

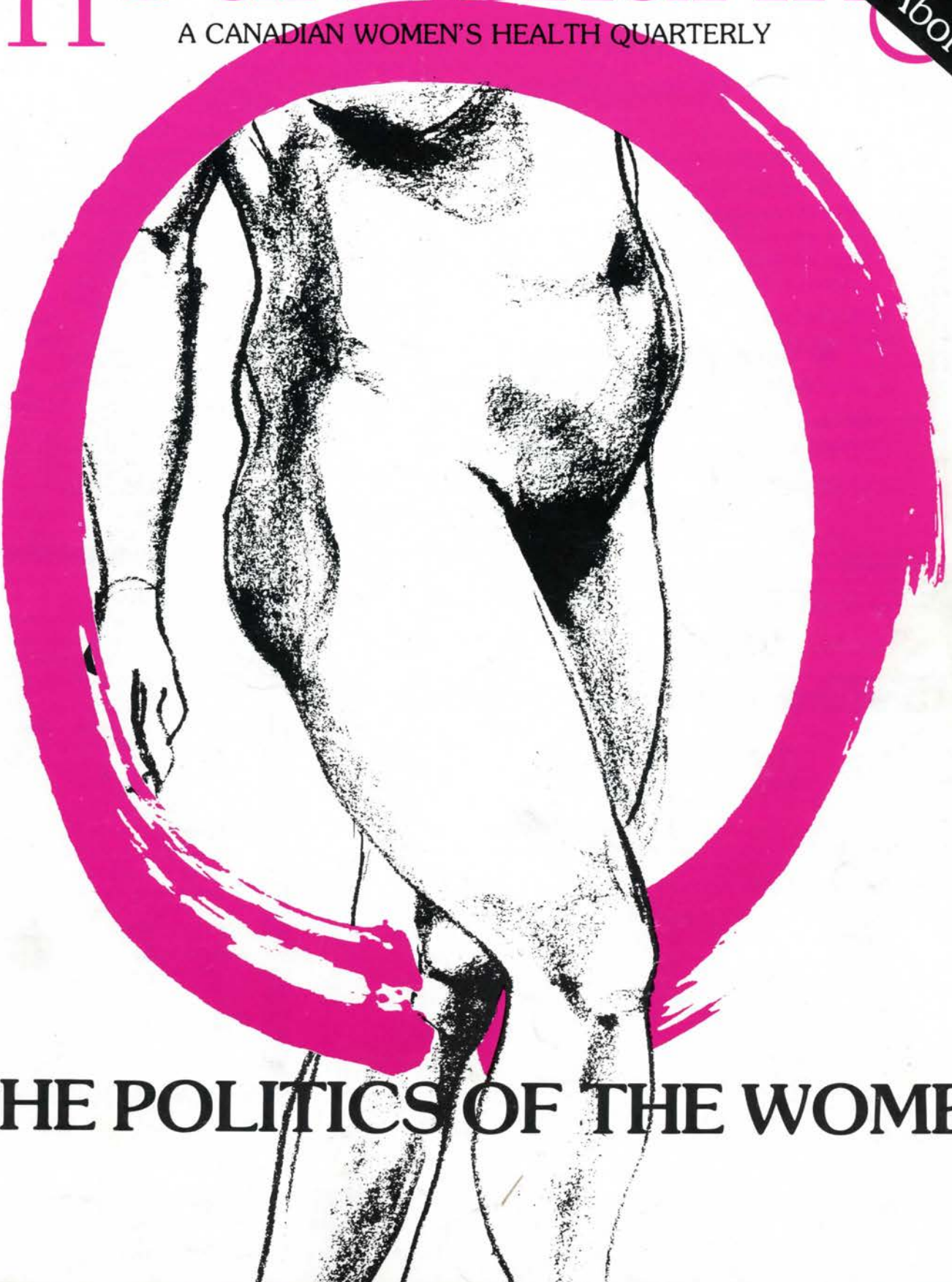
Winter 1983

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Special Issue On
Midwifery and Abortion

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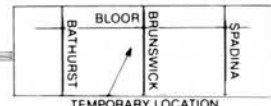
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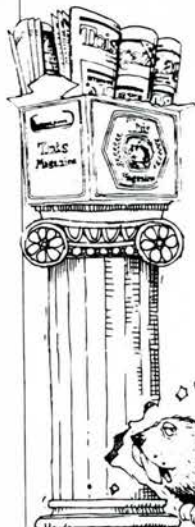
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Strength Through Grief

Amidst all the current furor and political activity surrounding the opening and state shut-down of free-standing abortion clinics in Winnipeg and Toronto, our collective sat down to edit an article we had been discussing for over a year — an article about grief following abortion. We are firm in our desire to publish *The Right to Grieve* but recognize that some women will see it as inappropriate, especially at this time. It is precisely at this time, when the pro-choice movement is surging for the first time in a decade, that this article can be a powerful contribution to strengthen and expand our movement.

Although many women touch abortion-linked grief, it is rarely acknowledged in feminist forums. That particular grief is shared quietly, intimately in kitchens, bedrooms, and counselling rooms. It has seldom been accepted openly and explored; it has most often been repressed.

The abstract concept of ambiguity about abortion might be incorporated into existing feminist theory without too much discomfort. But to take hold of women's emotions, to own our pain, our doubt, our rage and fear, is another thing entirely. To publicly admit the emotional ambiguity of abortion without diminishing the strength of our commitment to a women's right to choose can revolutionize abortion politics. It creates the possibility of welcoming as pro-choice sisters hundreds of women who have never spoken about their abortions or their friends' abortions.

We decry the male-dominated media's stereotype of feminists defining fetuses as blobs and blueprints. Yet, as a movement, we remain blind to the emotional impact abortion entails for many women. Few women are forewarned by doctors or friends of the depth of soul-searching which for many accompanies the decision to have an abortion.

We are not saying abortion is always a difficult or painful decision — it clearly is not. Much of the angst women now experience will diminish as we create humane, woman-controlled clinics. But just as clearly, as long as our culture continues to applaud mothering and attack any other power in the hands of women, some women choosing abortion will find that choice more difficult.

The public feminist image of abortion as a simple medical procedure, while appropriate to combat anti-choice slurs, undermines those women who *do* experience conflict, guilt or remorse after an abortion. Feminists can be surprised by the emotional impact of abortion. They may find themselves layering guilt about their guilt on top of guilt about their abortion. The guilt paralyzes.

Not seeing their emotional doubt reflected in the public statements of the abortion rights fight, women wrongly assume their conflict is rare, deviant or, at best, politically incorrect. Paralyzed or isolated, some women remain politically inactive. They continue to believe in women's right to make that same choice and to take the same action, but are unable to speak out for that right. They are unable to say publicly, "I am pro-choice," and to join or remain part of the pro-choice movement.

These women could and *should* be part of our movement. Now, as we take the offensive, as we test Canadian law, it is time to welcome these women. Now it is time for us to say openly, "You may cry. You may grieve. We know this and we will help you as best we can. And we will *never* let up the fight for you to make the choice yourself."

Betty Burcher
Connie Clement
Anne Rochon Ford

Diana Majury
Lisa McCaskell

Jennifer Penney
Susan Wortman

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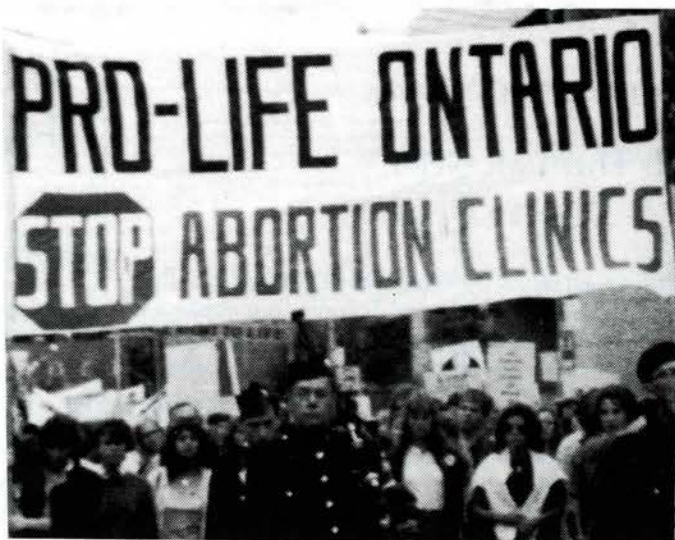


Photo: Gillian Rodgerson, The Body Politic

Demonstrators Dance for Choice

TORONTO — They couldn't help dancing. Even former federal Tory candidate Laura Sabia was tapping her foot on stage. The Parachute Club singing their hit single *Rise Up* had the crowd jumping, swaying, bumping to the optimistic strains of their ode to freedom.

But as a modest crowd of just more than 1,500 gathered in Toronto's Nathan Phillips Square to demonstrate their demand for choice on abortion, Oct. 1, their opponents were whistling a different tune at Queen's Park.

The pro-life rally, organized by the Toronto and Area Right to Life Association, had organized more than 20,000. Many came in 250 buses from cities all over the province and from as far away as Detroit and Buffalo. Many were students from Ontario's separate high schools.

In contrast to the joyous dancers at City Hall, they were organized by geographic region for their 'walk' past the Henry Morgentaler abortion clinic. As they filed out of Queen's Park, a Holiday Inn type jazz band droned in the background. Marching past the clinic and burned out Toronto Women's Bookstore, men holding signs urged, "Total Silence Please."

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Catherine Daw, vice-president of Canadian Abortion Rights Action League said pro-choice forces chose to show local support across the country rather than holding one central rally. "The silent majority can no longer afford to remain silent on this position," said Daw. "We must prove again and again we are right in our fight for freedom of choice."

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Daw said the anti-choice forces often portray a stereotype of pro-choice women as having no feelings and callously make the decision to terminate a pregnancy. As she held her son aloft to the crowd, her love and concern showed just how false the image is.

Carolyn Egan, an Ontario Coalition for Abortion Clinics representative, said women still believe that our fight to control our bodies is fundamental to our liberation.

"Thousands of us are showing today the movement is vital. For the first time in a long while we're seeing victory," she said. "We've been organized (in Ontario) for over a year but now is the crucial time. Nov. 21 is the Ontario trial date for the Morgentaler clinic."

Meanwhile, across the country, there were marches in Victoria, Vancouver, Calgary, Regina, Moose Jaw, Winnipeg, Ottawa and Fredericton. Public meetings were held in Halifax and Saskatoon. In Montreal a theatre group, the Improvisation League, held an evening of drama Sept. 30 and pro-choice groups ran ads calling for repeal of anti-abortion laws in four daily papers in Quebec.

By Julie Wheelwright

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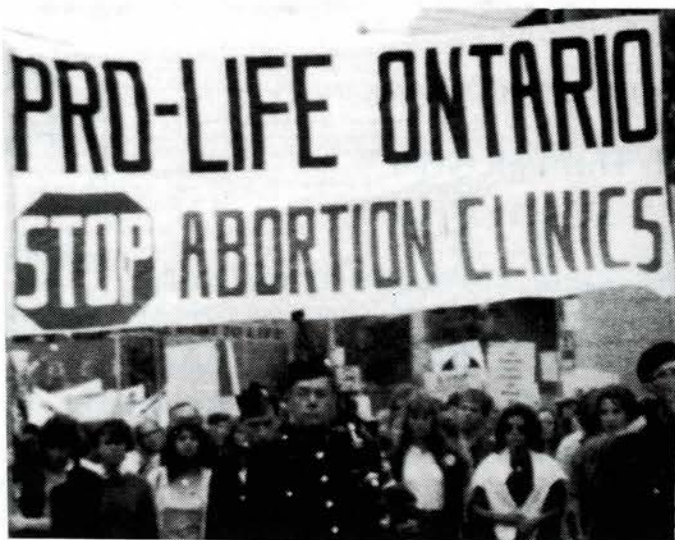


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Prostitutes Form Alliance

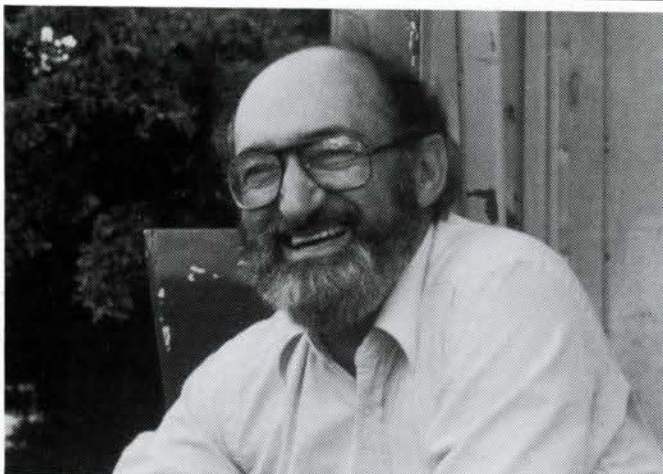
VANCOUVER — Vancouver prostitutes began organizing this spring when they and their supporters staged the first-ever march on a Canadian city hall. The prostitutes registered their opposition to proposed amendments to the Canadian criminal code concerning street soliciting.

Prostitutes were outraged that city council members supported the amendments as a means of cleaning up downtown streets. They charged that these "band-aid" solutions will do nothing to change the underlying economic and social conditions that drive women to prostitution to survive. Community organizations and women's groups were encouraged to expand upon this analysis.

The proposed amendments would no longer require that soliciting be "pressing and persistent" to constitute an offense. The definition of "public place" would also be amended to include cars or buildings visible from the street. If arrested, prostitutes would be required to pay huge fines or spend days in jail. Although clients would also be liable for arrest under the proposed amendments (especially where juvenile prostitutes are involved), prostitutes fear actual law enforcement would continue to be biased against them.

In Ottawa, proceedings are on hold until the recently established Fraser Commission can evaluate briefs from women's organizations and community groups on the subject. Statements concerning prostitution or the proposed amendments can be addressed to: Paul Fraser, Commissioner, Department of Justice, Ottawa.

On the local level, with the recent cutbacks in youth services as part of the provincial government's restraint program, more and more young people are turning to prostitution.



Dr. Henry Morgentaler laughs in the face of adversity

Photo: Lee Lyons, The Body Politic

On Trial in Winnipeg

WINNIPEG — Dr. Henry Morgentaler and the staff of his Winnipeg clinic appeared at a preliminary hearing from Oct. 5 to 19 on eight charges of conspiring to procure an illegal abortion and three charges of procuring an illegal abortion. Judge Chris Stephanson found there was sufficient evidence against each of the eight accused to proceed to trial.

Early in the hearing, Senior Crown Prosecutor Wayne Myshkowski announced that charges against Suzanne Newman, a volunteer receptionist at the clinic, had been dropped. But in another surprise move, the Crown announced it will proceed only with the conspiracy charges.

For the first time nurses and counsellors, as well as physicians, are charged with violating

Section 251 of the Criminal Code. Historically conspiracy charges have been used to prosecute political rebels.

The Coalition for Reproductive Choice, an umbrella organization of about 40 feminist and community groups, is organizing funds for the defense of the accused. As a part of this campaign, "Co-Conspirators for Choice" buttons are available from the Coalition, P.O. Box 51, Station L, Winnipeg, for \$1 each. The eight accused are only a few of the many members of the "conspiracy" to improve women's reproductive health. Funds for the defense are urgently needed. Send donations to the Morgentaler Defense Fund c/o The Coalition for Reproductive Choice at the above address.

By Lissa Donner

"It's frightening," says Marie Arrington, a founding member of the Alliance for the Safety of Prostitutes. "Kids working the street are getting younger and younger. Many of them are pretty green and, therefore, in great danger, both from clients and from pimps. We are trying to talk to them — finding ourselves filling in a lot of gaps that cutbacks in services had left wide open. And the situation is getting worse."

On the street level, ASP members regularly "stroll" the areas where prostitutes gather to make contact and keep them informed about relevant issues.

ASP publishes a "bad tricks sheet" with detailed descriptions of reportedly dangerous clients so that women can avoid them.

ASP members meet weekly with prostitutes in the informal atmosphere of a downtown restaurant. There prostitutes can share information (about VD or how to handle police harassment, for example), offer each other support, or simply get together. ASP members say the meetings help break down the isolation felt by people who work the streets.

By Lorna Zaback

Obstacles in Alberta

EDMONTON — Alberta remains the only province to refuse physicians the right to attend homebirths. Women can choose to have homebirths with the assistance of midwives, but midwifery has no official status in Alberta.

Midwives who attend homebirths risk possible legal action, while mothers face enormous pressure. They know that if anything should go wrong and they are transferred to a hospital they will face a punitive and judgmental staff. In one case a woman who had a homebirth had difficulty finding a physician to register the birth.

Despite these conditions between 80 and 100 homebirths took place in Edmonton last year. Alberta midwives recently submitted a paper to the provincial government proposing their practice be designated a health occupation under the Alberta Health Occupations Act. This would set standards for midwives and allow them to practise.

Although the government has not released a final decision, it appears unlikely the proposal will be approved. The strong opposition of the Alberta College of Physicians and Surgeons (whose claim that homebirths are unsafe was unsubstantiated by their own 1981 task force on the issue), is a major stumbling block. Home birth advocates claim the real reason for the College's strong stand is fear that competition for patients might develop.

By Ellen Seaman



Collective Faces Crisis

VANCOUVER — The Vancouver Women's Health Collective is one group that has been hard hit by the British Columbia government's oppressive "economic restraint" legislation.

For the past six years, the Health Collective has been granted \$119,000 a year from the B.C. Ministry of Health. But, as of Sept. 8, 1983, the Collective's funding was completely slashed.

The Vancouver Women's Health Collective has been one of the cornerstones of the B.C. women's movement for more than 10 years. The Collective has existed in many different forms during that time, beginning, in 1971, with women getting together in informal consciousness-raising, educational and support groups focusing primarily on women's health. In 1972, the Health Collective opened the Women's Self-Help Clinic where women could receive diagnosis and treatment for gynecological problems and learn about prevention in a supportive atmosphere.

More recently, we have been concentrating our efforts on public education and on disseminating information about women's health and about how the health care industry affects women. We no longer run the clinic but continue to teach Breast Self-Exam, Cervical Self-Exam and other simple health-maintenance skills to women in groups.

The Health Collective has facilitated support groups and public education sessions on topics such as menopause, birth control and sexuality, stress reduction, holistic health, and alternatives to psychiatric drugs. We have responded to requests from women's groups around the province and across the country, as well as from community groups and educational institutions, to speak about women's health.



Photo: Vancouver Women's Health Collective

Lorna Zaback, Vancouver Health Collective member organizing support

Although losing our funding has meant we've had to cut back on some of our work, we are determined that the Health Collective resource centre will remain open so that the information (files, books, journals) we have been collecting for the last 12 years will be available. We are busy training volunteers to staff our phones and to help women when they come in for information. We are continuing to do pregnancy and abortion counselling and education about birth control. We will keep on fitting diaphragms and cervical caps.

We have received an emergency grant from the City of Vancouver to cover basic expenses and we are currently applying for other funding

(some from the federal government). We are also soliciting private donations and letters of support. Statements of protest can be addressed to Jim Nielsen, B.C. Minister of Health, Legislative Buildings, Victoria B.C.

Along with our day-to-day activities, we are maintaining our involvement with groups like Women Against the Budget and Lower Mainland Solidarity Coalition, to more effectively fight the government's actions. We see the funding cuts to the Vancouver Women's Health Collective not as an isolated incident, but as part of a thorough and organized attack

By the Vancouver Women's Health Collective

Citizens Lose Herbicide Trial

HALIFAX — A recent decision by a Nova Scotia judge to award court costs and damages to a paper company charged by a group of local citizens with planning to spray herbicides around their homes, came as a shock to the plaintiffs.

Fifteen citizens had attempted to block Swedish-owned Nova Scotia Forest Industries' plans to spray around their homes with the phenoxy herbicides 2, 4-D and 2, 4, 5-T. (Newsfronts Fall 1983).

Judge Merlin Nunn rejected

the plaintiffs' arguments Sept. 15 and awarded NSFI \$200,000 in court costs and more in damages yet to be determined. The plaintiffs have already spent more than \$140,000 presenting their case.

The harsh financial implications of the judgement have come under fire from all federal political parties and from the provincial NDP and Liberals. But Nova Scotia's provincial Tory government says the court decision "vindicates" their claims.

By Susan J. Hower

Midwives Fight Charges

HALIFAX — The death of baby Dara Brackett on July 18 brought a new charge for Nova Scotia midwives Donna Carpenter, Sharleen MacLellan and Linda Wheeldon.

Following the decision of hospital authorities and the baby's parents to discontinue life support systems for the child, the Nova Scotia crown prosecutor changed the midwives' charge to criminal negligence causing death. The midwives had previously been charged with criminal negligence causing bodily harm. The more serious charge carries a maximum penalty of life imprisonment.

The baby's death was not made public and the midwives did not receive the news for nearly a month afterwards. The baby's death occurred exactly six months after her January birth in Halifax, when she was delivered with apparent breathing difficulties.

The preliminary inquiry for the three midwives was slated for Oct. 26 and 27, in Halifax.

Families and Friends Organized for the Re-Establishment of Midwifery (FORM), an Annapolis Valley support group, presented a brief to the Nova Scotia Select Committee on Health urging an investigation of the feasibility and desirability of reintroducing midwifery in the province. Mercedes Sturgeon and Sharleen MacLellan presented the brief which was well received by the committee.

The Association of Parents and Professionals for Safe Alternatives in Childbirth (APSAC)-Nova Scotia continues to support the midwives and to manage their national defense account (19 Fairmont Road, Halifax, N.S. B3N 1H5, 902-479-2969). A newsletter is being published for all APSAC members and contributors to the fund.

By Susan J. Hower

Bennett Slashes Services

VICTORIA — The provincial budget in British Columbia has cut a wide swath into social services, including many women's health and counselling services.

Planned Parenthood, with 17 clinics province-wide and an annual provincial operating grant of \$116,000, had their funding cut completely as of Sept. 8. According to reports in September's *Kinesis*, Vancouver's Post Partum Counselling group and Natural Family Planning group also experienced cuts.

"Also threatened, either directly or indirectly by these cuts are crisis and preventative services for women and children who are victims of violence and sexual abuse, daycare and programs for handicapped children, the elderly, services for the disabled, help with financial planning and legal aid. The only community corrections centre for women is being closed," said a report from Women Against the Budget.

Cuts in the provincial Human Rights Branch translate into cuts for transition house workers, family counsellors and frozen welfare payments. The B.C. Teacher's Federation has announced that resources such as child abuse workers and special needs teachers will also be eliminated.

If the union and the government fail to reach an agreement, the province's teachers, and some university staff will be walking the picket lines on Nov. 9. The Hospital Employees Union and the civic workers may join them the following week. In a show of support Nov. 6, Canada's provincial public sector unions raised \$3 million for a BCGEU strike fund.

"In all of this legislation this government has a message for the people of British Columbia," say Women Against the Budget. "If you can afford it, it's yours and if you can't it's your fault."

You can make your opposition to these cuts known by writing to the provincial government in Victoria. Letters concerning cuts to the Vancouver Women's Health Collective should go to Health Minister Jim Nielsen, The Legislative Buildings, Victoria, B.C. V8V 1X4. The B.C. Human Resources Minister is Grace McCarthy who can be reached at the same address.

Quebec Women Organize Centres

MONTREAL — Autonomous women's health centres in Quebec are working towards a network to tie them together. There are currently six health centres throughout the province in Hull, Quebec City, Trois Rivières, Sherbrooke, Launedière, and Montréal. Four of the centres perform abortions and operate as free-standing abortion clinics. These non-profit health centres operate on a collective basis, have active users' participation and offer a woman-oriented healing atmosphere.

Montreal's centre, le Centre de Santé des Femmes du Quartier, is fully operating this year. In addition to its usual abortion services (at a cost of \$50 or less), it offers medical and birth control information, cervical cap fittings, a "soft birth control" information group (barrier and natural methods), self-help workshops, pre-natal information and relaxation massage.

The Montreal centre is located at 14 East Boulevard St. Joseph, and the phone number is (514) 842-8904.

By Clara Valverde

Lougheed Limits Care

EDMONTON — In its most recent attack on the Medicare system, the Alberta government is only issuing new Alberta Health Care Insurance cards to individuals who have paid their premiums up-to-date.

Those who have not received a new card are not covered under the plan and must pay their doctor directly. Although hospital emergency wards are supposed to treat "real" emergencies whether the patients can produce a valid health care card or not, it is up to the attending physician to determine whether a case is really an emergency. People are being turned away from emergency departments. As many as 20,000 cards have been mis-addressed, leaving their rightful owners without direct medical insurance. New cards will be re-issued on a bi-annual basis to ensure that all Albertans "take responsibility" for their own health care costs, as the Alberta government would phrase it.

Meanwhile, the government has delayed until January 1984

the implementation of hospital user fees announced some time ago. The imposition of these fees is left to the discretion of individual hospitals but because the fee plan is cumbersome, it is unlikely many hospitals will actually begin charging patients. But hospitals that do not charge the fees will have to find cost cutting measures because the government has announced it does not intend to pay hospital deficits which could have been covered by user fees.

By Ellen Seaman



**Look Dick!
See Jane Organize!**

Up in Smoke

Recent research by two Australian doctors reveals that some impotent men must choose between giving up normal sexual intercourse or smoking.

In a Sept. 6 *Medical Post* article, Dr. Warwick Williams, a psychiatrist specializing in sexual problems, says for some impotent men no treatment will restore their potency while they smoke. "It is an established clinical fact that smokers with a

demonstrable degree of penile blood flow impairment often improve the blood flow if they cease smoking entirely," he said.

Dr. Williams and Dr. Rodney Lane, a vascular surgeon, explore the problem in an article currently being prepared for publication. A very high percentage of men complaining of impotence had a significant degree of impairment to blood flow to the penis, said Dr. Williams.



Support and Self Help

Elizabeth Allemang would like to contact other women interested in forming an abortion support group which would offer support to women who are considering or have had an abortion. She would appreciate hearing from women who have been involved with such a group.

Elizabeth would also like to hear from women interested in forming a gynecological self-help group, or anyone having information on gynecological self-help.

Please reply to Elizabeth Allemang c/o Healthsharing P.O. Box 230, Station M, Toronto, M6S 4T3

Incest Survivors

I am a 38 year-old professional woman and I have recently discovered that I am a survivor of mother-daughter incest. I would like to try to contact other women who have had similar experiences. Anyone who wishes to write to me may do so care of my therapist, Dr. Naida Hyde, 2nd floor, 3446 West Broadway, Vancouver, B.C. V6R 2B3. Please do not telephone.

Artificial Insemination

Women who have used artificial insemination, either in or outside clinical settings, and who would be willing to be interviewed — please contact Rona Achilles, 147 Wheeler Avenue, Toronto, Ontario M4L 3V5. 416-694-1745.

**AIDS Affects Us**

by Lisa Freedman

The facts surrounding AIDS (Acquired Immune Deficiency Syndrome) are scant. What we do know is that AIDS is a syndrome that affects the immune system, a part of the body which protects us from assault by outside agents. A non-functioning or poorly functioning immune system leaves the body open to a variety of opportunistic infections, a number of which appear to be specifically related to AIDS. One of the most important questions surrounding AIDS is its exact mode of transmission. According to information from the Centre for Disease Control in Atlanta, the most probable way that AIDS is transmitted is through direct contact (including sexual contact) with either blood, saliva, mucus, urine, semen or feces of an AIDS victim.

We know that AIDS has an alarmingly high mortality rate. We also know that a number of groups appear to have a higher risk of contracting AIDS than others in the general population. These are homosexual men, intravenous drug users, Haitians, hemophiliacs, and sexual contacts of high risk persons. We know that the rumours surrounding any discussion of AIDS and susceptible groups are creating a backlash against those who are at increased risk of acquiring AIDS, particularly homosexual men and Haitian immigrants.

Women are affected not only as family, friends and health care workers of AIDS victims, but also as individuals who are potentially susceptible to the syndrome. At "Forum on AIDS for Women," a recent conference in San Francisco, a health care activist said, "Women do get AIDS, and we want to know about them. Some of us may be at risk through sexual contacts or through donor insemination." As reported in the *Washington Blade*, she continued, "We may be at risk if we use street drugs intravenously using contaminated needles. We are affected personally as people close to us get AIDS and fight for their lives. We are affected at our work places, particularly if we work directly with people who have AIDS."

At this time there have been no documented cases of health care workers who were in direct contact with AIDS patients having contracted the syndrome unless they themselves were in a high risk group. There are, however, four documented cases of non-high risk health care workers contracting AIDS who had had no contact with any AIDS patients.

As of September 9, 1983, Ottawa recorded 37 Canadian AIDS cases. Of these 37, four were women. In the United States there were 2339 cases as of the same date, with 151 women affected. Of these 151 women, 83 are alive and 68 have died. Sixteen of these women were Haitian and 76 reported intravenous drug use.

AIDS has affected some children. Yet statistics relating to children and AIDS are suspect. A number of immunological deficiencies that parallel AIDS symptoms affect this group. In Canada as of September 9, four children have died; two were Haitian, one was black and one was Caucasian. One child contracted AIDS after receiving blood transfusions from multiple donors. The others were children whose mothers were either in a high risk category themselves or were connected with others in high risk groups.

The number of people in Canada who have contracted AIDS is still small but new cases are continuing to appear. This fact alone tells us that women will be increasingly affected by this mysterious illness.

Women should be concerned about attaining AIDS information. While there are no easy answers to the issues of homophobia, racism and other prejudices, feminists have an obligation to fight media stereotypes creating this backlash against individuals associated with AIDS. Our concern can help mobilize forces and, more importantly, pressure the government for adequate research funding. We must ensure that funds are made available to discover the cause of AIDS and help develop a cure.

Lisa Freedman is a law student living in Toronto.

The Case for Lay Abortion

LEARNING FROM MIDWIFERY

By Connie Clement

IT WAS LATE Monday afternoon in a quiet, residential neighbourhood in Toronto. Colleen Crosbie was sitting in the sun on the front steps of the house where she had lived with friends for several months. She was talking with a housemate at the end of a day off. Her four-year-old daughter and a friend were playing in the yard.

There was nothing to distinguish 67 Cambridge Street from adjoining houses; nothing to distinguish that day from any other, except perhaps the kids' excitement at packing the truck to go to their collectively-owned farm four hours from Toronto.

When a car occupied by men with hard-set faces squealed to a halt near the house, Colleen gave only a second glance. It was only when the men stormed up the walkway she realized something was wrong. One man carried a sledge hammer; another flashed a badge and a warrant to search the house; uniformed police materialized to guard each door.

All trace of normality vanished from the day. It has yet to return for Colleen Crosbie.

The raid culminated a lengthy surveillance by the Toronto Police team investigating the bombing of Lit-

ton Industries, manufacturer of the cruise missile guidance system. Police interest in the house focused on political activities of some household members, particularly publication of *Bulldozer*, a prison reform newsletter, and support work for the individuals charged with the Litton bombing. Crosbie was not involved in either endeavour.

But Crosbie is the only person who has been charged. On June 20, 1983, a week after the raid, she was picked up by police walking home from the laundromat. They drove her around for nearly one and a half hours before charging her with procuring an abortion, possessing instruments for an abortion and two counts of theft.

The police acknowledged she was not the link to the Litton bombing they had hoped to find. Indeed, they offered not to press charges if she would give them information.

"I'll tell you everything I know about Litton," Crosbie told them, "It will take one minute. I know that Litton makes the cruise missile guidance system, that their factory was bombed and that people in B.C. have been charged.

"That's it. That's all I know."

illustrated by Pat Foote-Jones

**If it's necessary
you can take the tools
of the world in your
own hands. All that
crap about how you
have to be an expert
... it's all just a ruse to
make you feel
incompetent**

These are bare facts, explaining little about the implications of the charge against Colleen Crosbie. The charge comes at an opportune time for the government and it has been laid against a well-chosen suspect. Crosbie is trained and works as a registered nurse; more significantly she attends home births. If found guilty, Crosbie could lose her professional credentials and face a maximum imprisonment of life.

If the prosecution, the government, plays its cards right, the case could seriously weaken both the current abortion rights upsurge and movements to humanize birth. If women's health activists play our cards right, the case could be leverage to legalize abortion clinics, strengthen the political links among various birth attendants and allow a narrowing of the gap between pro-choice activists and birth activists.

For me, the charge against Colleen crystalized nagging, vague thoughts about the different routes of the abortion and midwifery struggles. During the past several years I have learned, in bits and drabs, about the recent rise of midwifery across North America, and especially in Toronto. As a feminist whose roots are in the independent left, I am more in touch with this year's abortion clinic struggle — I know the issue, my friends are in the thick of it. At *Healthsharing* we discuss and edit news of each of these two movements.

And they are separate movements. I often speak of "the" Canadian women's health movement, but our movement is more accurately a conglomeration of several activist networks: the mental health movement, overlapping with the addictions specialists; the pro-choice movement; the midwifery movement, overlapping with other birth reform

movements; spiritual and alternative healers; regional networks in major cities and some provinces; and a few special focus groups such as DES Action. The most publicly high profile of these are midwives and pro-choice activists.

The ideology of both pro-choice women and midwives rests on concepts of the right of women to control their own lives. When transformed into practice the ideology of each movement is weakened; the rhetoric of the two movements reflects the liberal concept of "choice." Furthermore, each movement focuses on a narrow number of choices: the pro-choice movement addressing the right to choose between pregnancy and abortion; the midwifery movement working to increase women's right to choose how to give birth.

Prior to the late nineteenth century when physicians attained hegemony, women — midwives and other lay healers — performed abortions. In many countries throughout the world reliance on lay healers who utilize herbal abortifacients, massage abortion techniques and invasive induction of miscarriage continue to be the primary means of abortion. Outside Europe and North America, lay healers are increasingly involved in modern abortion treatment. According to a recent piece in *Intercom*, a major population control magazine, midwives and other traditional practitioners in a number of countries are learning to perform early menstrual aspiration. By learning simple early abortion techniques, lay healers are able to provide abortions more safely than in the past and at a fraction of the cost charged by medical abortionists in the same communities.

Yet in Canada abortion providers and activists are isolated from midwives and women skilled in alternative healing. Consequently, their struggles have taken very different routes. The birth reform efforts, especially midwifery, aim to demedicalize birth; the pro-choice fight is to humanize the medical provision of abortion services.

Why haven't Canadian feminists fought the physician control of abortion? Abortion is among the simplest medical procedures performed, demanding far less range of knowledge and skill than attending births. The safety and cost-effectiveness of abortion provision by training paramedics has been proven in the Third World. Clearly it is possible to go one step beyond this

and provide abortion by trained lay women in non-medical settings.

Yet there are essentially no feminist or sociological writings about lay abortions in Western countries. A notable exception is the work of Pauline Bart, a Chicago based feminist sociologist, who has chronicled the workings of Jane, an illegal abortion collective. Jane functioned for four years from 1969 to 1973, at which time the U.S. Supreme Court legalized abortion and mainstream services became available.

In a paper entitled *Seizing the Means of Reproduction: A Feminist Illegal Abortion Collective: How and Why It Worked*, Bart states, "Jane proved that abortions could be performed safely, humanely and very inexpensively by non-professional paramedics working in apartments." Jane provided 11,000 abortions with (their wording) women at various stages of pregnancy. Their safety record for first trimester abortions was equal to that of New York State following abortion legalization in N.Y.

The first Jane member to perform abortions told Bart, "During the first 18 months, the responsibilities of the women in the service evolved from counselling and referring, then to medically assisting established abortionists and finally to doing the entire procedure ... When women in the Service became able to provide all service from counselling to midwifing induced abortions, we reached a new stage of autonomy and a new level of politics."

The women running Jane defined the Service as a point of growth for themselves and women coming to them for abortions. Standard health institutions by and large fail to provide humane, supportive care. Even alternative institutions have experienced only limited success in providing urgently needed assistance to a heterogeneous group of women, ranging in age from 11 to 50 and in occupation from a police-woman to a Weatherwoman.

Why did a feminist collective abortion model develop in Chicago in 1969 and no where else? What made it stay afloat? Why didn't any Canadian feminists implement similar strategies, then or now?

It seems Canadian feminists didn't consider moving outside the law by providing abortions without doctors. Our social context was different, our politics are different, and the timing of

the legal reform of the abortion law coincided differently with the growth of feminism.

Jane came into being in the midst of the outrage and disenchantment that followed the police brutality at the 1968 Democratic Convention in Chicago. The late sixties was a momentous, heady time of political and lifestyle change in U.S. cities; feminism became a major political influence in that setting. One Jane member believes their abortion service would not have been possible at another time.

Throughout most Canadian centres the same political changes happened, but a bit later and less extreme. By the time feminism began to gain numbers here, the law had been "reformed." The revision of Section 251 of the Criminal Code was ingenious on the part of the Federal government. "The reform that hardly was," as Eleanor Pelrine, author of *Abortion in Canada*, called it years ago, managed to find a middle ground that satisfied no one, but temporarily suspended efforts to affect abortion legislation. The law enshrined the rhetoric of reform well enough that pro-choice groups at first believed women would have access to abortion. The wording was restrictive enough that the government reassured anti-choice groups that abortion would only be available in very limited circumstances.

The focus of pro-choice activity has been, until very recently, to improve access within the existing law and to have abortion removed from the Criminal Code. The law, by its very existence and ambiguity, has framed the abortion struggle. Abortion is not illegal, but it is barely legal.

Not only was the law altered earlier in Canada than in the U.S., but feminism peaked more slowly. "We've always been behind in the women's health movement," says Frumie Diamond of Makkovik, Labrador. Looking back on her involvement in a Toronto health clinic in the early 1970's, Diamond remembers, "We were just starting and birth control and abortion had just been legalized in 1969. We were trying, but we were probably simplistic in our understanding of issues ... We were still very uncritical of the medical profession — well, we *were* critical, but not enough to take things into our own hands."

The Young Socialists (YS), a Trotskyist organization dominant in the early 70s which heavily influenced the



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The pro-choice activists among my circle of acquaint- ances fight for choice because it's impor- tant; the midwives I know are midwives because they love it.

development of the Canadian abortion movement, also steered us away from taking abortion "into our own hands." The YS believed that to build a political movement demands must be made on the State. "The radical feminist demand was 'Free Abortion on Demand.' The YS slogans were 'Repeal the Abortion Laws' and 'A Woman's Right to Choose,'" remembers Sue Genge, a Toronto feminist and former member of the YS. "The focus was too narrow. We never discussed how abortion fit into the total oppression of women."

The movement was even further entrenched into a legal orientation with the formation of the Canadian Association for the Repeal of the Abortion Laws (CARAL) in 1972. (CARAL later changed its name to the Canadian Abortion Rights Action League, keeping the same acronym.) CARAL organized, in part, to provide a forum for more moderate women. Both CARAL and the YS, for different reasons, sought broad appeal: The Choice slogans became entrenched.

As well, the model of the turn-of-the-century birth control movement was one of legitimization and legal change. Dr. Robert Dickinson, a gynecologist and ally of Margaret Sanger, in 1916 urged his fellow doctors to "take hold of this matter and not let it go to the radicals." When contraception was finally legalized in the U.S. the court ruling specifically allowed physicians to import, mail and prescribe birth control. Barbara Ehrenrich and Deirdre English, in *For Her Own Good*, criticize the racist and classist arguments taken by Sanger and the professionalization of birth control that was undertaken to legalize contraception. At the same time, they question whether the movement could have succeeded without such arguments given the social and political climate of that era.

The current abortion movement seems caught in a similar bind. While most pro-choice activists, holding feminist beliefs, openly and vehemently criticize existing medical services, no one openly suggests that we could do without the medical basis of abortion provision. Arguments instead emphasize quality of medical care and access to quality care. The fight to decriminalize abortion functions within boundaries established by the government.

The exceptions are the provision of abortion services in community health centres and private clinics in Quebec and the more recent establishment of free-standing clinics in Winnipeg and Toronto. None of these clinics fall within the criminal code requirement that abortions only be performed in "approved or accredited" hospitals.

In all these cases, the law has been challenged by charges laid against Dr. Henry Morgentaler, a Montreal physician who began performing abortion in the early 1970s. The reliance on someone who is a physician, a male and an independent maverick, is ironic for a feminist, relatively anti-medical group of women.

By not totally relying on physicians, midwives avoid this dilemma. Vicki Van Wagner, a member of the Toronto Midwifery Collective, says, "The real strength of midwifery is not allowing our issues to be defined by the State. We can go the route of nurse-midwifery, doctor-supervised practice or we can fight for an autonomous, woman-controlled movement. That choice is ahead of us."

Just as the pro-choice emphasis today is on testing the law, the midwifery struggle is currently focusing on several recent or upcoming trials and potential changes in health legislation.

In the spring of 1982 an inquest in Kitchener, Ontario examined the death of an infant who died in hospital under physician care after midwife-attended home labour. The inquest made two general recommendations: the public should be more informed about the pros and cons of hospital and home birth; standards should be developed for midwifery practice.

In a more current case now underway in Halifax, three midwives could stand trial following the death of an infant. At birth, after a healthy fetal heart beat, the baby failed to breathe. Suction and transfer to hospital were

immediate; the baby died after six months on a respirator.

The impact of the hearings has differed. In Halifax the case has greatly increased public awareness says Valerie O'Day, coordinator of the defense fund. "First *The Chronicle* referred to 'three women.' Now the media uses the word 'midwives.' There is active debate about home birth by people who had never previously considered it." In Ontario the inquest not only created public debate, but political banding together of midwives. Ava Vosu of the Ontario Association of Midwives, and one of the attending midwives at the birth in question, recognizes some positive outcomes of the inquest. "Even feeling threatened, being drained by the hearing the potential, the growth as we came together," she said.

Clearly there should be a great deal of mutual support between women involved in these two efforts: both are struggling to strengthen women's control over reproductive functions; both seek more humane health treatment; both vehemently criticize Canada's existing medical establishment.

Active support does not exist. There are few individuals in both movements; relatively little information is exchanged between the two networks. Although I have discovered no outright distrust or animosity, ignorance is widespread.

Why? Simply put: different women, different backgrounds, different politics all seem to outweigh the commonality of the two movements' goals. In writing this article, I have begun to cross that divide.

I find myself drawn by the extreme vitality among midwives, something I have not experienced in myself since the earlier days of my political awakening. The commitment among women in the two movements is equal; both believe fiercely in their work. But there is a difference of spirit. The pro-choice activists among my circle of acquaintances fight for choice because it's important; the midwives I know are midwives because they love it, because it's their life.

For some of the midwives, politics is a recent addition to their lives. The new midwifery movement is young. Each step forward brings with it new learning and excitement.

One drawback of such freshness, such enthusiasm, is that it is sometimes accompanied by political naiveté. The

tendency is to respond to need, and sometimes without a full understanding of political implications.

In comparison, the pro-choice movement has more political history and draws on a wider range of feminist theory. A large proportion of the pro-choice movement has been active in feminist issues or abortion rights struggles for years. They've learned to analyse the possible implications and outcomes of actions *before* undertaking the action.

As midwives have become more and more political, they have collapsed the boundaries between the personal and the political. Nearly all Canadian midwives came into midwifery through their own or friends' births. Some of them stumbled into it simply by being in the right place at the right time. The number who turned to midwifery as previously active feminists seeking fulfilling and political work are countable.

Just as socialist and Trotskyist politics influenced the form and strategies of the choice movement, the counter culture has infused the style of the midwifery movement. Thus, midwives' distrust of medical authority is coupled with the kind of anarchism prevalent in the back-to-the-land movement. Behind midwifery lies a kind of 'if They can't do it right — and They can't — we'll do it ourselves' philosophy.

Widespread faith in human potential among the counter culture was allied with faith in things natural and spiritual. Hence, although Canadian midwives have moved beyond the spiritual midwifery first espoused by Inna May Gasikin of The Farm (a large alternative community in Tennessee), there continues to be a reverence for birth. For some midwives this belief in birth as an elemental and natural force becomes so extreme that birth is mistakenly defined as the key moment in the lives of *all* women. Notwithstanding the occasional extremism, midwifery is stronger for its spirituality and faith.

Mary Daly, radical feminist philosopher, has often argued for such incorporation of the spiritual. As early as 1975, in a paper entitled "Demons, Drugs and Doctors," Daly called on women "to transfer our energy to a nurturance and support of other women."

And *all* midwives do nurture and support women through the provision of midwifery services; *some* midwives



are also political activists involved in the struggle to legitimize midwifery. Women involved in the pro-choice movement, on the other hand, are *all* political activists; *some* are involved in nurturing and supporting women through abortion-related services such as pregnancy counselling and referral; only a small number actually provide nurturance at the moment of abortion.

Among politically active midwives the mixture of the personal day-to-day involvement with women in all stages of pregnancy and birth, and the political legal midwifery work, reinforces the personal politics style inherited from the counter culture. Because not all pro-choice activists work in abortion, the political debates can more easily become intellectual debates. The political runs a greater risk in this context of los-

ing contact with the personal complexities, even though every woman knows someone who has had an abortion.

The emphasis on the personal may be one of the reasons modern Canadian midwives were able to learn the skills of their craft several years ago when there were few teachers from whom to learn. For instance, one Ontario midwife attended her first birth, while still a nursing student. She was told a midwife would be attending, but no one showed up but her. It was an "amazing experience — I had never read anything on midwifery skills, yet I did my first vaginal to check dilation, and supported and massaged the perineum. Never thinking twice about being there, just totally wrapped up in what was happening." That birth led to another and to study and improvement of skills.

A Toronto midwife said, "The move- ments ... are not alike. One is about life and one is about death."

One of the Jane abortionists caught the essence of this philosophy when she said, "The important thing about the Service is that people really learn that if it's necessary you can take the tools of the world in your own hands. All that crap about how you have to be an expert ... it's all just a ruse to make you feel incompetent in your own life. One thing we all learned is that if you want to do something you can learn how to do it."

Although two months ago I would have cited the pro-choice movement as the primary example of *feminist* health politics in Canada, after numerous conversations to prepare this article, I now view those midwives who are political as at least as feminist.

Back in 1974, when Barbara Ehrenreich spoke on behalf of three California lay midwives charged with practising medicine without a license, she compared the goals of the radical health movement and the feminist health movement. Radical health activists, best typified by the New York-based Health Policy Advisory Center (Health/PAC), criticize the consumer/commodity model of health services. Proponents of radical health theories argued for more quality controlled services, for less money, or more people.

According to Sheryl Burt Ruzek in her book *The Women's Health Movement*, Ehrenreich posed that feminists had moved beyond the limitations of the radical theories and were addressing the health experience. To change the health experience the system must be demedicalized and deprofessionalized, she stated. The feminist position was more radical than the so-called radical health movement. The radicals, in calling for a socialized medical system, would change only who paid the bills. Feminists, by envisioning a non-authoritarian collectivist health system, were calling for a transformation of the entire structure.

By leaving abortion in the hands of doctors, the pro-choice movement is falling short of these feminist ideals. As it exists today, the Canadian pro-choice

movement is reformist, not radical. Yet many or most of the women active in the movement are self-defined as radical. The midwives, as judged by their practice, are radical. Yet some or many would reject the label.

The radical nature of the midwifery struggle can perhaps best be seen in many midwives' willingness to risk jail. Theo Dawson, for example, is a Toronto midwife who is openly practising without a physician in attendance. Each and every time she does so, she knows it could be the last birth she attends for some time; she continues her work, not knowing if or when charges might be laid.

Except for the Winnipeg and Toronto clinic staff, pro-choice women don't risk quite as much. The pro-choice women's courage is in their willingness to be public about an issue which divides families and turns co-workers against one another. The abortion issue has a moral complexity and depth totally different from any issues related to birth. And by and large, pro-choice activists are very open about their abortion politics, even in health work with clients.

Not all midwives have the same expectation that clients will respect differences of opinion about matters as important as abortion.

In October, as part of a discussion to share their mailing list with the Colleen Crosbie Defense Fund, the Toronto Midwifery Taskforce discussed fears. One midwife, although personally comfortable with sharing the list, felt some individuals on the list would be offended. Further, Taskforce members were afraid some recipients might interpret the mailing as pro-choice and anything hinting of pro-choice leanings would diminish support for midwifery.

By expecting, and accepting, a conflict between abortion access and midwifery, these fears hold back both movements. It's high time the midwifery and pro-choice movements become one coalition. It's time for pro-choice activists to reassess their reliance on medical professionals and for midwives to examine their fear of being labelled pro-choice.

We must *all* ask what we are seeking to achieve ... not today, not in relation to a particular immediate action, but overall. When we envision women's health and health care, what needs to change?

Researching and writing this article reawakened visions of a powerful sisterhood, a sisterhood comprised of different women, with different skills, fighting different struggles, but all sharing a common dream. We must move beyond the narrow, liberal focus on 'choice' and find ways to embody the ideal underlying the choice rhetoric in each movement: women's control of our own lives.

Each movement stands to gain a lot by closer affiliation with the other. And together we could be a tremendous feminist force. Vital, vibrant, politically astute and grounded, nurturing, self-reliant, courageous. As Colleen Crosbie said when I telephoned to interview her about the raid and charges against her, "What you are proposing is overwhelming — tremendously exciting, but frightening. As we stand now, each movement is only half whole. If we really become what you are suggesting we'd be too powerful for them to let us exist."

Perhaps, but maybe not. By learning from each other we *might* be able to create space for joyful birth *and* joyful abortion. In 1972, I did my first vaginal self-examination and learned about menstrual extraction from Lolly Hirsch, who with her daughter published *The Monthly Extract: An Irregular Periodical*. She talked about abortion done with friends as a positive and energizing event, a sometimes joyful celebration. I was stunned — I knew I had touched a truth.

During the past ten years that truth was submerged. A hospital therapeutic abortion can hardly be called joyous, and for several years I counselled women being referred for hospital abortions. The potential remains.

Only by taking both birth and abortion into our own hands, and regaining control over those life passages, can we begin to achieve reproductive rights for women. A Toronto midwife, when contacted in connection with this article, said, "The movements ... are not alike. One is about life and one is about death."

She's wrong, dead wrong. Both movements are about life, about women achieving the kind of life that always seems just out of reach.

Connie Clement is a member of Women Healthsharing who, if pregnant, would want to have an abortion or give birth in her own home.

NURTURING MOTHERS

by Sheila Kitzinger
illustration by Dawna Gallagher

I want

to speak to you today as a social anthropologist who studies the culture of childbearing in different countries, as a childbirth educator, and also as a mother of five daughters. I have chosen a deliberately ambiguous title, "Nurturing Mothers," because I believe that women may find it very difficult to nurture their babies spontaneously and to get real pleasure out of it, if they are not nurtured themselves. And one important element in nurturing a woman is to give her social recognition as a person, not just as the mother to her child, the wife to her husband, or as a baby-producing biological organism.

Motherhood, in our western society, is a second-rate occupation. A recent study of pregnancy at work, done in Britain, has shown, for example, that women are often moved to backroom jobs because they tarnish the cosmetic image of a firm when they become pregnant. This is very very different from, for example, what I discovered when I was doing research on childbirth and parenthood in the Carribean, where, when the local midwife goes round to the villages, and sees a young woman coming up to her, she says,

"You be getting fat" because the nicest thing you could be told is that you might possibly be pregnant.

Birth is not just a physical act. Nor is it only an emotional process. It is a bio-social event. Birth defines what it is to be a woman and a mother in that culture. How birth is handled, how it is conceptualized, the fantasies that exist about birth in that society, how the woman is treated, how the baby is treated, all help to define what birth is, the meaning of birth in that society.

When we look at birth in our own culture, it is really very surprising that any woman is not depressed after childbirth. And the really interesting question is why do some women *not* get postnatal depression, rather than why do so many get it. Those who do not feel themselves nurtured and valued sometimes feel that they have nothing left to give a baby. The undermining of confidence, the systematic disorientation of women's psyche starts the moment a pregnant woman becomes a patient; it starts very early in the system of prenatal care. The pregnant woman is given all sorts of implicit messages in the way she is treated during pregnancy. She is told in effect, "You are in a dangerous state. Your baby is not your own. The fetus is valuable; you are merely the

container for that fetus. Because you are a woman, you are a threat to the fetus."

It is often taken for granted that medical care, costly, elaborate medical care, must be a good thing in pregnancy. But research is now demonstrating that much prenatal care is not only unnecessary, but can actually be counter-productive.

Dr. Marion Hall has studied the productivity of routine prenatal care, in terms of the predicting and detecting of obstetric problems, and she's discovered that it is very cost ineffective. For example, over diagnosis is common: for every case of intrauterine growth retardation correctly diagnosed, there are 2.5 false positives. For every case of preeclampsia or hypertension diagnosed correctly, there are another 1.3 false positives. And, of course, this leads to over-investigation, to unnecessary admission to hospital, induction, forceps, caesarean sections. These procedures, I would suggest, are part of a ritual system to institutionally control the passage through pregnancy and birth, to protect men from women, to protect society, which is organized by men, from women.

It is, I think, not a matter of 'being nice to your doctor,' in order to try to negotiate the kind of birth you want individually. What we are facing is a grossly unequal power relationship. Power is invested in those who control the territory. Patients are temporary and subordinate members of a tightly organized hierarchical and bureaucratic medical system. The rules are controlled by those who define the setting, who exercise authority over admission to it, who regulate the timing and the sequence of events, and who formulate the kind of interaction taking place.

Those

of us in childbirth education have a long history of arguing about what we are trying to do, about what our goals are. I suggest that one important goal is to help women develop confidence in their own bodies, trusting themselves, and that another very important goal, which is becoming even more important with our complicated care today, is learning how to cope with the medical system. Birth education has, in the past, often reinforced the power of professionals by introducing yet more rules, more constraints on women and preparing them

to exert self discipline, not to cry out, to be nice to the nurse and the doctor, to cooperate, to obey instructions.

This issue of control is basic. For to be "in control" in this context is to *surrender* control to the obstetric team. It is called patient compliance. The great aim, for example, of pain-relieving drugs used in labour, according to the blurb of the drug companies, is to get a "fully cooperative patient." In many childbirth classes and especially those taught in hospitals, women are taught to be ready to compromise, to ask for things tactfully, not to antagonize the staff, not to have preconceived ideas about the way they want the birth to be, to avoid setting their standards too high, to use feminine wiles in order to get minor concessions. They are being conditioned to submission.

The latest book I have been writing (I'm branching out a bit) is called *Woman's Experience of Sex*. Through interviewing and talking to women I have learned that through their sexual lives too, women have been taught to accept a medical view of the female body, a male view of their bodies and body functions. We have learned, for example, to equate intercourse with penetration, as if that is what sex is all about. We have been taught to ignore our own experience. For example, we've been taught that an orgasm is what a man experiences, which is a build up of tension, a high, and a release ... and then it's all over. As a result, women have not themselves realized when they had waves of desire building up as warm heat suffusing their bodies, dying away again and building up again in yet another wave, and going on four, five, six times perhaps, that what they are experiencing is the female multiple orgasm. We have been trained to think in terms of foreplay ... before *what?* Before ejaculation, of course. And we have been taught time and time again, in sex generally, as in childbirth, to ask "What did I do wrong?"

Now all this doesn't happen just by chance. We live in a society which molds women into compliant housekeepers, mothers and patients. Let us see what happens when a woman becomes a patient. A hospital turns a woman into a maternity patient through a series of rites remarkably similar to those which in a Third World society mark the transition from one social status to another, puberty rites for example. In our society the medical profession has largely taken over the power of

the priesthood to supervise these rites, designed primarily to reinforce the power of the institution and to control the activity of everyone, staff as well as patients, inside the structure.

Transitional rituals are always composed of specific ceremonial phases. The first and very important phase is that of separation, separating the initiate from family and friends, removing him or her to a different place. There follow ceremonies of depersonalization, acts designed to obliterate all signs of individual identity. The clothing which is usually worn, for example, is removed, and everything else which distinguishes one individual from another. There are often rites of infantilization which reduce the initiates to the status of small children. They are not allowed to make decisions even about the most basic physical functions, such as eating, drinking, and elimination. Other important rites are those of cleansing and purification. The initiate is purged, often literally, with purgatives and purified by a ceremonial bath.

An important part of many ceremonial rites is the stimulation of fear. The initiate is supposed to be terrified by the changes which are taking place, overwhelmed by their awesome significance. And since these physiological and social changes would otherwise often take place smoothly, the journey is made deliberately distressing. Tribal elders may don masks of the spirits of the dead and chase and beat the initiates. They may trap them physically in order to mark them with the stigmata which are signs of their changed status, having their teeth knocked out, or being tattooed or circumcized for example. During all this time, instruction is given as to how they must behave in their new status. They are submitted to examination, then assessed to see if they are worthy to go on into the new status. And finally there is an act of rebirth, a purifying bath, the initiates are dressed in fresh garments, and welcomed back into society in their new identity with celebration.

Rituals

of this sort always support and reinforce social systems so that individual wishes and personal differences fade into the background against the values which are superimposed by means of these ceremonies. They are powerful agents

of social control. In large hierarchical institutions such as we have in the West, in hospitals, for example, there is special likelihood of ritual being used to reinforce the existing system, rather than for the benefit of the individuals for whom the institution is stated to exist.

Let us just look at our hospitals today. There are, first of all, the admission procedures, when a woman is "prepped." She gives up her own clothes and is dressed in a hospital gown, with an identification bracelet fixed to her wrist. The usual means by which she defines her identity are removed. She is surrounded by people in sterile garments. There have been





unless she is severely constipated. It is, in fact, a ritual purging of pollution and a powerful way of demonstrating to the woman that the territory of her body, including the functioning of its innermost parts, is firmly under the control of the hospital staff. We have other ways of showing the woman this too. Her membranes are artificially ruptured and an electrode is fixed to the fetal head. The message is given that the woman's most intimate and previously private body functions, and those of her unborn baby, are under medical control. Many women are still put to bed as soon as they are admitted in labour. Being tethered to an electronic monitor with an intravenous drip in your arm makes it difficult to move, even if in theory a woman is free to choose her own position. These apparatuses not only immobilize her, but may also leave her feeling physically helpless and trapped. The fetal monitor, like the enema and shave, conveys a forcible message that caregivers control the labouring woman's body and the whole process of birth. And they proclaim that the doctor's esoteric knowledge, the omens and portents that only he, like shamans, priests and witchdoctors, can interpret, enables the doctor to control birth by methods far beyond common human understanding.

In an obstetric delivery the patient is often covered from the waist down by a sheet and the baby is born through a little hole in the sheet. I was very surprised when I first came to the United States, years back, and saw a birth film with a baby apparently not emerging from a woman's body at all. It looked as if somebody was moving house and they'd covered the furniture with dust sheets and the baby was coming out in the middle. The doctor transforms the lower end of the woman's body into his "sterile field." This is a very convenient obstetric fiction because the juxtaposition of the vagina and the anus makes it impossible to have a really sterile field at delivery. Anyway, even if you could get it, it isn't *his*. But these drapes have an important ritual function because they distance the obstetrician from the woman. They produce an armour against communication between the two as human beings and they symbolically represent the medical nature of the act of birth and the way in which in Western culture delivery has become a process performed by a team of professionals on the body of a woman, rather than an act of birth-giving on her part.

various studies which show that there is no practical benefit in fathers wearing masks, overshoes and caps. But they have an important ritual function. Way back in the sixties, Roth's study of the use of sterile garments revealed that the higher up in the hierarchy an individual is, the fewer sterile garments are worn. Whereas those at the bottom of the hierarchy, the father for example, must wear protective overshoes, gown, cap and mask. The specialist, the obstetrician, can come in his own suit, with his gown undone.

The woman is frequently addressed in an anonymous way, as "dear" or "mother," (terms often used towards

women patients in hospital, anyway). Very often the perineal hair is shaved. There have been studies done of perineal shaving which show that not only is it unnecessary, but that it actually increases the chance of infection, because you can't shave anyone, however expertly, without nicking the skin. Shaving thus provides a passage for bacterial infection. But the practice persists because in many hospitals it is a ceremony by which the woman is desexed and infantilized and is returned to a prepubescent state.

The routine enema or suppository is another rite of admission. It has been shown to be of no benefit to a woman,

The Third World has its childbirth rituals too. I was very interested when I was in Jamaica to go round with the folk midwives and see them massaging the pregnant women's abdomen — they call it "shaping" the baby and "making the baby grow right" — and counselling her about nutrition and the things that she must eat, callalu, which is like spinach, in order to make the blood strong, for example.

The rituals which are used in childbirth in the Third World tend to perform a different function from hospital rituals in the West, though hospital rituals which we have exported are now invading the whole developing world. Third World peasant rituals, instead of reinforcing the role of professionals and the power of the institution in which birth takes place, have the major function of providing what we might call a language of metaphor, through which the labour is given meaning and is dramatized and in which the significance of the act of birth for the society as a whole is vividly expressed. The right progress of labour — the dilatation of the cervix and the opening of the vagina — is seen as dependent on the right ordering of relationships between the parents, in the kin group, within the lineage, and in the larger society. And if relationships aren't right, the labour will go wrong. In parts of Africa, for example, people close to the labouring woman may be asked to confess any hatred they feel, for it is thought that negative emotions can hold up dilatation. Sometimes one of the parents is asked to confess an act of adultery before the way is made clear for the labour.

Ritual also links the forces which are bringing this particular child to birth with universal forces, and ceremonial acts harness the power of natural phenomena for the safe delivery of the baby.

Some of

you may know Levi Strauss' description of the psychodrama enacted by the Cuna Indians of Panama, in which the shaman recounts a dramatic story of entering the labouring woman's abdomen, going up into her uterus with the help of all the insects and animals through the cervix where they fight with the great god of childbirth who is holding onto the baby inside the uterus. On the way they are only able to go one in front of the other; when they come out they can go three abreast — the cervix

is dilated! In parts of southern India, a tightly furled dried flower is put beside the woman in labour and, as the petals unfold in the heat, she knows that her cervix is opening in the same way, and that when the petals are spread wide, her cervix will be fully dilated. It is an outward and visible sign of an inner physiological process.

In many parts of the world today there are situations of acute culture conflict in childbirth, and then the comforting symbols, the support provided by religion, helps women through the ordeal of labouring in an alien environment, among strangers. Peasant women in Jamaica, for example, take their bibles with them into the labour ward, and they shout passages from the Psalms. They clasp each other, rock their pelvises in unison, and cry out 'Jesus, Jesus, Jesus, Jesus — ah-ha, ah-ha, ah-ha, ah-ha,' (and then the midwives say 'She's second staging.' They don't need to examine her.) There is a synthesis of birth, sex and ecstatic worship. This is exactly what they do in the revivalist churches up in the hills when they experience spirit possession. They call it 'labouring in the spirit'.

The kind of care in childbirth that we provide in our society treats women as irresponsible and selfish children. They are not expected to behave like adults; they are not treated as adults; they are simply sucked into the obstetric system. Many times this is a beneficent system. At other times it is not. But the point is that women are not treated as if they are capable of being responsible for themselves or their babies. This is artificially producing a child-mother, who continues to be dependent, who is unable to make decisions, who becomes very anxious when she is supposed to take on the full responsibility of the baby and who looks to experts for advice. It is a meticulously conditioned helplessness. The stillness and passivity associated with the concept of motherhood in our society are really exemplified by the image of the Virgin Mary and her child. And it is a male construct.

The briefest introduction to the reality of motherhood is enough to convince us that this is wholly false. The woman on a pedestal, just like the woman on the delivery room slab, is an image created by men. A baby's cry, a baby's distress, a baby needing you is the most disturbing, mind-shattering call to action which as adults we can ever experience. And suddenly the draped, still folds of that blue madonna robe are

rent. The madonna pose is revealed as an entirely artificial, idealized male construct. If women are to be enabled to act as adults, they must be *treated* as adults.

Women are now reclaiming their bodies in childbirth. We are beginning to challenge the whole medical system which men have imposed on us, and which professionals have imposed on us, because of their fear of the female essence. It is a system based on fear of everything which flows out from within the centre of a woman's body, out through the orifices, the flowing power of womanhood; from their fear that they will be emasculated by the power of menstrual blood, by the strength of the contracting uterus, by the life-giving force of the placenta; their dread that the cervix will not open sufficiently or that the tissues of the vagina will not flower and open and give.

In this conference over the last few days we have heard many statements which express, I believe, the fear that men have of women's bodies, and that children feel about their mother's sexuality, their anxiety about being held by the uterus, expelled through the vagina, and of experiencing all the power of a woman's body in birth. And we have heard of the fear which is associated with envy of woman's ability to give birth, envy of female sexuality, and dread of it. I think many of us women here today will feel compassion about this, but will find it difficult really to comprehend the intensity of this cringing terror, this dread of the female body, of what Leboyer has described as "the monster" who "not satisfied with crushing the baby, twists it in a refinement of cruelty." For some of us here, birth is not like that.

Birth is glorious. Birth is an embrace. Birth is a benediction. Birth is an act of love. To relive it in imagination is to rediscover, not birth trauma and terror, but the depth and strength of that love, and the supreme affirmation of life expressed in all the striving, the pain, the longing and desire, and the fulfillment of the birth passion.

The preceding was the text of a speech given by Sheila Kitzinger at the First International Congress on Pre and Peri-Natal Psychology. The Congress took place on July 8-10, 1983, in Toronto, Ontario. Kitzinger is an English childbirth educator, social anthropologist and the author of a dozen books on childbirth.

The right to Grieve



Two women talk about their abortions

We met initially in the clinic where Heather works. Although we came together as counsellor and client, we discovered many common threads in talking about our recent abortion experiences.

We find it difficult, both personally and politically to discuss the grief surrounding our abortions. We worry about whether this is the right time to raise this thorny issue. The political climate is hot. Will the anti-choice forces use this acknowledgement that abortion can be a complex and ambiguous decision as ammunition?

Yet it is the right time. We feel the power of the movement that gives us the courage to discuss our experiences. We both

believe in a woman's right to choose abortion and we've never doubted we made the right choice. Despite this, we found the decision an anguished one and both experienced depression and grief.

Our experience is not unique. Nor do we think that every woman having an abortion experiences the same trauma we did. We found support from each other in discussing our experiences. We were no longer alone and feeling crazy. We feel it is important to acknowledge the personal issues surrounding each woman's choice. By assisting women to sort out these issues, we can only bring added strength to the pro-choice stand.

NAOMI: I knew I was pregnant because of a number of physical signs which I recognized from a previous pregnancy. It took me about a week to go see my gynecologist and confirm it. I put off going in order to stay the pending emotional tide.

When it was confirmed I fell apart. I didn't have time to think. I was rehearsing ten hours a day and coming home and collapsing. I was exhausted, and completely unable to deal with the situation. I just couldn't decide what to do. I felt buried by the weight of the reality. I needed time to be hysterical, and then sift through the options.

HEATHER: I was sure I was pregnant two days after I missed my period. I was charting my cycles and I knew. I remember throwing my thermometer across the room and bursting into tears. My mind started racing, working overtime to figure out what to do. I got out all my nursing textbooks to look up pregnancy symptoms and how long I had to wait for the urine test, the "confirmation." I went for it as soon as I could, to a huge drugstore where I was anonymous. I remember hiding my left hand when the druggist told me the results. All the old-fashioned values were coming back to haunt me!

NAOMI: I had accepted the possibility of another pregnancy after my first abortion. But when it happened I was completely unprepared. I was filled with confusion and fear. Questions constantly churned through my brain. Was this some sort of sign that I should have a child? After all, this was the second time in a year and a half that I had gotten pregnant. I had used the diaphragm the first time, and the IUD the second, and yet here I was, pregnant again. I felt victimized.

HEATHER: My pregnancy was also a diaphragm failure. I couldn't believe it could happen to me. Here I was, using birth control responsibly, a nurse and teaching birth control. All these years I had fought for control over my life and body. Having an abortion was a way of gaining control, of saying "no" to fate. I wasn't just accepting what happens, I was saying a very profound no. I really held onto that. It gave me courage to continue with my decision.

But I was really pulled apart. It was hard to say "no" to this potential child. I felt selfish, saying "not now, I'm not ready, I can't give a child what I want."

NAOMI: I felt I was choosing between a person and a career. That was very ugly. After the abortion I felt more committed to my work. I realized that in retrospect I was being ridiculous, that the decision for a career wasn't a decision *against* a child. I was pretending there was a need to choose between the two. Selfishly, there were too many things I wanted to do before becoming a parent. Saying "no" to a potential life is a frightening and onerous decision. It is not made lightly.

HEATHER: These are really tough choices. I hear both of us saying we were selfish.

NAOMI: Yes, we *were* selfish. Being selfish is not necessarily bad. To say "no" to parenting, to becoming a mother, is not an awful sin.

HEATHER: Yes, we strive for fulfillment in jobs and other activities, but still the bottom line socially expected of us is to be mothers. Saying "no" to children comes out in our guilt as "selfishness" rather than simply being able to say "no, not now," or maybe "never."

NAOMI: It was definitely my decision, but my partner was very involved. We discussed it extensively. We walked, talked and cried for hours. He was the most important person I talked with, but it was my decision and he understood my need to make the final choice. That was possibly the only clear thing: that it was my choice alone. It is ultimately a closet experience. It happens deep inside and therefore no one else can really understand.

HEATHER: My situation was similar. I knew that I had to live with my decision. The reality of biology came full force. We are the ones who get pregnant. On the one hand, I was delighted that I was fertile. And despite the morning sickness, the frequent bathroom trips, and the fatigue, I enjoyed the physical reality and was awed by the rapid changes.

However, I knew the pregnancy crisis could spell the end of my relationship with Paul. We had only been together for four months. I didn't want the relationship to end, but I wasn't optimistic, especially if we differed on what to do. Strangely enough, we got very close. He was there and supported me through all the visits, the surgery, the tears, the grief. It was hard on him too, as it called into question all his life goals. He felt that he got me pregnant. He was guilty. I

kept saying "we got pregnant. I'm not blaming you."

NAOMI: Michael was really supportive. But he felt that he had to deny his own feelings in order to be there for me, which turned out to be a way of blocking his emotions. Looking back, it grabs me in my gut. My response is primal, emotional. For him, it was a more intellectual experience.

HEATHER: One of the supportive things for me was sharing with other women having abortions. I ended up spending a lot of time talking to a seventeen-year-old woman in the next bed. She had told no one about her pregnancy other than her next door neighbour. Although I felt a lot older, she was going through the same things as I was. Listening to her, I was ostensibly helping her, but I was also helping myself.

NAOMI: I also talked with another woman in the hospital. We didn't really have a conversation, rather she spoke and I listened. She was perhaps thirty, a recent immigrant to Canada. She had one child, and had been forced by her husband to have this abortion, her second in six months. She kept repeating that she wanted to die. She felt that she had killed her child. She had not been allowed a choice, and her anxiety was tremendous.

HEATHER: I had a bad time after the abortion. At first I was relieved it was over. I thought I had taken care of myself before the abortion. I had told a lot of friends, and they were all very supportive. But afterwards I spiralled into a depression. I just felt miserable. I wasn't sleeping or eating. I felt more morose than before the abortion.

I went to a folk festival, hoping it would cheer me up, but all I saw were babies. The words that finally came to me were, "I never got to see this child." Paul asked me if I regretted the decision, had it been the wrong one? Had we made a mistake? I told him no. I had carefully weighed it all out. It was still the right decision at the time. But I still had to cry, to grieve the loss of this potential child, and the loss of my pregnant state.

I knew I was a mess, that I had to heal myself. I decided to go camping on Lake Superior, which was a special place for me. So I rented a car and took off, spending my last cash. I remember the first night I was away. I went to bed because I was in so much pain. I didn't

know if it was physical or emotional and I didn't care.

I woke up in the middle of the night. I felt like the soul of the fetus was telling me it was okay, not to be so upset. Then I felt I must be crazy because I had a departed soul coming to speak to me. I didn't tell Paul or anyone else about this experience for several months because I thought they would really think me crazy.

Anyway, I began to recover, but it wasn't fast enough for me. I would think I was together, and then I'd find myself in tears again. I looked at everything I could find written on abortion and the emotional aftermath. I knew I was grieving, and I also knew that I was clinically depressed. But how long was this going to last?

Well, like every grief it took time. Time heals. Gradually I stopped crying so much. I found that once I hit six weeks I was much better. But every time I got my period for the next seven months I would say "I would have been four months pregnant," then five, and so on. I searched out everyone I could to find out other women's experiences. I discovered that the two dates women remember are the expected due date, when the fetus would have been born, and the date of the abortion. I knew I wouldn't be out of the woods until I hit that nine month period. Sure enough, I was very sad around that time, but after that I felt relieved that I had made it. My time was over.

I'd like to say that I'm through grieving. Once the nine months were over I was okay. But I remember. It's there on my soul. The pain is less, but it's still there.

NAOMI: After the abortion, I felt like a trapped animal. It seemed that all that anyone else was interested in was what birth control was I going to use? I was angry at the medical and scientific professions. They offered me two alternatives, chemicals or seemingly unreliable barrier methods. "I'm putting you on the Pill. I'm not doing a third abortion on you, young lady," said my male gynecologist. "Drug her and keep her sterile" — that's what I felt they wanted. I was fitted with a new diaphragm and took home literature on the cervical cap, the Pill and foam and condoms.

HEATHER: I was so freaked out that barrier methods obviously didn't work for me that I chose to go on the Pill for

six months. I knew I couldn't handle another pregnancy and all the decision-making in such a short time. I had been on the Pill ten years ago and had had side effects. Also my age and family history meant that I was high risk to be on the Pill. But the risk of getting pregnant was worse than the long-term effect of the Pill and all the side effects.

We have changed to condom and foam and I still freak out every month until I see my period. I feel like a rabbit, that I could get pregnant so easily. That fear does wonders for your sexuality. I'm interested, but I think about it every time. Where am I in my cycle? What are my chances this time?

A lot of women have told me that they are afraid to make love after having an abortion. There is the real fear of getting pregnant, of what doctors will say if you come in for a repeat abortion. That's real. There's also what you say to yourself, "I've made a mistake once, I just can't do it again." I think it's a lot of the old "good girl, bad girl" stuff. That no matter how liberated we think we are, no matter how much we think it's okay to be sexually active, when we get caught the morality of "sex for procreation and only in marriage" catches up to us.

NAOMI: After my first abortion I remember thinking I'd rather abstain from sex permanently than get pregnant again. It wasn't worth the risk. The abortion definitely put a strain on the relationship. Imagine the all-too-common scenario: I sleep with this man every night. We love each other. But I wouldn't let him touch me; the whole situation was too painful to discuss. It becomes a Catch 22.

HEATHER: I found that I had to convince myself that I could have intercourse. Since I was on the Pill I knew I wouldn't get pregnant again, but my interest in sex was down, partly because I was depressed and partly because I was on the Pill. Paul was patient but it took time.

NAOMI: Time seemed to be the only consistent reality. It dragged while I was waiting for the abortion but it worked positively afterwards. We got over the emotional trauma simply by living through and working through it for a prolonged period. There's a substantial difference in our relationship because we've made it all the way through.

HEATHER: After going through the

abortion and the grief I feel more solid with Paul, and I trust him. Having gotten through this experience, I feel we can get through anything.

NAOMI: Michael was definitely the most important person through this experience. The women I talked to weren't all that supportive of my feelings. In fact some of them were cruel, telling me not to be so upset. After all, I had chosen this. I was young. I could still have children later on. Basically what they were saying was that they didn't know how to deal with what I was going through. I ended up not even telling one close friend because I couldn't take one more rejection. I was beginning to feel ashamed of being ashamed that I had had an abortion.

HEATHER: Yes, exactly. I felt I wasn't allowed to express my grief, because I had *chosen* to have an abortion.

NAOMI: No one seemed to understand that a decision could be weighted to one side, but still filled with grief and uncertainty, that the decision to have the abortion wasn't the end of it all.

HEATHER: I remember being angry at the feminist movement, which I am wholeheartedly a part of. I didn't expect such an emotional experience, especially the grief. I felt guilty and ashamed that I was so upset. We don't talk about the grief and the angst because we're afraid the Right-to-Life will use it against us, saying "See, so many women have a hard time with abortion." But still I felt betrayed that abortion was made to look like an easy decision, and it wasn't for me.

This experience hasn't changed my position on abortion. In fact, I feel more committed than ever to every woman's right to choose what's best for her. But I'm much more aware of the depth of feelings involved. Abortion is an emotional experience, not just a political one.

NAOMI: The abortion issue is topical, it's a political issue, and we forget that it affects individual human beings. It is a complex process; it's not black and white. Too many women go through it alone. We don't need only the choice. We also need support and compassion and the right to grieve.

Heather and Naomi are pseudonyms for two women living in Toronto



MIDWIVES & HEALERS *the Newfoundland experience*

by Cecelia Benoit
illustrated by Mary Firth

I was raised

in the Stephenville area on the west coast of Newfoundland. I am one of eleven children, ten of whom were born at home with the local midwife attending. I have vivid memories of our midwife making her rounds in the community. She was one of the village's most important and respected people.

At university I became involved in women's issues, but adopted a rather simplistic notion of women as perennial victims of a male-dominated society (if they were not involved in the women's movement). Armed with this theoretical approach and a tape recorder, I studied the role of mothering in a Newfoundland community and wrote an M.A. thesis which was on the whole bleak and lifeless. The women in my study were only partly real for I had left out the positive aspects of their lives.

I realize now that what was sadly lacking was a detailed picture of the history of Newfoundland women. But how was I to reveal what had so quickly become buried since industrialization? I went back again to the people and asked them about women in outport Newfoundland. Over and over again they told me about the midwife and her special role in their lives.

The concept of

"midwife" as it is usually used today — a woman who assists another woman in childbirth — severely limits our understanding of the community approach towards health which was characteristic of midwives and village women in Newfoundland and Labrador prior to the takeover of modern medicine. On the Island and along coastal Labrador, (and I suspect in other rural societies as well) the role of midwife was a many-faceted calling. These women were vital to the village community, not only as assistants to birthing women, but also because they were indispensable to the other members of their isolated society, the young and old alike, of either sex. In the words of one man, Phil, whose mother had been a midwife practicing in Conception Bay:

She was the midwife, an' she was the nurse ... She made her own medi-

cines. The government paid her nothin'. She was jus' there on call for any, any family who wanted 'er.

According to Gertie Legge, from Heart's Delight:

She understood sickness and set bones and everything, even did animals.

In 1949 when Newfoundland united with Canada, there were about 1,500 rural communities or outports scattered in isolated places along the rugged coastline or on islands. Most of these communities had less than 300 residents. There were no modern facilities, such as telephones and electricity, and most roads at that time were not much more than cowpaths. Outport people, when they did travel outside their village, (for example, during the fishing season, to seek work in the lumber woods, or to purchase supplies and food staples such as flour, tea, and molasses from the merchant store) used the sea as their highway.

The women rarely left their village and spent their lives working "at the fish" (curing cod fish for winter consumption), tending the gardens and farm animals, gathering berries and wild plants and, of course, caring for their families. In most villages there existed a sharp division of labour between the women and men. Even the men would readily admit that the women kept the household and village together.

Few villages had their own minister or priest nor was there usually a resident doctor or trained nurse. Prior to the establishment of the modern hospital system, doctors, trained nurses, and emergency medical facilities were in extremely short supply. The modern facilities that did exist were almost exclusively located in the capital city of St. John's. In 1933, for example, there were only 83 doctors, of whom 33 were situated in St. John's. This meant that there was one doctor for approximately 5000 people. The nursing situation was equally precarious. In 1934, for example, only eight communities could afford a trained nurse.

The diet of the majority of the people was simple and limited, especially during the long winter months when staples were difficult to come by and fresh foods rare. Families were large (ten or more children was considered normal), houses were uninsulated and inadequately heated with drafts a perennial problem. However, as the people

point out, no one starved. Villagers were expected to help each other out during times of hardship or family crisis. There existed a kind of informal barter economy in most villages which meant that no person was left destitute. Neither did anyone become wealthy. The greatest peril of most villages was the contagious diseases and fevers which were initially carried to their communities by foreign supply boats or man-of-war ships. During the first half of the twentieth century, Newfoundland and Labrador had the highest rate of tuberculosis on the North American continent.

In spite of this rather bleak picture, outport communities were not unprotected from illness. Each isolated community pooled its resources, developing a rational way of dealing with the health concerns of its residents. Healing knowledge, learned by a process of trial and error, was passed on through an oral tradition. Many techniques for curing illness were practiced: setting bones, mending wounds, employing poultices and plasters, using tonics and brews, practicing massage and so forth. Although some older men did practice as healers, none attended childbirth and few had the central role that the midwife had in most villages.

According to oral accounts, those women who became midwives/healers had certain character traits in common. Midwives were generally older women (40+). There were a number of reasons why this was so. During this period people associated old age with wisdom and respect. They believed that only after persons had lived through many trials and life crises, and had demonstrated their ability to meet these problems in a rational manner, could they be trusted with the job of village healer.

Midwives were always mothers and usually widowed. The villagers believed that only a woman who had experienced childbirth could know what another woman was going through when she was giving birth. In the older, widowed mother, they saw someone who was aware of the daily health concerns of the household. Moreover, she had experienced the death of her husband and thus had passed the test of endurance of one of life's greatest trials. Villagers no doubt felt a mixture of concern and respect for her, seeing the role of midwife as a way for her to make a living for herself and her children.

But to be a widowed mother was not enough. The midwife had also to express a strong desire to perform the duties of midwife/healer. She had to express an inner "calling" or deep "feeling" for her community role. In one sense this feeling was an extension of her mothering role. Yet it was more than this. Long before she set out on her own as an independent healer, the midwife had to demonstrate to the local people that she *liked* to care for them, that she was willing to go to them in times of sickness and that she desired to attend women in childbirth. The meager monetary reward that the midwife might receive for her work was perhaps the last reason why she undertook her role as village healer. In fact few of these women received money for their work, accepting instead compensation in kind or sometimes just tending to the sick "out of the goodness of their heart." The midwife Aunt Ri from L'ance au Loup on the Labrador coast recalls:

I received one five dollars once, and that was for a month's work in Pinware. Usually it was only one dollar, sometimes nothing at all.

(Aunt Ri attended people between Pinware in Labrador and Long Point in Quebec, a distance of 30-35 miles.)

The people were well aware that the midwife attended to their health care needs for other than monetary rewards. In fact, midwives were treated by everyone as their close kin, called "aunties" or "grannies."

One final characteristic which these women had in common was that they were uneducated. Like others in their communities, few midwives could read or write.

In contrast to the method of recruitment of health professionals in the modern era, via formal schooling and clinical training, these rural women learned their art of healing either by informal apprenticeship with an aging midwife or perhaps by going about with their mothers or female relatives who were experienced in the practice of midwifery and healing. One midwife, Aunt Mary-Ellen, who lost her husband at sea, described to me how she learned her art of healing from her mother:

I first learned to doctor the people by going about with my mother who was also a midwife. We would go out during hay-making time and pick seeds

and dry them. I learned how to steep a caraway seed brew for a new child. Or if a youngster had "summer complaint" (diarrhea), we would use a brew of yellow root. Sour duck seeds made a healthy drink for anyone with fever. And I learned to give new mothers a nice drink of senna tea after the birth of their child ... My mother was still smart at the end, but getting blind when she gave up and I took her place in the village. People after that used to come to me with their problems and, of course, I always went to visit the sick, and when a woman was nearing her time, I'd be there at hand. The people I nursed were really close together; they trusted a woman like me over a stranger from some foreign part.

Sometimes a midwife would get her first opportunity to practice on her own when the older midwife was already engaged. Clara Tarrant, a midwife from St. Laurence, who practiced until the arrival of the hospital to her village in 1953, describes her experience:

I got into a situation when I just had to and there was nobody but myself. I had been at a birth and had seen deliveries and I had children. Seeing is believing, but feeling is the naked truth. So you knew what it was all about when you had some yourself.

Not all women, however began their practice of village health-care by assisting a woman in labour. Flossie Noble, a midwife from Curling on the west coast of the Island, recalls how she first felt a calling for her future role during a time of family crisis:

When I was thirteen years old, my mother had pneumonia. She was unconscious and she used to go: "Aaah, aaah". She had such a fever; she was in [an] awful condition. I kept bathin' and bathin' her. With a little bit of boric acid in the water, bath after bath. She was burnt up with fever. But she got better ... I went to Boston an' I had three months training of midwifery. Well, I got the details. I think I was born to be a nurse.

Regardless of their path to recruitment, each midwife had to meet the expectations of her community. Usually an informal process of selection took place over a number of years. Irene Bradley who practiced in the area of Eastport, Bonavista Bay, describes how

she was chosen:

I always enjoyed public life and community work and at an early age I started visiting the sick and aged. My life ambition was always to be a nurse ... I learned some things about obstetrics from my mother who had also been a midwife. I delivered several babies in emergencies ... Then, knowing that, Dr. Smith (who travelled to numerous villages scattered along this stretch of the coastline) came to me to help him out. When I asked him how he came to pick me, he said that he had asked questions and that I had been recommended by several people. So that's how it all started.

These women did not hold a monopoly over the existing health knowledge nor did they consider themselves a class above the common folk. They were of the same social status as the rest of the villagers, and were always willing to share their limited expertise of curing practices with those whom they treated.

Because the midwives were mothers themselves, they had first-hand experience of the fears and pains as well as the special joys of being a woman. Like most other women in their community, they knew what it was like to be frequently pregnant and a mother of a large family. They believed that sympathetic understanding, encouraging words, a lot of touching, and gentle rubbing and stroking were the best tools for getting through life's natural hurdles. Hence they prodded their fellow-villagers to engage in self-care as much as possible, knowing well that, as one midwife put it, "an ounce of prevention is better than a pound of cure". Yet when the villagers really needed some extra help they knew that the midwife was close at hand.

The people remember these women with genuine warmth, often reminiscing how the local midwife could be seen coming down the outport road in her large white apron, with her black nursing bag under arm. Gertie Legge, from Heart's Delight, says "She was jist like an angel in 'er white smock". The contents of her black bag — a pair of scissors, cord ties, cotton wad, perhaps eye drops for baby, lotion, herbal mixtures, and, for Catholic midwives, a bottle of holy water to spread about the home in order to ward off any evil spirits lurking about.

Apart from her

own family duties, and her treatment of the various illnesses of the villagers, the midwife was expected to be available whenever a birth was imminent. In some instances the midwife might visit the expectant mother in her own home beforehand in order to check for possible complications. Few women remember such formal visits, however. Instead they recall meeting the midwife in the village, perhaps at the church or merchant store or during a knitting or spinning frolic. Information concerning pregnancy was often given by other women as well, perhaps when they were involved in their various productive activities — collecting berries, gardening, hay-making, working at the fish, and so forth.

These midwives were well aware that the majority of women can give birth naturally, without complication for either mother or baby. In those cases, however, in which problems were anticipated (such as breech birth), most midwives did their utmost to see that the expectant mother received special medical attention. There are numerous accounts of midwives accompanying a sick expectant woman for many miles over rough terrain or stormy seas, to a hospital or nursing station where a doctor or trained nurse could be sought out.

If all appeared well, the midwife would caution the expectant mother on how to prepare for the birth itself. Prior to the beginning of the "lying in" period (usually a period of ten or eleven days, from the onset of labour to "up-sitting-day"), a special birthing room had to be prepared, away from the main routes of the household traffic, and warm and dry in winter. Birthing sheets, layers of paper covered by a clean white sheet, were made to collect any blood and the afterbirth, and to provide protection for the mattress. A clean sheet had to be secured to catch the baby at delivery time. Baby clothes had to be made. Finally, a cradle had to be set up. James Carroll from Makinsons remembers that "Cradles were good and clean and every bit of the house was crystal clean waiting for the child".

If a new mother could not afford to pay for these various necessities, then either the midwife supplied them herself or, typically, the village women pooled

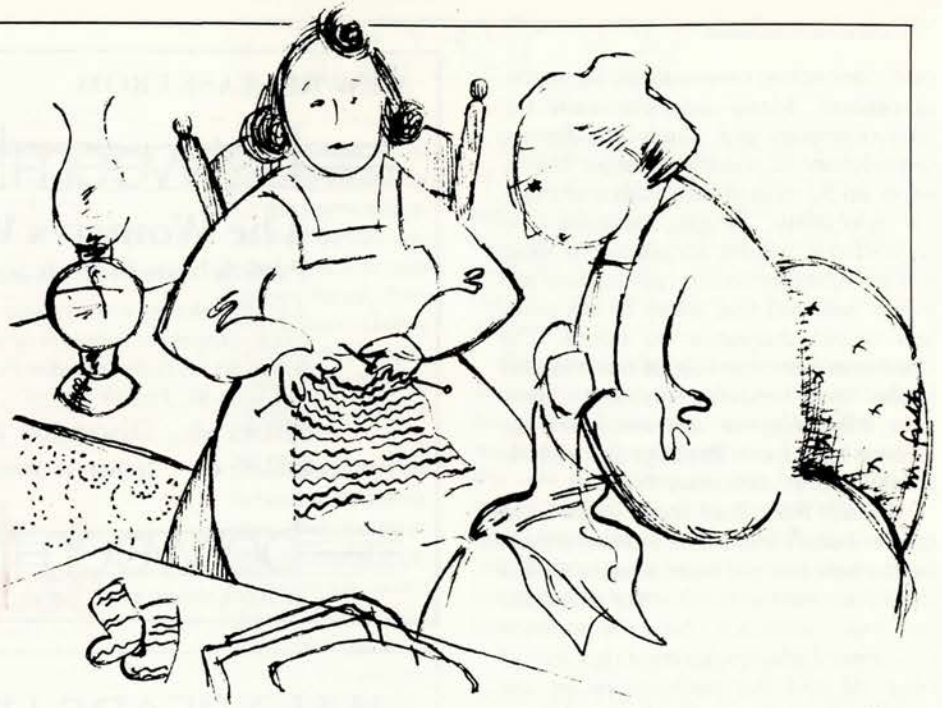
their skills and material resources and came to the mother's rescue. Aunt Mary-Ellen recalls how the women's network operated in her community:

Whenever one of my mothers was due, we all gave her clothes for the newborn that our little ones had grown out of. Often we'd also have a 'bee' to make quilts and diapers and knitties out of a piece of flannel or leftover things. Of course, it wasn't fancy but it served the purpose well.

Midwives had to be prepared to attend a birth at any time, day or night, and in all kinds of weather. They had to take themselves to the birthplace which was often 20-30 miles away.

The midwife was an advisor to the labouring woman; she counselled the expectant mother on when to anticipate pain and on how to cope with it. According to Aunt Clara Tarrant, "They had their minds made up to it, human nature being what it is. It came naturally". During this emotional (and potentially dangerous) time of childbirth, the midwife brought compassionate understanding and reassurance to all involved. She would examine the woman by palpating her abdomen with both hands. If the labour was imminent, and if there were no problems, she would encourage the woman to move about, perhaps to do a little light housework together. Most women continued to move about during contractions and would sometimes lie down when they temporarily subsided. Gertie Legge explains: "You'd be all over the place. You wouldn't be able to stay in bed sure. You'd have to move about". The midwife encouraged the woman to adopt the birthing position most comfortable to her, whether on her side, on her back, supported against another woman or in a sitting or crouching position. Aunt Elsie Piercey from Hopeall recalls how she preferred not to give birth in bed at all: "I'd kneel on the floor with my arms over the back of the chair".

The midwife had a spiritual role as well. After the birth she was expected to offer words of thanks, such as "God bless the baby". She then gave the infant to its mother for its first feeding. Catholic midwives would often place a blue medal on the infant in order to ward off the "evil eye". If the baby had a birthmark, it was the midwife's duty to cross the mark three times with her wedding ring to "bless it away". The



midwife would then see that the birthing sheets were disposed of. Aunt Clara Tarrant describes this ritual:

It was a very private affair. The burning was seen to by the midwife, that was all part of the performance. There was never a speck of anything to be seen.

Of course, the midwife seldom coped with childbirth alone. Almost always she was accompanied by a helper and she also received help from the neighbouring women. As Aunt Mary-Ellen, who told me she assisted well over 500 deliveries, puts it:

There was always other women from around coming and looking out to things that needed to be done. No one starved, let me tell you, when a woman was lyin' in.

On the last day of the lying-in period, traditionally referred to as "up-sitting-day", the neighbouring women, accompanied by the midwife, would gather in the house of the new mother for a cup of tea and sometimes a piece of "Groaning Cake", often prepared by the woman's husband. This mini-celebration was seen as a token of appreciation given by the new mother to the women who had offered their assistance. If she could afford it, the mother would also give the midwife something special in payment for her services — perhaps a piece of cloth, some fish or, if available, a little money.

Finally, about a month or so after the baby's birth, or whenever a minister or priest would visit the village, a public celebration would take place in the form of a christening. Baptism was believed to further protect the child from the "evil eye" and its godparents were expected to guard the child in case of misfortune.

In the isolated

areas of the Island and along the Labrador coast, the midwife practiced her art of healing relatively unaffected by the outside world until the early 1960s. These women would no doubt have appreciated access to emergency medical services, which would have made it possible to combine their own caring skills and intimate knowledge of the local people with the positive benefits of modern medicine. But they found few doctors or trained nurses willing to adopt such a strategy. As Aunt Clara Tarrant puts it:

A doctor's work didn't seem to be in that then. Some of them ... didn't know too much about maternity either. Didn't want too much to do with it.

Ultimately, childbirth and most other life events (including aging and death) came under medical control. The scientific age arrived in most outports at roughly the same time as roads were

built connecting communities to regional centers. Many outposts were uprooted entirely and whole populations were forced to resettle in larger towns, serviced by modern hospitals and medical specialists. People, regardless of their status, gained access to the modern government health-care system and it was believed that every health problem would thereafter be cured. The once indispensable role of the midwife/healer was rendered obsolete. However, this "progress" also involved a significant loss. Irene Bradley, the midwife from Eastport, describes this loss:

I really think that some ways were better. I don't think that women should be cut unless it is a must to save a life. I think that there's too much of that done and that people don't have the patience anymore. I always believed that lots of olive oil and the patience to let the mother do it slowly gave better deliveries. Nowadays the hospitals are in too big a hurry to get it all over with and the mothers are being torn up.

Or, as Aunt Mary-Ellen told me:

Now the doctors are operating for this and that. Everyone seems to have their womb or some organ missing. I don't know, we were good for the people in many ways. I sometimes think that my homemade remedies and how I cared for the people were real good medicine.

This article owes a great deal to a number of people. I would like to thank Women Healthsharing for their comments and assistance in writing this article. Special thanks to Phil Hiscock for access to material in the Folklore Archives at Memorial University, St. John's, to Sheila Wilson for interviews with people in Trinity Bay, and to Barbara Doran for her paper on midwifery. Hilda Chalk-Murray's More Than 50% gave me valuable information on aspects of birthing in outport Newfoundland. It was a good experience to knit our collective knowledge together to gain a deeper understanding of the history of women healers.

Cecelia Benoit is presently working on her Ph.D. in Sociology at the University of Toronto, and plans to do further research on women's health.

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WHO READS HEALTHSHARING

You do, of course, but who else? Are other readers like you? Are they like us, the members of the collective? Until recently we each had our own ideas about who Healthsharing readers were, but we had little definite to go on.

Now, because of your answers to our Readership Survey (March, 1983), we can tell you a little about who reads Healthsharing.

Nearly all readers are feminist. Many are socialist, pacifist or active in environmental issues. Most women are employed in education or health care services, or are working maintaining their homes. Most of you have a college or university degree. Nearly all readers' incomes fell within the \$10,000 to \$40,000 range; so on paper at least, that gives you an average income of \$25,000.

Readers tend to live in cities, and with one or more people. Most of you exercise or take part in some sport on a regular basis. You buy vitamins, bulk foods and whole grains. We don't know anything about your favourite restaurants, but we do know most readers seek out women's books, music and art. Women without children out-number

mothers.

Almost half of you found out about Healthsharing from a friend, and 93% of respondents have subscriptions.

Over half of you read Healthsharing cover to cover every issue. Favourite columns are Newsfronts and Healthwise, with Reviews and My Story, Our Story following close behind. Respondents want to read more about nutrition, mental health, feminist health care alternatives, holistic medicine, reproductive health and violence against women. They don't want more fiction.

A rough picture of the 'perfect article' emerged: it contains general information or research findings; it's analytical and political, is about four pages long, and is not overly technical, theoretical or superficial.

A readership survey can only tell us the most general of information. Please keep in touch, share your opinions; write us letters, for publication or just for the collective to read. We want to hear from you and so do the other women who read Healthsharing.

MY STORY, OUR STORY

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

Powerless in Hospital

by Marlene Pyykko

When I became pregnant in the summer of 1981 I immediately began reading whatever I could find on pregnancy and childbirth. I decided to give birth in a hospital because I was nervous about unforeseeable complications during delivery. My husband, Garry, and I attended a prenatal course at a community clinic where we learned the Lamaze method to help relax during labour. The ability to relax and trust in one's body are key elements to a good birth experience.

Before my pregnancy I had always been a "good patient". My relationship with my GP, Dr. N., was warm. Seventy per cent of her practice was obstetrics and I felt I could trust her to carry through with the type of childbirth that would suit me both medically and emotionally. Dr. N. was responsive to my requests to give birth in a labour bed, and to avoid medical interventions if labour progressed normally. Garry and I were confident that we would have the care we wanted and needed.

On the morning of my due date, I experienced mild contractions and at 2:30 p.m. my membrane ruptured. Concerned about the risk of infection thought to accompany membrane rupture, Dr. N. insisted I go to the hospital. Although Garry and I would have preferred to remain at home for much of the labour, we decided to go to the hospital.

Garry and I worked to create a relaxed atmosphere in the hospital with soft lighting and classical music. The mood was interrupted by the chief resident, Dr. M. He told me I was not dilating quickly enough. He wanted to stimulate my contractions by breaking the membrane as he doubted the membrane had broken. He pressured me repeatedly and when I told him I wasn't ready to take that step, he got angry and stormed out. I tensed up after his visits. I began to lose control. From 8:30 when my problems began with Dr. M., until around midnight, I didn't dilate at all.

Shortly after Dr. M.'s last visit at 10 p.m. my doctor called. Her motherly attitude and respect for me were dropped in favour of an authoritarian approach. She was enraged that I would challenge the medical procedures, despite this being a normal labour. Garry spoke with her when I could no longer, but Dr. N. hung up on him when he put the phone down to help me with a contraction.

I was shocked and distressed by this reversal in Dr. N.'s behavior towards me. I felt betrayed by her and, being in conflict with one's doctor during labour, feelings of panic and desolation overwhelmed me. Nothing was clear and I felt very much alone. My contractions stopped for a full hour after the phone call and we were worried that my dilation would not resume because of the extreme tension I was experiencing. The mood and sense of control which we had worked so hard to create was destroyed. We understood that we had to change our expectations; it wasn't worth the conflict to insist on what I had wanted; we had to keep the experience from becoming disastrous.

When my contractions returned they were very intense and painful. My confidence had been broken and the breathing techniques didn't help. I clenched up during the contractions, unable to relax at all. Time moved incredibly slowly. After 1½ hours of this a new nurse told me I was still only 4 cm. dilated. I asked for an epidural because I knew I couldn't continue like this all night. Twenty minutes later when Dr. M. came in to authorize the epidural I was 5 cm. The nurse's calculations had been inaccurate, but at least I was dilated enough to receive an epidural. (An epidural cannot be administered too soon in case the relaxing effect slows down the labour even more.)

The epidural was an incredible relief. The physical and mental calm I experienced helped us salvage our positive expectation of the birth.

We heard Dr. N.'s voice from down the hall but she didn't come in to the labour room to see me. She and I met in the delivery room when she chatted amiably with the nurse. It was clear that there was a break between Dr. N. and myself, but we kept it under the surface while we still had a job to do together.

The nurse, who allied herself with Dr. N., refused to turn off the overhead light when I asked and insisted that my legs be tied in the stirrups. I didn't argue with her because I certainly didn't need further tensions. After 3 hours I felt a slight urge to push.

Repeatedly throughout the evening a nurse came in to check the baby's heartbeat. It was strong and healthy — no cause for any worries. This nurse, the one reassuring person I met at the hospital, told us that everything was normal and that I had until 2:30 the next afternoon to deliver the baby (i.e. 24 hours from when the membrane had broken).

Pushing the baby out was more strenuous than I had expected, but forceps were not needed and only a small episiotomy was done.

My beautiful sticky, purple little girl was born at 4:45 a.m. on April 3rd, 1982. A few minutes after she was born I breastfed her, and Garry and I spent a half hour alone with our new daughter, Cora.

I spent the next 2 days in the hospital. For a 'family-centered' maternity ward I found the atmosphere remarkably un-family-centered. I didn't enjoy fitting in with the hospital's schedule, so I left sooner than the staff or Dr. N. wanted.

This experience, by combining the intensely beautiful with a despair brought on by others, has contributed to a positive change in me. I know I that I must be much more active in maintaining control in my interactions with people and institutions who attempt to have power over me. I no longer see my difficulties as personal, relating only to myself. Now I am meeting women, forming alliances and finding ways to speak out. At 30 I am learning that my humiliation and struggles are not unique.

Marlene Pyykko lives in Montreal with her husband and 20 month old daughter and is currently studying creative writing and women's studies at Concordia University.

Filling Up With Fibre

Reviewed by Jo-Ann Minden

The F Plan Diet, Audrey Eyton, Bantam Books, Toronto, 1983, \$13.95 hardcover.

Audrey Eyton's *F-Plan Diet* is worthwhile reading for dieters and non-dieters alike. Its 236 pages provide information on the importance of fibre in the diet, the advantages of a high complex carbohydrate/low calorie diet, what foods contain fibre and in what quantities, and how to prepare and incorporate fibre into your daily meals.

Fibre is that part of the plant cell-wall which does not get digested by the human digestive tract. It is present in varying amounts and in different forms in all whole grains, legumes, vegetables, and fruits. It is not present in meat, poultry, fish, or dairy products.

Eyton's Plan is based on the fact that any diet must limit calories, and one way of consuming less calories is by eating fibre-rich foods which fill us up faster and control our hunger from one meal to the next. She claims that weight-loss

is quicker on a high-fiber diet than on a normal diet, because more calories are excreted along with fibre, due to less efficient digestion in general. This does not mean, of course, that one cannot overeat on a high fibre diet, in which case weight loss could be slow, or weight could even be gained. She does not exclude meat, fish, poultry, or eggs, but includes small amounts of these foods with foods rich in fibre.

Fibre begins its "magic" wonders in the mouth. The bulk and texture of fibre-rich foods necessitates more chewing, automatically slowing down eating and increasing the flow of saliva, which adds bulk to the food. The rate at which you eat is a crucial element in weight control, claims Eyton. Rapid eaters consume more calories in the twenty minutes or so that it takes our stomachs to feel full after commencing a meal.

Fibre-rich food stays in the stomach longer than fibre-depleted foods, thus holding off hunger pangs that so often occur shortly after a meal of refined carbohydrates.

Fibre found in vegetables and cereal grains absorbs large amounts of water during digestion, thus increasing the bulk of the food. This increased bulk makes for rapid, easy passage through the colon or large intestine. There is some speculation that this rapid elimination decreases the exposure time of possible harmful bacteria, and may reduce the risk of colon cancer. Constipation and other intestinal ailments have also been successfully treated with fibre in the diet.

The importance of fibre in today's diet is well-documented and is becoming common knowledge. What is perhaps useful about this book, is that it provides a healthy framework within which to lose weight and reduce the risk of lifestyle and diet-related diseases, such as heart disease, atherosclerosis, diabetes, and intestinal cancer.

Dieting is a difficult endeavour for most people. It is made complicated by long-established eating patterns, psychological and physiological factors, as well as a glut of diet information ranging from gimmickery to downright quackery. The popularity and quantity of fad diets that appear each year, testify to the fact that people want dieting made as easy, quick, and painless as possible.



Workbook / cpf

Alas, few of these so-called revolutionary methods seem to keep those pounds off for much longer than the duration of the particular diet.

Although Eyton's main audience will probably be chronic dieters, and although she also makes claims for her diet as being faster, easier, and more effective than other diets, I feel this book makes a valid contribution to nutritional information for today's consumer. Eyton calls for a reduction in fats, sugar, and other refined carbohydrates, as well as an increase in a variety of foods containing fibre, all of which is recommended by major nutritional authorities today. This book is useful to people who want to lose weight and also for those who want to maintain their weight and health. Charts and tables provide a guideline for selecting a wide range of high fibre foods.

A cautious approach to any popular diet is advisable. Variety and the proper balance between protein, fats, and carbohydrates are key factors to look for. *The F-Plan Diet* is to be commended for its attention to such details.

Jo-Ann Minden is a student in Foods and Nutrition at Ryerson Polytechnical Institute, Toronto and is currently working with Healthsharing.

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**AUDREY EYTON'S
Extraordinary**

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PLAN
DIET**

**LOSE WEIGHT FAST
AND LIVE LONGER**

No Cesareans Happily Ever After

Reviewed by Patricia Holtz

You Don't Need to Have a Repeat Cesarean, Nicki Royall, Frederick Fell Publishers, Inc. New York, 1983.

"In the not too distant past, when most mothers were anesthetized for deliveries and most fathers were not present, there was more similarity between a vaginal delivery and an unplanned cesarean. The elements of teamwork, seeing the child's birth and everyone staying together afterwards were missing from both experiences. When these elements are expected, however, and a surprise cesarean comes instead, a woman may find herself grieving for a lost dream."

In pursuit of her dream, author Nicki Royall found a sympathetic obstetrician and set out to have her second child vaginally (her first child having been delivered by cesarean section after labor failed to progress). This book chronicles that pregnancy through to successful vaginal delivery. As well, the author briefly discusses the cesarean birth rate, the surgical procedure, the psychological impact of cesarean surgery on mothers, and gives short case histories of women who have had vaginal births after cesareans (VBAC).

The book is simply written, structured in a fairly practical way and unwaveringly enthusiastic in tone. And, to give the author her due, Royall does make some effort to look at the matter of vaginal birth after cesarean from the medical point of view as well as from the perspective of natural childbirth proponents.

Some of the guidelines offered here are useful, especially those which are essentially common sense and can be applied to preparation for any pregnancy. However, this book is likely to seem more substantial to those who haven't had a cesarean than to those

who have. The book lacks a detailed analysis of what the surgical process involves or what a second cesarean would entail, and it treats the various indications for a cesarean and for a VBAC only superficially. There is not enough information to satisfy the reader who has herself undergone a cesarean.

There is an almost fairytale quality to the writing that is potentially misleading. The style is so simple and pat that it is easy to imagine guidelines being misconstrued by a naive reader. (The author, who gained 45 pounds during her cesarean pregnancy decides, for example, that weight may have been a problem and so determines that she will simply eat less this time. Fine — in moderation, and with educated, medically-oriented supervision, if only the author would caution the reader.) Repeatedly, Royall slides back to the happily-ever-after refrain (which happened to be true in her case, but is not true in every case): you don't need to have a repeat cesarean.

Where there needs to be substance, the author falls short, contenting herself with smooth generalizations that do little to advance her basic contention. Certainly, there is substantial support for the argument that not all cesareans are necessary; it is just that this book does not manage to argue the case for VBACs — or, for that matter, against repeat cesareans — as soundly as it might have.

In one telling passage, Royall recalls her final Lamaze class, where she and her equally pregnant classmates were asked to imagine the best and worst outcomes of their deliveries. Worst on their lists was delivery by cesarean, followed by infant death, maternal death, deformity and illness. She devotes considerable space to relating the feelings of failure and depression, of "unwomanliness," of "being cheated" which she and other cesarean mothers experienced. All of this may nearly move the woman who has taken a cesarean in stride (however much it is possible to take any major surgery in stride) to feel that she is unwomanly or has failed simply by not seeing her cesarean as a personal failure.

The goal is first and always to safely bear a healthy baby. To plan one's

**YOU DON'T NEED
TO HAVE A
REPEAT**

Cesarean

by
Nicki Royall

With an introduction by
Camilla Spirn, M.D.

childbirth primarily as a political statement, a way of defining one's purpose in the world or as a celebration of the ego is foolish, selfish and immature when it does not take into account, or actively ignores, all the conditions that pertain to one's particular situation. To see any cesarean, every cesarean, automatically as an empty victory of the medical establishment over the natural processes is more than a little naive and in some cases dangerous.

No doubt, this book will prove useful and encouraging to many women who can successfully give birth vaginally following a cesarean. My lingering wish is that Royall's simple and enthusiastic writing had occasionally taken on a slightly more serious and responsible tone. It is too easy to forget that without cesareans some babies, and some mothers, simply would not live beyond delivery.

Patricia Holtz is a Toronto writer and editor. Her son was delivered by cesarean section.

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

Progesterone Not Approved for PMS

I wish to point out to your readers that, contrary to the impression given by Karen Walker in *Help for PMS* (Fall, 1983), the FDA has not, to date, approved the use of progesterone in treating PMS. Progesterone's use is approved for treatment of some hormonal imbalances, but the FDA has yet to complete even initial studies into its effect on PMS.

Gwen North
Sioux Narrows, Ont.

Womanpower

All stresses of living, of change, of growth are made more bearable, are kept in perspective when one is aware of and in touch with womanpower — power from within, power from good friends and such as you. Thank you. Your editorial (anti-cruise, Summer 1983) is especially direct and inspiring. We of course are doing all we can in Cherryville, Lumby, Vernon. The distance makes it just more of a challenge.

Leila Ward
Lumby, B.C.

Thank You

The Central Alberta Women's Emergency Shelter Society would like to thank all those shelters, transition houses, and interval houses who took the time and energy to fill in our questionnaires in the fall and winter of 1982-82.

We also appreciated all of the extra information given us, as the material submitted assisted us a great deal in formulating our policies and determining guidelines. The result of all this effort is that in September we will be offering service delivery to women and their children in crisis from a 16-bed shelter in Red Deer that has a 24-hour counselling staff and safe emergency accommodation. Contact us at: *Central Alberta Women's Emergency Shelter*, P.O. Box 561, Red Deer, Alberta, T4N 5G1; phone: 346-5643.

Insurers Put Home Birth at Risk

The following is a copy of a letter which Kootenay Parents sent to the Canadian Medical Protective Association (doctors' insurers) in response to a letter sent by that Association to doctors in Nelson, B.C. Kootenay Parents was formed in 1981 to promote public awareness and education regarding safe alternatives in child birth.

It has come to our attention that the Canadian Medical Protective Association recently has sent a letter to medical practitioners in Nelson, B.C. recommending they refrain from becoming involved with patients/parents who are planning home births. We understand that the reasons given for this recommendation are that home birth is not safe and that litigation is a problem.

As present and prospective parents in the Kootenay Region, we are deeply concerned and saddened that the association has adopted this position. In effect, your recommendation advocates a denial of medical services to a particular group of individuals who are exercising the legal and human right to give birth where and with whom they choose. We believe this is improper and irresponsible.

Home birth is an established cultural pattern in the Kootenays. It has been and is practiced by a significant proportion of birthing families and it is recognized and valued as part of family life by the community as a whole. In the past, many doctors have supported home birth by offering pre-natal care and emergency hospital services to families planning home births. In their professional and ethical judgement, families planning home births were entitled to medical care. As a result of the recommendation contained in your letter, some of these doctors now feel that they must withdraw their services to families planning home births, not for medical or ethical reasons, but because they are fearful of losing their insurance. It is our view that you are intimidating the doctors in our community to conduct their practices in a manner

which is not consistent with their own medical and ethical judgement. You are also threatening the continuing safety of home birth in the Kootenays, which depends on professional medical assistance, and you are interfering with the cultural patterns and identity of our community.

With respect to your claim that home birth is less safe than hospital birth, we suggest that there is no evidence to support this view. Indeed there is increasing evidence to show that home birth is at least as safe as hospital birth, and in many instances safer.

With respect to your concern about litigation, we would like to ask how many doctors are actually facing litigation as a result of their involvement in home birth and how this number compares to the number of doctors facing litigation as a result of hospital births. We would also like to know, in both cases, how many of the suits are brought by patients/parents and how many by other parties.

We have decided to send copies of this letter to a number of individuals, including politicians and the press, because we believe this issue should be discussed in an open forum. We hope there will be more and more open discussions about childbirth alternatives in which we can all participate.

Maureen Jansma
Kootenay Parent
Nelson, B.C.

NDP Push For Women's Committee

I was pleased to see mention of the NDP proposal for a standing committee on the status of women in the Summer 1983 issue. I agree with you that we need action. The lack of government action is a major reason why I am urging the establishment of a committee. While I do not believe that establishing a parliamentary committee will guarantee action, I do believe the committee would provide a mechanism women could use to demand accountability and action from Parliament. A parliamentary standing committee

would have the power to recommend the implementation of action to improve the status of women. It would provide a public forum for women across the country to exert pressure on the government for legislative and policy changes.

On International Women's Day, Judy Erola, the Minister responsible for the status of women, opposed the committee on the basis that divorce, pensions and childcare were "social issues" not women's issues. While I agree with the Minister that all Ministers and committees must be concerned with the impact of legislation and policy on women, a standing committee on the status of women would provide a focal point and a greater assurance that women's issues would in fact receive the priority they demand.

Margaret Mitchell, M.P.
Vancouver East, B.C.

Mutilation Understated

There are a large number of serious factual mistakes (in "Genital Mutilation," Summer 1983) that should be rectified. It is also very unfortunate that your readers are given no opportunity to inform themselves further on this subject and that you have failed to provide any reading list and/or a list of articles in other women's publications that are readily available.

Unfortunately, for somebody who has never heard of genital mutilation there are no health facts given on these operations that are life-long and do permanent physical as well as psychological damage; this in a journal that calls itself *Healthsharing*, yet you fail to share this most essential information that would put the whole article in a different light.

What is more, there is no mention in the article as to where the operations are practiced, another serious omission, nor is it stated how many women are affected.

Concerning the factual errors: (1) The article makes believe that excision does not cause frigidity; I refer you to the *Hosken Report*, chapter on health facts,

Printed and bound by union labour.

RESOURCES & EVENTS

Our Jobs, Our Health

This new book by The Massachusetts Coalition for Occupational Safety and Health and The Boston Women's Health Book Collective, is a good introduction to occupational health and safety hazards of concern to women. It includes information on recognizing hazards, job design, stress, toxic chemicals, workplace cancer, reproductive issues, hazard control, health and safety standards and legal rights (U.S.), taking action and further resources.

The cost is \$4.00 for individuals and can be ordered from Boston Women's Health Book Collective, Dept. O.H., Box 192, W. Somerville, Mass., 02144.

Rural Women

The Rural Women's Project is sponsored by The Prince Albert Women's Work Co-operative. It is working to establish links between women in rural communities in order to encourage the setting up of networks and informal associations. Part of this process will include connecting women to resources, assisting in planning programs or workshops that may better serve the special needs of women living in rural communities.

The Rural Women's Project office is located at #2-1109 Central Avenue, Prince Albert, Saskatchewan, or write Box 1356, Prince Albert, Saskatchewan.

Sterilization Booklet

A new 15 page booklet, *Sterilization: It's Not as Simple as "Tying Your Tubes,"* has just been written and published by The New York Committee for Abortion Rights and Against Sterilization Abuse (CARASA). The booklet explores popular ideas about sterilization and explains why sterilization is not always voluntary,

is not reversible or risk free, is not a solution for sexual problems or a cure for over-population.

Currently available in English and Spanish, the booklet sells for \$1.00/single copy, or \$.80/single copy for bulk orders of 10 copies or more, plus postage and handling. Order from CARASA, 17 Murray Street, 5th floor, New York, N.Y. 10007. (212) 964-1350.

The Second Canadian Congress of Rehabilitation: Call for Abstracts

The second Canadian Congress of Rehabilitation will be held in Vancouver from June 10-12, 1985. The theme of the Congress is "Sharing Expectations in Rehabilitation". The focus will be on original rehabilitation research and innovative rehabilitation programs and techniques. Abstracts for poster sessions and workshops are now being accepted. If you wish to participate please request a form which is to be returned with a 200 to 500 word abstract. The deadline for submission is March 1st, 1984.

Direct inquiries to: Canadian Rehabilitation Council for the Disabled, One Yonge Street, Suite 2110, Toronto, Ontario, M5E 1E5, Attn: David A. White.

The Media Book: Making the Media Work for your Grassroots Group

This book, written by The Committee to Defend Reproductive Rights (CDRR) in San Francisco, is a step-by-step guide to the "nuts and bolts" of media work. It de-mystifies the media and demonstrates how political groups with limited resources can effectively plan a media campaign. Included are real life examples from CDRR's own abortion rights media campaign.

Cost is \$8.00. Send to CDRR, 1638B Haight St., San Francisco, CA., 94117.

Midwifery Task Force

The Midwifery Task Force of Ontario is an organization working toward the official recognition of midwifery in Ontario. Membership in the Task Force is \$20.00 for individuals and \$25.00 for couples. Interested persons are encouraged to join one of the MTF committees, such as public education, fundraising, membership, legislation and lobbying, day-care or conference planning. Contact the Midwifery Task Force, Box 489, Station T, Toronto, Ontario, M6B 4C2.

Women and the Impact of Microtechnology

The report on the conference held in June 1982 is now available. The report contains conference proceedings, lists of films on microtechnology, bibliographies on women and technology in French and English, and networking lists.

Cost per copy is \$10.00, individuals; \$15.00 institutions. A limited number of copies are available. Order from Women and Technology Committee, c/o Lynda Barrett, 2782 Springland Drive, Ottawa, Ontario, K1V 6M4.

Women and Education

A special issue on *Women and Education* from Resources For Feminist Research/Documentation Sur La Recherche Feministe (RFD/DRF), includes up-to-date listings of women's studies courses and programs in Canadian high schools, colleges and universities, reviews of books relating to gender and schooling, extensive annotated bibliographies, a filmography, upcoming conferences, women's educational networks and much more.

Cost is \$5.00. Order from RFR/DRF, O.I.S.E., 252 Bloor St., W., Toronto, Ontario M5S 1V6.