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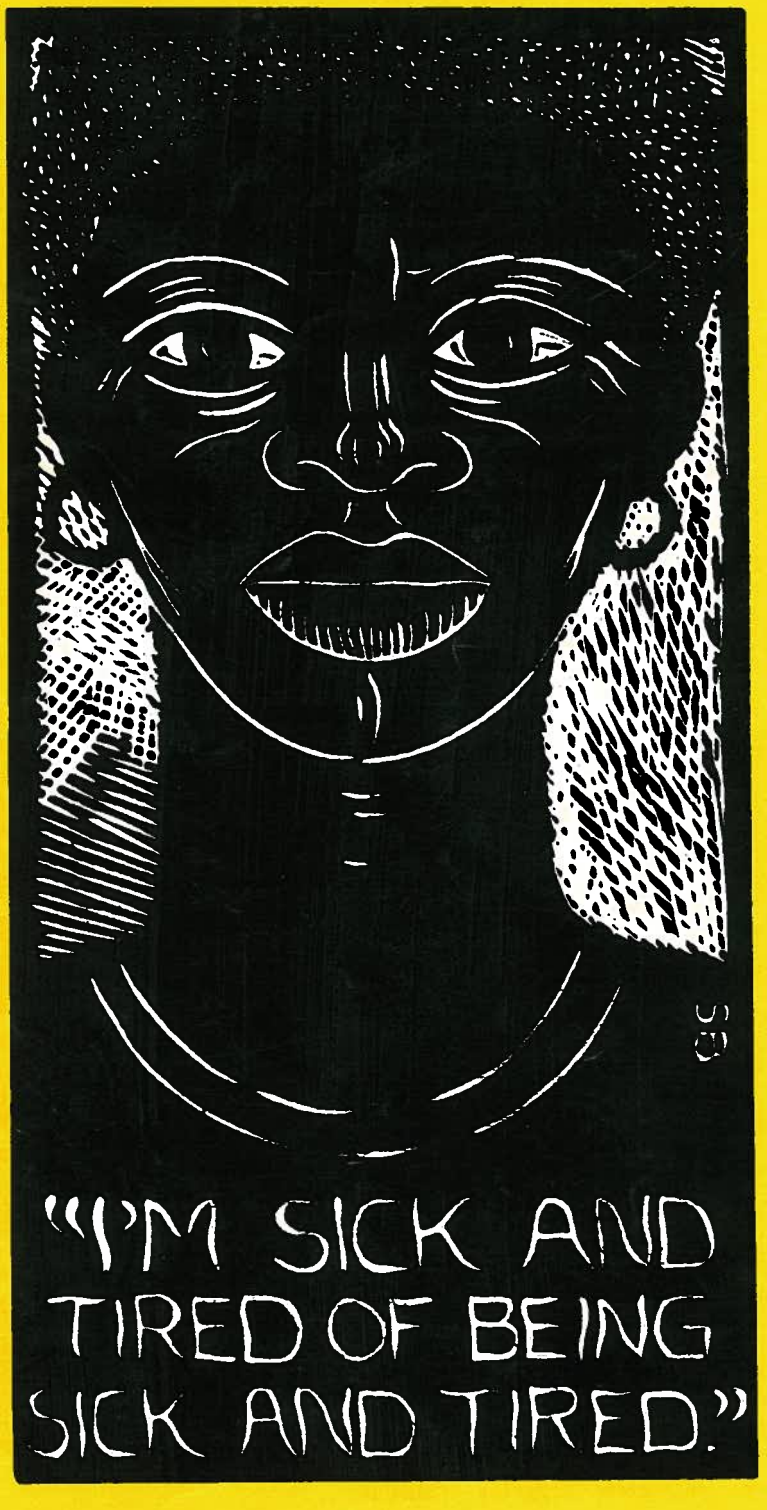

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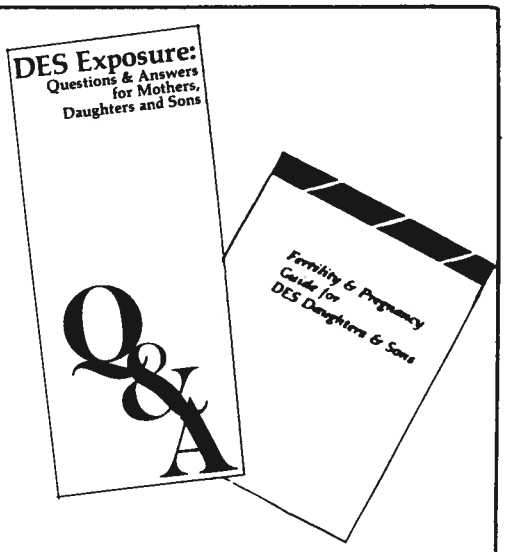

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COLLECTIVE NOTES

The Politics of Cancer

To wealthy Victorian women, tuberculosis was a romantic disease. It was the glamorous killer that whisked many the heroine of a romantic novel away to join her makers in the heavenly choir of Visimule. Upper class ladies so idolized this disease that they took arsenic to whiten their complexions, and some died as a result of this tribute to fashion.

American essayist Susan Sontag has recently published an article arguing that today our romantic disease is cancer. Anyone who has watched the scene in *Terms of Endearment* where heroine Debra Winger languishes in a hospital bed, stoically wishing goodbye to her loved ones as the audience weeps with sorrow, will recognize the problem. The romance of cancer — its inevitability — depends on our acceptance of it as something we can't fight, or stop because "everything causes cancer these days." We can't even understand it because it's so complex. This attitude lulls us into passive acceptance as we grieve for the loved ones we lose to the disease or are numbed with the fear of falling victim to it. Huge profits are generated by this misery.

Breast and lung cancers are fast becoming leading killers of Canadian women. This is particularly shocking when we consider the fact that some cancers can be prevented. But it seems that the federal government and charitable institutions that fund cancer research are more concerned with blaming the victim than considering increasing evidence that a high percentage of cancers are environmentally caused.

The Canadian Cancer Society now conservatively estimates that 30 per cent of cancers are environmentally caused. The society prefers to funnel money into expensive research projects that will find a "cure." Their prevention programs stress the individual's responsibility to stop smoking and lead a healthier lifestyle. But our priorities must change if we accept the estimates of Samuel Epstein, author of *The Politics of Cancer*, that environmental factors account for at least 80 per cent of cancers. And yet, tightening pollution emission controls for industry, legislating better working conditions for workers exposed to toxins and reducing carcinogen levels in food, is a much more complex and politically sensitive strategy for government to follow.

Government and funding institutions also largely ignore non-traditional treatments such as macrobiotic diets. Cancer victims who pursue these alternative methods find they are very expensive, information about them is difficult to obtain and they receive little support from the medical community. It's strange that any method producing positive results should be ignored if the search for effective treatment is sincere.

Examples of these environmental hazards are everywhere. In this issue of *Healthsharing* we present an article on the hazards of household cleaning products that we take for granted as harmless. Author Harriet Rosenberg suggests that many of these toxic products can be replaced by ordinary household substances. But if these cleaners are harmful, why do they continue to sell? Because they make lots of money. It's time to start taking a hard second look at what these substances are doing to us.

There are no easy solutions to this problem. In an era of economic restraint and massive unemployment, unions reluctantly give up health and safety issues as a top priority. Attacking environmental causes of cancer also requires a change in the way we think about the problem. Individually we can refuse to accept the myth that everything causes cancer, a myth which lulls us into passive acceptance. We can begin by eliminating toxins from our diet and workplace or home. Collectively we can pressure the government to make environmental health a higher priority and refuse to accept the search for a "cure" for cancer as the solution to this extremely complex problem.

Betty Burcher
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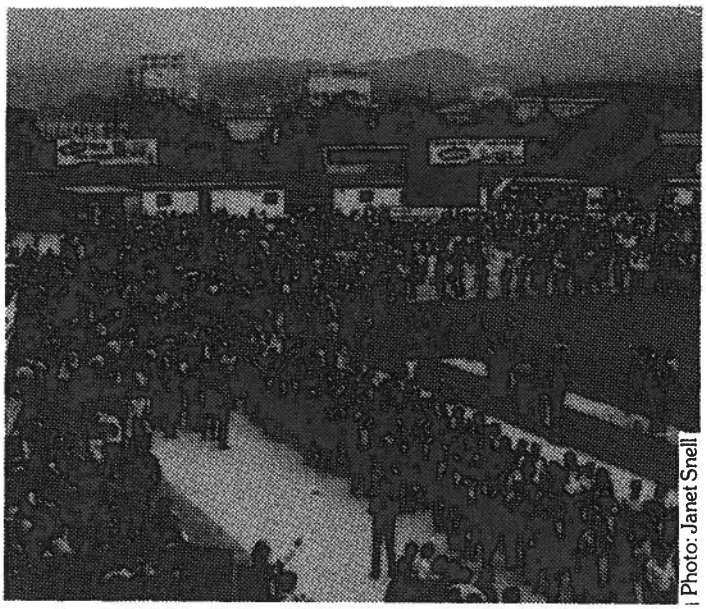


Photo: Janet Snell

B.C. Feminists Still Battling Budget

VANCOUVER — A Vancouver feminist community group will launch a two-pronged attack against what they call the provincial government's recent assault on social services.

Women Against the Budget decided at its Dec. 11 conference in Vancouver to develop a program of action dramatising the budget's crippling effects on women and children, to educate the public and increase support for WAB.

Other suggestions from the 50 women at the conference included more neighborhood leafletting and door knocking, and fostering contacts with other active women, even those in the Social Credit party, to widen WAB's base of support.

"We must reach out to new people, to isolated women, and rebuild the momentum that we lost," said WAB's Sara Diamond.

Many WAB members, sporting Operation Soldout buttons, expressed bitterness and dissatisfaction with the Kelowna agreement reached Nov. 13.

"There's been a phony separation of labor and community groups. Those guys (in Operation Solidarity) don't represent union members anymore than they do us," said WAB member Jean Rands.

"Even though the mobilization was great, it was heading for defeat because nobody challenged the myth of restraint and we weren't really asking for what we wanted."

Members decided to list the actual social services women need and to hammer out a position on the restraint issue. They discussed adopting an offensive strategy to fight the firing of social workers, instead of continuing their defensive stance.

They also passed motions calling for concrete action to prevent the closure of Vancouver's Transition house, which is scheduled to be privatized or closed by March 31; a wake comparing human rights in B.C. with that of Orwell's world in Nineteen Eighty-Four; and a "budget university" designed to educate communities about Socred policies and its restraint program.

WAB members promised to support other job actions and to continue fighting for the rights of trade unionists as well as feminists.

By Muriel Draaisma

Improved Image for Alcohol

A small (6 oz.) glass of beer can help mothers nursing for the first time to relax and make breast feeding easier, according to a recent study on the health effects of modern alcohol consumption published in the John Hopkins Medical Journal.

Among other findings, the study showed that moderate drinkers had fewer heart attacks, less coronary artery disease and higher blood levels of high density lipoprotein cholesterol, which appears to offer protection against atherosclerosis.

Nursing mothers should confine their drinking to moderate levels while pregnant women and drivers should consider alcohol off-limits.

Charges Dismissed

HALIFAX — The Nova Scotia Crown was unsuccessful in its recent attempt to sustain charges against three Nova Scotia midwives, Donna Carpenter, Charlene MacLelland-Brent and Linda Wheeldon.

The charges of criminal negligence were laid as the result of the death of baby Darah Bracket on July 18, 1983, six months following her birth.

As the three day preliminary inquiry and testimony of 16 crown witnesses concluded, Judge W.A. Gunn said there was insufficient evidence to indicate the women had shown "wanton and reckless disregard for the lives and safety of other persons." Gunn refused to send the midwives to trial. After extensive consideration of the trial transcripts, prosecutor Fran Potts said the Crown would take no further action.

Tory s Shut Door

TORONTO — The Ontario government recently announced it plans to close six medium-sized residential facilities for the mentally handicapped, affecting almost 1,000 residents.

Frank Drea, Ontario's community and social services minister, announced centres in St. Thomas, Aurora, Coburg, Whitby and Woodstock are slated for closure over the next five years. While the minister claims the residents will find better accomodation in group homes, critics are charging the government move is calculated to save more than $100 million.

"The kind of specialized care required of many mentally handicapped people can only be obtained in a structured institutional setting," says a statement by Metro Toronto's Labour Council. "While cutbacks may save the government $100 million the question has to be asked, 'at what price to a group in our community who are least able to protect themselves and defend their rights'."

According to a joint statement by two Toronto unions, many of the developmentally handicapped need the specialized care they receive in these institutions. The joint Canadian Union of Public Employees and Ontario Public Service Employees Union statement says the handicapped will be uprooted and moved to large institutions away from their home communities without adequate support.

"The rest will be dumped into the community," reads the statement.

Group homes in Metro Toronto currently have waiting lists with up to 400 names, and at least a year's wait for admission.

The government said it has not considered increasing existing services that support developmentally handicapped people in the community.

But a coalition of parents, workers and community organizations had formed to fight the closures. The group is calling for a moratorium on the closings until there is concrete evidence supporting services for integration of the handicapped.

De-institutionalization is a concept that grew in the 1960s and refers to a system of community based care where people live in group homes or their own apartments rather than in government facilities. This concept has been used to shut several large psychiatric institutions in Ontario.

Sterilization As Contraception

More American women are now using sterilization as a contraceptive than any other form of birth control, according to a recent U.S. survey. According to the fall issue of *Intercom* magazine, 35 per cent of an estimated 33.4 million American women practicing contraception rely on sterilization (20 per cent have been sterilized and 15 per cent had partners who had undergone vasectomies); 30 per cent rely on the pill, followed by 13 per cent who use condoms. Only seven per cent use the IUD, six per cent the diaphragm, and all other methods combined added up to nine per cent (including withdrawal at three per cent and rhythm at two per cent).

These findings are based on a reanalysis by the Alan Guttmacher Institute of data collected in 1982 by a New York research firm. Questionnaires were mailed to 6,500 married and 3,500 unmarried women aged 18-44 in families. The findings are the first to cast light on current contraceptive practices of all American women of reproductive age since a major national survey conducted in 1976.

Nurses Seek To Amend Canada Health Act

Tabled in the House of Commons December 12th, the new Canada Health Act dealt a severe blow to nurses and consumers lobbying for reforms to our high cost, illness-based health care system.

In a 15-page bulletin entitled *Preserving and Reforming Medicare: The Nursing Alternative and the Canada Health Act*, prepared by the Canadian Nurses Association, the demands of the nursing profession regarding the new Act are clearly articulated: "While the bill does attempt to control extra billing and user fees, the great disappointment of the Canada Health Act is the narrow definition of insured services. The federal government continues to promote a doctor and hospital dominated health care system. It does nothing to extend the types of services which could be insured under the provincial health schemes and therefore nothing to increase accessibility to alternative, less expensive and more preventive health care."

As the bill enters second reading and is referred to committee for debate, nurses are seeking meaningful amendments to the Act:

- Insure extended health care services
- Include nursing as insured services so that patients have a choice of entry points to the system
- Ban extra billing, user fees and premiums.

These amendments are based on the need to re-allocate existing resources so that our health care structure will make better use of all health care personnel. In addition the health care system must develop home and community based care as alternatives to hospitalization.

Nurses play a vital role in this restructuring of the health care system.

By Allie Lehmann

Parents take Hospital to Court

TORONTO — An Ottawa mother recently won an injunction in the Canadian Supreme Court to prevent the use of silver nitrate drops in her newborn baby's eyes.

Susanne Peterson won the injunction Dec. 23, 1983 by challenging the procedure was an incursion of her civil rights under the Charter of Rights and Freedoms. The procedure is a preventative measure against opthalmia neonatorum, an infection most often caused by gonorrhea in the mother. Peterson proved to the court that she did not have the disease and the procedure was unnecessary.

But at the Ottawa Civic hospital, where Peterson's child was born, all babies will be made temporary wards of the Children's Aid Society to ensure they receive the drops.

The public health regulation requiring the use of silver nitrate became law in 1917. The main objection to its use is that it impairs infant/parent bonding because it stings the baby's eyes and causes temporary blindness.

At the time of publication, a full hearing into the constitutionality of this question was scheduled for February 1984.

A defense fund has been set up to enable Susan Peterson to challenge the Ontario Public Health Act regulating the use of silver nitrate in newborn babies. Please send donations to: Silver Nitrate Challenge Fund, c/o 36 Herridge Street, Ottawa, Ontario K1S 0G7.

By Bonnie Heath

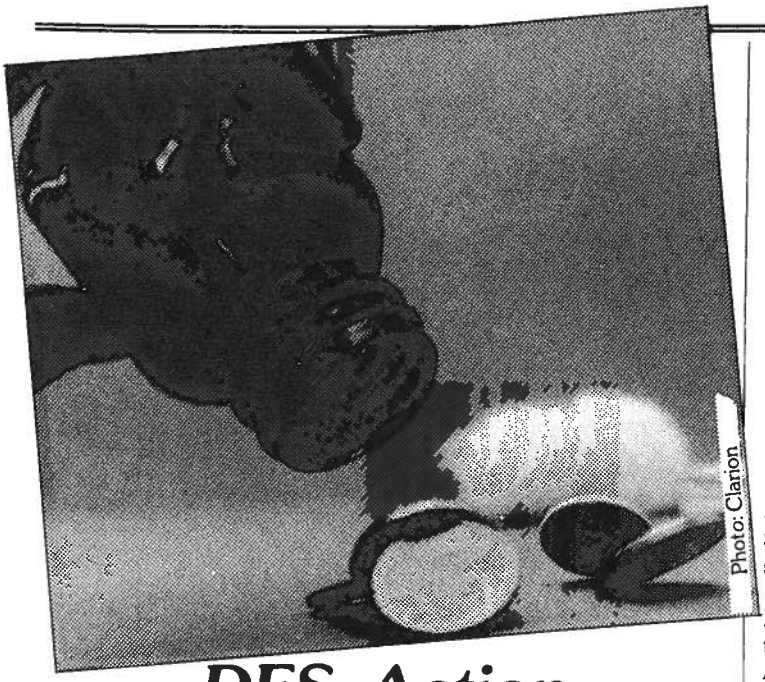


Photo: Clarion

DES Action On The Move

TORONTO — In an effort to reach all Canadians who were exposed to DES (diethylstilbestrol) between the years 1941 and 1971 (See *Healthsharing*, Fall, 1983) DES Action groups are being set up across the country. With the aid of a Health and Welfare grant received last spring, Harriet Simand of DES Action/Canada in Montreal has helped establish similar groups in Toronto, Vancouver and Ottawa. In the next few months, groups will be forming in Winnipeg and Sydney, Nova Scotia, and women in London and Kitchener, Ontario have expressed an interest in forming local DES Action chapters.

A major problem the group faces is assuring that there are physicans trained in the screening of DES-related problems in parts of Canada where they are most needed. Based on the assumption that southern Ontario is one of the areas where the drug was most heavily prescribed, attempts are being made to obtain funding for a DES Information Centre in Toronto. Dr. A. D. DePetrillo, Head of Obstetrics and Gynecology at Toronto's Wellesley Hospital is working with DES Action/Canada and DES Action/-Toronto to secure government funds for a Centre. Since the extent of DES-related problems in Canada is still unknown, the Centre would serve as a storage base for information on DES-exposed across the country. Health care professionals needing information about DES screening could direct their inquiries to the DES Information Centre, should it receive the necessary funding. A similar type of DES registry, in the U.S. which has been operating for the last few years, recently had its funding cut by the Reagan administration.

DES Action/Canada recently submitted a resolution to the National Action Committee on the Status of Women (NAC) to be put forward at their Annual General Meeting in Ottawa in March. The resolution requests that NAC urge its affiliated members to support DES Action in its commitment to the identification and education of those exposed to DES, and to DES, and to urge all levels of government to support information programs and medical research in this area.

For more information on DES or DES Action groups in your province, write to DES Action/Canada, Snowdon P.O. Box/C.P. 233, Montreal, Quebec. H3X 3T4.

by Anne Rochon Ford

Rely Super Tampons Implicated (Again) In TSS

The suspected link between menstrually associated Toxic Shock Syndrome and Rely Super tampons has not been scientifically proven. Or has it?

It is now four years since Procter & Gamble's Rely Super tampon was removed from the American market because of its link to TSS. Procter & Gamble faces or has faced more than 200 lawsuits, only four of which have gone to trial; most have settled out of court.

Evidence revealed during a recent lawsuit trial against Procter & Gamble in Fort Worth, Texas implicates Rely Super more strongly than ever in TSS, an article in the Journal of the American Medical Association recently reported. Findings of a 1981 study by Merlin Bergdoll of the University of Wisconsin presented at the trial indicate that the growth of toxin producing bacteria was significantly greater on Rely Super tampon when compared with other major tampon brands. Bergdoll identified the polyester foam cubes unique to the Rely brand as a major source of toxin production. Procter & Gamble later reproduced these results, but their findings were not introduced into court.

Court testimony further revealed that Procter & Gamble made attempts to suppress the scientific data confirming the TSS link. Although Bergdoll's study was financed by Procter & Gamble and his results duplicated by Procter & Gamble scientists, the company has not made the scientific findings public. In fact, Procter & Gamble maintains it was unaware of any scientific evidence indicating Rely was harmful or contributed to TSS development. The article also states that Procter & Gamble attempted to keep the evidence presented at the trial from the public.

Procter & Gamble has cornered the market on toxic shock research. Following the 1980 removal of the Rely tampon from the market, the company set up a toxic shock scientific task force. It has spent more than $3 million on its research program.

Questions remain despite these new findings. The toxin causing TSS has not been conclusively determined. TSS is still occurring although the proportion of menstrually associated cases is steadily decreasing. Osterholm, a Minnesota researcher, claims the risks of TSS are associated with the absorbency of a tampon rather than simply with tampon use. But if the toxin may be produced in high absorbency tampons at high levels, why do most women never get TSS?

Bergdoll speculates that most women acquire an antibody to the toxin, and his studies indicate 95 per cent of women over the age of 30 have this antibody.

Younger women who have not yet acquired the antibody are at most risk, according to Bergdoll. Osterholm has confirmed the predominance of TSS in women between the ages 12 and 18.

Bergdoll is currently developing a commercial test kit that could be used to detect the presence of the toxic shock toxin antibody.

By Elizabeth Allemang

Pat Foote-Jones

Students Slam Health Services

PETERBOROUGH — For many years, women students at Trent University have talked about their bad experiences with the campus student health service.

But embarrassment and intimidation prevent women from making formal complaints about doctor-patient relationships and unmet health needs.

Women are able to share their experiences, their needs and their frustrations with one another, but not with Health Services.

The intimidation not only blocks criticism, but is the source of the problem. Doctors abuse their position of authority by not acknowledging their patients' needs, and allowing their own biases and judgements to colour their advice, according to many women on campus.

Two women recounted similar experiences. They approached Health Services after educating themselves on the advantages and disadvantages of available birth control methods, deciding the diaphragm was the most appropriate to their needs.

To their surprise, the response from Health Services was to question the morality of their sexual involvement, stressing the importance of emotional commitment. Personal questions concerning unwanted pregnancy, raising a child alone and the safety of the pill intimidated these women. They expressed concern for other women who may not be well-informed and therefore might be misguided by "well-intentioned" medical advice. Both women questioned the manner in which the medical advice was given.

The service's director Dr. R. Pritchard claims neither he nor his colleague Dr. Martin impose their "thoughts, beliefs and morality" on their patients. But he does admit they "come from a different generation." Significantly, only 20 years ago, local practitioner Dr. Joyce Barret was told repeatedly by a gynecological professor to "never believe a goddamn word a woman tells you."

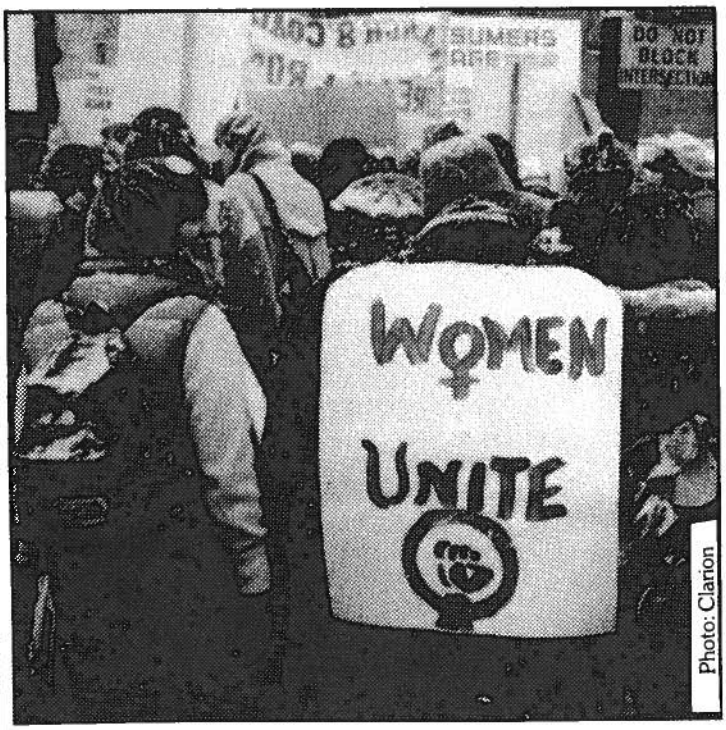


Photo: Clarion

Recently, students told Health Services they need better access to a variety of non-sexist information on sexuality, birth control and unplanned pregnancy.

Jennifer Reid, a student who met with adamant opposition from Health Services for attempting to distribute free condoms during orientation week, says the service is too concerned with its image to acknowledge complaints.

"There is a danger that a university's health service's concern for politics may supercede the health of students," Reid warned.

By trying to maintain a good image, Reid says some controversial health issues are not recognised or dealt with.

Pritchard acknowledges the campus committee set up to deal with complaints is ineffective. By referring student criticisms to the Health Services Committee, doctors avoid confronting concerns on a personal level. Also, students can't be expected to share confidential health information with an entire committee of volunteers.

Women do not make formal complaints partly because they are unaware of the procedure, or they are too embarrassed and intimidated to make use of it. A woman may assume the incidents are infrequent, and therefore insignificant. Even if she knows many women encounter behaviour making them uncomfortable, she might feel she should simply shrug it off.

When a woman "shrugs it off" she has succumbed to authority "from above". By their own admission, members of Health Services view themselves as being "above" the students. Pritchard's claims that students "won't listen when it comes from above" shows his assertion of power.

A woman who feels vulnerable will not proceed with a formal complaint. In contrast, when a woman is aware of the importance of her feelings and that her experience of discomfort is not an isolated case, she immediately recalls the circumstance. Evidently, they are anxious to have someone listen.

By Sheila Nopper
Reprinted from Arthur by Canadian University Press

Calgary Women's Health Collective

CALGARY — A recent health conference in Calgary marked the first major project of the newly formed Calgary Women's Health Collective reports *Webspinner*, an Edmonton women's newspaper.

Barbara Ehrenreich, a well-known American health activist, provided the keynote address to the two-day conference entitled "The Politics of Women's Health." The conference also featured a series of workshops related to current women's health issues, such as childbirth, women and addictions and feminist therapy.

The conference was well attended. Workshops were filled beyond capacity, and participants came from throughout western Canada to attend.

The collective plans to compile a listing of the health information and resources gathered at the conference. Other future plans for the collective include organization of a women's health resource centre and a referral service of feminist therapists and doctors.

Medical Rights

CALGARY — An overwhelming majority of Canadians feel the right to medical care transcends many other rights, according to a poll recently cited in the *Medical Post*.

A public opinion poll recently released by the Canada West Foundation found that of 2,020 adults surveyed (685 of whom live in Western Canada), 94 per cent of the national sample and 95 per cent of the Western sample agreed medical rights are a priority.

Quitting Smoking Is A Subversive Activity

by Phyllis Jensen

National statistics tell us that, while fewer women are smoking than men, men are quitting at a faster rate than women. Apart from collecting statistics, little research is being done on women smokers, with the exception of smoking during pregnancy. There, the focus and concern is for the fetus. Yet, smoking is a health hazard for the woman herself and for women, smoking seems to be a different problem than it is for men.

Most women learn to smoke when they are young teenagers. They begin for a variety of reasons: to appear adult, to demonstrate their independence, as a response to peer pressure, or in the belief that smoking will depress their appetite.

The fear of getting fat is a central concern for women thinking about quitting smoking. Deep down every smoker wants to quit, she just doesn't know how.

Smoking is not a simple habit or merely an addiction. It is a complex interplay of altered physiology, habitual behaviors, emotions and a psychology of guilt and fear, held together by numerous rationalizations. The cold turkey method doesn't sever the links which hook the smoker into a pack-a-day habit. Let's look at these links.

Physiological

First, nicotine, the active ingredient in tobacco, is a very powerful poison to which the smoker builds a resistance and a craving to maintain a habitual level in her body. It takes approximately 72 hours for the body to get over the physiological craving and weeks for it to restore itself to a normal state. During this readjustment period, the woman may experience fluid retention and irritability which can lead her family and friends to suggest that they prefer her smoking to her grumping around.

Second, nicotine alters the blood sugar cycle by stimulating the liver to release glycogen (stored sugar). Hence the sensation of appetite suppression. Having a cigarette is similar to eating a candybar, it creates its own need within 20 minutes when the blood sugar drops after its abnormal high.

Third, smoking may mask the symptoms of hypoglycemia or a food allergy which may lead the smoker to overeat. Quitting may similarly mask the symptoms, allowing the quitter, unaware of her metabolic problems, to blame her overeating and weight gain on not smoking. It wasn't quitting that did it, but ignorance of her own condition.

Fourth, nicotine stimulates the heart rate to increase up to 10 beats per minute. This increase, combined with the internal sugar hit, is what gives the smoker her feeling of a lift. In reality, the lift is simply reduction of the discomfort created by the artificial state of nicotine addiction. If the quitter does not increase her activity to use up those few calories that the increased heart rate used, then over a period of time she may gain a couple of pounds.

Habitual Behaviors

Smoking becomes an integral part of a woman's life that it seems like an old friend. Smoking behaviors become so automatic that often the smoker is not even aware of each cigarette she lights up. Since smoking is such a central feature of her life, she associates it with herself and good times. Ads reinforce this idea.

Roslyn Schwartz

Smoking creates an oral need much like the sucking behaviour of a baby hooked on a plastic pacifier. The quitter, unaware of the need to eliminate sucking behaviour, will often feed the habit with alternatives like food, gum, candy, or anything fattening.

Emotional

A smoker will often select friends on the basis of their mutual habit. When they get together they will trigger each other to binge-smoke. Quitting smoking may destroy the friendship.

Cigarettes may act as a reward for women who don't have the time, money, freedom or power to reward themselves in other ways. Smoking is often the excuse a woman uses to give herself a five minute rest. It's what she does when she needs a break or time to think out a solution to a problem — time that does not seem legitimate otherwise.

Psychological

The smoker is often afraid to quit, so she tells herself she enjoys the habit.

She learned to smoke and now what she needs to do is learn to quit. It's not willpower that she needs, she's got lots of that. What she needs to learn is to take control —often a difficult concept for women. Once she has learned to take control in this area there is a spillover into other areas of her life. Learning how to quit smoking is a subversive activity — it builds strong healthy women in charge of their lives.

Phyllis Jensen leads 8 week workshops for women in learning how to quit smoking. (416)465-1323

THROUGH THE MEDICAL MAZE

Cancer. Despite all our enlightened attitudes, despite the positive, uplifting tone of the ad campaigns that assure us that "cancer can be beaten," it is still a word that strikes a note of dread. For women, breast cancer carries a double threat — the threat of death, and the threat of being maimed, of losing part of our "womanhood." Unless we are forced to deal with cancer in ourselves, or with a close friend or relative, for the most part we avoid thinking about such things. We don't want to know; and we would prefer that those who do keep it to themselves.

What do we really know, then, of the reality that a cancer patient faces, of the life crisis that can be precipitated by a diagnosis of cancer or any life-threatening disease? In this interview Sheila (a pseudonym), a real estate agent and divorced mother of a nine-year old son, recounts her experience of breast cancer with anger, anguish and humour. Her breast cancer was first diagnosed two years prior to the interview. She opted at that time for a lumpectomy rather than a mastectomy.

by Kathleen McDonnell

I discovered it accidentally, reading in bed, lying on my side, and I reached over to scratch under my arm, I felt something. This was not the first time I had discovered a lump: twice before I thought I had felt lumps in my breast, which turned out to be nothing. *Schmaltz*, I was told, that's all it was, *schmaltz* being a yiddish word for fat.

Both times I saw a surgeon about it, and each time this is what it turned out to be. They did the needle test, extracted cells with a huge needle, there in the office. So without any fear and trepidation I made another appointment, this time with my gynecologist, who was away, and who I'd seen six months before. I saw his partner, who I realized was concerned right away. He said nothing, and he made an appointment for me with a specialist.

The specialist informed me, after

feeling it, that it was not the only lump. He found the primary in my breast, which really surprised me. In six months, not only had it formed, but it had spread.

Well, right away, I knew. He didn't have to do the test, we both knew. But he did it, and he told me yes, that he was 99 percent sure that he wanted to do a biopsy as well, and do a mammogram, and a thermogram, and all kinds of things like that, which we proceeded to do.

Well, the mammogram was positive, the thermogram was negative (thermogram's a waste of time, in my opinion, in my doctor's opinion as well — they're not reliable) and....I've had so many tests in the last three years, it's hard to keep track.

He wanted to do it immediately. His diagnosis was correct, the treatment he recommended was a mastectomy, followed by radiation of the underarm area. I rejected that almost immediately, just a gut reaction, for two reasons. One, my age, I was 34 — I thought, "Oh, no, I'm not ready to deal with this at this age, this is more than I can handle right now." And also, I didn't see the point in removing the breast when it had already spread out beyond the breast. It's like closing the barn door after the horse is gone.

My brother had died of cancer. And in my grandfather's generation, all his brothers died in their late thirties, early forties, all but one, I think, from cancer; my grandfather had cancer; my maternal grandmother was one of the originals — she had a mastectomy when my mother was in her teens. That was a long, long time ago.

So, knowing that it runs in the family, I had made it my business to read and know a lot about it. And I'm glad I was informed, because I was able to deal with it more rationally when it happened than I would have otherwise.

I told my doctor I wanted to speak to a woman doctor about it — I wanted other opinions. He was all for it. The man is nothing if not cooperative and understanding.

So I spoke to a woman specialist. I couldn't see her, because she was too busy, but she did take the time to phone me. We had a long conversation. She agreed with my doctor about a mastectomy, however she could see just removing the tumours, plus a year of chemotherapy, as an alternative. And I spoke to another surgeon as well, for another opinion. He was an appalling man, a young man, a little older than myself, who came on with "If you were my wife, this is what I'd recommend" — not only a mastectomy; he would also have the ovaries removed as well, because the ovaries produce this hormone (estrogen) when you're premenopausal that increase the risk, escalate your chances of the disease recurring.

I spoke to another surgeon...who came onto me with "If you were my wife, this is what I'd recommend" —not only a mastectomy; he would have the ovaries removed as well.

He was terrible. He was just knite-happy. So, as a result I decided I would just have the tumours removed and the year of chemotherapy. Once the operation was done, I told the surgeon I wanted to explore other forms of therapy before I committed myself to chemotherapy. My brother had had chemotherapy and having seen him go through it, I knew exactly what I was in for.

The surgeon wanted me to make up my mind; he didn't want to leave it indefinitely. I'm sure if it had taken me three or four weeks he would have been fine, but he wanted me to know that I had to really be serious about this and not just let it go. He gave me the time to explore things. I give him credit for doing that.

Immediately after I left the hospital, I went to see a naturopathic physician who uses natural treatments, diet, etc. I wanted to explore everything, leave no stone unturned before I made up my mind. I was there to find out about this alternative and make up my own mind. He didn't like that. He wanted me to put all my faith in him. His response was, you're with me or against me. If you don't believe, if you aren't here with an open mind — I was with an open mind, but I wasn't committed — if you're not committed, then really he wasn't prepared to treat you.

Following that, I had another appointment with my surgeon — I guess he was waiting for me to ask him for the results of that test to determine how many of the lymph nodes were malignant, which I did. All but two were affected, which is a very high ratio. I thought, "Oh Jeez, you know, that's pretty serious, I better not fool around."

So I went with the chemotherapy.

Everybody that I know, and everybody that my sisters know who knew anything about an alternative form of therapy, phoned me, put me in touch with people — I really did my homework. And I read extensively. I made my own decision and I was happy with it as a result. I felt that I was sufficiently informed and knew what I was doing, and that was my choice. And I think if I had it to do over again, I would. Even though chemotherapy was every bit as awful as they say it is, I think I still would.

The initial one was done intravenously. It really hits you; it's a real blast of the stuff. That became just so awful for me. There's a certain odour to it that to this day, the memory of it is so firmly planted that it can just turn my stomach. And of course nausea is the first and most common reaction. Luckily he gave me a prescription for it which really helped a good deal.

My eyes were very definitely affected, seriously affected. It quite alarmed me. I had eye infections, one after the other, a continual series of eye infections, the whole year. And my vision was impaired; it wasn't sharp. My memory loss was due, I'm sure, in part

to depression and anxiety and all that kind of thing, but since I've been off it I've noticed the same sort of thing. I sometimes wonder if the brain cells weren't affected by it. It's my feeling. And they're not going to back me on that. (Laughs.)

I had a very, very good memory, extremely good, especially for dates, figures, that kind of thing, phone numbers. There'll be times now when I forget my sister's phone number. I've been dialing it for years and years and years. That still bothers me.

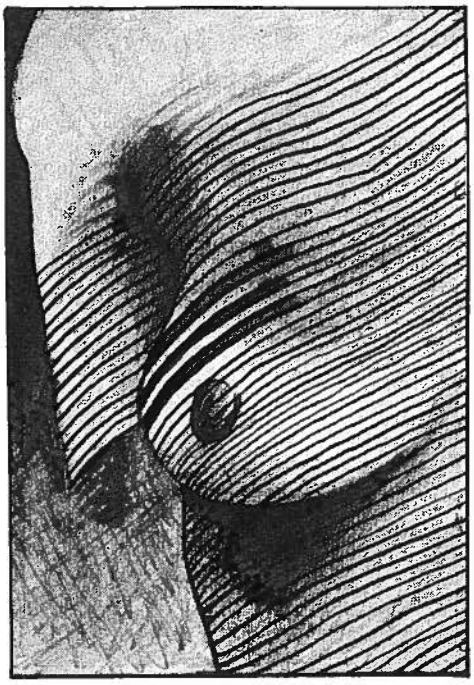
What else? The throwing up, the nausea, hair loss, putting on weight.

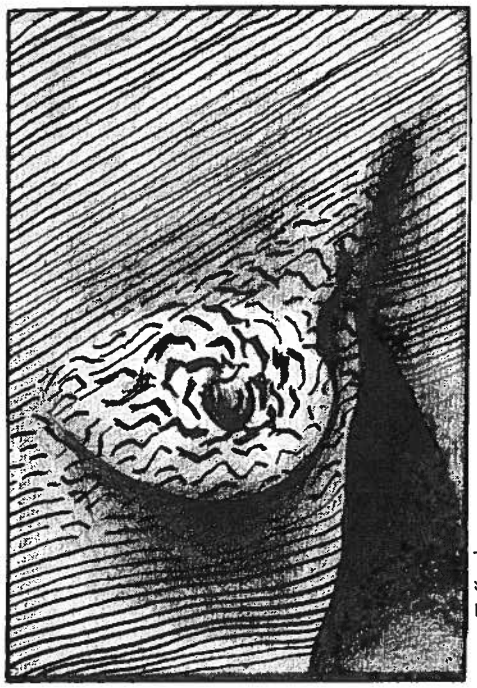
After the initial intravenous, I took three pills a day for the rest of two weeks. For the whole two weeks I'd feel just crummy. And then by the end of the two weeks off, I was beginning to feel back to normal. They started off quite slowly, and my doctor assured me that at any point if it was absolutely intolerable, he'd pull back. He often asked me if it was intolerable, he said, "You ought to be able to function, you ought to be able to work." Which I did. I suppose really, when I look back on it, I should have said, "Enough already." But I didn't. I put up with it and struggled through, and I was a real soldier. God knows why! (Laughs.)

So, towards the end, I developed incredible chest pains. And I had a whole other set of tests. I'd had a whole battery of them initially, just after the operation, the bone scan and the CAT scan and the intramammary scan and so on. I've had all the scans, every part of me has been examined on one of these machines. So we did the whole thing, and they're all fine. Except the bone scan showed that I had arthritis in my ankles!

I think really the pains were caused a lot just by anxiety and — I was exhausted, plain old ordinary exhausted. Right after the injections, I'd feel so sleepy and so drowsy, extremely anxious, but if I slept I'd feel a little better. But by the same token I got very, very little sleep that whole year. Because I'd just be so anxious, I couldn't sleep. At bedtime I'd be wide awake. I was just plain old ordinary exhausted. It was just too much. If I had to do it all over again I would not work. Or not as much. I'd have more help.

Towards the end there were great mood swings as well, and that whole time, I was very angry, very angry, as





Karen Tufford

well as extremely depressed.

When I was off I felt terrific, and when I was on I was really low. It was way up and way down. The changes were imperceptible initially, but later they became just so extreme. Towards the end, I had to force myself to go, I had to force myself to take those damn pills. I would start reacting before I took them!

I refused the self-help groups, because I wasn't interested in playing "True Confessions." If I wanted to talk to somebody, it had to be a professional and somebody that I had a great deal of confidence in.

I was so worried about going this route and discovering that I was involved with somebody that needed more help than I did, which is very often the case. I started seeing a psychiatrist in about July, I guess. And that proved extremely beneficial in dealing with all this. Because once the chemotherapy was over, I thought, "It's all over and done with. I booked in for a year and the year's over, I've done my time, and aren't I lucky." And I had all the battery of tests all over again, at that time, just to make sure that everything was fine. And then just before New Year's, I discovered another lump. I couldn't handle it. I thought, "Oh, God." The last tests would have been in September and this was three months later. And I thought, "Somebody up there has it in for me. This is not fair." When I discovered it, I sat here and worried about it, and cried, and carried on. If the lump is wiggly, is soft, and moveable, ten to one it's nothing. If it's hard, and it seems firmly anchored, that's it. That's a tumour. Except I knew that if it's tender, that's a very good sign.

So I called my doctor's answering service, and he was at his farm, for Christmas and New Year's. I guess I was hysterical enough; he phoned me back within an hour. And there was nothing he could do, and I knew there was nothing he could do. He said all the right things; he didn't try and deny it; he didn't tell me everything would be all right. Well, when I saw him, he said that he thought it was benign, because of the tenderness, but he was going to remove it anyway, just to have a look at it. The biopsy was going to be done under a local anesthetic, and with a light heart I went in for it.

Unfortunately, in the middle of it, he

said to me, "You're not going to believe this." There was a benign tumour — and underneath it was a malignancy. He just went a little deeper. That whole biopsy was such a horror. He hadn't frozen deep enough; he started to cut; I went straight up off the table, whereupon he said, "All right, allrightallright," and shot me full of stuff. I can still remember the feeling. This is the sad thing about any of these experiences, they become so firmly implanted in your mind that you never forget the sensation. And also he nicked an artery in the process, and while I'm lying there I could feel, I'm actually lying there feeling my own blood, running over my shoulders and into my hair, into my ears. And I'm saying, "You're in trouble, aren't you?"

He could tell by looking at it. He removed it, and he said, "I know. We'll test it, but I know now."

So we had a long talk after that, and he decided against more chemotherapy. It hadn't really done its job and the thing to do was have radiation. So I thought about that and decided that I could live with it. My brother had had it, and I knew exactly what I was in for. I was on three different machines, every day for six weeks. Again, I kept working. I wouldn't work through all that, again. I was just exhausted. And I burned terribly. I've got a very fair skin. It became purple, and felt on fire. One side is still a different colour from the rest, and always will be.

Then my son decided that he couldn't handle it, and he started running away from school and talking about suicide. So I had to get help for him too. I felt I just wasn't being as much of a help for him as I could have been.

So I had the radiation, and once the burning healed, everything was fine, pretty well, until July. And one day — Saturday, I was fine, Sunday morning I was fine — by Sunday afternoon I started to feel really cold, and thought I might be coming down with something but I wasn't sure. By Sunday evening I was freezing. It's the middle of the summer, everybody's fine, but my teeth are chattering. I'm just beside myself. I thought, I don't know what this is, but this is serious enough to take myself home to bed.

I had blinding headaches, and a fever that was so bad that when I stood up and went to the bathroom I thought I was going to pass out. I really thought I was going to faint. I think I stayed home for another 24 hours, and then I got myself over and into the hospital. Apparently it's not an unusual reaction in radiation patients. What is unusual is that it should be so many months later. It's caused by, it's either a staph or a strep infection, I can't remember which. They put me on antibiotics, for a week, and sent me home.

All through this I always wanted to know, right up front, the whole thing the worst... And I'm much better knowing everything myself.

It took me another month or two to recover from that, just because I was so tired. My resistance to anything has been so drastically reduced, first by the chemotherapy, then by the radiation. This infection just went rampant through me, recovery was really slow.

So, what else happened? In November my doctor was very concerned about the fact that one breast is so much redder than the other — it looks like I've got a sunburn. His concern was that this redness was masking symptoms, and he wanted to do another biopsy, that it could be cancer in the skin cells themselves. They wanted to do a mammogram right after he did the biopsy, and I learned another valuable lesson: you don't do that, you wait until it's healed, because it splits the incision open, and then it got infected and ... ooh jeez. The mammogram consists of taking a photograph — the breast is on a plate kind of thing, a machine, and they squeeze it to its lowest or its thinnest possible mass. I should have figured — the pulling — but anyway after I started bleeding all over the floor I learned another lesson — you don't do that, they can bloody well wait for their mammogram until I'm healed.

So, he wanted to do another biopsy. And I thought about it, I'm not as calm as I used to be any more about these things. I decided I'd rather know than not know — all through this I always wanted to know, right up front, the whole thing, the worst, and my doctor's been very good that way. He's never kept anything from me, and I'm much better knowing everything myself.

So we went with it. And as it turned out it was all negative, everything was fine, there was nothing there. Now, the cure rate is five years. If you're free of anything for five years, then they consider you cured. Since that biopsy it's been a little over six months. After three years, I'm only six months ahead of the game, if that.

I had my three-month appointment this past week, and I cancelled it. On the day I did it, I convinced myself that I was just exhausted — I hadn't been sleeping for almost a week prior to this. I called and said, "I just can't come in." And it wasn't until the day after that I realized what I'd done, and that I just didn't want to deal with it. And that I hadn't been able to sleep because I was worried. I thought, "Come on, you have to really get it together, it may not necessarily be bad news." I keep hoping that, as time goes by, it will become more remote, but it doesn't, it becomes more difficult to cope with, not easier. I think it's because of the recurrences and the continuing problems. Initially I booked in for a year, but now we're going into number three, and I don't want to play anymore. That's what it boils down to, I

just don't want to play. I want to take my marbles and go home.

I guess what I'm saying is that I'm starting to deny, although I'm aware of it, whereas before it was the last thing. I was right on top of it. It's interesting to me that that should happen, when I'm just in the first remission.

Then I lost my job in April, which was another severe blow. The radiation was just finished, and in a matter of weeks I lost my job.

It's a mixed blessing in a way, having been off all this time, I know that it's done me the world of good, not working and resting. Which makes me realize that if I had to do it all over again, I wouldn't have worked while I was having the radiation, for instance. I would have taken more time off and not been such a trojan, a stoic, through the whole thing. But on the other hand, working, you can pretend that you're still a normal functioning member of society. It has its advantages. So physically, not working has helped. But emotionally, I've just traded one set of anxieties for another. Waiting to see if the next time everything will be all right, and how long it will be all right, and you don't dare to hope that it's really all over.

I wouldn't change the decision not to have a mastectomy. I guess because I'm still not prepared to deal with the fact that I would be minus a breast, it just boils down to that. I didn't feel that having a mastectomy was a life or death thing at that point, and I still don't think it would make the difference. And if — I'm quite prepared, if I see it as necessary, to go ahead and do it ... but until then, no. But it had spread beyond the breast. Even the secondary one was not in the breast —it was a lymph gland in the chestbone — and I didn't see the point in having a mastectomy when it had already spread beyond the breast. Obviously the chemotherapy, although it's system-wide, did not prevent a lymph gland between my breasts from becoming malignant.

No, I wouldn't have changed, even with all the side effects and everything else. Now that's a very personal thing, it's how I feel; but I've talked to other people who've had cancer as well. The only person I know who was happy about a mastectomy is the woman that I was talking to in the cancer society, who was in her forties but had had the mastectomy in her thirties. Her husband was going away on a business trip, and she actually had the mastectomy while he was away. Her mother took her kids, and she just checked

herself in without telling anybody anything, and it was done. And when it was over — it only takes a few hours — when it was over she told everybody. And that was her way of dealing with it. She was positive to the point of nausea. "Everybody should run out and have a mastectomy, it's a wonderful experience." Give me a break! I doubt very much that that's how she felt about it, initially.

One of the things that has been most difficult for everybody around me to cope with, and this includes doctors, nurses, everybody, is the fact that I haven't looked sick, throughout any of it. My way of coping is, if I look good, then I must feel good. I didn't realize that, but that has made it extremely difficult for everybody to cope with as a result! I'd encounter all these different people, and they'd sort of look at me and almost want me to produce all these credentials — prove you're sick, you don't look it.

I learned that you really have to be informed, to know exactly what you're doing, and you have to convince the doctor in the first five minutes that you know exactly what you're doing, or you're doomed. They take over. You are no longer in control. So I've been very careful to establish, in the first five minutes, who is in control here.

My mother was really difficult. From the onset the relationship was extremely strained. I think when there's a trauma like this, a crisis, it brings out a lot of stuff that possibly would have remained buried forever. You're all forced to reexamine it, take all this garbage out and look at it, and maybe you can put it away again and maybe you can't. I've thought about it a lot, and I don't think I'd go back and change anything; I think that I coped with it as best I could, and my mother and my sisters just had to cope themselves.

But they hung in there. And it goes for my friends as well, I've been most fortunate in everybody that I have been involved with throughout this period. And the support. I have one friend who I meet for drinks or we go out every now and then when I feel like it, and —I would just talk, go on and on and on, and he always agreed. One day again we were having dinner. I said something to the effect that, "This isn't making sense, is it?" and he said something like, "You haven't been for the last two years." I thought — now if that isn't the measure of friendship, I don't know what is!

This interview was carried out in 1983 as part of a Breast Cancer Resource Kit project for the Health Promotion Directorate of Health and Welfare Canada. We thank the Health Promotion Directorate for their permission to publish it.

HAZARDS in

drawings by Ruth Jones

One of the central struggles of the Women's Movement since its rebirth in the 1960s has been focused on domestic labour, the unpaid work women do in the home. Despite the fact that media frequently portray feminists as anti-housewife, it has been the Women's Movement that has drawn attention to the long hours of work that women put into the home, the economic importance of that work to the economy in general, and the social and economic costs that would accrue if that labour were purchased in the market place.

What has drawn the anger of the media and the male establishment are not just the calls for payment for housework, or pension rights for women outside the paid labour force. The real threat has come from feminist insistence that housework is not a natural, sex-linked, God-given characteristic of being female. Women have argued that there are no genetic, hormonal or sacred reasons why only some people should do childcare, shop, cook meals, do laundry and soothe the frayed tempers of others. It has been hard enough for women to struggle against sex-bias in the paid-labour force and even harder for them to point out that the same bias exists in the home.

One of the key features of the division of labour by sex in the household is that it promotes a widely held ideology that what women do in the home is not really work. This basic myth serves to obscure the often stressful and physically hazardous nature of domestic labour. Women marry and have children to fulfill basic human needs for love, intimacy and security. But the work that accompanies wifedom and motherhood also requires skill, training and experience.

Most workers are not expected to love their jobs. If they do so even some of the time, workers are considered to be quite lucky. Housewives, on the other hand, are considered to be married to their jobs and are under enormous pressure not to admit or analyze the negative aspects of the jobs they do. When they do so, women begin to ally themselves with waged workers who are struggling for safer, healthier working conditions in which they will be treated with dignity.

Expert advice to women tends to cluster in the areas of household tips, childhaving and rearing, and sexual performance. Books on these subjects are cheap, written in simple language and readily available in supermarkets, drug stores and bookstores.

It is important to question how much of this advice is valuable, how much is idiosyncratic, and how much is blatant guilt-inducing propaganda. One thing is clear: we are surrounded by it.

On the other hand, it is very difficult to find information about product or appliance safety. Women who do domestic labour are forced to rely on advertisers for information about the chemical content or safety aspects of products. Here we enter the realm of make-believe. It is the aim of advertising to sell myths, to sell glamour, to sell sex, love, warmth and security. When this powerful myth-making machine enters the household it swirls around like a white tornado leaving the residual feeling that nothing bad could happen in the happy homes it portrays.

However, in the real world, chemicals, toxic substances, pollutants and safety hazards do not lose their potency when they cross the threshold of the North American household. And workers in that household are constantly exposed to a variety of hazards.

Dangers of Home Cleaning Products

Home cleaning products are used by domestic workers virtually every day. Some are dangerous, yet this is difficult to determine since there is almost no product safety information easily available about them. Table 1 outlines dangers of commonplace home cleaning products.

Some products, like dishwashing detergent or laundry detergent, can be lethal to small children. In fact, the average household has as many as 250 chemicals which, if ingested, could send a child to hospital. Women who do motherwork in the home and are responsible for the health and safety of their children are surrounded by products like floor and furniture polish, wax, ink, adhesives, paint, shoe polish and room deodorants which are not identified as poisons. The result of this negligence by industry is that a United States child swallows a poisonous substance every 60 seconds. Since women engaged in motherwork are not informed about how hazardous these common products are, they cannot be held responsible for accidents. Yet they are accused, or accuse themselves, of being negligent. Mothers absorb the guilt of industrial irresponsibility. Manufacturers should be forced to label all potential poisons adequately, and to specify lethal amounts.

The image of happy carefree housewives dancing around their clean and wonderful kitchens costs advertisers millions of dollars a year. Procter and Gamble, for example, spends $300 million a year promoting bliss through detergent while systematically avoiding any real discussion of the substantial hazards of their products. A worker in industry would never settle for this form of information dissemination about potentially dangerous workplace chemicals.

Safer alternatives such as salt, baking soda, vinegar, get very little advertising exposure beause they are much cheaper than supermarket cleaning compounds. They are as effective as the fancy "improved" chemical cleaners and have been tested by women in households for a long time.

Commercial cleaners are so dangerous they should not be stored under the sink where kitchen and cabinet designers assume they should go. Put them on a high shelf and lock them up whenever possible. Daycare centres are required by law to do so.

Home Environment and Equipment

The home does not act as a magical detoxifying barrier. Products which are hazardous in industry remain hazardous in the home. Vinyl chloride, for example, is a chemical that is dangerous at point of production, dangerous in the household, and dangerous at the point of disposal. Vinyl chloride (VC) is a common chemical used in the production of many plastic products. It is

our Household

by Harriet Rosenberg

found throughout the house in polyvinyl chloride (PVC) products. PVC is not known to be toxic, but VC is. Some workers exposed to VC have developed cancer, hepatitis, chronic bronchitis, skin diseases, deafness, vision failure and liver dysfunction.

The worry about VC in the home is that it can leach out of a PVC product early in the product's life. PVC is found in building and construction materials (pipes, siding, windows, lighting) and a range of products such as plastic baby pants, toys, footwear, outerwear, records and food packaging. VC can leach into water and food in new plastic piping, food wrapping and plastic bottles.

At present, in the United States, there is an industrial threshold limit for VC exposure set at one part per billion. However, this is such a dangerous substance that labour unions and public interest groups are pressing for a zero-tolerance level. Women, as domestic workers, should be made aware of these dangers and join in this campaign.

Insecticides are another example of products which pose health hazards, not only to factory and farm workers but also to domestic workers. Housewives are assaulted by advertising campaigns which insist that the elimination of all mould and bugs is absolutely necessary. This cult of cleanliness which far surpasses public health requirements encourages consumers to use the chemical equivalent of a cannon to kill an ant.

One such "cannon" is Kepone, commonly found in ant and roach traps. It is so dangerous that it was actually banned from industrial production in the United States in 1974. It causes damage to the brain, liver and testes of workers, and cancer in laboratory animals. This substance was considered so unsafe that no state would bury it, nor could any disposal company secure permission from the U.S. Environmental Protection Agency (EPA) to burn it. Yet the EPA has approved its sale in household insecticides, and the stipulation that the substance is to be sealed in hard-to-open insect traps is not always complied with. Since ant traps and roach traps are often placed on the floor they pose a serious hazard to young children.

Other common chemicals in pesticides in the home are arsenates, diazinon, dichlorvos and DDVP. These are all extremely dangerous. DDVP, for example, enters the home in hang-up anti-pest strips and in cat and dog flea collars. This chemical has cancer-causing properties and may have the potential to induce genetic alteration. Women who work and live in houses with these strips may be exposed to nerve poison for over 100 hours a week. Over 12 million strips are sold annually in the USA. In addition, 32 million dogs and 22 million cats wear flea collars containing DDVP.

Gardeners may bring a variety of toxic substances into the home including 2, 4, 5-T, a component of Agent Orange, the defoliant used by the United States Air Force in Viet Nam. 2, 4, 5-T has been linked to high miscarriage rates in Eastern Canada in areas of extensive spruce budworm spraying. Nitrosamines, cancer-causing agents in animals, have been found to routinely contaminate weed killers.

Captan, a fungicide, is extremely hazardous to pregnant women and young children. It has been found to cause cancer and birth defects in pregnant animals. It is used by home gardeners in the form of benign-sounding rose bush and fruit tree sprays. And, unbeknownst to most people, it is also found in cosmetics, wallpaper paste, vinyl textiles, and polyethylene garbage bags.

In the United States and Canada it was approved on the basis of testing carried out by Industrial Bio-Test Laboratories. Accusations of falsification of Captan test data have been leveled at IBT, and IBT officials are currently on trial in Illinois. Keith Schneider explores the case well in *Faking It: The Case Against Industrial Bio-Test Laboratories* (*Amicus Journal*, Spring 1983).

Other hazards of work in the home stem from construction and insulating materials which contribute to indoor air pollution. Household pollution has become a serious health hazard in North America as soaring heating costs have produced more effective insulation methods which trap airborne hazards in the home. Ventilation alone may not be sufficient to dilute indoor pollution to an acceptable point. A 1981 U.S. National Research Council report suggests that appropriate pollution control measures must be used to reduce exposure to indoor contaminants. This is especially crucial to domestic workers who face long term low-level exposures to potential cancer-causing substances, or contaminants that may cause respiratory infections and cardio-vascular disease. Some of these dangers are listed in Table 2.

Home Accidents

Many appliances that women routinely use in the home are potentially very hazardous. These dangers are discussed in Table 3.

Industry claims women are responsible for all accidents occurring in the home. In a somewhat condescending fashion one industrial spokesperson in a 1977 item in *National Safety News*, told "today's woman (she) ... has responsibility for much more than how her home looks. She is also legally and morally accountable for the safety of herself and others inside that home."

Table 1. Dangers of Home Cleaning Products

PRODUCT	DANGERS	PRECAUTIONS	ALTERNATIVES
DRAIN CLEANER (lye) [1]	The most dangerous product in home use. Can eat through mouth, skin, stomach; or damage eyes. There is no effective antidote.	Always store in a locked cabinet.	Rubber plunger or plumber's snake. Prevent clogs with drain strainer. Hot water + 1/4 cup washing soda; wear rubber gloves.
TOILET BOWL CLEANER (ammonia) [2]	Can burn skin on contact, or respiratory tract if inhaled. Liquid from in-tank cleaner harmful if swallowed. Fumes *fatal* if mixed with chlorine bleach.		Scrub with stiff brush.
SCOURING POWDER [3]	Rapidly absorbed through mucous membranes and scraped skin. Can cause red rash on any area that comes in contact with product.	Use rubber gloves.	Salt or baking powder clean and disinfect effectively.
OVEN CLEANER (lye) [4]	Extremely dangerous. Can burn skin and eyes. Inhaling fumes is hazardous. Some brands don't have childproof closures.	Wear an apron, rubber gloves, safety goggles and face mask.	Damp cloth and baking soda. Scrape hardened material with a knife. One commercial product contains no lye.
CHLORINE BLEACH [5]	Could cause corrosive burns if swallowed. Induce vomiting if swallowed. Fumes *fatal* if mixed with ammonia.	Rinse surfaces thoroughly after use.	Safer when diluted. Useful as a multi-purpose cleaner.
WINDOW OR GLASS CLEANER [6]	Swallowing can cause nausea or vomiting. Can irritate eyes. Lethal dose for a child is over one pint.	Keep out of reach of children.	Warm tap water alone or 1/2 cup white vinegar mixed with 1 quart cool water. For chrome use flour and a dry cloth.
DISINFECTANTS [7]	May irritate skin and eyes. Spray can irritate throat. May cause nausea and diarrhea if swallowed. *Lethal dose* for small child is 1/5 oz.	Should not be used routinely. Use only *on advice of doctor.*	Soap and water.
ALL-PURPOSE CLEANER [8]	Hazardous to eyes. Products containing petroleum distillates can cause a *fatal* lung condition. Can burn throat and stomach lining if swallowed.	Avoid products in breakable bottles. Wear rubber gloves. Dilute liquids. Powders are generally safer than liquids.	Diluted bleach or detergent. A slice of potato removes finger prints on painted wood.
DISHWASHING DETERGENT [9]	A *lethal* dose for a small child is 2 oz. Enzymes can be highly irritating.	Use rubber gloves.	Use less. Rinse dishes immediately after use. Scour with a stiff brush and/or salt and baking soda. Soak burned pots overnight; boil; cool; scour.
AUTOMATIC DISHWASHING DETERGENT [10]	Major cause of poisoning in children. Irritating to skin, respiratory tract. Long term effects of residue not known.		Use less. Vinegar in rinse cuts spotting; less residue is ingested.
LAUNDRY DETERGENT [11]	A *lethal* dose for a small child is 1/7 oz. Swallowing can cause nausea, vomiting, diarrhea. A few grains can damage eye cornea if left untended.	Store out of reach of children. Don't expose to skin.	Soap powders are safer. Liquid laundry detergents don't contain sodium carbonate, a corrosive present in powders.
FURNITURE POLISH [12]	A drop or two of solvent *fatal* if swallowed. Flammable. Aspiration can cause a form of chemical pneumonia. Nitrosamines (present in some products) can be absorbed through skin; causes cancer in laboratory animals.	Keep away from children. Use in ventilated area. Use rubber gloves.	Tsp. of vinegar in a cup water; buff with a dry cloth for wood furniture. Mineral oil for shine.

The promotion of highly unnecessary cleaning standards contributes to home accidents. Advertising is unrelenting in its assertion that shiny, and therefore slippery, floor surfaces are a meaningful sign of good housekeeping. Since it is estimated that 38% of home accidents result from falls on the level and only 14% from heights it is clear that slippery surfaces are a real danger. Of all fatal falls in the home, 57% involve women.

Other home accident causes can be traced to industry as well. When one person is injured walking through a glass door, that may be considered an individual problem. But when over 250,000 Americans a year are killed or injured in glass-related accidents then we must look to the systemic problems of design, manufacture and installation. Glass doors and other architecturally used glass in the home are considered so dangerous that the Consumer Pro-

ducts Safety Commission (U.S.) lists it 16th of one hundred hazardous consumer products. Consumer groups throughout the U.S. and Canada have fought to change building codes so that glass with shatter-resistant qualities would become required in house construction.

Fire is another significant contributor to home accidents. However, flame retardants are not the solution. When plastics treated with such retardants burn, they release large quantities of poisonous smoke. Since 80% of victims of fire die from smoke inhalation and are not touched by flames, the value of flame retardants does not seem great. Furthermore, any burning plastic, treated or not, will release toxic substances when burning, and rooms with plastic furniture (common in mobile homes) are characterized by very rapid oxygen depletion.

Plastic manufacturers do not make information about burning properties easily available to housewives buying plastic furniture, drapes, toys, rugs, foams, lacquers or adhesives. All consumers are affected by product safety questions and all suffer from lack of adequate information about and control over what enters their homes. Yet since women are charged with the care and protection of households they are in a particularly difficult situation. Several years ago mothers were encouraged to buy children's sleepwear treated with fire retardants. Tris — one of the products used to treat sleepwear — was later identified as a potential carcinogen and was banned in 1977 in the United States.

The Tris episode highlights the fact that home and industry are integrally related and that the household is permeable to all the excesses of inadequately regulated industry. However, industry prefers to imagine that home and work are two separate spheres. It can ignore its responsibility for home health and safety and insist that this is women's responsiblity. But industry also has a second vision related to wifework.

It is women who are the custodians of the industrial worker "off-the-job," says one industrial spokesman in a telling article called "How the Little Woman Keeps Her Man Safe," (*Industrial Supervisor*, 1974). It is her duty to provide a harmonious home environment so that the worker's mind will be "... uncluttered with worry and concern about personal problems." Worrying is the wife's job, according to one industrial writer. If a woman does not keep her man happy his attention may lapse and a routine job procedure may become a "... crippler — or a killer."

This message from industry obscures workers' struggles in creating safe working conditions and shifts the responsibility for industrial accidents to bad wives. We want to turn this equation on its head and see industry bear responsibility for *household and workplace* safety.

Strategies

Women cannot successfully resist the stresses and hazards of domestic labour alone in their households. The Women's Movement has provided significant encouragement in bringing women together to identify and solve problems.

Table 2. Environmental Dangers of the Home Workplace

POLLUTANT	*DANGER*	*SOURCE*	*PRECAUTION/ALTERNATIVE*
ASBESTOS [1]	Can irritate lungs. Known carcinogen.	Home insulation, dry wall, patching compounds, ceiling tiles. Some baby powders, humidifiers, hair driers, ironing board covers, and oven mits.	Seal cracks, expecially in older homes. Substitute corn starch for baby powder. Use asbestos-free building products.
LEAD [2]	High levels can cause irreversible brain damage or death in children. Lead in the environment can be absorbed by pregnant women and lead to miscarriages. 4—600,000 US children have high levels in their blood (1975-78).	Leaded house paints found in older homes. Dust contaminated by leaded gasoline (90% of all environmental lead). Leaded solder in evaporated milk cans, especially serious when used for formula of under-3-year-olds.	If you live in older home with peeling paint, have children's blood tested. Support groups fighting to remove lead from gasoline.
PCBs (polychlorinated biphenyls) [3]	Liver, heart, blood vessel damage, chronic bronchitis, asthma and limb numbness as a result of long term exposure.	Cork wall tiles (over 1 ppm); drinking straws, kitchen film wrap, baby's plastic pants, plastic foam weatherstripping (under 1 ppm).	Banned in Sweden and Canada. US has partial restriction on PCB use.
FORMALDEHYDE [4]	Respiratory problems and allergies. Formaldehyde is cancer-causing in animals. Especially high concentrations found in mobile homes.	Foam insulation. Aldehydes and other organic substances outgas from formaldehyde used in manufacture of particleboard, plywood, fabrics.	Urea formaldehyde foam is now banned in US and Canada.
AEROSOLS [5]	Heart problems (cardiac arrythmias). Lung cancer. Explosive if heated. Rarely child-proofed. Hydrocarbon or fluorocarbon propellants also dangerous.	Small size of aerosolized particles are deeply inhaled into lungs. Especially dangerous in ill-ventilated bathrooms, e.g. deodorants, room fresheners, disinfectants.	Avoid products packaged this way. Open windows to dispel unpleasant odours or set out a dish of vanilla and water or vinegar and water. Use soap and water to disinfect.

Table 3. Potential Dangers of Appliances

POLLUTANT	DANGER	PRECAUTION/ALTERNATIVE
GAS STOVE [1]	Gas stoves emit carbon monoxide and nitrogen dioxides in varying amounts. Exposure to carbon monoxide on a day-to-day basis may aggrevate or cause a wide range of chronic conditions including anxiety, physical fatigue, rheumatism, arthritis, muscle pain, and headaches.	Forced draft ventilation to the outside may help. Stoves with pilot lights constantly leak small amounts of pollutants into the house. However, some newer stoves don't use pilot lights.
REFRIGERATOR DRIP PANS [2]	Self-defrosting refrigerators have coils which generate temperatures of 100°F. Below them are drip pans. Bacteria grow in this hot moist climate and circulate into the kitchen air from the front gate even when the fridge door is closed.	Drip trays should be cleaned outdoors once a month.
RADIATION: MICROWAVE OVENS [3]	Radiation leakage through faulty seals may result in tissue damage, especially to the eyes. Irreversible cataracts may result. Nerve tissues and white blood cells are also vulnerable to the thermal effects of microwaves. Some research has indicated fetal abnormalities in mice exposed to low levels of radiation.	Examine microwave ovens for evidence of shipping damage. Never insert objects around door seal or tamper with locks. Do not clean seal with abrasives. Stay at least 3 feet away from oven while it is operating. Do not permit children to operate.
RADIATION: TELEVISIONS [4]	In the late 60s some TV sets were found to emit radiation above the maximum recommended level.	Avoid older model TVs. The Surgeon General of the US recommends viewing TV from at least 7 feet away.
RADIATION: LIGHTING [5]	Fluorescent lights, common in kitchens, emit ultraviolet radiation. Exposure may damage the eye. Minute reactions in the eye may occur for years until cataracts are produced. Since the eye lens contains no pain receptors, damage may go undetected until a serious problem develops.	Don't overuse fluorescent lighting.
RADIATION: IONIZATION-TYPE FIRE DETECTORS [6]	All battery powered detectors contain radioactive materials confined in metal containers. How effective these containers are in keeping exposure to a minimum is not yet known.	Photoelectric detectors contain no radioactive material.

The struggles women engage in are varied. They range from fighting for good, inexpensive day care to organizing around issues of equal pay for work of equal value. When women realize that the quality of their household environment is determined by forces outside the home, they may also join the struggles of consumer groups and ecology activists to fight the excesses of industry.

These and many other efforts directly enhance the power of women who work in the home, offering them new maneuverability and choices. These struggles break down the isolating barriers between household and community.

But another barrier must also be breached. That is the division between home and workplace. It is in industry's interest to see these as separate spheres, but it is not in the interests of women or men, waged or unpaid workers. One obvious link to be forged is between unions and housewives. This link already exists in "wives' committees" that sometimes appear to offer support to strikers. But broader and more long-term connections can be made. Women need to know more about household chemicals, pollutants and hazards — information also sought by health and safety committees. Unions need to learn that these problems do not stop at the factory gates. Joint educational and political programs mobilizing waged-workers and domestic workers would be very significant in achieving mutually desired goals.

Creating links between home and workplace also has important implications in breaking down the barriers between men and women. The present system which identifies domestic life as a woman's major task and the workplace as a predominantly male sphere creates the conditions whereby both men and women can feel exploited by the other. It is not enough to get women into waged work. Men must also be brought into domestic labour — child care, housework, emotional support — in deeper, more committed ways. To do so, by demanding, for example, a shorter work week and extensive paternity as well as maternity leaves, will inevitably transform both waged work and domestic labour. The home would no longer be seen as a reward for men's "real" work, but as a worksite itself where both tedious and rewarding tasks are done.

In the struggle to break down all of these barriers lies the potential for a revolutionary transformation of society.

This article is excerpted from a longer article titled "The Home is the Workplace: Stress, Hazards and Pollutants in the Household." It is from a collection entitled "Double Exposure: Women's Health Hazards on the Job and at Home". Copyright © 1984 by Wendy Chavkin, M.D. Reprinted by permission of Monthly Review Foundation. The book is available from 1140 Beaulac Street, St. Laurent 382, Quebec, H4R 1R8

Harriet Rosenberg teaches Anthropology and Women's Studies at York University and has researched housework for most of her life.

BLACK WOMEN ORGANIZE FOR HEALTH

by Makeda Silvera • linocuts by Susan Barsel

Erica Mercer was one of the founders of Toronto's Immigrant Women's Centre where she presently works as a counsellor. She has been working around health and other issues of concern to the black and immigrant communities for a number of years.

Makeda Silvera is a writer and community activist in the black and immigrant communities. Her first book, ***Silenced****, a collection of oral interviews with West Indian domestic workers, will be published early in 1984.*

This year Spelman College in Atlanta, Georgia, was the scene of what has been called the "Conference of the Decade." (Some 1500 students are enrolled at Spelman. Founded in 1881, Spelman is an independently-funded black women's college offering a four-year undergraduate program.) It was a weekend of workshops, speeches, films, self-help demonstrations, exhibits and cultural and physical activities that brought together about 2,000 women from across the United States. The conference was sponsored by the Black Women's Health Project and the National Women's Health Network.

MAKEDA: The theme of the conference — "I'm sick and Tired of Being Sick and Tired" — what does it symbolize?

ERICA: This saying is credited to Fannie Lou Hammer to whom the conference was dedicated. Fannie Lou was a founder of and delegate for the Mississippi Freedom Democratic Party which tried to unseat the "official" all white, all male delegation to the Democratic Convention in 1964. Although it did not get seated, the Mississippi Freedom Democratic Party forced the Convention to begin to take up Civil Rights issues. An activist, freedom fighter and "first lady of civil rights," Fannie Lou was often heard to say in her struggles to effect changes in Mississippi, "I'm sick and tired of being sick and tired." Yet in spite of her tiredness, she remained steadfast in her unwavering commitment and continued her activities for many, many years. The theme is rooted in our historical experience and represents the struggles of black women. It is an expression that black women immediately identify with. I certainly did. I went to Atlanta "sick and tired," but I returned to Toronto with a feeling of renewed commitment.

MAKEDA: What were the objectives of the conference and what motivated the organizers to embark on such an undertaking?

ERICA: The conference brochures state five main objectives:

1. To educate black women about health care and health facts.
2. To present a cultural and historical perspecive on health.
3. To instruct and provide guidance on self-care skills and promotion.
4. To increase awareness about public policies that have an impact on health access and the establishment of a network among black women.

The idea for the conference came into being after the organization of the Black Women's Health Project, a project developed around the model of mutual and self-help activism to empower women to make health care decisions and increase their awareness of reproductive health issues. The conference was perceived as being an integral part of charting a new activism in the quest for good health and well-being. As Byllye Avery, Director of the Black Women's Health Project, put it, the conference would give black female health consumers the opportunity for once to tell health care providers including white men and white women and black men to their faces what we want, need and demand.

MAKEDA: To what extend did low-income women participate in the conference?

ERICA: About 25% of the conference participants were low-income women who were able to attend only due to the extensive outreach and fund-raising effort of the BWHP. Many of the Southern rural women had done their own fund-raising and some of the groups had made attendance at the conference one of their goals and held activities around this goal. I think the conference organizers deserve special credit for making this an important item in the conference. They realized the added burden this put on them but felt that it had to be done.

This is something we should make note of. How often have conferences been stages for special groups and you find 'spokespersons for' instead of representatives from the groups affected? And how often have conference organizers self-righteously condemned a "lack of participation" and "lack of interest," when they never once considered that the time may be inconvenient or one simply could not afford the registration fee or the means of getting to the conference?

MAKEDA: Did you have any special expectations of the Conference?

ERICA: My immediate interest was as a black woman. The idea of such a conference being held excited me so much that I talked to everyone. I could not possibly have missed such an event. What I expected when I stopped to think about it, was the chance to hear from black health care workers and consumers. I expected to compare and share with them types of activities and approaches to problem solving. I hoped

that I would return with lots of materials that I could share with my colleagues at the Immigrant Women's Centre.

MAKEDA: Could you talk about the workshops and presentations? I understand that some were very dynamic and special.

ERICA: There were 60 workshops, and I thought, as I tried to make a selection, that this was madness. The best workshops seemed to run concurrently and it was impossible to attend all those that I was interested in. But I realized that what the organizers had done was to deal with all the issues so that they could accommodate as many interests, needs and viewpoints as possible. The topics ranged from reproductive rights, to aging, self esteem and lifestyles. The workshops were facilitated by health advocates, practitioners and community activists. They were so well-structured that, although they were only one and a half hours long, there was enough time for discussion so that participants really got into the topic.

MAKEDA: What about the presentations that were given? I recall you saying that they were also very powerful and moving.

ERICA: The opening session by Dr. Jane Jackson Christmas, Director of the Behavioural Science Program of the School of Biomedical Education, City College of New York on "Black Women and Health Care in the 80's" was powerful. The thrust of her presentation was directed to the United Nations Declaration on Health — the concept that "Health is more than the absence of disease; it is a state of positive well-being, physically, mentally, socially and spiritually in all its aspects." She defined the "triple jeopardy"' of oppression — racism, sexism and classism and how these interrelate under capitalism. Dr. Jackson called on us to learn the historical causes of sickness, the reasons why we are sick and tired, and to organize for change. She drew a standing ovation and thunderous applause when she called on black voters to make Reagan a one-term president.

The other plenary speaker, Dr. Alyce Gulattee, Administrator of the Alcohol and Drug Abuse and Addiction Program at Howard University (an independently-funded co-educational black university in the District of Columbia) talked on "The Politics of Substance Abuse." That was quite an experience. She talked a great deal on the risks and dangers in drug and substance abuse — the damage to mental functioning, the congenital and genetic abnormalities abuse brings to the reproductive system and how the life force of the black population could be destroyed in one generation. She dealt with issues of race and class, making the connection to drug use and the racism inherent in the way that statistics are compiled and disseminated. Again the message was how important it is for women to take control of our health as the first battle in the struggle to transform our lives and society. The atmosphere was that of a revival meeting — she brought us to our feet so many times. There were tears, cheers, and a lot of stamping and banging. Outside of the chapel where the plenary session was held, I heard women nodding in tearful agreement that, had this been the only address they heard, this by itself would have made the weekend worthwhile. But there was lots more that made the weekend worthwhile for me.

MAKEDA: You mentioned experiences of a very personal nature, do you want to talk about that?

ERICA: Yes. This was a workshop "Black — What is the Reality?" It was so popular it had to be repeated. The workshop was facilitated by Lillie Allen, of the Department of Health Education at the Morehouse School of Medicine. She very skillfully guided a sister to share very intimate and deep-seated feelings that she had held for years. I was very skeptical of what she would achieve with this because I don't trust those soul baring, let-it-all-hang-out sessions that seem so popular with women's groups. That is why what happened in that room was so incredible, why it was such a moving experience for me. There was such an outpouring of love and empathy that I found myself in tears. I cried for me, my mother, my sisters, my friends I left behind in Toronto. We were instructed to hold the person next to us who was in tears. Of course I was not going to hold anybody, I don't like strangers touching me, but as I was crying, I felt these arms around me and I felt warmth and understanding and I felt secure.

The other workshops in Stress Reduction and Burnout Avoidance, Black Women and Sexuality, the Black Adolescent and her Pregnancy were all very dynamic and worthwhile.

MAKEDA: What about abortion? How was that issue addressed?

ERICA: I can tell you how it was addressed by giving the title of the workshop — "Abortion: Choice or Genocide?" That in itself is revealing of the concerns and problems that pervade that issue.

MAKEDA: Can you be more specific? On other occasions we've talked about the attitudes of white women — the fact that they say the black women benefit from the fight for freedom of choice but are not active in that struggle.

ERICA: Yes, that is a sore point with me as you well know. I am talking about the difference not only in perception, but also in standpoint. Black women and other women of colour support a definite distinction between being pro-abortion and being for abortion rights. As black women, we have had our reproductive rights curtailed, beginning with slavery when our children were taken from us as free labour. Some of us aborted and others even killed their children rather than see them grow up as slaves. But choosing between death or slavery for our children was no choice. We support abortion rights because we know only too well the consequences of their denial. We are the ones who have to resort to the back street abortions and the often fatal consequences. The pro-choice campaign, as articulated by "the women's movement," comes from a very middle-class white perspective which assumes that *all* women *can* make choices as to how they will develop their potential, advance their careers, have children or not, be able to provide for the children they have. But for black women, for Third World women, for women of colour who form the majority of poor women, there are no choices. We are battling for our economic survival — combatting low wages, high unemployment, housing and so on — which interferes with any notion of choice in the matter. Pro-choice has not addressed our reality.

MAKEDA: In the past the women's movement has also been criticized for not speaking to the needs of black women, particularly because of the high incidence of sterilization among

poor black women.

ERICA: As far as sterilization goes, there is a difference between the situation in the United States and in Canada, even in so far as the extent of the sterilization abuse practices in the States. Here in Canada this does not seem to have occurred to the same extent, although there are reports of sterilization abuse of native women and among the developmentally handicapped.

There is a more fundamental issue that goes beyond abortion rights. It has more to do with attitudes coming from a class perspective. It is in keeping with the fact that the composition of the white women's movement, although experiencing oppression because of sex, is actually in a position of dominance. This blinds the movement to the real concerns and priorities of the women they presumably set out to help. Unless the women's movement undertakes some critical analysis of itself and the ideological underpinnings of the movement, I think we will continue to have the problem of them badgering us to take the "correct" position and we will continue to criticize them for being classist and racist. I know of some progressive elements in the women's movement here in Canada who are trying so I don't think we will remain at that impasse.

MAKEDA: Since we are on the subject of racism I understand that some white women who attended some workshops were asked to leave. What are your feelings on that and why were they asked to leave?

ERICA: I was in a workshop on "Black Women and Sexuality" where women asked for the white women to leave. It was not billed as a black only workshop. Not all the women agreed that the white women should leave, but I voted with the others because I appreciated the sentiments expressed about not revealing one's most intimate self to strangers. The facilitator, sensing the disappointment and anger of the white women, asked them not to regard the exclusion as rejection. I do agree that it should be made clear from the outset which workshop was exclusively for black women, but we will have to continue to make these separations, given the tradition of mistrust that exists between us.

MAKEDA: And what about feminism

ERICA: The question was not raised. In fact, I don't think I heard the word feminism once. Yet it was obviously a very feminist undertaking. What could be more feminist than women organizing themselves to talk to each other and everybody else about their health concerns? That by its very nature is feminist. In Atlanta I was among sisters, among family. It was as though I were at home just waiting for my room to be fixed up. And that is sisterhood, the essence of feminism.

MAKEDA: Were your expectations of the conference fulfilled?

ERICA: My expectations were fulfilled in more ways than I could have ever imagined. There were some beautiful experiences. I also got a lot of information and materials that I brought back with me. The renewed commitment that I referred to earlier came from seeing the displays of the self-help groups and listening to the women talk about the different ways they organize themselves around specific issues. It gave the concept of self-help new meaning. I was able to see, in a way that I had not perceived before, the potential and power of such groups. I immediately began to envision the groups that could be formed around a number of health issues and the resources that could be unleashed. Though most of the groups remained basically oriented to health issues, the analytical and critical work they engaged in is bound to take them beyond health as such.

MAKEDA: When you came back from Atlanta you said that the general feeling of black women present was that they were at war. What exactly does that mean?

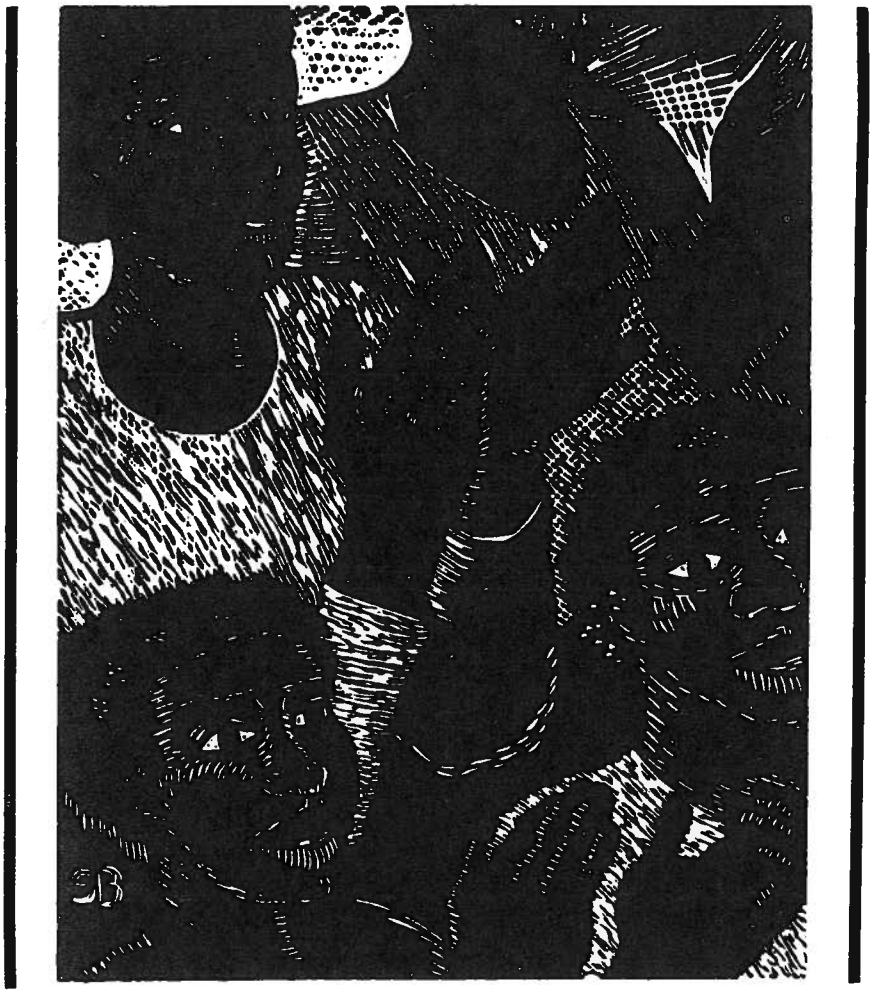
ERICA: They are "Women at War"; they are unarmed combatants fighting against the economic policies of the Reagan administration that seems hell-bent on annihilating them. There were chilling statistics that showed the effect of budgetary restraints and cutbacks in federally funded programs. According to the National Health Law Program, in 1981, infant death rates increased in eight states: Alabama, Alaska, Kansas,

Michigan, Missouri, Nevada, Rhode Island and West Virginia since Reagan's election. There was a strong undercurrent of urgency around the situation of blacks in the U.S. today. In just about every workshop, in every presentation, women were being called upon to prepare themselves physically and mentally to take on the struggle, to prepare to return to their communities and, if not involved in community action, to start immediately. That is a war cry.

MAKEDA: What would you say was the most significant thing about the conference for black women? Would you say it was in methods of organizing around general health care or was it around a particular health concern, for example, high blood pressure?

ERICA: I would say both areas were significant. *Network News*, the newsletter of the National Women's Health Network, featured the Conference and discussed some of the particular health concerns raised. Black women have double the rates of high blood pressure, infant mortality, diabetes, teenage pregnancy, cancer and lupus as the rest of the population. Of all the factors that account for the health differential between blacks and whites, high blood pressure and related diseases make the greatest contribution. One of every four black adults suffers from hypertension, as opposed to one out of every six white adults. Not only is it more frequent among blacks, it also develops earlier in life, is often more severe, and causes higher mortality at an earlier age. Deaths from high blood pressure before the age of 50 are six to seven times more common among blacks than whites. (NN June 83)

According to Dr. Gerald E. Thomson of the Harlem Hospital Centre in New York City, for all ages of black women, the incidence of high blood pressure tends to be either equal to or higher than that of black men, depending on the survey reported (NN June 1983). Some of the contributing factors of particular importance to black women whether they are hypertensive or know someone who is, are heredity, obesity, salt intake, birth control pills and smoking. High blood pressure is considered by many to be the greatest health threat to blacks in the U.S. For every black who dies from sickle cell anaemia, an estimated 100 die from high blood pressure-related diseases. What must be noted as well when we talk about hypertension, is the incredible stress of being black and poor in a racist society. We talked earlier about black women being at war — no population at war can expect not to suffer heavy casualties.



MAKEDA: Do you think it's possible to have a similar type conference for black women, sponsored by the Immigrant Women's Centre for example?

ERICA: Wouldn't that be wonderful! But I'm afraid such a conference is not something that can be organized in the immediate future. Let me list the many reasons why. First we have to get rid of a lot of stuff that gets in the way of organizing ourselves as black women in order to give us the kind of clout we need to demand our rights from the state. We first have to deal with our diverse backgrounds in a constructive way. This is not a major problem but our differences are exploited by the people whose interest this serves. So instead of getting down to brass tacks we find ourselves arguing over who arrived on Air Canada or who came with the underground railroad and which group has the right to make demands on the state and which group should be grateful to be present. Until we get rid of that garbage we can only come together as small, separate, weak groups.

There also has to be a heightening of consciousness around health care as an important issue around which to organize women. Women's health care has been on the back burner, left for later when other matters are taken care of. Unless we ourselves recognize that fact and begin to change our perspectives, then such a conference is not possible.

We should not consider holding a conference without allowing the time needed to plan properly, to strategize so that we get the outcome we want. Too many national conferences have left me wondering about the outcome when the last resolutions had been written. I don't think we can afford the expense of time and resources. We learned some valuable lessons in Atlanta that we should heed.

MY STORY, OUR STORY

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

Greenham Common Cloaked in Purple and Green

by Carol Hay

In September last year I went back to England to visit my family and friends, to rekindle a piece of my past. The current political climate also shaped my visit. I knew about the siting of the cruise missile in Europe, I had read about large demonstrations of protest in many European capitals and I wished our protests here in Canada could be as powerful ... but I had never faced what it must be like to actually live in the European theatre where the battle for nuclear superiority is in progress. Being close to that level of arms escalation stirred up many thoughts in me. In the midst of these realizations I learned more about the women's peace camp at Greenham Common, which I had previously heard about only from piecing together friends' letters and the occasional news story in the Globe and Mail.

Greenham Common is a Royal Air Force base leased to the US Air Force for the deployment of cruise missiles. Greenham is common land — that is, owned by all — situated outside the small town of Newbury, 85 kilometres west of London. For over two years a women's peace camp has been set up there to protest the placement of nuclear missiles in England. It was started when a group of women marched from Wales to Greenham to show their opposition to the arms build-up and to focus public attention.

The women have made the public land surrounding the base their home, using the chain-link fence as walls on which to hang photos of their children, friends, lovers and symbols of life: flowers, children's toys, mementoes and poems. In places the fence has been crocheted to transform its coldness with brightly coloured wools and cottons. The women have adopted the green and purple colours of the British suffragette movement for their banners, posters and buttons. There were some women at the October 22 rally in Hyde Park wearing Victorian dresses in the Greenham colours. A link back to that bit of history.

From a small group, the Greenham movement has grown until it is now a symbol of nuclear protest throughout England. Last December 30,000 women converged on Greenham Common to "Embrace the Base," literally holding hands and enclosing it. There have been keening days at the Houses of Parliament, where women have wailed in sorrow. Women have blocked the laying of sewer pipes at Greenham by lying down to prevent bulldozers from working. Others have woven large woolen webs as a symbolic protection of the land from nuclear destruction. One 70 year old woman for months climbed the fence every day as her protest.

When I left England last Halloween weekend, 187 women were arrested at Greenham as, armed with two foot bolt cutters, they cut through the chain-link fence. Police and U.S. marines ran up and down the perimeter rolling in barbed wire to stop the women from getting onto the base. As the first missiles arrived women chained themselves to the fence. Over 500 were arrested.

The closer to death the world comes, the greater I feel the need to create, to celebrate like those women at Greenham who climbed the fence and danced and sang on the nuclear silos at dawn on New Year's Day. It may sound corny, but I really think there is a place for the power of love, for a life force in overcoming the destructive forces that draw us closer to annihilation. Perhaps this is the source of strength we need to know how to survive and continue to live in a world that verges daily on disaster. I want to feel the force of women, tenderness and sensuality, openness and nurturing. I want us to reclaim our creative powers and use them to combat destruction.

While I was in England, my brother read my palm. He said I had a life line that splits. One life is stronger; the other fades away. I don't know whether that means my life in Canada and my life in England, or my political life and my creative life.

Carol Hay is a former community worker now involved in theatre. She wrote this text as part of an all women's theatre event scheduled for performance in Toronto in March 1984.

REVIEWS

Menopause Resource Kit

Facing the Change of Life, *Planned Parenthood Newfoundland/Labrador, 203 Merrymeeting Road, St. John's, Newfoundland, A1C 2W6. $35.00 including postage and handling.*

Reviewed by Sidney Thomson

According to the introduction, *Facing the Change of Life* "... was intended to be used as reference material by a group leader in order to facilitate discussion in a self-help group on menopause." In my opinion the kit carries out its purpose admirably. It is the first "teaching manual" on menopause produced in such detail that I've seen, and I'm impressed by the number of topics covered, and differences in viewpoints expressed. For example, in the section dealing with Estrogen Replacement Therapy, we are told in detail about the different ways estrogen may be taken, the potential benefits and risks, possible side-effects, contraindications, other factors to consider, as well as being given reading references from a variety of sources. Altogether I feel the writers have given a reasonable and well-balanced presentation of this difficult and controversial topic.

The information in the kit (usefully presented in a loose-leaf binder) is meant to be used over six session periods. We are given first an introduction and guide to its use, as well as a page outlining in detail all six sessions, including handouts for each. Next are the session materials themselves: each containing an outline, resource material in painstaking detail (with footnotes), recommended readings for both leaders and participants. These are followed by photocopies of some of the reading material. Other readings are in the form of pamphlets in a pocket at the back of the binder. In fact, most of the material recommended for reading and/or handouts (with the obvious exception of books) come with the kit — a great convenience and time-saver.

I have two minor quibbles: the handouts are listed only in the general outline at the beginning of the kit, and I think it would be useful to have them included as well in each session outline. More frustratingly, there is no source reference on the photocopied material at the end of each session. If you want to use it independently of the kit, as I did with a particular excerpt, you must return to the list of Recommended Readings to find the source, then type it on the material itself before photocopying.

Finally, at the end of the kit are a comprehensive bibliography and information on how to obtain some of the pamphlets and audio-visual aids.

The resource material for the six sessions covers all of the important aspects of menopause itself, and there is good coverage of related topics. The subjects include: definitions of menopause and social attitudes toward it: the physiology of both menstruation and menopause; good information on hysterectomies; symptoms and remedies, including a thorough examination of ERT; other stresses and changes in personal life which may coincide with menopause; male mid-life changes; sexuality, birth control and aging (all three in one session!); the role of diet and exercise; women's health in general with emphasis on better use of doctors and the health care system. There isn't much about some aspects of self-help care (e.g., herbal remedies) in which there is a growing interest, and my own preference would be to enlarge on the social and psychological aspects affecting aging and women's self-esteem in the years following menopause.

However, I think it is important to remember that this kit was produced in and for a specific geographical area, with its own outlook and resources. What impresses me is how much the kit is applicable to all regions and to all women. It is potentially a very valuable tool in any menopause workshop. The authors have avoided complicated medical jargon. I like their straightforward, easy-to-read style, which I find both an appropriate and effective way to present this type of complex material to a lay audience.

Both the Project Manager and the Researchers/Writers are to be congratulated on an excellent and much-needed piece of work. The cause of raising the quality of life for women in their middle years has been well-served by their efforts.

Sidney Thomson is a freelance facilitator of workshops for older women. She is especially interested in health issues surrounding menopause and in the potential for personal growth and new learning which both men and women have in middle life.

More Than Just Sex

Woman's Experience of Sex, *Sheila Kitzinger, G.P. Putnam's Sons, New York, New York, 1983, $24.95 hardcover.*

Reviewed by Cynthia Manson

As I read the Contents page of Sheila Kitzinger's new book, I felt slightly daunted by the task that lay ahead of me. Was all this material necessary? Halfway through the book, I answered my question. Yes — of course!

As women, we need to know and understand our bodies and feelings, our transitional stages. We need to know and discuss relationships and sexual difficulties, as well as sex and power, loss and grieving. All of these topics and more are included because they are part of every woman's experience regarding sex and her sexuality.

This is not, as Kitzinger states, "just a how-to book." Writing in the foreward, she says that she has "deliberately weeded out the assumptions made about our sex and our feelings which do not fit women's direct experience. That is, I have rejected men's explanations of our behaviour and feelings as irrelevant, except in so far as they affect our view of ourselves." Through women's responses to her

research questionnaires, she defines and explains the depth and variety of women's experiences.

As I read through each chapter, I kept thinking that most of what is discussed has been said before, but still I felt excited at reading, learning and relearning many things, and being made to look at some issues in a new light.

The opening chapter deals with sex and self-worth, sexual stereotyping, sexual ideologies, sex and language. There is also a good and concise historical presentation of society's attitudes towards sex (and more precisely women), from Victorian times through the 1920s, into the sixties and beyond. She provides a good discussion on the difference between feminists and the sexual liberationists with whom society always seems to compare feminists. Kitzinger wraps up the chapter by writing, "It is time we reassessed widespread assumptions as to the overriding importance of genital sex in our lives."

One of the best chapters is entitled "Sexual Life-Styles." The first section deals with "loving men." In the opening paragraph Kitzinger states that there is a "difficulty in writing about heterosexuality, because for many women it is the unstated and implied basis of our sexuality ... It is 'natural'." She also states that women "are certainly no longer accepting monogamy as God-ordained." She, as are most women, is questioning the concept of marriage as it relates to the new roles of men and women in society.

The next section is devoted to "loving women." Kitzinger realized that as a heterosexual woman she could not and should not write this chapter and turned it over to her daughter Celia, a lesbian and a psychologist, who had helped her with the research. For this, Kitzinger must be praised and applauded. As she mentioned at the beginning of the book, she has "rejected men's explanations of women's behaviour and feelings." So too should lesbians reject what heterosexuals write about them, as being irrelevant.

This section opens with the statement "A lesbian is a woman who loves women" — a simple yet powerful statement because it takes lesbianism out of the realm of just sex and portrays it as a lifestyle that is political, powerful, joyful and fulfilling. There was one part that I had a little trouble with, — the section on "telling people." While I agree wholeheartedly with the direct, honest and non-apologetic approach espoused, it does seem easier said than done. On the whole though, "loving women" is just that — loving, caring, respecting and very well presented.

The last section of this chapter, entitled "Celebrating Celibacy," is perhaps one of the best analyses I've read on the topic. Differentiating between the "unwilling celibate" and "positive celibacy," Kitzinger demands that society re-define its language regarding single women and its attitudes towards them. Choosing to be single and also celibate in a couple-oriented, sometimes sexually obsessed, society can be very difficult.

The following chapter deals with relationships — how to communicate your feelings; developing your self confidence; touching and timing (stressing their importance); massage; and also a section on the physically challenged. I was very pleased to see this section included, because all too often we forget that the physically challenged can and have a right to be sexually active, if they choose. The section talks about the inhibitions of others, sexual aids, stimulation and arousal, planning ahead, contraception and making love. A must for all to read.

"Children and Sex" treads into areas where most people, however enlightened and progressive, fear to go. Kitzinger's opening line "Even babies have sexual experiences" is bound to create a stir in some quarters. The method of presenting the information is good, accurate and non-threatening. The section on baby massage is particularly good. Kitzinger re-affirms what others have stated — children learn their values and attitudes about themselves, their bodies and their sexuality from adults. If adults are not comfortable with the issues, neither will be their children.

In the chapter "Sex and Power," Kitzinger draws on women's experiences of sexual abuse — incest, rape/sexual assault, sexual harassment — to describe society's attitudes towards women and how those attitudes affect our feelings about ourselves. Her statistics are valid and the description of the range of feelings and emotions quite correct.

The last chapter deals with loss and grieving. As I mentioned at the start, I wondered about the inclusion of some of the topics, but I see now that this is a necessary one, as it is one that seldom is discussed. Kitzinger deals with the shock of death, the death of a loved one, the death of a baby and all the feelings that surround this topic. She also includes a section on mutilating operations — hysterectomy and mastectomy — and the changes that they can make in our lives.

Kitzinger's *Woman's Experience of Sex* is perhaps one of the best and most comprehensive books on sexuality. The photography by Nancy Durrell McKenna does much to enhance the text. It is a book that encourages us to take a more positive look at ourselves as sexual as well as emotional beings and to use both to become more fulfilled. It is highly political, but not in the usual didactic sense. We know all the women whose experiences are portrayed — they are all a part of us.

Cynthia Manson is a volunteer with and a trainer in human sexuality for Planned Parenthood, Ottawa.

LETTERS

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

Feminist Debate Encouraged
I am writing to thank all of you for the courage, intelligence and sensitivity of the last issue. I understand the criticism you risked, both as individuals and as a collective. The issues you raised are ones that will encourage debates which must happen for feminism to move forward and have a deeper impact on our world.

Thank you for discussing the grief of abortion. Because I am a midwife who is pro-choice, many women have shared their feelings about abortion experiences with me. I have often been disturbed by the extent to which many women keep hurt and pain about abortion hidden. They have no context in which to understand or come to terms with these feelings, and this may have a profound effect on their willingness to defend women's right to choose when and whether they wish to give birth.

In unchosen pregnancies, women may deeply regret that they are not in a situation which would allow them to raise a child. Anti-choice propaganda often presents abortion as an indulgence for the convenience of an individual. And many women, although they find they cannot raise a child, internalize this attitude and feel that it is themselves i.e. their *personal* situation, which is to blame.

But for many women I know, it is not clear that they don't *want* a child, it is clear only that they cannot raise a child in the situation our society puts women in.

The grief around abortion is a sorrow that we do not live in a world that supports mothers as human beings with lives to live beyond raising children. It is a sorrow that we do not live in a world that welcomes and cares for children, and values parenting. The pain comes from having to act out and take responsibility for *our society's rejection of children.* Women during unplanned pregnancies mourn the fact that they live in a world in which abortion is a necessity for so many women.

Many people who spoke to me in response to your article expressed a great deal of discomfort over the idea of joyful abortion. Considering all I have just mentioned regarding the sorrow of abortion, I feel it is important to share my response to this as well.

There is an incredible range of emotion that can be involved in most reproductive experiences. Through pregnancy, labour, birth, miscarriage and abortion, women feel pain, pleasure, joy, sorrow, fear, courage, anger and love, often simultaneously. I remember a woman who wanted a child more than anything else, confessing to me a day after her miscarriage. She found it strange and almost shocking that although she was devastated by the loss of her baby, the experience was exciting and powerful.

I would like to confirm Connie Clement's assertion that for a woman who faces the choice of being operated on and needlessly anesthetized, the emotions involved in choosing to participate in ending her own pregnancy could include joy.

Thank you also for both offering your criticisms and recognizing the strengths of the midwifery movement. Midwives draw support from a very broad base of women. They fear they will alienate families from very traditional backgrounds if they publicly take a position on the abortion issue. Women who are involved in organizations such as the Midwifery Task Force, fighting for the legal recognition of midwifery, feel their mandate is to work to make the services of midwives available to all women. There is no consensus among them around the abortion issue, although many of them are strongly pro-choice.

As midwives, part of our hesitation on this question may reflect the very real fear of harassment, arrest and trial which we all live with. Part of our history as women helping women, includes the murder of millions of women, many of them midwives who provided women with information and care about birth, birth control and abortion. Today the persecution of midwives is rapidly increasing and very frightening to us. Perhaps this part of our history, and these very real fears of taking access to control of reproduction, limits both the pro-choice movement's willingness to question the medical control of abortion and determines the midwifery movement's desire to ignore the abortion issue altogether.

Your article has helped both supporters and midwives themselves to understand the potential for unity of all who are working for reproductive choice for women, and to question the underlying power structures which rely on controlling and limiting women's choices.
Vicki Van Wagner
Toronto

Taking Control of Our Lives
We are writing to commend Connie Clement for her courage in writing "A Case for Lay Abortion". While it is politically unfashionable these days to talk about controversial issues, such discussion is essential if we are to recover our bearings and clarify our goals. Connie's article is one of the few that has appeared which attempts to return to radical "first principles," and that, moreover, challenges many of the technocratic assumptions of those defining issues.

What can be demanded of the state seems the limit to some people's imagination; people taking control of their lives is an alien concept, although the lowest common denominator and "one issue at a time" may seem more effective.
Don Alexander, Jennifer Sells, Samuel Wagar
Toronto, Ontario

Genital Mutilation Debated
In reply to Ms. Hosken (See *Healthsharing*, December, 1983), I would like to begin by saying that she is renowned for her contribution to the good and just cause of eliminating female circumcision and genital mutilation and her additional comments on the subject are welcome.

My article was not reproduced in its entirety and some of her queries may have been answered had it not been for the inevitable editing process. Where she criticizes the article for being so superficial as to be useless, I cannot concur with the opinion that the reader is ill-informed by the omission of most of the facts. Ms. Hosken, who with her extensive and specialized knowledge on female circumcision, considers herself one of the world's foremost authorities on the issue, and will naturally find an article aimed at the readers of *Healthsharing* to be not far-reaching enough.

Secondly, Ms. Hosken seems to ascribe to me the opinions of those people whom I interviewed and whose quotes are used. If she were to reread the piece carefully, she would undoubtedly see, for example, that I am not attempting to support the introduction of the operation into hospitals. Rather, I allow for the opinions of African women (whose opinions, after all, should be sought) like those of Aissatou Diop, who propose hospital operations as a short-term solution.

In response to Ms. Hosken's comment that "there is no mention of how many women are affected and where the operations are practised," I would refer her to the sixth paragraph "It is estimated that between 20 and 74 million babies, girls and women have undergone some form of genital mutilation" and further down on page 17, third column, second paragraph, "Infibulation is practised in southern Egypt, parts of Ethiopia, etc.".

It is well known that any group of people attacked in a sanctimonious and self-righteous manner on traditional practices (however objectively undesirable) will respond defensively. An understanding and less contemptuous approach, however, is more likely to lead ultimately to self-examination, increased knowledge and hopefully, the termination of the tradition.

Ms. Hosken, with all her knowledge and experience in this field, can, I would submit, much better serve the cause to eradicate genital mutilation by adopting a posture of tolerant understanding rather than one of blitzkrieg overkill. I have tried in my article to present both sides of the issue (however clearly people of our culture and values may see the issue as one-sided)

and let the reader reach her own conclusions.

For my part I cannot see how genital mutilation can be reasonably defended and any impartial, independently-minded reader must come to the same conclusion.

Paulette Roberge
London, England

Evening Primrose Oil Reduces PMS Symptoms

Please renew my subscription to one of the most interesting and useful magazines around.

While I have your attention I would like to comment on Karen Walker's article on "Help for Premenstrual Syndrome". Having suffered, yes, suffered with PMS for years, I tried the whole range of methods suggested by the author except for the hormone therapy. That was too scary for me after having been a user of The Pill.

None of the methods described in the article touched the problem of my PMS. However, after 10 days on Evening Primrose oil suggested by my chiropractor, my PMS symptoms were reduced by 75%. A month later the symptoms were reduced by 95%. I say 95% because I am not quite certain if the 5% symptoms are really PMS or simply my experience of menstruation, an awareness of the process.

Why does Evening Primrose work for me? It is because I have an essential fatty acid deficiency. No I am not skinny but rather my body seems unable to convert lineolic acid to gamma lineolic acid which is the precursor to prostaglandin production. This last element is essential for local organ control. Without local organ control or reproductive system control over the menstrual cycle, the pituitary or master gland takes over giving a systemic response to what should be a local condition. Voilà, you have a total body reaction to menstruation or PMS. With Evening Primrose Oil supplying the necessary gamma lineolic acid I can produce my own prostaglandins and leave the pituitary out of my menstrual cycle.

The result is that I feel and look forward to my menstrual periods as a time of increased energy and cleansing of my body, rather than a time to dread in which I would have to exert enormous control over my emotions and change my clothes to one size larger. Three cheers for Evening Primrose Oil. I hope the PMS clinic in Mississauga takes note, but it might just put them out of business.

Phyllis Jensen
Toronto

Cover Insults Women

The cover of the Winter '83 edition is, in my opinion, insulting and demeaning to women.

Is the next issue going to show the same parts of men?

Why not?

Mrs. E. Amey
Maple Ridge, B.C.

Magazine Not Relevant to Northern Women

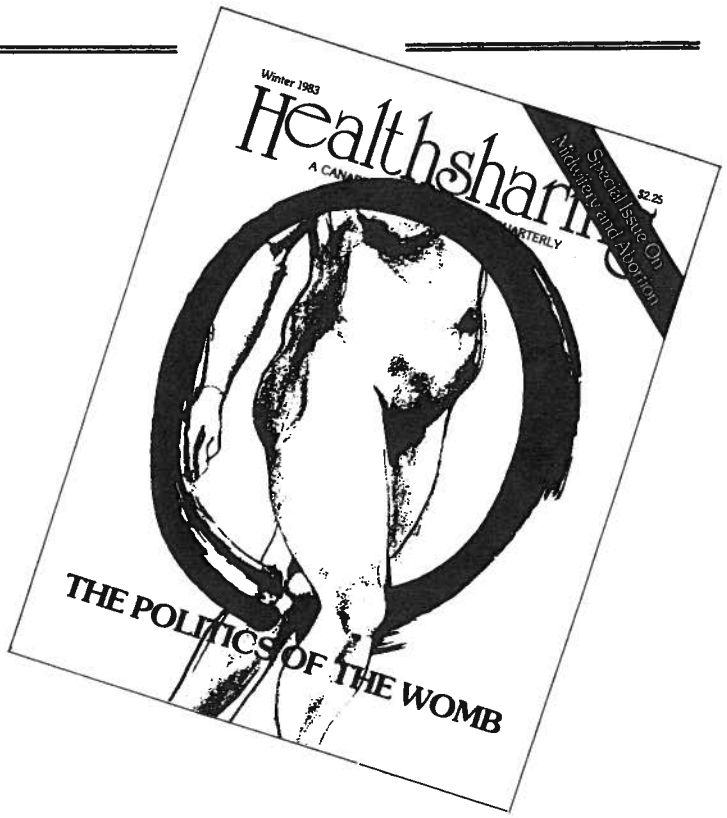
Thank you for the dear Ex letter — it was well worded and a good idea. My reasons for not renewing include the fact that I don't make very much money anymore and *all* my resources are committed to the struggle of Native people for land resource use rights. On a personal level I have more reading than I can keep up to surrounding these issues.

Your magazine is an excellent resource for urban women but it is not too relevant to the problems of isolated rural and northern women — just getting a nurse in northern Canada is a great problem.

With your limited resources I don't imagine that our issues will ever be able to be addressed and I'm not sure that your format can cross the class barriers involved. The fact remains that we still on a day to day level are an *oral* culture of poor isolated people and do not have access to the support systems that generate the kind of choice your magazine is about.

Along with a *small* handful of North American magazines yours can be included as useful, supportive, progressive etc. I hope you continue to have the resources to keep publishing — if I had extra resources and time I would continue subscribing.

M.
Pinehouse, Saskatchewan



DES Action Responds

On behalf of DES Action/Canada I would like to thank you for the in-depth story you recently published on DES in your magazine.

We want you to know that you have helped us tremendously in reaching our goals of making the public aware of this issue, and we are most grateful that Canadians are now getting the proper health care required.

Shirley Simand
Secretary DES Action/Canada
Montreal

My Story Corrected

Your Winter 1983 issue is very strong. I was proud to have My Story included in it. I was upset at what had been done to the story during the editing process. It was a relief to learn this kind of editing was due to unusual circumstances.

Besides the typos and choppy editing (which considerably lessen the quality of my piece) there is one serious alteration which gives false information on my birth experience. My statement that "after 3 hours I felt a slight urge to push", which is tacked at the end of the paragraph where my doctor comes to the hospital and I am brought to the delivery room actually comes before that paragraph. After receiving the epidural it was 3 hours until I felt the urge to push. This is clear in my original, unedited version. I can't imagine why that statement was taken out of context.

I am a careful writer — always trying to be clear and to avoid exaggeration. This image of me lying in stirrups for 3 hours, just staring at the ceiling is ridiculous.

You should correct this in your next issue. I would also appreciate an apology for the poor editing and proofreading. In tone, quality and information "Powerless in Hospital" is poorer than my original story. For me it is the weak spot in an otherwise excellent issue.

Marlene Pyykko
Montreal, Quebec

Apologies

- To Ruth Chernia for spelling her name incorrectly in the masthead in our December issue.
- To Janice Tufford for overlooking to include her name in the December issue masthead.
- To Vicki Van Wagner for not crediting her with the transcription of Sheila Kitzinger's lecture *Nurturing Mothers* which was reprinted in our December issue.
- To Marlene Pyykko for the poor proofing and editing job we did with her piece *Powerless in Hospital* in our December issue.

64 St. Clair Ave. W., #612
Toronto, Ont.
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Professional Development Workshop

Maximizing the potential of women and families is the theme for this one day conference on Nutrition and International Development, to be held at Ryerson Polytechnical Institute, in Toronto, on Saturday, June 30, 1984, 9:00—4:00pm. Workshops include: Nutritionists as Agents in the Process of Development, Women and Co-operative Initiatives, Birth Control/Family Planning, Food Production and Processing, Health and Consumer Education, and Development and Planning.

The fee of $40.00 includes lunch. Mail fee and choice of two workshops to: Professor Jennifer Welsh, Department of Food, Nutrition, Consumer and Family Studies, Room S241E, Ryerson Polytechnical Institute, 50 Gould Street, Toronto, Ont. M5B 1E8.

Sexually Transmitted Diseases

The Montreal Health Press, a non-profit women's collective, has just published *A Book About Sexually Transmitted Diseases*. This replacement of the popular *VD Handbook*, provides a serious and thorough discussion of STDs both from a social and medical perspective. Complete and informative, it promises to be a valuable resource to anyone working in the educational, community or public health field.

As with other Montreal Health Press publications, pricing is intended to encourage bulk purchases for subsequent free or cheap distribution. Large bulk orders (500 and up) cost $250 per 1,000 plus shipping. Small bulk orders (300 copies or less) are sold in lots of 50, with prices, including shipping, ranging from 60¢-90¢ per copy. Individual copies cost $2.00 including postage.

Order from: Montreal Health Press, Inc., P.O. Box 1000, Station "G", Montreal, Quebec, H2W 2N1. Phone: (514) 272-5441.

Self-Help Group Handbook

Helping Ourselves: A Handbook for Women Starting Groups is an easy-to-use practical book for women who want to share and solve problems with other women. It is published by the Women's Counselling, Referral and Education Centre of Toronto, a non-profit organization committed to providing alternative mental health services for women. The book is available at a cost of $5.00 by writing to W.C.R.E.C., 348 College Street, Toronto, Ontario M5T 1S4.

Women's Self-Help Kit

The *Women Self-Help Educational Kit* is a resource kit designed to help women, particularly isolated and rural women, gain access to the skills and information they need to make changes in their lives. This kit is intended for use by women in groups and can be used to create, sustain and support groups exploring issues of personal and social change. The kit includes three sections: a Facilitator's Training Manual, a Self-Help Handbook and a Collective Handbook.

The kit costs $25.00 and is available from the Women's Self-Help Network, Box 3292, Courtenay, B.C. V9N 5N4. Phone (604) 338-1133. Also available is a half-hour long video-cassette (½ inch) for a cost of approximately $20.00.

Magazine Promotes Self-Care

Wellspring is a new magazine dedicated to promoting self-care. It is chock-full of information and resources on how the individual can become an educated and discriminating consumer of health services.

A one year subscription (four issues) costs $10 ($8 for seniors, students, or multiple orders). Send to: Wellspring Magazine, Network Centre of Self-Care, 435 Simcoe Street, Victoria, B.C. V8V 4T4.

Menopause Booklet

The Time of Our Lives is a booklet designed to answer questions and allay fears that commonly occur around middle age and menopause. Written in consultation with health professionals and middle-aged women, the pamphlet is intended primarily for women who would not be likely to ask questions or to research menopause. The language is simple and easy to understand.

Pamphlets are free, but quantity is limited. Send orders to: Ann Thurlow, Box 4, Souris, P.E.I., C0A 2B0.

Birthing Film

Birth In The Squatting Position is a new film showing this traditional method of giving birth adapted for use in a modern hospital setting. The ten minute, 16 mm or video cassette colour film is available from the Canadian Learning Company, 67 Mowat Avenue, Suite 338, Toronto, Ontario, M6K 3E3. Telephone: (416) 535-7368.

Help for Fundraisers

The Grassroots Fundraising Journal is a useful quarterly publication for grassroots groups trying to keep on their feet. For subscription information write: Grassroots Fundraising Journal, P.O. Box 14754, San Francisco, California, 94114.