent light unleashes the "stress hormones" ACTH and cortisol, speeding up metabolism, affecting blood composition and causing other assorted pathological disturbances.

Laboratory results also show that epithelial cells degenerate rapidly and are often destroyed by incandescent and fluorescent lighting, but fluorescent light is by far the worst. What further effects degenerated epithelial cells may have on the human body are as yet unresearched. However, one could speculate that because of their function in hormonal production their degeneration would lead to a dysfunction in systems that depend on them.

This has special ramifications on women's health. What effects the disruption of melanogenisis by artificial light could have on pregnancy, as well as on dysmenorrhea and osteoporosis due to interference of calcium absorption remain to be studied. Needless to say the effects could be far-reaching and should no longer by ignored by scientists.

as a result. Quandt reported in 1979 that fluorescent lights in schools produced general ill feelings, nausea, eye strain and headaches among students. A. Rogers and F. Tongy have reported emotional depression as yet another affect. As well, artificial lighting changes colour perception and visual discrimination. For example, fluorescent lighting makes peoples' skin appear to have a ghostly pallor.

What are we to do about so prevalent a pollutant as artificial light — one on which we have all grown dependent? There are basically two levels on which we can work to affect change in our environment. One is more short-term and personal; the other more long-term and collective in nature. As individuals we can affect a limited amount of change in our lives by making a point to spend some time each day outdoors, walking, biking, working. The morning and early evening are good times to soak up some of the necessary ultraviolet radiation without exposing oneself to the more harmful rays that are at their peak between 11:00 a.m. and 3:00 p.m., especially in summer. When indoors, wherever possible opt for being near windows. Even though glass filters out much ultraviolet radiation it does allow for less dependency on artifical light sources. Turn off artificial light if you can do without, which is often quite possible when there are windows nearby. When it is necessary to use artificial light try to use "full spectrum" fluorescent lighting which is an improvement though it does not actually duplicate the full spectrum found in sunlight.

Collectively we can fight for reduced dependency on artificial lighting. In our schools and workplaces, through our unions and community groups, we can raise the issue and begin to reassess our working and living environments to build plans for a safer and healthier future. No more factories and schools without windows! New materials for windows already exist that make use of daylight as much as possible and work-shifts that allow workers maximum exposure time to daylight hours. And lastly we need research into better forms of artificial lighting and their effects, as well as better building and window designs.

To take the hazards of artificial lighting into careful consideration will force us to reassess the priorities of the workplace and of our society at large. Artificial lighting has definitely allowed for extended hours of production, larger workplaces and a greater division of labour — all of which add up to increased productivity and profits. After one hundred years of prolonged daily use of artificial light, it is only now that we are beginning to research what the costs of this innovation have been to working people and children.

The story of artificial lighting, which is only now being unravelled, is yet another example of how production has been valued more than human lives and how the scientific profession has unwittingly colluded with capital to perpetuate this confused order of priorities. Now is the time to call this order into question.

Thanks to Lucien Royer for helping to collect and interpret the scientific data used in the article.

Roberta Rivers works for wages as a waitress in Toronto and is concerned about occupational health and safety.

Reviews

At Highest Risk

Reviewed by Donna O'Connor

At Highest Risk. *Christopher Norwood, McGraw Hill Ryerson Ltd., Toronto, 1980.*

Christopher Norwood (a woman), has synthesized findings from medical literature into a highly readable and very important book. The evidence she cites indicates that even slight poisoning from the environment during gestation and the early years can cause both birth defects and chronic health problems later in life. She focuses on the known and potential perils an industrial environment imposes on children.

Looking at the incidence of normal births Norwood examines trends of resistance to illness, new syndromes and age of onset, chronic illnesses, malformation rates and early deaths. These signposts indicate the scope of the problem. Some of her data is suggestive. For example, cancer can be induced in animal offspring in the womb by approximately 50 carcinogens that cross the placenta. Studies of DES (diethyl-stilbestrol), a drug that was prescribed to women during pregnancy to prevent miscarriage, confirmed that drugs cross the placenta. DES resulted in children born with heart defects, limb reductions and problems of sexual development. Current research on birth defects acknowledges that the real causes of 65-75 percent of malformations are still unknown.

Norwood discusses specific variables such as water supply in an attempt to show the complexity of the relationship between the environment and the human organism. She cites geographic clusters of birth defects and unsuccessful pregnancies in women living near vinyl chloride plants and chemical dumps such as the Love Canal. She explains the vulnerability of our reproductive cells to genetic damage and mutation and their alteration in response to the hundreds of chemicals we encounter both in the environment and through lifestyle choices.

Implications for institutions outside the health care system are touched on. She cites a McGill study that found by measuring trace metal content of children's hair, predictions could be made with 98 percent accuracy as to whether teacher rating scales and standard psychological tests would characterize the child as learning disabled. This correlation is one Norwood feels warrants further study.

Women as guinea pigs for medical science are evident in both the thalidomide and DES experience. The role of chemicals ingested by the mother is another area the author has investigated. DES has been established as a cancer causing agent in some offspring whose mothers took DES during pregnancy. One carcinogen that is readily available throughout the North American diet is sodium nitrite, a common meat preservative. The research and debate on this additive are well documented. Other very toxic chemicals such as benzene, carbon tetrachloride and chloroform concentrate in higher levels in the fetal bloodstream than in the mother's. Is there a link between these exposures and future cancer as a child or adult?

A thorough discussion of the hazards of radiation and occupational exposure to toxic chemicals are included in this book. Norwood examines the risks and effects of a technically and chemically controlled labour and birth. For example, problems of gross motor development may be related to inhalation anesthesia received by the mother.

A short section at the end of the book asks questions about the nature of medical treatments and who benefits from many procedures and laws. After reading her text one can only conclude they do not favour the health of our children.

The book contains a glossary of medical and technical terms and notes, arranged according to page, that cite the major studies, research and articles referred to in each chapter. This is extremely useful for further research. A list of selected readings and an index are located at the end of the book.

At Highest Risk provides a precise overview of environmental hazards. It should be useful to anyone concerned about public health, those involved in working with children, and all present and potential parents. Norwood brings the invisible warnings to light in such a convincing manner that even the most complacent reader cannot help but recognise the relationship between the environment and the health of both children and adults. We *all* are at risk.

Donna O'Connor is a Saskatchewan based writer and educator.

The Woman's Encyclopedia of Health and Natural Healing

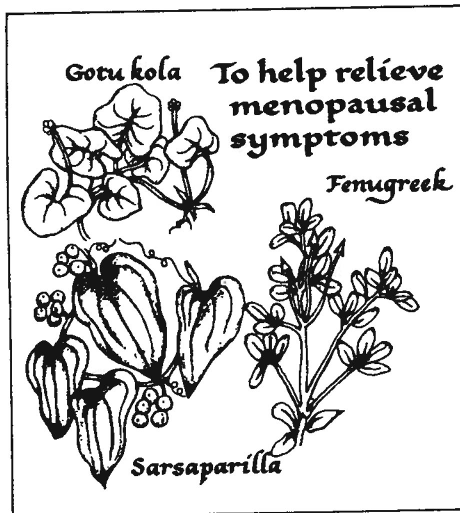
Reviewed by Anne Rochon Ford

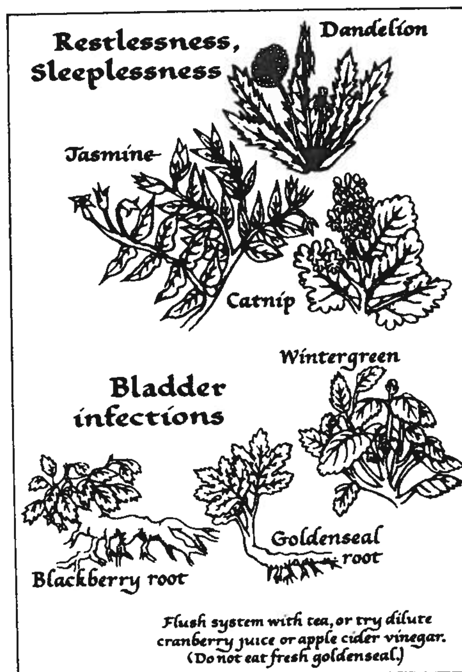
The Women's Encyclopedia of Health and Natural Healing.
Emrika Padus, Rodale Press, Emmaus, Pennsylvania, 1981. $19.95 hardcover.

Rodale Press, which for years has brought us *Prevention* magazine and a host of other health-related publications, is to be congratulated for a valiant effort to try and cram everything you might want to know about women's health into one — albeit 600 page — book. The press release accompanying the book claims it will answer "virtually every question a woman has concerning her body". That's one awfully tall order to dill and here's one reader who put the book down with a lot of questions unanswered. The author, Emrika Padus, and her exhaustive lists of consultants, have unfortunately sacrificed quality for quantity.

The Table of Contents invites you to curl up with the book, and the Forward, by Alice Rothchild of Harvard Medical School, sets a promising tone with talk of the "ongoing struggle to redistribute the power between doctor and client, to demystify medicine by supporting an aware and informed consumer", (although I have difficulties with marketplace analogies when we're talking about health). Having read something like that, you might be led to think that the rest of the book will be flavoured with a socio-political atmosphere, in the way that say, *Our Bodies, Ourselves* is, to name but one. Unfortunately, it does not continue in that vein for long. It is in this respect that I constantly felt as I was reading, "There's something missing here". To many feminists, this book will appear extremely cautious in its approach to women's health, perhaps at times, even naive. To give you but a few examples:

- Attempts are made to dispel the myths and reveal the truth about fad diets, bust developers, cellulite, douching and other "sensitive topics". However, in the case of bust developers, for example, more than five pages of the *Encyclopedia* are devoted to analysing the efficacy of the different methods for bust development (Mark Eden, estrogen creams, etc.) without any kind of critical perspective or — heaven forbid — analysis of why women are compelled to turn to these things.
- Similarly with wrinkles. Rather than trying to encourage positive attitudes about the physical signs of aging, or point out the origins or the dangers of Western society's obsession with staying eternally young, we are told by a Dr. Albert Kligman that, "Apart from looseness, every wrinkle that you can see with your eyes or feel with your hands is due to an environmental insult. It is not a natural thing." Thank you, Dr. Kligman.
- Lastly, in a section entitled *Gynecologists and their Alternatives,* one brief reference is made to gynecological self-examinations, the only such reference I was able to find in the entire book. Rather than placing any emphasis on the wealth of positive things that are to be gained from doing self-examinations, its mention is followed by the comment "Of course, it isn't for everyone."





In spite of these glaring shortcomings, the *Encyclopedia* offers much that has not yet been presented in the spate of general resource books on women's health that have been published in the last ten years. It attempts to give some information on non-gynecological diseases and conditions which are particular to women, an area which has been pitifully neglected in medical research generally. It contains an extensive reference guide to drug side effects and interactions which, though not as exhaustive as something like Joe Graedon's *The People's Pharmacy,* is very accessible. Another plus is a very beautifully illustrated section on herbs for women, with directions and certain cautions where necessary (e.g. "Do not take cohoshes, penny-royal or tansy in excess.")

The *Encyclopedia* goes beyond the scope of similar resource books on women's health by including such topics as household health hazards, vitamins and minerals for women, health spas, love (love?), saunas and hot baths, and a lengthy, illustrated fitness routine.

Perhaps the book's biggest problem is that the author does not seem to know who her audience is, and consequently gets caught up in trying to please "all the women all the time". One thing that is certain, however, and is well-illustrated by reading this book: alternatives to traditional medicine in Western society incur costs that most cannot afford to meet. Have no illusions about this book—because of its cost, and most of the information in it, it is really only for those who have money to spare.

Anne Rochon Ford is a student at the University of Toronto completing an undergraduate degree in Sociology and Women's Studies. She is also a prospective member of the Healthsharing collective.

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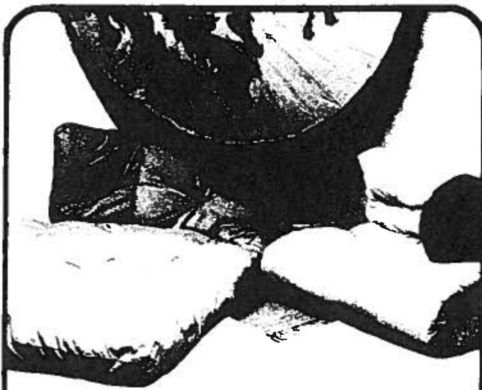

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Regional Reports

BRITISH COLUMBIA

VANCOUVER — Lorna Zabeck

Faith in the Employer: Have you heard the one about Cominco and the WCB? Several years ago, the Workers' Compensation Board of B.C. fined Cominco Ltd. $24,000 a month for violation of the airborne lead standards at its smelter in Trail. Presumably, the fine was to be an "incentive" for the company to start upgrading its equipment at its Trail plant. This penalty was one of the stiffest ever imposed in North America.

In 1978, the WCB agreed to end the penalty to Cominco in return for a faithful promise from the company that it would complete a $425 million modernization program on schedule. Apparently "on schedule" now means that the program will begin in 1984 and be completed in 1986.

Workers are angry; they are suspicious that Cominco will not keep its promise, especially since it no longer has the financial inspiration to do so. Several large unions plan to take part in appealing the decision.

The actions of the Workers' Compensation Board in B.C. in this and other cases are now coming to the attention of the general public. The Board is being openly criticized by groups such as Vancouver Committee on Occupational Safety and Health (VANCOSH) and Women's Action on Occupational Health for being sympathetic to employers and not operating in the interests of worker health and safety.

Meanwhile, the WCB is demonstrating its faith in Cominco's word. Besides ending the monthly penalty, the Board is *refunding* the company $800,000 of the money it has paid in fines.

VICTORIA — Susan Moger

Post Mastectomy Class: Sally Elliott, associate program director at the Victoria YM-YWCA, is starting a post-mastectomy exercise class. There will be floor exercises, water exercises and a tea and talk time. She is hoping that after convalescence women will want to get in shape again, and that they will use this class as a reintroduction to other fitness programmes. This class will be the first of its kind in Victoria. Sally would appreciate hearing from anyone involved in similar programmes. She can be reached at the YM-YWCA, 880 Courtney Street, Victoria, B.C. V8W 1C4

ALBERTA — Ellen Seaman

Strikes, strikes, strikes: Alberta's doctors, demanding a 30.3% basic fee schedule increase plus substantial benefits, pose a major threat to Medicare. Their tactics have included day long mass "study sessions" on a rotating basis and withdrawal from "voluntary" activities, such as Therapeutic Abortion Committees, denying services to patients. As of January 1, the Alberta Medical Association attacked Medicare directly by encouraging doctors to "direct-bill" and "extra-bill" patients. Despite pressure from consumer groups, the provincial government has remained silent and many feel it is tacitly encouraging the disintegration of Medicare.

And more strikes: Alberta's nurses are also on the point of striking, over better pay and working conditions. The nurses, who enjoyed wide-spread public support in their 1980 strike, have managed to contrast their demands favorably with those of the doctors. However, they have lost some of their credibility this time, in part due to public squabbling between the United Nurses of Alberta and the Alberta Association of Registered Nurses but primarily because the Nurses' support staff are currently on strike citing demands similar to those of their bosses. UNA members have been crossing their employees' picket lines to perform administrative functions.

Baby-buying: Catherine Chichak, an Edmonton Conservative MLA, has presented a private members' bill to the legislature which would attempt to discourage abortions by paying young pregnant women to have their babies and put them up for adoption. The money to make these payments would come from potential adoptive parents. A woman who accepted money under the scheme would have to pay it back if she changed her mind and kept her baby. The bill, supported by anti-abortion groups is expected to go nowhere. However, Conservative private members' bills bear watching as they have a habit of resurfacing in revised form as government legislation.

SASKATCHEWAN

SASKATOON — Donna O'Connor

A Is For Asbestos: A 52 year old city worker was recently awarded compensation when the Workmen's Compensation Board ruled that his disease is likely related to past working conditions. Ted Dawson suffers from mesothelioma, a cancerous tumour on the pleural surface of the lung. Medical officials acknowledged the relationship between this rare disease and inhaling asbestos dust at Centennial Auditorium where he worked more than 10 years ago.

The auditorium was constructed 14 years ago when it was common practice to use asbestos as insulation for heating pipes and as a fire retardant. As director of light-

ing and electrical maintenance, Mr. Dawson had repeated opportunities for exposure to asbestos.

Air samples over the past five years had been labelled safe. However, in November an increase in air fibre due to the deterioration of the asbestos coverings, was noted in a number of areas.

The city undertook an estimated $140,000 project to cover over deteriorating asbestos with gyproc. On December 3 the auditorium was closed because staff walked out over health concerns related to the resurfacing. Protective clothing, breathing apparatus and a second fan system to ensure that air-born asbestos particles would not re-circulate in the building have facilitated the re-opening of the auditorium.

REGINA **Regina Healthsharing**

Health Conference: Women in Saskatchewan concerned about health issues have followed the lead of sisters in other provinces by sponsoring a women's health conference.

"Women and Health: A Forum for Change" proved to be an eye-opening experience for most of the 285 delegates, many of whom stated that they came away with a stronger understanding of feminist issues as well as health issues.

The Women and Health conference, held November 21 and 22 at the University of Regina was organized by Regina Healthsharing, a group of about 250 women who lobby for better health care in the province. Co-operating sponsors were Status of Women Canada, Health & Welfare Canada, Saskatchewan Labour and Regina Plains Community College.

About 30 women from around the province, representing such diverse groups as Women in Trades, University Women's Club and native women's groups, received expense money from a Status of Women grant to attend the conference. Twenty different workshops looked at such topics as native women's health, occupational health, battered women, mood-modifying drugs, sexism in advertising, adolescent pregnancy, women in poverty, alcohol abuse, sexuality and self-examination, post-partum adjustment and menopause.

MANITOBA — Lissa Donner

Report on Teenage Pregnancy: The Community Task Force on Maternal and Child Health has released a discussion paper entitled "Adolescent Pregnancy in Manitoba: Current Status, Future Alternatives". The paper includes research and recommendations relating to the risks, both medical and social, to pregnant adolescents, as well as the risks to their children. It looks at the options open to, and the problems faced by pregnant adolescents — difficulties of obtaining a therapeutic abortion in Manitoba, problems of teenage marriage, economic difficulties faced by teenage mothers, and lack of day care.

Some of the recommendations of the Task Force are: 1) compulsory family life education curriculum from kindergarten to grade 12, 2) school-based adolescent clinics, 3) advocacy services for pregnant teenagers, 4) support groups for adolescent mothers, and 5) opportunities for teenage parents to continue their education.

Copies of the Report may be obtained for $3 each from the Community Task Force on Maternal and Child Health, 412 McDermot Avenue, Winnipeg, Man.

QUEBEC — Clara Valverde

Cervical Cap: The cervical cap is finally coming to Montreal and will soon be available at two clinics: Head and Hands, and Centre de Santé des Femmes du Quartier.

Collatex: Research is being done in a Montreal hospital on a new method of birth control, Collatex. It consists of a little sponge, measuring an inch and a half in diameter, and made of plastic fibres. The sponge is impregnated with a concentrate spermicide. The sponge is dipped in warm water and inserted in the vagina against the cervix, where it expands another half inch. Collatex would act as a contraceptive for 48 hours. It is disposable. This new method is not yet on the market.

NOVA SCOTIA — Deborah Kaetz

Well-Woman Manual To Be Revised: Nova Scotia's Women's Health Education Network (WHEN) has announced the receipt of an employment development grant from the Canadian Employment and Immigration Commission (CEIC). Two full-time employees and one part-timer will undertake a revision of the 1977 Organization Manual and Report on Well-Woman Clinics in the province. In the five years since their publication, there has been no official compilation of clinic activity or data in the province and the manual has not been updated.

NEWFOUNDLAND/ LABRADOR — Barbara Luby

Grace General Hospital Seeks Funds for Laser Gun: St. Johns' Grace Hospital in St. John's has undertaken a fund-raising campaign to obtain a laser gun, the world's best known treatment for cervical cancer. The present treatment pattern for cervical cancer is biopsy, cyro-coagulation, and hysterectomy. Send your donations to Major W.S. England, Campaign Coordinator, Grace Genral Hospital,St. John's, Nfld. A1E 1P9.

Opportunity for Advancement Group Development Session: On November 2, 25 women from various health and social-service agencies in Newfoundland and Labrador met in St. John's to attend a week-long session facilitated by "Opportunity for Advancement" and sponsored by the Newfoundland Status of Women Council. "Opportunity for Advancement" is a program for sole-support mothers living on public assistance.

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Letters

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

Inspiration and Visions

I want to say a few words about what *Healthsharing* has meant to me. It has brought me in touch with women who have similar interests. It has enabled me to find out more of what's happening throughout the country and it has given me inspiration — affirmation that I am not alone, and that what I am doing (what we all are doing) is needed and worthy. I so like and admire the fact that your collective saw a need and *did something about it.* The magazine gets better with each issue. You are obviously working well. Congratulations to you all for offering us a vehicle and instrument for information, change and support.

I would like to tell you something about Victoria and the community here . . . We suffer from the same kind of isolation and lack of womanpower here that women in most cities and towns in Canada experience. As with women before us, we are trying to remedy the situation. The networking concept is getting known here and we are trying to connect more within Victoria, on the Island, to Vancouver and the rest of the province. I find it appalling that one hand does not know what the other is doing, even here among our own four walls. I do see important changes happening though. Among the new projects are a Victoria Women's Network and a Women's Building Society. The women's health community has always been small, although I don't think that is unique to Victoria. Our current abortion battles at the hospital board level have brought hundreds of people out. I only wish even half of them would show the same kind of concern for a broader spectrum of women's health issues.

Susan Moger
Victoria, B.C.

One Lousy Doctor

I would like to thank *Healthsharing* and Vicki van Wagner (Vol. 2, No. 3) for her article *Controlling Conception — Naturally* which helped me to decide to go off the pill after seven years! I'd also like you to know what happened when I tried to obtain safer birth control.

I went to Dr. W.R. Plimbley of Jasper, Alberta who refused to give me a diaphragm because I wouldn't answer irrevelant questions such as: "Are you single or married? What would you do if you got pregnant? Would you have an abortion? Do you have a steady boyfriend?"

When I asked why he wanted to know these things, he answered, "Because I am asking you." (makes sense, eh?) and "Don't you trust your doctor?" (how reassuring — what a line!) . . .

I don't know what would have happened if I had *passed* his quiz, but I certainly wasn't sticking around to find out. I firmly stated that I did not have to answer these questions. He said that if I wasn't going to cooperate *we*'d just have to forget about it. I stood up and walked out . . .

Compare that experience with the one I had in Vancouver two weeks later. I phoned the Women's Health Collective and that night I went to a woman's house and sat on her bed while she fitted my diaphragm. Another woman checked the size. I practiced putting the diaphragm in and removing it until I felt comfortable with it. Two hours later I left with a diaphragm, plastic speculum, a huge tube of jelly and a 20 page info pamphlet — all for $12.

It was a wonderful experience. I was not nervous at all and felt quite at ease — "at home". Too bad more women's health experiences couldn't be like the latter rather than the former.

Gail Moran
Jasper, Alberta

Fertility Awareness Author Concurs

I certainly appreciated the two letters in response to my article on sympto-thermal birth control. I especially wanted to thank Lissa Donner for her perceptive observations about the method. I too have had reservations about its most commonly used name — Natural Family Planning. I personally prefer using Fertility Awareness, and will now also use Periodic Abstinence when I refer to the method, since it involves both aspects.

Women should be very aware of the points of view from which various teachers teach this method. I have had a young single woman call me in tears after a session where she learned this method from a teacher whose attitude towards the man's involvement, and towards pre-marital sex, really disturbed and intimidated her. However, other teachers have welcomed me to refer adolescent girls who were interested in fertility awareness.

There is definitely a need for more research into this method, and a need to clarify this issue of a greater risk of fetal deformity. It is my understanding that conceptions occurring when the ovum is over-ripe usually result in unnoticed miscarriages with the woman's next period. This needs to be clarified.

Thanks for the comments.

Vicki Van Wagner
Toronto, Ontario

LESBIAN FORMER NUN SEEKING OTHERS

Two lesbian former nuns are collecting material for a book. If you are a lesbian former nun, please share your stories of convent life, of coming out as a lesbian, of struggles to transform your spiritual consciousness etc., in either written or tape form.

Send by October, 1982 to: Rosemary Curb, Rollins College, Winter Park, Florida, U.S.A. 32789, or to Nancy Manahan, 1066 Terrace Drive, Napa, California, U.S.A. 94558. You may phone Rosemary at 1-305-645-5318, or Nancy at 1-707-252-7419.

POST PARTUM HELP

A group in Greenwood, Nova Scotia is organizing a post-partum help line for women and couples having problems with the emotional stress of ceasarean births. They have been unable to attain information from local medical centres, and would appreciate any information or advice.

Please contect Mrs. Brenda Jennix, P.O. Box 154, Greenwood, N.S. B0P 1N0.

SHARE EDEMA EXPERIENCES

Eileen Fingerman is interested in hearing from women who have been diagnosed as having "idopathic edema", or who have fluid retention not associated with their menstrual cycle. Her research includes the use of spironolactone (aldactone) and its possible correlation to breast cancer. Please send any information to Eileen at 47 Winthrop Road, Brookline, Mass., U.S.A. 02146.

FEMINIST HEALTH COURSES LINK-UP

A network of faculty members who teach feminist courses relating to health care issues has been proposed. A summer workshop may be sponsored. Please contact Barbara Barker or Patricia Farnes at Rhode Island Hospital, 593 Eddy Street, Providence, R.I., U.S.A. 02902 (1-401-277-5003).

Healthsharing,
Box 230, Station M,
Toronto, Ontario, M6S 2T3

Resources & Events

Buckle Up Baby

The Buckle Up Baby program run by the Jaycettes of Canada provides public education in infant and child car safety. Besides telling you what you *should* be doing they also make it easier by providing cheap rental of infant car-seats (for babies under twenty pounds). The cost varies from $5.00 to $15.00 for a six month rental. Available through local units. For more information write: Bev Daquano, National Chairperson, Buckle Up Baby program, 40 Irwin Cres., Georgetown, Ont. L7G 1G1.

Law Review Series — Manitoba

The Community Task Force on Maternal and Child Health has published a series of nine papers on various laws affecting childbearing families. Topics include: Adoption, Employment, Healthcare, Illegitimate Children, Regulation of Mutagens and Teratogens, Midwifery, Abortion and Prenatal Family Allowances.

The whole series is available free from the office, or for $2.00 mailing charges. Individual reports cost $.50. Pick up or send for the series at 412 McDermot Avenue, Winnipeg, Man. R3A 0A9. Phone: (204)942-0074.

Alternative Health Conference

The Consumer Health Organization of Canada is sponsoring a one-day conference on alternative health therapies called Total Health '82, to be held at the Royal York Hotel in Toronto on March 13. Eighteen different speakers will be presenting information on topics ranging from homeopathy to breast feeding and home births, alternative cancer treatments, disease as an opportunity for growth, herbal treatments, sexuality and mental health. Tickets are $13.00 in advance and $15.00 at the door.

Further information and advance tickets are available from The Consumer Health Organization of Canada, P.O. Box 248, 108 Willowdale Ave., Willowdale, Ont. M2N 5S9. Phone (416) 222-6517.

Informed Home Birth and Parenting

This U.S.-wide non-profit organization now has a Canadian Regional Director. Informed Home Birth and Parenting is a childbirth education, assistance and support organization. Services in Canada are flexible, providing what is necessary depending on the needs in a given area, and may help with hospital births as well.

To locate an Informed Home Birth teacher, a midwife or supportive doctor in your region, contact Heather Burton Simopoulos, 6441 Dunray Court, Mississauga, Ont. L5N 1E7. Phone: (416) 826-6374.

A New View of A Woman's Body

Researched and written by lay health workers of the Federation of Feminist Women's Health Centres, this book is an important new resource. True to its origins in self-help, *A New View* is full of graphic illustrations — redefining the clitoral anatomy, clarifying medical procedures and indicating yoga and massage techniques for menstrual cramps. It also contains pages of color photos illustrating the variation of a healthy clitoris, and cyclical changes in the cervix.

The text is clear, supportive and specific. Chapters include health problems, birth control, menstrual extraction, abortion care, surgery and self help clinics. *A New View of A Woman's Body* is available in many bookstores. It is a Touchstone book, published by Simon and Schuster, New York, 1981. Cost: $8.95.

Conference: The Female Connection

The Women's Inter-Church Council of Canada has organized this conference at Lakehead University in Thunder Bay, Ontario on June 7-11. The conference goal is to establish links and to share experience between non-Canadians, Immigrant Canadians, Native Canadians and Multi-generational Canadians. Speakers representing these groups will be present. Workshops on health, poverty, violence, work, assertiveness training and fundraising will be held. Entertainment, food and resources will also be available.

Cost for the conference and noon meals is $35.00; accommodation for four nights, breakfast and evening meals are provided for an extra $115. Send a $10 deposit to register, or contact for information: Shirley Davy, WICC — National Gathering, 77 Charles Street West, Toronto, Ont. M5S 1K5. Phone: (416) 922-6177.

Abortion Newsletter

Concerned Citizens for Choice on Abortion (CCCA) has launched a newsletter. The newsletter notifies subscribers about CCCA activities and projects and gives information on hospital statistics and the criminal code.

Although CCCA is based in British Columbia they liaise with other pro-choice organizations across Canada and provide important national information.

Cost is $5.00 per year for individuals and $20.00 per year for groups (6 issues per year). Mail to Concerned Citizens For Choice on Abortion, P.O. Box 24617, Station C, Vancouver, B.C. V5T 4E1.