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Healthsharing

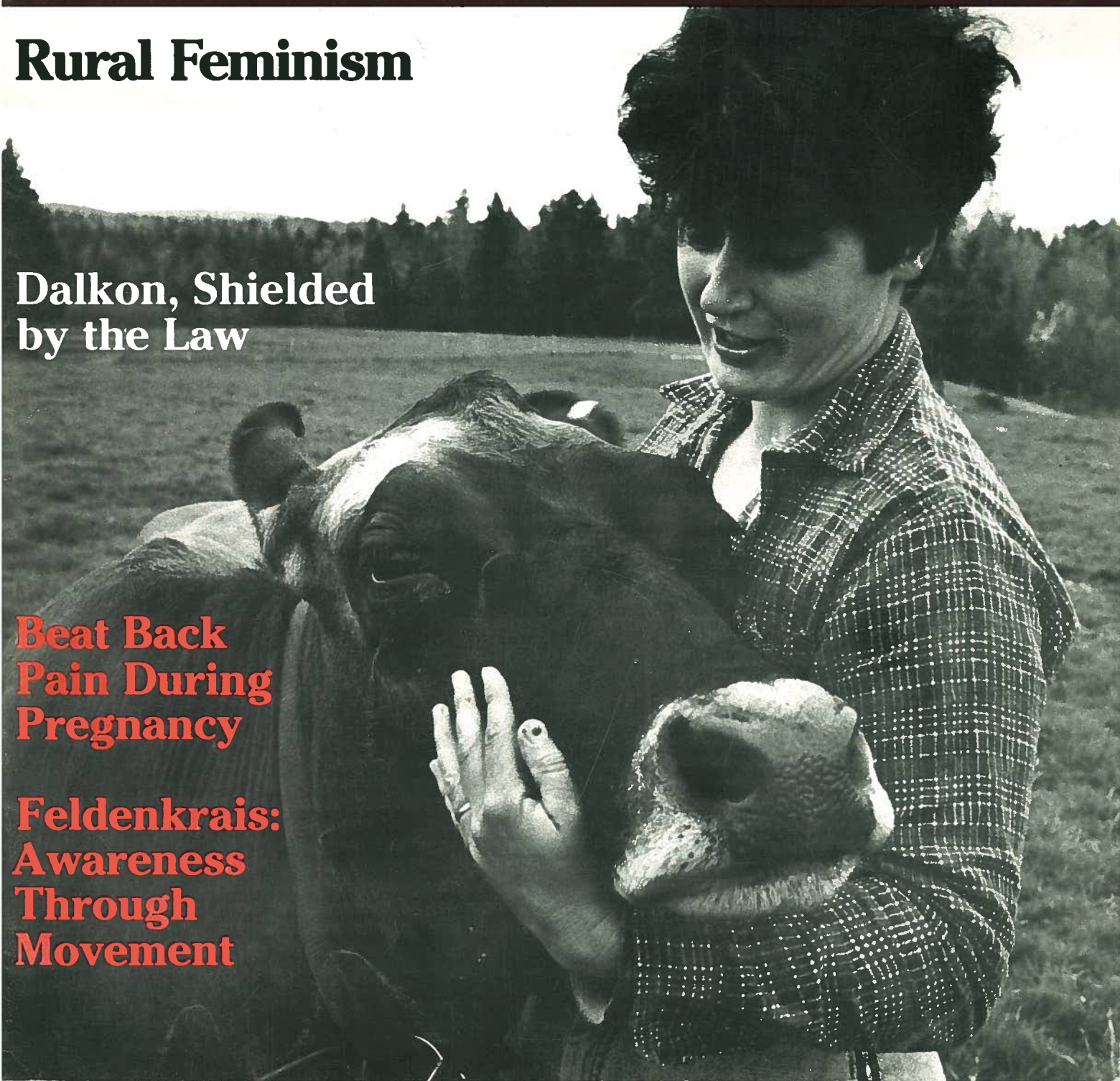
A CANADIAN WOMEN'S HEALTH QUARTERLY

Rural Feminism

Dalkon, Shielded
by the Law

Beat Back
Pain During
Pregnancy

Feldenkrais:
Awareness
Through
Movement



INSIDE

Healthsharing

Vol 7: 1

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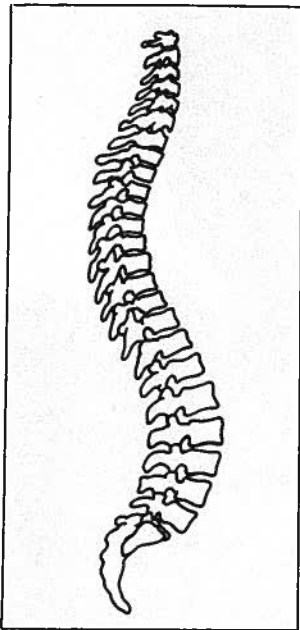
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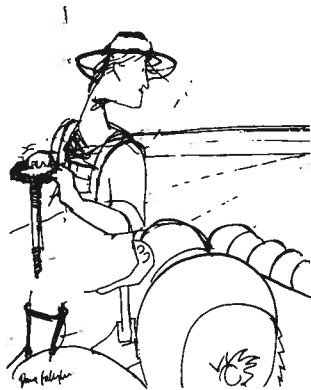
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COLLECTIVE NOTES

Better Than Ever

As *Healthsharing* moves into its seventh year of publication, we as a collective continue to work towards becoming even more representative as a national magazine. We've learned more about the constraints of our Toronto location and, with each issue, we learn better how to reach beyond our geographical boundaries.

Healthsharing was initiated to fill a major gap we perceived in mainstream newspapers – the lack of coverage of health issues, from a pro-woman, critical perspective. Additionally, mainstream media has ignored and continues to ignore grass roots and regional news items. Yet for us at *Healthsharing*, it is of utmost importance to know, for example, what women in Debert, Nova Scotia, and in Kamloops, B.C. are doing and what health concerns are issues for them.

Healthsharing continues to try to address this need, to be pan-Canadian. Part of doing so is the recognition and respect of our diversity in its many forms: geographically, and also in terms of our language, our class, our faith, our physical and mental abilities, and our sexualities. It is important to know both that we share common experiences (for, example, *My Story, Our Story*) and equally, the different impacts of events on different women; to understand the commonality of our differences, as it were.

What are key issues for one group of women might, for another group, be irrelevant or overshadowed by other more immediate concerns. For example, when the Women's Health Education Project offered workshops, the women of Newfoundland did not want reproductive health sessions, they wanted to talk about unemployment and about being mothers of teenagers. When Inuit women talked

about health concerns at a recent conference, they spoke about economic and cultural survival. In terms of rural-urban population differences, a turn-out of 50 to a health-oriented event can reflect just as positive a response as a turn-out of 500 in another larger community.

Our readers have greatly helped us, and each other, toward a fuller and more concrete understanding of how different are the many regions of Canada. Collective members and friends of *Healthsharing* have tried to facilitate and promote that understanding. But it is the Regional Reporters, those women whose names and reports you have seen and read in the magazine over the years, who have played the key role in portraying and celebrating the commonality of our differences. More than any other aspect of *Healthsharing*, it has been the regional news within the Updates section that has kept alive our coverage of the diversity of both the women's health movement and the places in which we live. One difficulty we have recognized is our failure to adequately credit *Healthsharing* Regional Reporters who, working from their homes varying distances from our offices, have maintained a strong commitment to *Healthsharing* issue after issue. Our appreciation has never quite kept pace with the level of input they have given. And as many of them move on to other activities, we would like to pause and say "thank you" to them all.

During this time of reflection and future planning, we are seeking ways to improve *Healthsharing*. We decided to overhaul our design to make reading the magazine easier and more enjoyable. As part of developing our new look, the Update pages will be newsier, better spaced and will include more photographs.

We hope our new design will help us reach out to new readers and yet remain true to our long-term readers' expectations.

We have also decided to redesign the cover, in hopes that it will have more appeal and visibility on the newstands. The covers of the next few issues of *Healthsharing* will feature the faces of women, women as they are, not women "made-up" for media presentation.

We have changed our typeface and column style to reflect our desire to appear more friendly and accessible. All in all, we want these changes to reflect our vitality and strength as a progressive, feminist health magazine and as a collective.

And we have not restricted our changes to design. We are trying to improve the diversity and depth of our content. We're seeking new ways to develop articles. "Feminism on the Farm" represents the first article in *Healthsharing* developed in response to collective members asking a particular group of women about their health concerns. In this case, we telephoned and wrote rural women with whom we had had contact or about whom we knew; an enthusiastic group of women in Huron County, Ontario, responded by sitting down with two collective members and an author. We hope the result can serve as a model for future article development.

We want to hear from you. Please give us suggestions for improving news coverage from your part of the country; let us know about local events and projects; tell us if our new design works; tell us what articles you'd like to read and what articles you might be interested in writing or helping to develop.

As collective members we continue our commitment to *Healthsharing* being a magazine of Canada's women's health movement. We offer our time, our editorial design and administrative skills. Please become an active reader, a reader who helps make *Healthsharing* your magazine as well as ours.

Liz Amer, Amyra Braha, Connie Clement, Connie Guberman, Barbara Lamb, Diana Majury, Lisa McCaskell, Heather Ramsay.

UPDATE

DEPO PROVERA APPROVAL LIKELY

BIOSELF 110 Launched

ST. LAMBERT, P.Q. — No doubt about it, the BIOSELF 110 is a very clever device. This electronic fertility indicator, hailed by its distributors as a "real breakthrough in natural family planning," was launched by its Quebec-based manufacturer at a press conference in September. Designed by a Swiss architect, the discreetly egg-shaped device contains a temperature probe, a timer, calendar, microprocessor and signal lights. It employs a combination of the calendar and the temperature method of fertility awareness and is intended for both women who are planning to conceive and women trying to prevent pregnancy.

The calendar method involves charting six consecutive menstrual cycles, and, assuming that ovulation occurs about 14 days before the onset of the menses, counting backwards to estimate the fertile period. A woman need only press a button on the BIOSELF when each period begins, and by subtracting 18 from the shortest and 11 from the longest of her last 6 cycles, BIOSELF will tell her when her fertile period begins. For greater accuracy, a woman will also have her basal body temperature taken each day by the electronic probe. In fact the device will beep to wake her up each morning as a reminder. When a temperature shift higher than the average of all previous readings for that cycle is recorded, ovulation is

assumed to be over and the BIOSELF signals green (presumably for GO).

The literature which accompanies the BIOSELF 110 is vague about accuracy rates and the device has not been approved yet for contraceptive purposes. Women have been practicing fertility awareness for a long time without needing a microprocessor. The underlying assumption of those who promote the BIOSELF 110 is that learning about our fertility is a complicated and time-consuming process that most women cannot cope with. Women must "discipline themselves rigorously if they are to avoid mistakes in diagnosis." With the BIOSELF, however, the difficulties of marking days on a calendar and plotting temperatures can be avoided, at the cost of \$97.

Once again it seems to be a case of someone taking what we've already got, repackaging it, giving it a high-tech name, and selling it back to us for a tidy profit.

Although BIOSELF will be welcomed by some women who can afford to buy its convenience, don't count on it as birth control unless you're prepared to abstain from day 1 of your menstrual cycle. Wait for a device that has the ability to predict ovulation.

BARBARA LAMB

TORONTO — Depo Provera could be approved as an unlimited use contraceptive by Health & Welfare before spring. The Upjohn Company of Canada, manufacturer of Depo Provera (medroxyprogesterone acetate), an injectible hormone, has had an application before Health & Welfare to permit Depo to be used as a contraceptive without any restrictions for some time. A favourable mention on Depo included in a recent government report makes approval of the request likely.

In September, Health & Welfare released a special advisory committee report on oral contraceptives. Buried in the report was a four-paragraph mention of injectible contraception. Without specifically mentioning Depo by name (although Depo is *the* injectible contraception) the report lauded injectibles, actually calling them an advantage over most other methods of contraception in certain situations.

Among the women for whom Depo was suggested as advantageous, are women with a risk of infection from IUDs, smokers (especially those over 35) and women seeking relief from uncomfortable menstrual periods or with pre-menstrual syndrome. The report also said Depo "has fewer known risks of serious adverse reactions than have the other highly effective methods of contraception." The report did not mention that Depo has been linked to cancer and blindness, among other serious side effects, over long term use.

This attitude contrasts that of many other countries. If Upjohn is successful in receiving approval to market Depo as a contraceptive, it would mark the first time the drug has received approval in North America for contraception. The use of Depo as a contraceptive was denied in the U.S. last year after lengthy hearings and public debate.

An Upjohn company repre-

sentative says he expects "no opposition" in Canada. This is, in part, because Canada, unlike the U.S., does not have mechanisms for public involvement in drug marketing and approval of decisions.

Canadian approval might also be felt outside Canada. A Bill presently before the U.S. Senate would allow the importation of any non-approved drug into the U.S. provided the country of origin has a regulatory department similar to the U.S. Food & Drug Administration. While Depo is imported into the U.S. already and approved for limited non-contraceptive purposes, legal opinion indicates that interpretation of the legislation now before the Senate could mean that uses approved within the country of origin would have weight within the U.S.

Canada is one of the countries eligible under this pending legislation to deport drugs into the U.S. This could allow Upjohn Canada to send Depo into the U.S. for contraceptive purposes, as well as sell in Canada if our government approves contraceptive use for Depo Provera.

ANNE PAPPERT

CALL TO ACTION

Readers, please write the Honourable Jake Epp, Minister of Health & Welfare Canada, Ottawa, Ontario. Tell him you are concerned about the safety and need for Depo Provera. Tell him you want the drug to be denied contraceptive use status.

For more information about Depo, see *The Case Against Depo Provera* by Janis Sarra, and our editorial, in the Fall, 1982 issue of *Healthsharing*. Or contact a women's health organization near where you live.

Code of Caution for Typists

EDMONTON — Alberta chiropractor, Dr. Percy Boyko, is the author of a new code of caution for typists, in which he warns that ignoring symptoms can lead to severe and chronic lower back pain. Speaking for the Canadian Chiropractic Association, Dr. Boyko said that for keyboard operators such as journalists, and computer operators as well as office workers of all kinds, back pain

is a common occupational hazard.

Stiff necks, sore shoulders, dull headaches, and numbness and tingling in arms and fingers are caused by sloppy posture and badly-positioned desks, chairs, typewriters or monitors. The physical results include prolonged hyperflexion of the neck, rounding of the upper spine and shoulders, a forward jamming and compression of the neck vertebrae and discs. These conditions can lead to reduced circulation to the arteries supplying the brain. People in this position experience occasional loss of balance, clouded vision and fuzziness of thought, said Dr. Boyko. "Certain irreversible damage can result and there can even be a domino effect, causing even more symptoms of distress to muscles, organs and tissues."

The chiropractic profession recommends the following:

1. Place feet flat on the floor, bottom of the spine pushed back into the back of the seat, arms straight from the elbows to the keys. Allow fingers to drop comfortably onto the keys.
2. Position computer and word processor screens at eye level.

Do not bend the neck in any way. Once a computer or word processor has been adjusted to suit an individual, the set-up should remain as it is for the exclusive use of that individual.

3. Switch material being referred to while typing from one side of the typing machine to the other, to prevent any bias on the neck.
4. Raise and lower the chin regularly to prevent the neck from locking in one position for lengthy periods.
5. Get up from your seat and move around every 20-30 minutes.
7. Do not put your head back or do backward neck rolls to relieve stiffness. The cervical and brachial collection of nerves pass through bony openings between the vertebrae at the base of the head and the back of the neck and could be adversely affected by such maneuver.
8. Do not neglect neck and backpain, cramps, nausea, dizziness, eyesight symptoms, sleeplessness, anxiety, tiredness, bad temper, and poor diet.

PAM RUSSEL

We've Come How Far?

OTTAWA — New Democratic women MPs have denounced a tobacco company's plan to publish a book on women in politics. "The tobacco industry is a death industry and this gimmick is insidious and deplorable. We are calling on all women in politics to reject this solicitation outright," says Lynn McDonald, MP for a Toronto riding.

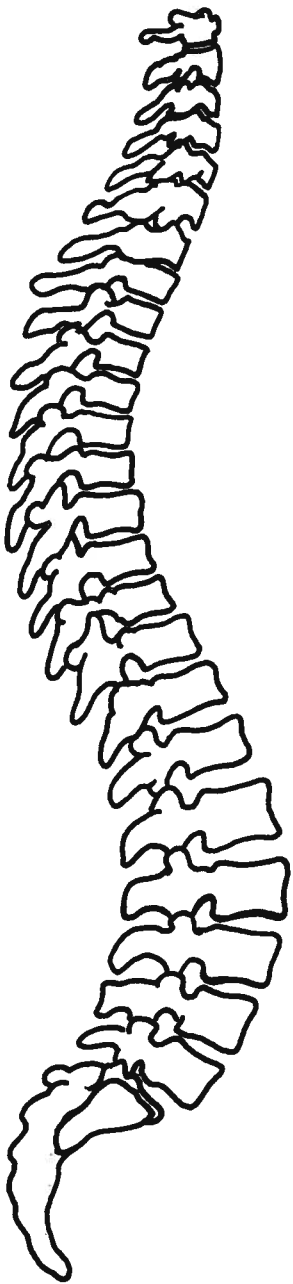
Benson and Hedges, Inc. recently wrote the MPs asking for photographs and short biographies to be included in the book. MPs are angry that the book — which will focus on Canadian women in politics at the federal, provincial and municipal levels — will identify cigarette smoking with active, intelligent, political women. They say they refuse to be a part of something that feigns promotion of women's equality but in reality is a scam to promote a product.

McDonald answered the company's letter saying, "I most certainly will not participate in a project sponsored, funded and promoted by an industry which also promotes illness and early death." She has also said all advertising of smoking products should be made illegal.

In 1983, 28 per cent of Canadian women (aged 15 and older) smoked, compared to 32 per cent in 1970, according to statistics in *Smoking Behaviour of Canadians* compiled by Health and Welfare Canada. The 34 per cent of Canadian men who were smokers in 1983 dropped from 49 per cent in 1970.

NDP critic for health and the status of women, Vancouver East MP Margaret Mitchell, says, "Men are quitting smoking in record numbers and industry is attempting to compensate by attracting women and youngsters. This kind of promotion would lead only to equality of men's and women's death rates due to lung cancer and heart disease."

ANNA KOHN



Saying Good-bye to Regional Reporters

It is with sadness, and great thanks for all they have done over the years, that we see several of our long-term regional reporters resign. Susan Moger of Victoria, Ellen Ticoll of Edmonton and Susan Hower of Medway Harbour, Nova Scotia have been with *Healthsharing* since the early years of *Regional Reports*, a column which began in our 2nd year of publishing back in 1981. Lorna Zabeck of Vancouver and Lissa Donner of Winnipeg are also considering the need to move on. Each of these women has written consistently, sharing news and events from their part of the country with you.

Throughout 1985 three reporters joined us. Deborah Van Wyck of Montreal replaced Clara Valverde; Bonnie Woodland of St. John's replaced Pamela Hodgson, and Carol Gordon of Regina has replaced Su Cooke. We welcome these writers, some of whom have written for several issues now, and thank both the newer writers and those who undertook new activities in their lives.

Thank you all.

AIDS in Infants

TORONTO — Acquired Immune Deficiency Syndrome (AIDS) has now been recognized in children as well as adults. As of October, 1985, 17 pediatric cases have been reported in Canada. Two are older children who are thought to have acquired the AIDS virus from blood transfusions or blood products. Fifteen are infants who were born with the disease.

AIDS in adults affects the body's immune system leaving victims susceptible to opportunistic infections such as a certain type of pneumonia and a rare form of skin cancer. Survival time is usually around two years. AIDS in infants is more difficult to recognize since there are a number of inherited immune deficiency syndromes which must first be eliminated in diagnosis, and because symptoms are more varied and more severe.

AIDS infants are usually small at birth, remain below average in growth and development and are susceptible to recurrent infections, particularly a form of pneumonia. As with the adult form of AIDS there is no known cure yet. The average survival time for AIDS infants is less than one year.

Examination of the mothers of these infants has revealed that most of them either had AIDS themselves or were members of a high-risk group for AIDS. Women who are high-risk include women who have partners who are infected or high-risk, women who are intravenous drug users and women who are prostitutes.

According to Dr. Stan Reed from Toronto's Hospital for Sick Children, researchers now assume that the AIDS virus, which can be isolated from the infected infant's blood, is transmitted directly from the mother to the fetus across the placenta in a manner similar to other viruses such as hepatitis or rubella (German measles).

SUSAN ELLIOT

Community Health Representative Conference

THUNDER BAY — An historic meeting of 80 Community Health Representatives (CHR) from across Ontario took place in Thunder Bay from September 23-26. Community Health Representatives are paramedic resident workers on Indian reserves. This is the first time that the CHRs organized a conference on their own to address their needs and concerns, as well as those of their communities. (They normally meet under the auspices of Health

and Welfare Canada who control Native Health Care policies.)

Of prime importance to the CHRs is the improvement of basic working conditions and benefits. For example, they are often called upon to work out-of-hours and yet do not receive overtime pay. They also do not receive any northern benefits that other federal employees receive.

Appropriate training and continuing education is another

issue. The CHRs would like control over their education and to that extent established a board made up of CHRs to develop a relevant curriculum.

The resolutions adopted out of this conference will be taken to a national conference to be held this coming spring. The resolutions will also be used to lobby Ottawa for changes.

FRUMIE DIAMOND

Nurses for Social Responsibility

TORONTO — Nurses will be marching under their own banner, Nurses for Social Responsibility, in the upcoming October 26 rally to 'Stop the Arms Race and Feed the World' in Toronto. The newly formed group wants to promote nuclear disarmament as an important health issue for nursing.

As well as becoming more visible, they have been quietly lobbying the Registered Nurses Association of Ontario (RNAO) with great success. At the last RNAO convention they put forward a motion to endorse multi-lateral nuclear disarmament. It passed easily. Nurses for Social Responsibility are now working closely with the RNAO's subcommittee on social issues to develop strategies in support of the resolution.

Further lobbying took place at the national conference of the Canadian Nurses Association where a similar motion was passed which also included an endorsement against further testing of the cruise missile. Groups from Alberta and B.C., Nurses for Nuclear Disarmament have also formed and took an active role at the conference.

The Nurses for Social Responsibility operate as a collective and are interested in addressing other social issues facing nurses. At present they are on

a membership drive and would also like to make contact with other interested groups and individuals across the country. Contact Cathy Crowe, Apt. 402, 550 Ontario St., Toronto, Ont. M4X 1X3, (416)928-0958, or Laura Cowan, (416)465-3124.

To contact Alberta Nurses for Nuclear Disarmament, contact Bernie Belley, 1923 - 73rd St., Edmonton, Alta. T6K 2B6. British Columbia Nurses for Nuclear Disarmament can be reached at 2056 West 13th Ave., Vancouver, B.C. V6J 2H7. An Ottawa group, also called Nurses for Nuclear Disarmament, can be reached c/o Loris Jordon, 5 Miriam Ave., Ottawa, Ont. K2G 0L2.

FRUMIE DIAMOND



NETWORK DAWNING

OTTAWA — When 22 women with a range of physical disabilities met in Ottawa last June, the result was the formation of DAWN (DisAbled Women's Network). DAWN has just become the first national women's group to join the new Amazon computer network.

The meeting, sponsored by the Women's Program of Secretary of State and the Disabled Person's Secretariat, began with information sharing and general discussion of issues. Participants identified the following for focused discussion: accessibility to the women's movement and services; violence against women with disabilities; affirmative action; parenting and childcare; sexuality and reproductive issues; assertiveness and self-awareness.

Participants agreed to return to their regions and work towards organizing disabled women. A core group are seeking national funding.

Contact women are: Fran Dinn (Newfoundland; 709-579-6212), Susan Buchanan (P.E.I.; 902-566-3165); Margaret Hiltz (Nova Scotia; 902-422-2283); Marie St-Germain (New Brunswick; 506-764-5592); Maria Barile (P.Q.; 514-725-4125); Pat Israel (Ontario; 416-691-8965); Paula Keirstead (Manitoba; 204-943-2092); Pat Danforth (Saskatchewan; 306-949-0337); Irene Feika (Alberta; 403-464-1861); Joan Meister (British Columbia; 604-254-8586).

CONNIE CLEMENT

Quebec Nurses 'Sont Tannées'

Once again nurses are having to battle the powers that be to simply maintain their position within the health care status quo. The latest affront came with word of amendments to the Health and Social Services Act (L.R.Q., chap. S-5) which would effectively deprive nursing of any administrative authority within hospitals.

On the 7th of August of this year, an Order in Council was introduced which proposed modifications to the 'Organization and Administration of Establishments' (Decret 1320-84). These modifications would pave the way for medicine to take over the administration of everything from nursing personnel to

budgeting for nursing care within health care establishments.

Some might consider it surprising that doctors would want to take on the enormous job of planning and implementing quality nursing care 24 hours/day for an entire hospital. Yet some nursing leaders see this move as a direct response to the increasing authority and professional self-confidence of nurses in recent years. MD's look approvingly south of the border to Johns Hopkins University Hospital where 'Clinical Chiefs' (i.e. MD's!) are in charge of all departments — a supposedly progressive move in times of budget crisis. In fact, the

medical profession is clearly taking advantage of the situation of upheaval within health care systems to both further reinforce its own power and to guarantee that nursing continues to be seen as a collection of handmaiden functions subservient to medical directives.

L'Ordre des infirmières et infirmiers du Québec, the professional body of Quebec nursing, have not been idle observers here. Since 1979 they have mounted six separate lobbying attempts to have established in law the roles and responsibilities of the director of nursing — and, by implication, to have acknowledged the independent professional role of nurses. Such attempts had no effect, despite the fact that medical, dental, and pharma-

ceutical administrative functions have become considerably clearer. In addition, nurses have been consistently ignored during policy formulation.

So now nurses are going to strike where it hurts: at the polls. While the ONQ will continue to use steady pressure to try to affect policy — or at least to embarrass the PQ administration into action — nurses and their allies will begin to discover their true mobilizing strength when the election campaign heats up.

DEBORAH VAN WYCK

Top Selling Drugs

NEW YORK — It should come as no surprise that Valium remains on the "Top Ten" list among brand-name prescription drugs in the U.S. Valium, however, now ranks only fourth, being superceded by anti-hypertensive and cardiac drugs.

The list, as reported in *Health Facts* (Septemer, 1985), is compiled by *Pharmacy Times*. It ranks the drugs by brand name according to the number of prescriptions filled. Since the same generic drug can be marketed under more than one brand name, the list is not entirely reflective of actual drug sales.

Health Facts comments, "A drug's placement on this list suggest great therapeutic value, the power of advertising, misuse or all of the above." One factor in the increased sales of anti-hypertensives and cardiac drugs is the increasing number of people living into old age, individuals who have become a prime market for the pharmaceutical industry.

The list follows, with brand names followed by generic names. A brief comment, not

meant to be comprehensive, is given about each drug. Consult a pharmacist or pharmacology text for more complete information.

1. *Dyazide* (hydrochlorothiazide/triamterene) — a diuretic or 'water pill' used in the treatment of edema (fluid retention) and hypertension. Several recent studies raise serious questions about its efficacy in the treatment of mild hypertension.

2. *Inderal* (propranolol) — causes the heart and lungs to work more slowly, it is used to treat heart pain and severe hypertension. Other similar drugs have been found to have fewer side effects.

3. *Lanoxin* (digoxin) — increases the force of the heart muscle, it is used in the treatment of heart failure and heart rhythm disorders. To be safe, this drug must be taken strictly and doses may require modification from the averages indicated in physicians' references.

4. *Valium* (diazepam) — a minor tranquilizer used in the treatment of anxiety disorders, alcohol withdrawal and muscle spasms. Effectiveness has not been systematically assessed in long-term studies (beyond four months), and it shows addictive tendencies over time.

5. *Tylenol/Codeine* (acetaminophen/codeine) — a com-



bination of pain killers which when used together are more effective than either drug alone. Codeine is a narcotic and can produce dependence.

6. *Amoxil* (amoxicillin) — an antibiotic used in the treatment of certain bacterial infections.

7. *Tagamet* (cimetidine) — used in the short-term treatment of duodenal ulcers (affecting the small intestine). Several studies have shown Tagamet to be inappropriately prescribed. It can cause mental confusion among older users.

8. *Lasix* (furosemide) — a powerful diuretic used in the treatment of edema (fluid retention) and hypertension.

9. *Motrin* (ibuprofen) — a non-steroidal anti-inflammatory drug used in the treatment of

arthritis and menstrual cramps. It's affect is similar to aspirin and other non-steroidal anti-inflammatory. Like these other drugs, it can cause gastrointestinal bleeding.

10. *Darvocet-N 100* (propoxyphene napsylate and acetaminophen) — a combination of pain killers, the efficacy of which has not been conclusively demonstrated. Darvon, one of the components, has been shown to be less effective than placebos. Darvon has, however, been linked to 1,500 deaths a year through suicide, accidental overdoses and addiction.

FRUMIE DIAMOND

Anne Pappert

Dalkon Shielded by the Law

photograph by Robert Rose

In the 10 years since the A.H. Robins Company withdrew its Dalkon Shield interuterine device from the market, women seeking compensation for injuries related to the shield have been subjected to a wide range of legal maneuvers by the company designed to harass and intimidate them into settling their cases out of court or dropping legal action altogether. On Aug. 21, 1985, in its latest effort to gain the upper hand over thousands of lawsuits still pending against the company, Robins sought the protection of U.S. bankruptcy laws in a move designed to stall proceedings even more.

By filing under the Chapter 11 bankruptcy provisions, Robins became only the second company in U.S. history to employ so called "pre-emptive bankruptcy." This protection is available despite the fact the company is financially healthy and in no danger of going under. In a Chapter 11 bankruptcy filing, the company postpones payment of outstanding debts until a court-ordered repayment schedule can be drawn up. Although the courts have the power to liquidate the company's assets to pay the debt, normally Chapter 11 is a way of limiting debts to allow the company to continue. The first financially healthy company to use Chapter 11 provisions, the Johns Manville Corporation, faced billions of dollars in health claims from workers in its asbestos plants, and admitted it used Chapter 11 as protection. Robins, facing a potential \$2 billion in payouts over the Dalkon Shield, admits it filed for similar reasons.

The U.S. based National Women's Health Network has announced it would seek an injunction against Robins' efforts to use the bankruptcy laws as a method of handling claims against the Dalkon. If the courts should allow Robins to proceed with Chapter 11, the company stands to benefit substantially. The most immediate result is to freeze all outstanding claims against the Dalkon Shield, estimated at over 5,100. Before the move to Chapter 11 protection, Robins was receiving over 370 new claims a month.

Women suing Robins over injuries related to the Shield now face the prospect of having all of their cases lumped together. Any subsequent settlement would be split among the outstanding plaintiffs, rather than allowing each case to proceed on an individual basis.

Some of the attorneys representing women seeking damages see the Chapter 11 move as potentially beneficial to their clients, based on the fact that in the Johns Manville case the final settlement is believed to have been as high or higher than generally would have been awarded on a case by case basis. However, it may well be that, both financially and psychologically, Robins will be the ultimate winner.

Any settlement under Chapter 11 could be years in the making. In the Johns Manville case it took three years to agree on a final figure. During the interim, much of the explosive and damaging publicity generated by the court cases over the last several years would be avoided,

since no cases would be heard. As well, the \$615 million dollar litigation fund Robins set up in the spring to handle the remaining cases would continue to earn interest against any eventual settlement.

To date the company has spent \$378 million to settle just over 9,300 claims. Legal expenses for the company have added a whopping \$107 million dollars to settlement costs. But even these figures are deceiving. At least one judge involved in Dalkon cases has stated that the actual costs to the company are far lower. The barrage of tactics to delay cases, often for years, before settling has proven financially beneficial for Robins. The delays have allowed money set aside by the company to handle Dalkon litigation to pile up enormous earnings in interest which have offset (some say totally eliminated) any actual out-of-pocket costs to the company.

Most importantly, the effect of Robins' reliance upon Chapter 11 may be to deny thousands of women their day in court, for many the only opportunity to present their story.

The decision to file under Chapter 11 comes after Robins abandoned efforts in August to negotiate a settlement to be split equally among the women. The previous month, a federal court had rejected a request by Robins to designate the remaining suits as a single class-action.

The move to pre-emptive bankruptcy is the latest in a series of disreputable tactics Robins has employed since it launched the Dalkon Shield in 1970. The shield

marked Robins first foray into the highly profitable contraceptive market. The timing couldn't have been better. The Pill had recently come under attack at a series of U.S. Senate hearings examining its safety. (Indeed one of the first witnesses at the hearing was the Dalkon's inventor, Dr. Hugh Davis, who while attacking the Pill, praised a new method of intrauterine contraceptive, none other than the Dalkon Shield, while failing to mention his association with the device. Women were eager for an alternative method of birth control.

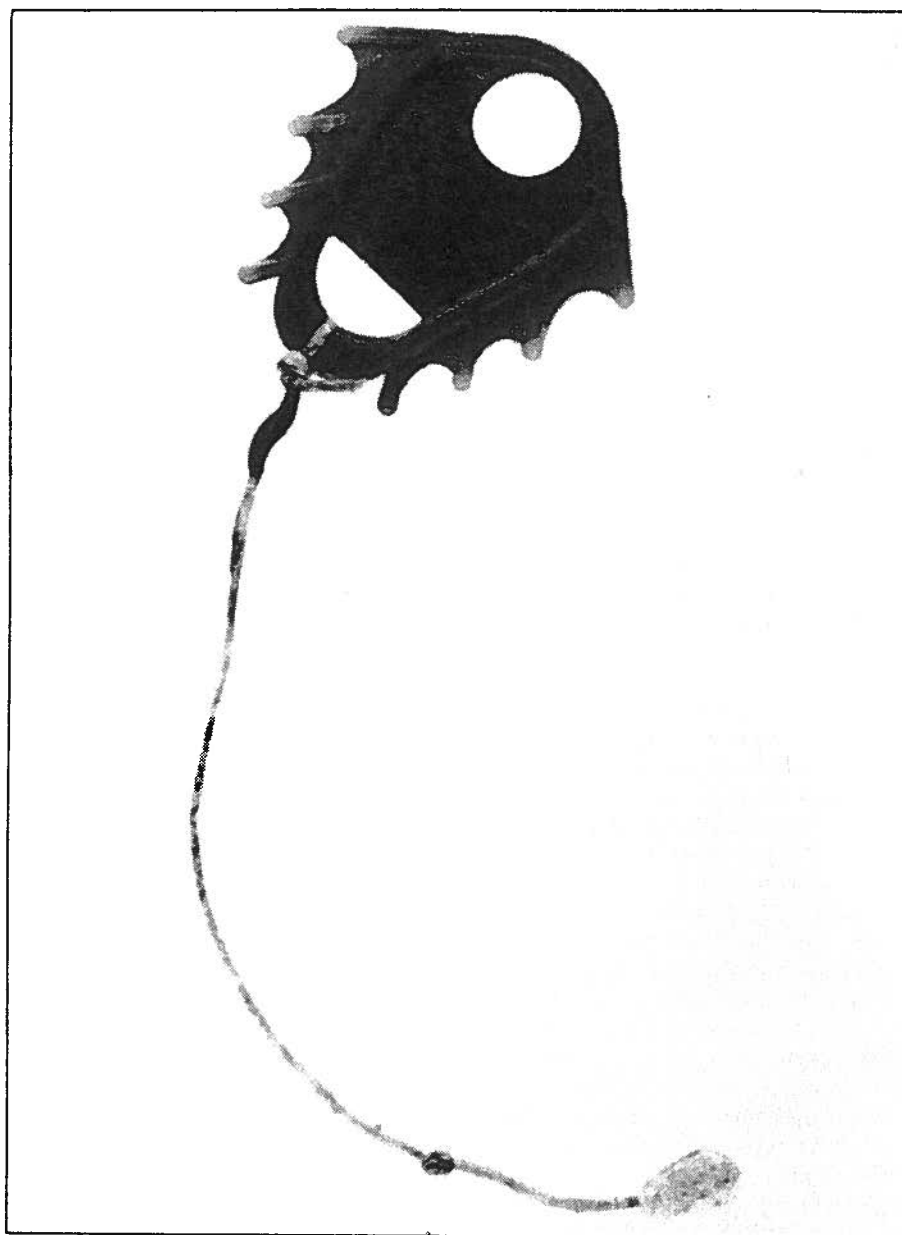
Robins claimed the Dalkon Shield had been tested extensively and found to be safe and highly effective with a pregnancy rate as low as the Pill. Both claims were later proven false. But in the meantime, women flocked to the Dalkon by the millions. By the time it was removed from the market in 1974, Robins had sold 2.8 million of them in the U.S. alone.

The Dalkon Shield was withdrawn from the market after reports surfaced linking it to pelvic inflammatory disease, septic abortions and perforation. Some 18 women are known to have died.

Company files show that Robins was aware the device posed a potential hazard even before the company purchased the patent for the Shield. Although the company stopped selling the product in the U.S. in 1974, and in Canada some two years later, it never issued a recall.

The National Women's Health Network sought a court order to force Robins to recall the Dalkon, but the company refused, fearing that to do so would be an admission of liability. This fall, however, the company did undertake an extensive advertising campaign in Canada and the U.S. aimed at alerting women who may still have a Dalkon Shield that it was time to have the device removed. The ad campaign made no mention of the problems associated with the Shield, but, along with the suggestion that women still wearing the device have it removed, was an offer to pay any costs associated with its removal. According to the company, some 4,700 women in the U.S. submitted claims totaling \$1.8 million for removal fees.

By withdrawing the Dalkon Shield



on its own, rather than waiting for government to order its removal, Robins hoped the fuss would blow over, leaving the company free to redistribute a redesigned Dalkon at a later date. Existing stocks of Dalkons were shipped to Australia, Israel and the Third World, among others.

To this day, the company maintains the device was no more dangerous than any other IUD on the market. Indeed, when problems with the Dalkon first began to surface Robins sought to hide the fact that it had been receiving complaints from doctors, including a partner in the original patent and a paid consultant to Robins, for some time and sought to blame problems on physi-

cians who had inserted the device. From the very first Robins has treated the Dalkon "as a litigation problem, not as a public health issue," an attorney for several plaintiffs has said.

The company's steadfast refusal to admit liability for the Shield has generated a string of tactics that places the women seeking redress for their injuries in a kind of double jeopardy. Rather than admit blame, Robins has sought to point the finger of blame directly at women themselves. In order to achieve their aim, Robins' attorneys have called into question the most intimate personal details of the women's lives, even before the Dalkon was inserted.

Women who have launched legal action have been questioned on every aspect of their sexual conduct, including the frequency of partners and even down to being asked to provide names, dates, locations and position used during intercourse, for sexual encounters that occurred from high school on. So intense have been Robins' defense tactics, that women who received a Dalkon while single are often advised by attorneys to settle out of court, since their lifestyle would be under scrutiny once in the courtroom.

Should a woman still feel inclined to proceed with legal action, Robins may give her ample occasion to question her decision when the case comes before the court. Robins' attorneys have not only questioned sexual frequency, but have also intimated perverse sexual practices with questions such as, "Have you ever had sexual intercourse with an animal," designed to humiliate the woman on the stand. Some women have likened the questioning to being raped. Of the 60 cases that have gone to court, out of over 14,000 claims Robins has lost just over half. Of the cases the company has lost, damage awards, particularly punitive awards designed to punish the company for their actions, have tended to be high. In May of this year a Wichita, Kansas jury awarded \$9 million to a woman who claimed her Dalkon Shield was responsible for her hysterectomy. It was the largest judgement made to date against the company.

The tactics Robins has employed have been so offensive that last year Minnesota Judge Miles W. Lord delivered a stinging lecture to top company officers in federal court prior to handing down a judgement in which he said the company was guilty of "corporate irresponsibility at its meanest." Judge Lord's statement made headlines across the country. In response, Robins sued the judge for slander.

A less publicized action of Judge Lord's was to order court-appointed officials to search Robins' files for evidence of misconduct. This action cleared the way for plaintiffs to demand access to Robins' files, previously all but impossible.

Although many documents released before the court-ordered search had

provided signs that Robins had knowledge of problems with the Dalkon from the beginning, the court appointed-officers, in a report to the court, said they found, "a strong *prima facie* case," the company and its lawyers had engaged in a fraud to misrepresent "the nature, quality, safety and efficacy" of the Dalkon. A judge presiding over pre-trial investigations on Dalkon cases later made a similar ruling and ordered the officials to continue combing Robins' files.

In a related move, a \$70 million lawsuit was filed in Atlanta at the end of September, on behalf of 99 women who claimed that the officers and director of A.H. Robins had failed to warn the public about the dangers of the Shield. It is believed that documents uncovered during the court-ordered search will be used to prove the case.

Perhaps the most important aspect of the Chapter 11 filing was to put a halt to the document search. This could mean that additional, potentially damaging documents may never be uncovered. Even if the Chapter 11 filing is ruled void, the time the company gains could be important.

Last year Roger L. Tuttle, a former lawyer for Robins who was responsible for the company's early Dalkon defense, turned the tables on Robins and began testifying on behalf of women suing the company. Tuttle testified that while at Robins he was ordered to destroy sensitive documents on the Dalkon. The company has denied Tuttle's statements.

Whatever the outcome of the company's attempts to use bankruptcy legislation to protect itself from further action related to the Dalkon, it's clear the company will fight every step of the way.

In commenting on the Chapter 11 move, Judge Lord said, "Many women have suffered and have waited patiently on court calendars intentionally delayed by A.H. Robins. I hope this isn't another instance of this kind of conduct."

We have just learned...

As we go to press, we have just been informed that the application for an injunction against Robins filed by the National Women's Health Network in the U.S. has been denied. The Net-

work sought the injunction citing the good financial and profit status of A.H. Robins as reason why Chapter 11 should not be allowed.

The judge in Richmond, Virginia, where Robins' head office is located, not only denied the injunction, he set December 31, 1985 as a deadline for filing of individual and joint cases against Robins for damages caused by Dalkon Shields.

Ann Pappert is a freelance journalist who has done two documentaries on the Dalkon Shield.

Our Shared Loss

Healthsharing learned with sadness of the sudden death of Kathleen McNally on October 3, 1985. Kathleen had done illustrations for *Healthsharing* in the past. She will be greatly missed by her friends and the arts community in Toronto.



Dawna Callagher

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Judylaine Fine

Beat Back Pain During Pregnancy

illustrations by Dorothy Irwin

"The back pain came on so suddenly and with such intensity that one morning I just couldn't get out of bed. I felt as if I'd been run over by a truck in my sleep."

Bev Randall, Teacher

"By the time I was in my fifth month my back was hurting so much that I couldn't stand for more than ten or fifteen minutes."

Alice Turner, Sales Clerk

"I finally figured out how to use a lot of pillows to prop myself up in bed at night and I'd try not to move around very much."

Homemaker

"I'd heard about postural changes and back pain during pregnancy, but I was confident I wouldn't have any problems. I was in good shape. I'd always exercised regularly and was rather arrogant about my physical condition. For my arrogance I had back pain for five months. I couldn't believe it."

Terry Anne English, Journalist

These five women, all pregnant for the first time, experienced one of the more common side effects of pregnancy: back pain. According to some obstetricians, the phenomenon (due mostly to unavoidable postural and hormonal changes) is inevitable. "Of course you'll have back pain when you're pregnant," says one Toronto obstetrician who doesn't feel that there is very much you can do about it.

Kim Swigger, a Scarborough, Ontario

public health nurse and prenatal instructor, disagrees. In her experience, 60 per cent of women suffer from back pain during pregnancy. "Some of them describe their back pain as a mild, quite bearable ache," she says. "Others describe it as all-consuming." But she firmly believes that most women could beat back pain during pregnancy if they understood the basic changes that the body goes through and how to counterbalance them with good posture, proper body mechanics, exercise and rest.

Changes During Pregnancy

In the middle of the menstrual cycle, ovulation takes place. While the egg is travelling from the ovary to the uterus, a small gland in the ovary called the corpus luteum begins to produce the hormone progesterone. The function of progesterone is to build a lining in the uterus, or womb, where the fertilized egg can develop. If the egg is not fertilized, however, this lining becomes unnecessary and the production of progesterone stops. The egg is expelled from the body, and a menstrual period follows, during which the built-up uterine lining is shed.

If, on the other hand, fertilization does occur, the lining of the uterus continues to build up and more rather than less, progesterone is needed. Around the 14th week of pregnancy, the body also starts to change shape in order to accommodate the growing fetus. Progesterone is involved in these changes as well. Massive

amounts of it are required and the placenta starts to produce it.

The increase of progesterone causes several changes to take place which, in turn, cause other changes. The broad ligaments that support the uterus and hold it in place relax so that the uterus can expand. The connective tissue linking the right and left sections of the abdominal muscles softens so that the abdomen too can expand. As the abdomen expands, the body's centre of gravity begins to change. As the centre of gravity changes, many women develop an excessively lordotic, or hyper-extended, posture which frequently causes muscle spasm in the lower back. As the fetus continues to grow and develop, pressure on the large blood vessels of the abdomen increases. This pressure can cause circulation to the legs to decrease. In addition, the developing fetus requires more and more calcium which, if not available from dietary sources, will be taken from the mother's calcium reserves. Many physicians believe that an inadequate supply of calcium during pregnancy – less than 1500 milligrams per day – can result in cramping and muscle spasm in the legs.

How the Uterus Expands

The uterus is located within the pelvic girdle in the space created by the round shape of the hip bones. There are three joints within the pelvic girdle: the right and left sacroiliac joints, which attach the hip bones to the sacrum by means of taut and powerful ligaments; and the pubic sym-

physis, the fibrous cartilage which joins the pubic bones at the pelvis' front. Chris MacHattie, a physiotherapist at Toronto's Western Hospital, explains the changes that take place. "By the 12th week of pregnancy, the uterus will have expanded to the point where it takes up all the space in the pelvic girdle. In order for further expansion to take place, progesterone acts on these ligaments, causing them to relax."

Normally, the sacroiliac joints are rigidly fixed by their ligaments, but when these ligaments relax, movement can take place. Nature is not always precise in matters such as these, however, and many women's sacroiliac joints move more than necessary, straining the ligaments. Rotational movements in particular (vacuuming or rolling over in bed are two good examples) put excessive strain on the sacroiliac joint ligaments. "If, around the fourth or fifth month of pregnancy, you begin to experience pain in the posterior hip areas directly over the sacroiliac joints, strained ligaments are most likely the cause," she says.

Much of the pain from strained sacroiliac ligaments can be avoided, or at least reduced, if you avoid rotational movements as much as possible. For example, when you get out of bed, first roll to one side, and use your arms to push your body into a sitting position. Then sit for a moment before standing. When doing household chores, move your feet to face your task rather than twisting the upper body. Try to carry two light bags of groceries, one on either side, rather than one heavy bag. Avoid bending over with the legs straight and pay particular attention to lifting techniques, especially if you have a young child. "It may take a little longer to go through your normal routine," says Chris MacHattie, "but it will also save you a whole lot of pain."

How the Abdomen Expands

The three sets of abdominal muscles act like a strong girdle to hold the upper body erect: the left and right internal oblique muscles, the left and right transverse abdominis muscles and the left and right rectus ab-

dominis muscles. Normally, the rectus abdominis muscles are attached in the centre by strong, taut connective tissue. As progesterone production increases, this connective tissue begins to relax so that the rectus abdominis muscles can stretch and the abdomen can expand. As the abdomen expands, the rectus abdominis muscles lose some of their ability to keep the spine erect. This, as well as the change in the centre of gravity, frequently cause pregnant women to assume a hyperextended posture. Women who have a tendency to stand with their knees locked seem to develop this excessive lordosis most often.

Excessive lordosis puts strain on several of the longitudinal ligaments of the spine as well as the facet joints, and either of these conditions can lead to back pain.

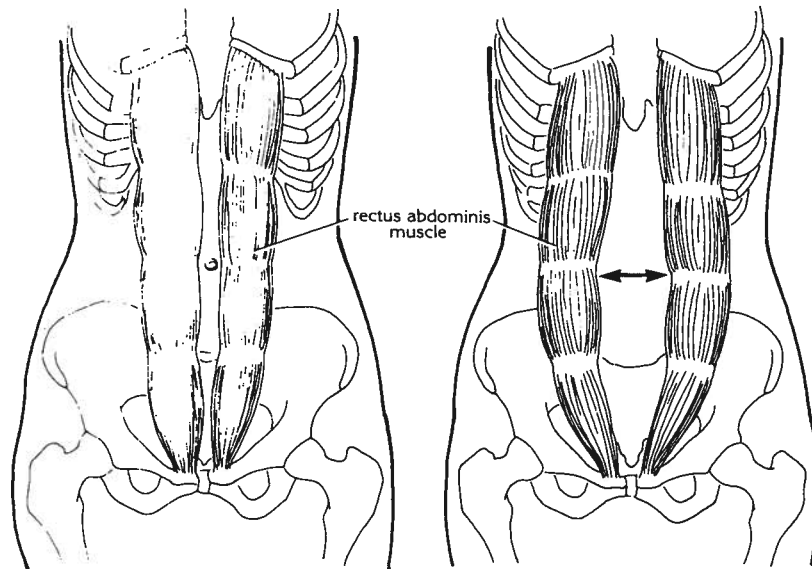
But in addition, a vicious circle sometimes results. The problem of excessive lordosis also causes additional strain on the rectus abdominis muscles which, in turn, causes even more lordosis.

Most serious of all is a condition called diastasis recti. Diastasis recti sometimes develops when so much strain is placed on the rectus abdominis muscles that they not only stretch but also separate. "A good

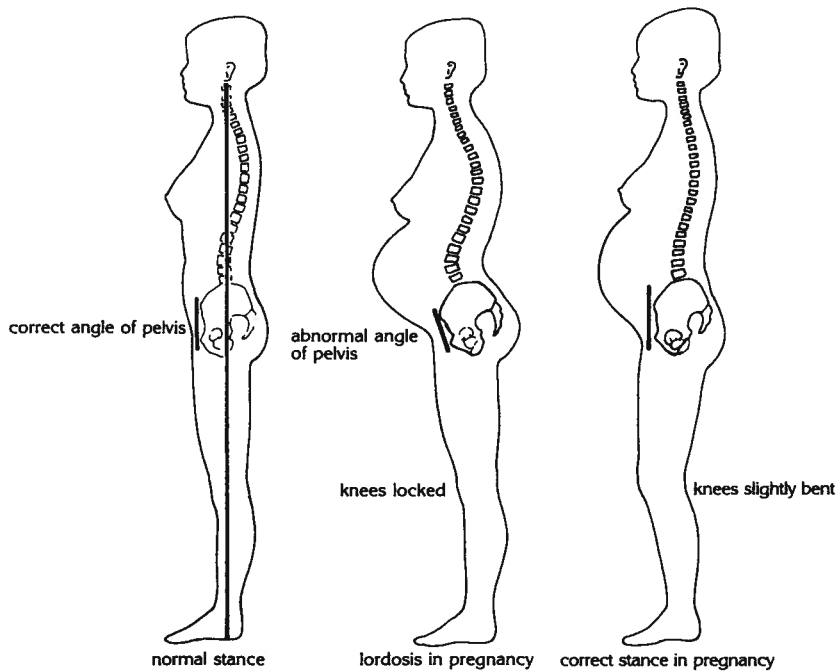
analogy of diastasis recti is a zipped-up zipper that has separated in the middle while remaining done up at both ends," says Chris MacHattie.

Neither excessive lordosis nor diastasis recti are inevitable conditions of pregnancy. If you pay attention to your posture and practise pelvic tilt exercises regularly, excessive lordosis and diastasis recti can almost always be prevented. When the pelvis is tilted, lordosis decreases, the baby can be held properly within the pelvic girdle and the abdominal muscles will have to endure less strain. Eliminate those exercises which require you to lie on your stomach as well as any which you personally find uncomfortable. You may also want to add the exercises described at the end of this article which are especially helpful during pregnancy.

Even if you exercise faithfully, it is a good idea to make sure that you are checked for diastasis recti after you have given birth to your baby. Normally, you will want to get back to a general exercise program as soon as possible after delivery. "If you have had some separation of the rectus abdominis muscles," says Chris MacHattie, who herself experienced this condition when her son was



diastasis recti



lordosis in pregnancy

born, "you should avoid sit-ups and any other exercises which will cause the abdominal muscles to contract *isotonically*." Diastasis recti can take anywhere from six weeks to a year to heal although an average is about three months. *Isometric* abdominal strengthening exercises are recommended.

Muscle Spasm

Another condition associated with pregnancy is muscle spasm in the legs as well as in the lower back. Most of the time, muscle spasm can be attributed to poor posture, although inadequate calcium in the diet and poor circulation can also play a role.

A calcium deficiency is simple to correct. Adult females require 700 milligrams to 1,000 milligrams of calcium per day; if you are pregnant, however, this amount should be increased to 1,500 milligrams per day. (While breastfeeding, you require 2,000 milligrams per day.) To avoid gaining excessive amounts of weight, stick to 2 per cent milk, rather than whole milk products.

Finding a way to get relief from the muscle spasm caused by poor circulation is more difficult. Some women find it helpful to sit on the floor with one leg bent and grasp the foot of the

straight leg with both hands, bending the toes forcefully upward toward the knee. Others find that placing a hot water bottle, or heating pad, under the cramped muscles for no more than 20 minutes at a time will provide relief. Fiona Rattray, a Toronto massage therapist, suggests that massages during pregnancy can also provide immediate short-term relief from muscle spasm. "It's soothing to have rhythmic pressure applied and released, and massage also helps to remove toxins and built-up lactic acid," she says.

Exercises Designed for Pregnancy

1. **CAT STRETCH** The Cat Stretch will gently strengthen your back and neck muscles as well as stretch them out.

Kneel on the floor on your hands and knees keeping your arms straight and your back parallel to the floor. Do not lock the elbow joints. While exhaling, round the back towards the ceiling, pulling the buttocks in and bringing the chin close to the chest. Hold this position for three seconds without inhaling. Now inhale, letting the lumbar spine sink to the horizontal position once again. Exhale and relax. Repeat this exercise a

minimum of five times.

A variation of the Cat Stretch is the Spinal Stretch. Assume the Cat Stretch starting position. Inhale. Keeping the back parallel to the floor, exhale and stretch the right leg straight behind, the toes pointed toward the floor and the leg parallel to the floor. Raise the head and look straight ahead. Inhale and return the knee to the floor. Relax and repeat five times. Start again, this time stretching the left leg.

2. **SINGLE LEG RAISE** The single leg raise will help to strengthen the abdominal, buttock and thigh muscles while stretching the spine.

Lie on the floor on your left side with the body stretched straight and the right leg on top of the left. Bend the left elbow and rest your head on your left hand. Bend the bottom leg so that the knee is in front of the body thus flexing and protecting the lumbar spine. Assume the pelvic tilt position. Inhale and lift the right leg about three feet off the floor, pointing the toes of the right foot. Hold for three seconds. Exhale and return the leg to the starting position. Repeat this exercise a minimum of 10 times. Turn to lie on your right side and repeat, lifting the left leg.

3. **INNER THIGH STRETCH** The inner stretch will strengthen the thigh muscles and help to align the spine.

Sit on the floor with the legs bent at the knees, the soles of the feet together and the heels as close to the body as possible. Hold on to the toes with your fingers. Inhale and straighten the spine while tilting the pelvic and tightening the buttock muscles. Hold this position to a count of three. Exhale while gently pushing the knees to the floor, keeping the back straight and the pelvis tilted. (It is normal to feel a good stretch along both sides of the spine, as well as the inside of the thigh.) Hold this position for 10 to 30 seconds and then relax. Move the legs and knees up and down for several seconds to relax the muscles and then repeat the exercise a minimum of three times.

This article is an excerpt from Your Guide to Coping With Back Pain by Judylaine Fine just published by McClelland and Stewart.

Susan Hundertmark

Rural Feminism

photograph by Susan Hundertmark

Memories of her first encounter with the health care system in rural south-western Ontario still make her angry.

Valerie Bolton moved to a farm in Huron County from Vancouver 10 years ago. Newly married and seven months pregnant with her first child, she missed her family and friends but expected to make her entrance into the community through her birthing experience. Instead, she remembers isolation, loneliness, helplessness and violence. "What made me tremendously angry was that the birthing should have meant meeting others like me and getting support from health care professionals. But, rather than seeing someone they could help, they saw a helpless persons. Afterwards I felt raped by the system," she says.

Because of her experience, Valerie says she felt a need to change the system to give the health consumer a greater voice. She discovered several women with the same concerns and in 1980, joined Women Today, a feminist organization in the country boasting 135 members. It has become a vocal advocate of rural women's health.

In neighboring Bruce County, another group of women got together when they grew concerned about the effects of the deteriorating financial situation in agriculture. Both Beth Slumskie and Doris Sweiger remember how frightened they were four years ago by the increasing number of farm bankruptcies and foreclosures and the growing strain on farm families who fought to keep their farms viable. The two women

called a meeting to voice their concern. Over 250 farm women turned out to share their alarm at the situation. Concerned Farm Women was formed at that meeting to lobby the government for the financial survival of their farms. The women also documented the psychological stress suffered by farm women in a study, *The Farmer Takes a Wife*, published in 1983, the first of its kind. One of the greatest benefits of the group has been its effects on the women involved. "When we first started, we felt as if we were victims. But, we've helped ourselves by getting involved. I can't even imagine what we would have done without the group," says Beth.

Though both groups were initiated for different reasons, they are characterized by rural women joining together for mutual support and, once together, growing, learning and working toward a better position for themselves and their families in society. This process seems to have grown naturally out of the circumstances of rural life.

Both Huron and Bruce counties have predominantly rural populations. They are situated along Lake Huron and bordered by the city of London at the south and the city of Owen Sound at the north. Their urban centres are small towns with populations no greater than 8000. Local industries include agriculture, small business and the Bruce Nuclear Power station. The area is characterized by its harsh, isolating winters.

Though many of the small towns have their own hospitals, limited finances and medical staff means that

alternatives to basic health care can only be found in cities. "We try to be generalists in small towns," says Dr. Harry Cieslar, the medical officer of health for Huron County. Consequently, rural areas have few specialists and little money to study health issues, such as wife battering or the effects of farm chemicals on health.

The mental health of the 56,000 people of Huron is served by one psychiatrist and one agency, The Huron Centre for Children and Youth, which specializes in counselling children and their parents, according to Dr. Cieslar. In Bruce County, the nearest psychiatrists are in the city of Owen Sound, says Chesley physician Marg Sanborn. She participates in a counselling service set up one and a half years ago in response to the high level of financial stress in the farm community.

Far from the slow-paced, idyllic existence it is often assumed to be, rural life is fraught with the same difficulties as urban life. Heart disease and cancer are the big killers in rural as well as urban Ontario – rural patients just have to travel further for treatment. Added to the health difficulties in a rural area are the lack of support services, including daycare centres and counselling services. Only in the past six months have transition homes for battered women been opened in both counties.

Farm life contains its own special dangers with farm chemicals, hazardous machinery, silo and manure gases, and large livestock. Add financial uncertainty to an already

dangerous occupation and a high accident rate is the result. "Farming is not a healthy lifestyle. Farmers have a surprisingly high mortality rate," says Dr. Sanborn.

Though it's a major employer in the area, the Bruce Nuclear Plant also causes stress in area residents' lives. "People don't talk about it much but I think everyone has the same thoughts of it sitting down wind from us. It's a double-edged sword though, since the plant has meant jobs paying more than anyone ever dreamt of getting in this area," Dr. Sanborn says.

In this setting, self-help groups like Women Today and Concerned Farm Women are seen as a movement toward better health. Because she feels rural women do not have access to health facilities, Nancy McLeod, a counsellor at the Huron Centre for Children and Youth, is excited about the groups. "Self-help groups are the way to go. The groups in themselves are therapeutic and the women involved in Women Today have such diverse interests, they're definitely going to have a big impact on health in the county. Other women are going to benefit from them," she says adding that facilities such as transition houses probably would not have opened without groups like Women Today.

The history of Women Today is a story of gradual evolution. A meeting five years ago of a handful of women concerned about violence against women has grown into a solid organization considered an important voice for rural women both by the Ontario ministries of health and agriculture, and the urban media.

Valerie attended the second meeting of the organization after reading an advertisement in a local newspaper. She was drawn to the group by her feeling of alienation in the community. "The women felt they wanted to reach out to isolated women experiencing violence in their lives. They also felt they wanted a support group with other women who wanted personal development and social change. I needed the group so badly to sort out my experiences since I arrived here," she says.

One of the group's first projects was a survey of local women's birthing experiences. With a borrowed tape recorder and a grant from the



Women Today members: Pauli Somers, Judi McMichael, Valerie Bolton & Debbie Selkirk.

Secretary of State to pay for child care, the birthing stories of local women were recorded and a questionnaire was compiled to be sent to area doctors about their birthing procedures. "It was really empowering because up until that point, we'd held it all in. Every woman thought her bad experience with birth was unique and her bad luck. Our common experience really bonded me with other women," says Valerie.

It took a year and a half before the group could work up the nerve to send out the questionnaire and, once they did, they got the negative response they feared. "We got incredible flak from the community. For two or three weeks I couldn't leave the house without people asking me why I did it," she says. When more and more women told Valerie how their doctors had saved their baby during special problems at birth, she was struck by the similarities of their stories with hers. "We were in the same situation but they didn't see it that way. The doctor always came out as this incredible hero and the woman was totally denied. Over and over, it was repeated to me - the

socialization of women accepting violence."

The press covered the group's questioning of birthing procedures in local hospitals. The community perceived the questions as a direct attack on the hospitals and doctors. Despite this community reaction, the group continued.

With a kit from the Health Promotion Directorate called It's Just Your Nerves, the group held a number of workshops on women and drug dependency. Women Today also got involved with local community colleges planning rural women's conferences and directing workshops on topics such as stress, dependency, violence against women, sexuality, unemployment, and separation and divorce. Through the Secretary of State office, members learned how to set objectives and goals in order to receive project funding. The group's latest project, called Women Being Well, is training women to set up their own self-help groups. Nine facilitators were trained in the first session and they plan to start groups throughout the county on various

topics including separation and divorce, youth, women and theatre, and birthing. "When we were doing the workshops we saw problems out there but it was hard to have any long term impact. Now, we want to empower women to set up networks for themselves by coming together and working on their specific concerns. It's more effective giving women the opportunity to learn on their own than handing out information with workshops," says Valerie.

For the past three years, the group has been building its strength with a board of directors, a constitution and more recently, incorporation. "It took Women Today a long time to establish organizational skills like how to work together and manage grants. It took time to establish credibility, contacts and an understanding of the existing power structure. It's all just starting to snowball now," she says. Valerie has been the executive director of the group for close to a year.

Both the past president, Fran McQuail, and the president, Debbie Selkirk, were attracted to Women Today because of the birthing issue. During her first pregnancy, Fran became concerned with the lack of birthing options in the area. "The nearest midwives are more than an hour away in Kitchener so I didn't have the choice of home birth with any professional back-up. I ended up having natural childbirth with a very supportive hospital staff but it took a real searching out and researching among other women," says Fran.

Increased accessibility to daycare in rural communities is another of Fran's concerns. The mother of two daughters, she is aware of the potential dangers on the family's hundred-acre farm. "I'm trying to think of one woman who doesn't take her kids out to the barn from the time they're in baby carriages; you have no other choice. But, a kid could be stepped on by one of the animals or hurt by the gutter cleaner or the grinding equipment in the feed rooms," she says.

That concern is shared by Debbie, the mother of two-year-old twins. Though she and her husband used to do most of the barn work on their farm when the twins were asleep in the house, she'd still worry. "You can't gather eggs or castrate pigs and look after them at the same time so

we'd leave them inside with the door locked. I'd still worry about fire or someone stealing them. Now that I'm nursing again, the boys have to go out to the barn with Ken to do chores and that's a worry too," she says.

Both Fran and Debbie work off the farm as well as contributing to the farm work and the housework. In Debbie's case, her third job pays for the food, clothing and house payments. She says her situation is typical of most farm women she knows. Because both farming and motherhood are relatively new occupations for Debbie, she's found Women Today to be a lifesaver for her. "I kept hoping a young woman in my situation would come knocking at my door. Since I've become involved, I've changed a lot and become aware of how women's issues relate to me. Now, everything doesn't have to be done just for the kids or Ken," she says.

"Farm women are often the most stressed of all groups since they're usually the most overlooked and underpaid," says counsellor Nancy McLeod. "There's such a traditional attitude here (in Huron County) that makes it hard for people to break out and change. Feminism has gotten blamed for family break-ups, but a lot of people haven't realized feminism isn't an anti-male thing but an improvement for both sexes. Joining groups where women can be understood and supported is a step towards health, she says.

During their fight for the family farm, members of Concerned Farm Women in Bruce County learned just that strategy. Though the financial situation has grown steadily worse especially for pork and beef farmers, the more than 60 women involved in the group have grown increasingly stronger. By taking action, they have gotten rid of some very strong feelings of anger and frustration, and gained support from each other. Women who had never spoken out before have learned to write letters, write briefs and seek funding from the government. "I just stayed at home without thinking about all these issues until the farm crisis hit me on the head like a sledge hammer. Now, I've been to Queen's Park so many times my little black car knows the way by itself," says Beth.

After identifying 250 women whose farms were undergoing the same financial crisis as theirs, Beth and Doris contributed to the formation of the group. To lend credence to their knowledge of the psychological effects of financial stress on farm families, the group prepared a 31-page questionnaire sent to 600 women and resulting in the study, *The Farmer Takes a Wife*.

The survey revealed mental fatigue, frustration, irritability, indecision, depression, headaches, hostility, anger and crying as stress symptoms caused by financial concerns. While the largest percentage of women reported the greatest satisfaction from going to their husbands for comfort and advice, others went to family, friends, ministers and doctors. Fifty-eight per cent of the women who went to doctors received drugs for their emotional problems while 25 per cent received both drugs and counselling, and 17 per cent received just counselling. The women were angry that doctors would prescribe drugs for an emotional condition, says the study.

Doris says she knows of women who do depend on tranquillizers to help them through the crisis. In fact, her doctor prescribed pills for her during one check-up. "When the doctor mentioned the word 'farm' I started to bawl, so he prescribed some pills. I didn't take them. No matter how tearful I get, I want to be in control," she says.

A rash that broke out on Beth's face and stayed for about five months last year was attributed to stress by a skin specialist. Though he recommended a holiday to clear up the condition, Beth lived with the rash since there was no extra money for a holiday.

The study also uncovered a low level of self-esteem among farm women. The greatest majority (66 per cent) felt their contribution to the farm was not worth more than \$5,000 while 32 per cent placed themselves between \$5,001 and \$10,000. Only two per cent felt their value topped \$20,000 while six per cent thought they were worth nothing at all to the farming enterprise. The feelings of low worth did not reflect the actual work women reported doing on the farm. While 60

per cent have done off-farm work, 55 per cent do chores, 87 per cent pay farm bills, 81 per cent keep farm accounts, 74 per cent do harvesting and 100 per cent do housework. "With Concerned Farm Women, we've really tried to raise the level of self-esteem. The women really needed their egos boosted so we're going to continue that," says Beth.

Published two years ago, the study has been presented to numerous conferences, meetings and university and government offices to no avail. Farm foreclosures continue at a rapid pace while the stress and problems the group focussed on continue unabated. Even Beth's farm, in financial trouble for five years, is being liquidated by the bank, though she and her husband plan to continue farming "somehow and someday."

Concerned Farm Women will not dissolve, even as members lose their farms. "We've developed such a thirst for learning and become involved in so many spin-off issues that affect our lives and good family living. Ten years from now, we'll probably still be trying to promote understanding about agriculture and tackling anything else that comes along," she says.

One of the spin-offs from Concerned Farm Women's study is a counselling service offered by local doctors and ministers at the medical clinic in Chesley. Dr. Sanborn says doctors had seen a lot of patients with stress-related problems such as high blood pressure, chest pain, depression and insomnia they felt were related to farmers losing their farms. The counselling began in March, 1984.

Losing a farm can be more pervasive than a death in the family since the farm family loses its source of income, its home and its lifestyle when it loses the farm, she says. The stress involved is felt by the whole family. But, when a family is fighting for the survival of its farm, Dr. Sanborn says she worries about women becoming victims of physical abuse. If there were serious problems in a relationship, it would be difficult to do something about them and upset the apple cart. The family has to be a unit to get through this kind of crisis," she says.

The Chesley hospital held an educational session with two films on wife

abuse and child abuse last winter but the topic is just emerging as something people will talk about. "From my private practice, I know the people who've been victims find it difficult to deal with it up here. It's still taboo. In a large city, though, everyone's talking about it."


Another worry is farm safety since farmers preoccupied with their finances are less likely to be careful in their work. The constant crisis situation is also felt by children.

Watching farmers struggle to keep their farms is difficult and Dr. Sanborn often wonders how many families have the energy to keep going. She says Concerned Farm Women has provided a role model for other women who aren't inclined to be activist. "Here they're in the middle of crisis and they're still trying to do something about it," she says. Though she believes the group wouldn't have begun without the farm crisis as an impetus, she says the group could be instrumental in changing women's roles on the farm. "It's politicized a group that's never been politicized before, and that's interesting to watch."

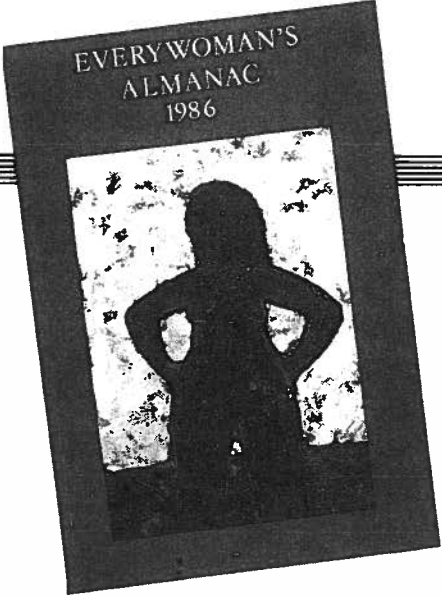
Beth and Doris are two good examples of women who've been politicized by their hardships in farming. It's a process that's meant more and more women have a greater, if not equal, say in the business decisions, meetings with predominantly male farm groups and in political lobbying. In response to their feelings of stress, many women have become the voice of the farm family demanding political action to save the agricultural community.

Judging from the experience of both rural women's groups, there's a convincing case to be made showing political action as a contribution towards good health. Women belonging to the groups in both counties discarded their helplessness and gained control over their lives with education and motivation from each other. Whether or not their political demands are immediately fulfilled, the women are healthier for making them.

Susan Hundertmark is a reporter with a strong interest in feminist issues. She works at a weekly newspaper in the town of Goderich.



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Phyllis Marie Jensen

Feldenkrais: Awareness Through Movement

photographs by Gary White

Being an "old" athlete, I figured I'd have to live with my "trick knees," "joint mice" and sounding like the Tin Man when I walked up the stairs. And I accepted my doctor's prediction of knee surgery in the same way I thought the chronic tightness between my shoulder blades just came with a desk job.

All in all it added up to a not so gradual decline into decrepit old age. That was until I discovered Feldenkrais. It's a method of retraining the body's movements, muscle by muscle, with pain-free existence as the outcome and the added benefit of elegant, graceful movement.

Months after I began Feldenkrais classes (called "Awareness Through Movement") and had a number of private "hands on" sessions (called "Functional Integration") with Marion Harris, a qualified Feldenkrais practitioner, I noticed an amazing difference. My knees and mid-back didn't ache all the time, and I felt supple enough to consider dancing – something I had not been able to do.

Feldenkrais therapy is not a one time fix-it treatment, but a form of preventive medicine because it teaches you how to move without damaging your body. There are sessions on how to get up out of a chair without hurting your knees or get out of bed without straining your neck, using your arms and how to bend without wrecking your back. For those with back problems, Feldenkrais is excellent because it allows you to live like an ordinary person without having to worry about your back giving out. Because of this I've

stayed with the classes for two years. I think I've still got a lot of bad habits to unlearn and many movements to simplify.

When I first heard about Feldenkrais I really identified with his problems because he was an "old" athlete with bad knees from soccer injuries. When his physician told him there was only a 50-50 chance of improvement with surgery, Feldenkrais decided to heal his own knees.

At that time he was a scientific officer with the British Admiralty. Prior to this he had completed his Ph.D. in mechanical engineering and high energy physics at the Sorbonne in Paris, as well as earning the first black belt in Judo in Europe.

During the second world war he fled to England and began an intensive study of anatomy, physiology, anthropology and Zen Buddhism. Focusing on the human body as a cybernetic, or feed-back system, with an ability for self-regulation and self-improvement, Feldenkrais began to apply these principles to his own body.

He knew that his body would reharmonize itself if it was given the chance, because our bodies have a built-in bias or tendency towards efficiency. All that is needed to achieve this state is new sensory awareness and new motor control or muscle habits.

The first step was to create a new environment for learning new movements. As a physicist he understood the implications of gravity on human movement. He tried to discover how to eliminate it and give

the body a chance to re-experience motion. The solution was found. He lay on the floor and reconstructed the movements he usually did upright. The change was sufficient to create a new awareness of habitual actions and introduce new patterns.

The next step was to reduce habitual patterns without conscious attention. It is not enough to want to change an awkward movement or bad posture. There must be a reprogramming of the involuntary system – the one that works without you directing it. Unless we change the involuntary system, as soon as we forget to "sit up straight" or "hold our stomach in," we slip back into the old pattern. To achieve this involuntary change, Feldenkrais movements are done just below the usual threshold of awareness. He compares it to feeling the difference between lifting a feather or a heavy weight with your arm. It is possible to feel the feather. That is why Feldenkrais retraining is so gentle; when you concentrate on a new small movement you can actually feel the freedom of it. You can feel your body releasing the tension and stress that you usually put into an action.

It's not just tension and stress that are eliminated, but parasitic movements. They are a lot like "tics," but on a grand scale. For instance, when I used to cut a slice of bread I always tightened up my neck and my forearm which was totally unnecessary. A lot of Feldenkrais is getting rid of parasitic movements which occur because we learn and reproduce movements in an emotional

context.

If we are under a great deal of stress or fear when we learn or repeat an action, then that stress and fear becomes part of the movement. Actors understand this phenomenon well because they learn to portray emotional states with body postures and physical movements – many of which have become stereotypes. All of us have made assumptions about people based on the way they hold their body and walk. Everyone has an image of the “uptight” person that includes a picture of body stances.

An important part of Feldenkrais work is getting rid of the psychological baggage that accompanies habitual behaviour by changing the physical movements. In releasing parasitic movements we also release old emotional responses. At this point our movements become pleasurable with a sense of peacefulness.

There are a series of detailed instructions in Feldenkrais' book *Awareness Through Movement*. Cassette recordings are also available. I prefer the class setting where a teacher will assist me when I haven't quite figured out what I'm supposed to do. Many of the movements are very subtle and are synchronized with the breath, whereas my natural inclination is to do things fast and big, or to stop breathing when I'm concentrating. It took a whole year of one-hour a week classes for me to unconsciously coordinate my breath with my movements and stop tightening my neck when I moved my foot. That's the level at which the retraining takes place.

In functional integration the practitioner demonstrates to the body and mind more effective postures and patterns of movements through a series of gentle manipulations. Your feet are re-oriented to the floor through the creation of a new floor – the practitioner's hands. Instinctively you can feel that it is right, although it does feel odd when you finally stand up. Your neck is gently positioned in an alignment with your spine. My tendency is to hold my head to the left which puts a strain on the right side; once my body got the message that it was easier and more comfortable to hold my head straight, it's been gradually recorrecting itself without conscious effort on my part.

That is the beauty of functional integration.

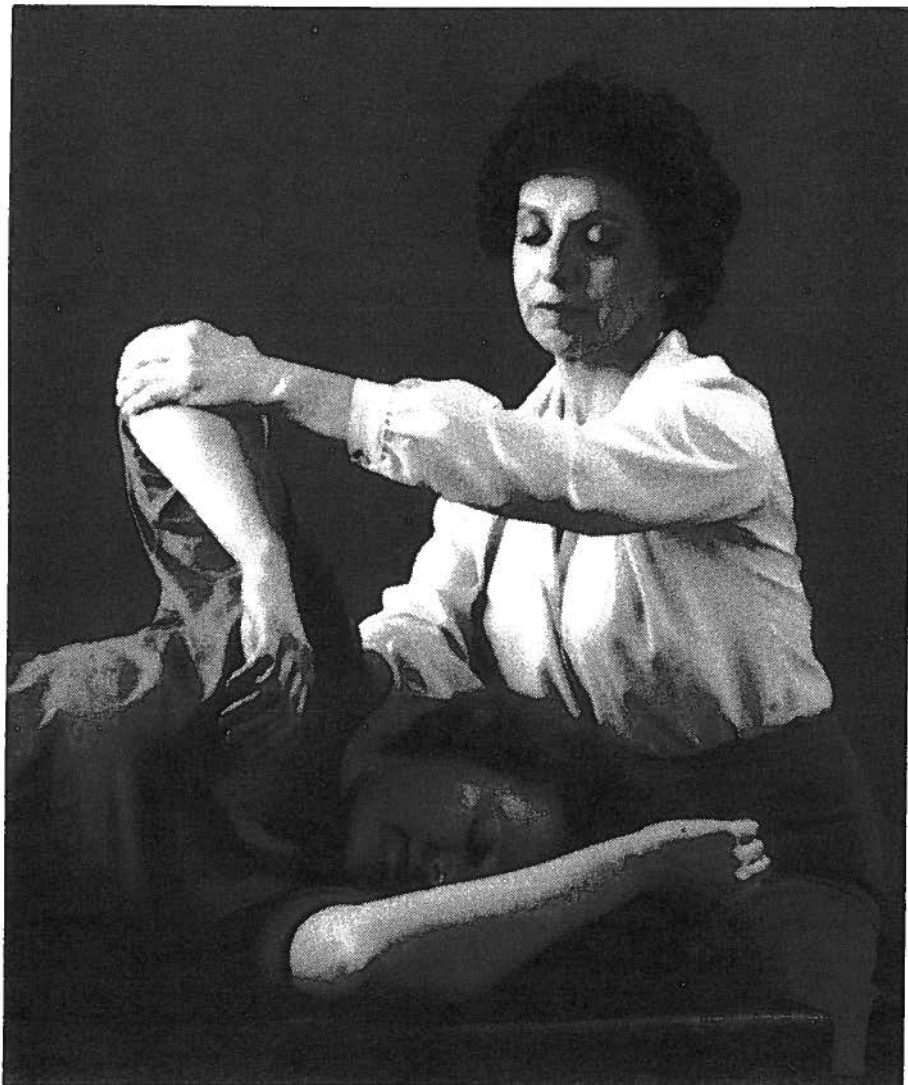
In 1970 there were only 13 fully qualified Feldenkrais practitioners. In 1975 a three year program was set up in San Francisco. The 65 graduates established The Feldenkrais Guild. In 1984, the year of Feldenkrais' death, the first Canadian training program was set up and now there are 22 Feldenkrais practitioners in Canada. Many of them are also physiotherapists who appreciate the potential it gives to their work.

The Ottawa General Hospital holds regular Feldenkrais classes for outpatients, but unfortunately the cost is not covered by our health insurance. Still, the price is minimal and the physical and emotional benefits are tremendous.

In classes the students do all the work. These are exercise classes, but totally unlike anything you've done

before. The aim is not muscle building and strength through numerous repetitions, but reprogramming the brain. There's no counting off the number of times you repeat a movement because the emphasis is not on what you do, but how you perform a movement. Sometimes I find myself concentrating so hard that I feel nauseated. It's not because it is physically difficult – we never sweat or strain – it's because we are creating new pathways in the nervous system.

Dressed in comfortable clothes we lie on the floor with eyes closed, quite unaware of each other. We are learning to tune into our “kinaesthetic awareness” or sensory experience of movement. We begin by noticing what parts of our body are touching the floor. Areas where the body is tense or tight – what Feldenkrais calls “holding” – do not touch the floor.





It's interesting and important to begin to recognize the differences between one side of the body and the other because one of the objectives is to create body symmetry. It's not just for aesthetic appeal; it's because if we overuse particular muscles they become fatigued over time and more prone to injury. After a while the overused muscles will try to gain a reprieve from overwork and begin to limit the range of movement or a whole series of actions. Being creatures of habit we become quite used to a limited range; we accept everyday aches, pains and distortions, and think that they are normal or a function of aging.

When I tune into my kinaesthetic awareness, I'm always surprised that my right side still feels longer, bigger and fuller than my left; although the difference is not as much as it used to be. When I started Feldenkrais work my right shoulder was noticeably higher than my left because for years I used to carry a shoulder bag. To ensure that the strap didn't fall off I'd lift my right shoulder a slight bit and hold it there. When I moved or walked the shoulder did not participate in the action the way it is supposed to. In fact, it became more or less immobile and I couldn't slide my shoulder blade away from the rib cage, the way it is supposed to work. When Marion Harris suggested it, I thought she was a bit mad; but it is actually possible and an important part of reaching, writing, playing the piano and racquet sports. Part of the pain I had been experiencing bet-

ween my shoulder went when I freed up my shoulder blades. It changed all kinds of things: the way I shake hands, touch other people, stroke my cats, type and play the piano. That's one of the delights of the Feldenkrais work – the unexpected changes. It definitely improves the way you make love.

In Feldenkrais the watch words are "if it hurts you aren't doing it right" – the opposite of Jane Fonda's workout principle of "burn baby burn" or many athletic training programs based on the notion of "no pain, no gain." Feldenkrais rejects this approach because when the body hurts it does not learn; it puts its energy into defending itself. Students are cautioned to make the movement smaller, lighter and slower, because it's not what you do, but how you do it that's important. Students are encouraged to be the judge of what they are doing, to be responsible to themselves and stop when they want to.

Most movements are very small and easy actions, like turning your head one way and your eyes the other. Because of new or old injuries or just tightness in the neck some people may find this difficult. They are encouraged to use visualization techniques or imagining the movement. When they have perfected it in their imaginations, then they try it. Much to their delight they are usually then able to do it.

Feldenkrais is not just about posture and healthy people, although good posture and freer movement are aims

that bring a lot of performers (dancers, actors and musicians) to class. Feldenkrais helps the disabled gain greater range and control over their movements. Children with cerebral palsy learn to walk with fewer or no supports. People suffering from muscle wasting diseases or strokes have simple functions improved beyond belief.

Feldenkrais' book, *The Case of Nora* published in 1977, documents the problems encountered by a middle-aged woman incapacitated by a stroke. Her physicians and physiotherapists had done their utmost; still she was unable to read or write and very depressed about it, as these activities were her greatest source of pleasure. She complained that she couldn't see the words. More than one person concluded it was a psychological problem, but it was a complex neuromuscular one in which her eyes would jump instead of following a line of words on a page.

The Case of Nora nicely demonstrates the discovery process used by Feldenkrais, and the experimental method he used to correct her disability. He was never the guru, content to create a new method of healing and have generations of disciples rigidly follow his pattern. Rather he insisted that the first principle was that there was no principle because each case was unique. He tried continually to instill in his students the need to re-evaluate and create new ways to deal with individual problems and get the client participating in his/her own therapy.

In one article he discusses his initial attitude of curing his patients. He later realized that he and the client were working together to try to achieve an understanding of the problem; only then did his work change and produce remarkable results. Only then was he certain about what was being accomplished – freedom of movement, pleasurable movement, efficient, elegant, free and natural movement.

Phyllis Marie Jensen, R.N., Ph.D., is the principal researcher on the Metro Toronto Justice Advisory Committee on Spousal Abuse. She also holds SMOKEFREE classes in Toronto to teach women how to quite smoking. (416)465-1323.

HEALTHWISE

Feldenkrais Lesson

Marion Harris

This lesson will free the neck, shoulders, rib cage and pelvis. It will have a beneficial effect on the entire back, from the tip of the spine right down to the tailbone. Throughout the lesson it is important to move slowly and gently, to find your range of comfort and ease, continually observing the quality of the movement and reducing any effort or strain. Your attentiveness to the process and awareness of what you feel and sense is more important than trying to do the movement 'right.'

Lie on your back, on a rug or mat, and observe how your body connects with the floor. Pay particular attention to your pelvis, spine, rib cage and shoulders.

1. Place your arms a comfortable distance from your body. Bend your legs and cross your right leg over your left (as if you were sitting in a chair with your legs crossed). Very gently begin to tilt your legs to the right and bring them to the centre again — about 10-15 times. Do not go to the full extent of your range, but rather let them tilt a little at a time, in an effortless way, gradually allowing your legs to move into their full easy range. Exhale as you tilt and inhale as you bring your legs back to centre. Observe where your body lengthens and where it gets shorter. Feel where it lifts off the floor. Notice how far up the spine you can feel the rotation. Be aware of any sensation your body is experiencing.

2. Rest. Stretch your legs out and observe how your body is connecting with the floor. Note any changes.

3. Bend your legs again. Place your feet on the floor about hip width

apart. Raise your arms to the ceiling and place your hands together forming a triangle with your arms. Keep your elbows straight without letting your arms get rigid.

4. Tilt your arms to the left, maintaining the triangle, and bring them back to centre slowly — about 6-8 times.

5. Keep tilting your arms and let your head and eyes follow your hands 6-8 times. Rest your arms briefly on the floor and observe how the back of your rib cage and shoulders feel.

6. Again raise your arms in a triangle and continue tilting to the left. Follow your hands with your eyes and turn your head to the right. Follow your hands with your head and turn your eyes to the right. Tilt your arms to the left while you turn your head and eyes to the right. Rest briefly.

7. Tilt your arms to the left and follow your hands with your head and eyes. Notice how much easier it is. Rest.

8. Cross right leg over left and tilt legs to the right a few times. Notice the improvement.

9. Do the same thing on the other side. Tilt the legs to the left as the left leg is crossed over the right. Then form your triangle with your arms and tilt them to the right.

Marion Harris completed her Feldenkrais training with Moshe Feldenkrais five years ago. She teaches classes at the Toronto Yoga Centre and does functional integration by appointment.

For a list of Feldenkrais practitioners across Canada, contact Marion Harris, 140 Erskine, Toronto, Ont. (416) 488-4272.



Dawna Gallagher

Gathering Identity

After many years of being somebody's daughter, somebody's wife and somebody's mother, I am finally gathering together an identity of my own. The first step is going back to school to receive some training in a field I've long been interested in. It seems to be a very traumatic experience. On one hand I am afraid to take the first step and on the other I want to plunge right in.

I would be very interested in hearing from other women who are either contemplating doing what I am doing or from those who already have. Any sort of encouragement, moral support or helpful suggestions would be greatly appreciated. Karen Cole, 251 Ball St., Cobourg, Ont. K9A 3H8

P.I.D. Society

The Canadian PID Society officially became a Society this summer. Our goals are to provide counselling support and resource referrals for women with pelvic inflammatory disease, to research PID, and to educate both the public and professionals about PID. Our president, Maureen Moore, would like to write a book about women's experience with PID, especially about chronic or recurring PID.

Any readers who wish to contribute their stories or to correspond with us can do so at: P.O. Box 33804, Station D, Vancouver, B.C. V6J 4L6.

Anthology on Menstruation

Blood is For Bleeding... an anthology on menstruation, to include poetry, prose, fiction, non-fiction, jokes, anecdotes and tall tales, is being prepared.

Send material and queries to Marlene Philip, 173 Robina Avenue, Toronto, Ont. M6C 3Y8.

REVIEWS

A Community Health Success Story

First and Foremost in Community Health Centres: The Centre in Sault Ste. Marie and the CHC Alternative, Jonathan Lomas, University of Toronto Press, Toronto, 1985, \$27.50 cloth, \$12.50 paper, 204 pp.

Reviewed by Sue Kaiser

The lion's share of Canadian health care dollars is spent on medical services: hospitals, doctors' fees, and related lab and pharmaceutical costs. That these millions of dollars could be differently and better spent is a message that has been voiced by health care consumers over and over again, often with seemingly small success. One of Canada's too little known success stories is that of the Community Health Centre (CHC) in Sault Ste. Marie.

In the late 1950's, Sault Ste. Marie was a thriving but isolated northern community. The expanding Algoma Steel Company was the single major industry. Local 2251 of the United Steelworkers of America was a strong, aggressive union with a successful negotiating history and active links in the union movement across North America. But in this promising situation, families found themselves faced with a shortage of physician services. Doctors posted "No New Patients" signs in their windows and residents queued up with 1,399 other people for one physician's time and care. In the same year, 1956, the average physician to resident ratio across Ontario was approximately 1:850.

Residents in the Sault also paid more than those in other Ontario cities for all kinds of medical care. Fees charged were more than twice as much as insurance plans paid for

reimbursement. Into this picture then, insert a few courageous and indefatigable union organizers and hundreds of volunteers with vision and time, and you have the ingredients which created Ontario's oldest and largest community health centre.

During the 1950's and 1960's, discussion of how medical fees should be organized for payment was developing nation-wide, but instances of group organization for *delivery* of service were few. When steelworker organizers decided to go beyond developing more generous insurance plans to contracting with physicians to offer care to their membership, they were wise enough to expect resistance. Government policies, while often claiming neutrality, have effectively supported physicians' solo practices as the only acceptable method of care delivery.

As Lomas explains:

The primary barrier to the development of alternatives has been the insistence of the government on maintaining that free choice means the choice of individual physicians rather than of method of medical organization. This insistence perpetuates the notion of the solo-practice doctor as the unit of health delivery. Experiences at the Sault since medicare's inception have shown clearly the difficulties caused by the free-choice provision as it is currently defined: the centre has to fight against reduced feelings of accountability for its patients; it must carry the costs of services used outside the centre but has no control over them; it is difficult to establish patient loyalty to the centre. These problems all work directly against the success of alternative prepaid health delivery. (This reviewer found it incongruous

and distasteful to recognize how the concept of "choice" was used to muddy public perception of the underlying issues of who cares for who and how.)

Sanctity of solo practice for physicians was difficult to challenge, even in the Sault where shortages, high costs, and lack of specialists were acknowledged throughout the community. Pressure from government and the medical establishment, plus heavy demands on community skills and resources meant the Sault Community Health Centre (CHC) was not able to implement its initial plan to hire its own doctors outright. Communities do not always have the needed skills for smooth implementation of a planned social change like a CHC: Lomas covers the organizers' mistakes as well as triumphs. But there is no doubt that the community *wanted* the CHC alternative to succeed, just as there is no doubt the government and the medical profession did not support changes in health care delivery.

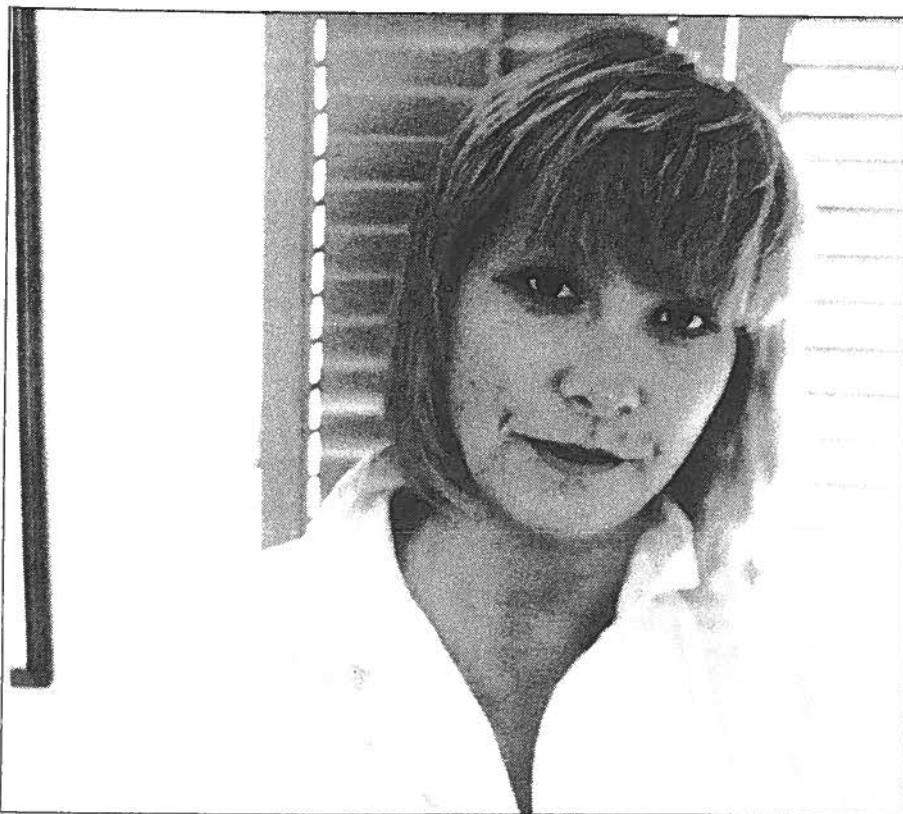
Until 1982, government funding for CHCs was only provided on an "experimental" basis and the instability of budget arrangements during this period did nothing to enhance new centres' development.

The medical profession's attitudes toward CHCs and the "alternative" arrangements for care delivery have changed little in the last quarter century. Indeed, Lomas' section on local medical resistance in the Sault read disturbingly like current headlines — "Extra billing essential to health."

Administrative and bureaucratic processes are not inherently exciting, but Lomas manages to give us a picture of the energy and excitement of the people involved in these seemingly endless aspects of establishing a CHC.

Anyone approaching health care delivery issues with the attitude that "we can do better" would do well to read about the Sault experience: the events may be 25 years old, but the lessons are current.

Sue Kaiser is a community worker.



DES – Faith to Betrayal

DES: An Uncertain Legacy, Distributed by National Film Board of Canada, Studio D; Directed by Bonnie Andrukaitis, 16mm, colour, 1985.

Reviewed by Sheila Goldgrab

DES: An Uncertain Legacy issues a powerful exposé we should all be aware of. Writer/director Bonnie Andrukaitis charts the history of the synthetic estrogen called diethylstilbestrol or DES which was prescribed to pregnant women between the years 1941 to 1971, to help prevent miscarriage.

The film records women's initial faith in DES and details the feelings of betrayal women experienced forty years later. This documentary criticizes the U.S. Food and Drug Administration's premature approval of the drug, and also casts suspicion regarding the responsibility of those doctors who educated themselves about DES by relying on its high-powered promotional advertising as a "wonder drug" used by pharmaceutical companies.

The strength of this exposé is supported by the emotional intensity of

the women who speak out in the film about the fears and frustrations they have confronted when trying to obtain information about DES. Shirley Simand, co-founder of DES Action: Canada with daughter Harriet Simand, is one of those women. She recounts her agonizing struggle to get access to her medical records from her doctor in order to determine if DES had been prescribed to her. She cautions women to be wary of "disappearing" medical records. We also watch and listen in horror to a series of interviews with DES-exposed women and men as they relate a range of medical problems they suffer as a result of that exposure.

For women who took DES and their daughters who incurred abnormalities in the vagina, cervix or uterus, or who have developed cancer, their frustration and self-directed anger has compelled them to work for political change. By reclaiming control over their bodies and criticizing the conventional medical system, they have made DES both a health and a feminist issue.

Although united against the chemical that endangered their health, women have adopted dif-

ferent techniques and focuses in their fight for change. The film examines these as well. In 1973, for example, in an effort to impose legal responsibility on the pharmaceutical industry, Joyce Bichler successfully sued the Elly-Lilly Drug Company in New York. The impact of this litigation has been far-reaching. No longer are the actions of individual drug companies viewed as separate from the actions of other companies in the industry. We listen to Bichler, one of the 500 victims of DES-related cancers in the United States, describe her difficulties in taking a stand and making her private agonies public. The film outlines how the regional DES Action: Canada representatives inform mothers and their children, as well as medical personnel, about the risks associated with DES.

While this documentary is informative and encouraging, it fails to address the conventional view that chemicals such as DES are no more than unavoidable incidents of medical progress. An investigation into the drug industry, medical profession, government regulators, and the interaction between them is the context in which DES must be discussed in order to effect change. If the present conventional allopathic medical model prevails, the prognosis for women's health care will further deteriorate. Films focusing on issues such as DES must take the courage to go beyond descriptive analysis and engage in critical analysis. We, in turn, must exercise our will to prevent science from the continued use of women as guinea pigs.

Sheila Goldgrab developed a vertical filing system for Women Healthsharing during the summer, 1985. She is now continuing her photography studies at Ryerson Polytechnic Institute in Toronto.



Dawna Gallagher

LETTERS

A Generous Farewell

This cheque represents the closing of the books of the Ottawa and Region Women's Health Collective. In the past two years I kept hoping that the collective would re-form. Since that did not occur, I see your magazine as the best forum through which our "collectives" goals can be met.

It is necessary to struggle to change on a day-to-day basis. I believe your magazine is a major catalyst in this on-going struggle in our widely scattered communities across Canada.

Marg Taylor
Ottawa, Ont.

Diet and Knowledge Better Help than Drugs

Thank you, healthsharers, for Mary Louise Adams' most illuminating and helpful article on yeast infections (Summer, 1985). The information in this article will likely save countless readers the anxiety and discomfort of symptoms that proliferate and vary according to life-style and physiology.

I suffer from several of the symptoms of Candidiasis, but until very recently the only "relief" was temporary due to hormonal changes in my monthly cycles. When I was younger, several doctors prescribed expensive creams such as Monistat and Nystatin for the vaginitis which can be quite painful with severe cases of Candidiasis. Not long ago I found out (I think through another *Healthsharing* article or letter) that plain vinegar and water used as a douche was far more effective than any prescription cream; so is avoiding high alkaline soap when bathing and getting regular exercise which can be difficult for people who suffer the general apathy and malaise

which accompany chronic yeast infections.

I now work as a reference librarian and Adams' article is pasted on the front of my reference file on self-help medication. I have also made a few photocopies of the article (I hope you don't mind) for three of my friends who suffer from yeast infections.

What mystifies me is - how can so many doctors (I have been to at least six for vaginitis and later for migraine headaches) still prescribe useless and expensive drugs for a disease which affects so many people and which can be controlled by a careful diet and awareness of one's susceptibility to Candidiasis?

Susan Yates
Gabriola Island, B.C.

Scare Tactics

I was alarmed by your article *Breast Milk: An Untold Story* (Summer, 1985) and wondered if a baby formula company was behind some of the thinking. More babies died in Third World countries as a result of the companies pushing formula rather than breastfeeding.

At last we have the majority of new mothers breastfeeding their babies and out comes an article condemning the practice. By the time one reads to the last paragraph saying the advantages outweigh the disadvantages, you have already set off the alarm. If we quit eating and breathing we might escape PCBs. Until common sense and the right to good health overcome greed, the environment will never be cleaned up to our satisfaction.

I breastfed four children and the youngest is now 25. They appear to still be healthy today. My own daughter is breastfeeding her second child and

she would be horrified if she read the article. You compared breast milk with cow's milk in regard to PCBs. How many babies are given cow's milk now - it is usually a prepared formula, with a lot of ingredients on the can that one can hardly pronounce.

I'm sure you didn't intend using scare tactics but as the article was published in the *Toronto Star* in part, I wonder how many new mothers changed their minds about breastfeeding their new infants.
Helen Kemsley
Weston, Ont.

Not The Whole Story

In her article *Breast Milk: An Untold Story* (Summer, 1985), Jeanne Jabanoski claims to be making an attempt "to weigh the possible hazards against the benefits to the baby of its mother's milk." She then proceeds to emphasize the hazards and downplay the benefits. I was left with the distinct impression that this woman has a personal bias against breastfeeding.

Surely, with a minimum of effort, she could have presented more than three advantages to breastfeeding. She totally overlooked the following:

- breastfed infants are much less likely to suffer from allergies
- breastfed infants are less likely to require orthodontic care
- breastfeeding is more convenient, efficient and cheaper than bottle feeding
- there is evidence to suggest that breastfed babies are less likely to have high serum cholesterol problems in later life
- breastfed infants are less likely to become obese
- there is evidence to suggest that women who have breastfed their babies are less likely to suffer from breast cancer
- nutritionally there are numerous differences between breast milk and cow's milk upon which most infant formula is based.

Other statements made in the article were also erroneous and/or misleading. Such as: "Notably absent has been any information on chemical con-

tamination." Where has Jabanoski been? Almost any reference book one would pick up on pregnancy and/or lactation mentions the contaminant problem.

If Jabanoski supported breastfeeding at all she would have provided a few more simple, practical ways in which women could avoid contamination of their breast milk, such as:

- avoid the consumption of fresh water fish during pregnancy and breastfeeding
- use low fat dairy products
- reduce meat consumption; trim off all visible fat from meat prior to cooking
- avoid crash dieting while breastfeeding
- use organically grown, or at least unsprayed, fruits and vegetables
- read labels to avoid chemical additives in food products.

The suggestions that Jabanoski makes are also perfectly valid, but they do not cover chemicals over which we have individual control. I agree with her statement "that the only real solution is to work at ridding our environment of these chemicals in the first place."

Writing articles to make women aware of the contaminant danger could be part of the solution. Writing such a negative, misleading, obviously biased article as this one certainly is not part of the solution.

Teresa Whitehouse
Vancouver, B.C.

Pharmaceuticals: Bad News

I am writing about the Update summary, *Pharmaceutical Overhaul Needed* (Summer, 1985) about the brief from the Canadian Federation of University Women (CFUW) to the 1984-85 Eastman Commission of Enquiry on the Pharmaceutical Industry. I want to correct the statement concerning Canadian prescription drug prices; prior to 1969 they were "among the highest in developed countries." Since the 1969 compulsory licencing amendment to the Patent Act permitting the manufacture of selected generic drugs in Canada upon payment of a 4% royalty, our prices have compared more favorably.

Cause for much concern today is the federal government's apparent rejection of the even-handed recommendations of the Eastman Commission that would ensure public control over royalties to be allocated for research and development at a modest overall increase in costs of about \$30 million a year to consumers. According to press reports, the federal Minister of Consumer and Corporate Affairs is bending to the pressures from the multi-national drug firms to sharply increase the period of exclusivity and royalty rates for drug patents. It is estimated that such concessions, without public controls over research and development investment in Canada or prescription drug prices, would add \$150 million a year to the drug bills of Canadians. Because of the large provincial stake in the public health drug programs, consumers should lobby provincial ministers of health to resist any such unwarranted steps to fatten the profits of the multi-nationals. According to Statistics Canada, their profits under the present system, which gives them 90% of production (i.e. the compulsory licenses account for only 10% of drug production), rose by 60% from 1979 to 1983.

Besides its main brief, the CFUW presented a Supplementary Brief that emphasized women's health risks and concerns, in particular their increased risk of adverse drug reactions because of inappropriate prescribing and the efficacy of alternative approaches to health maintenance and care besides treatment by drugs and surgery.
Claire R. Heggveit
Nepean, Ontario

Supportive Clothing

That was a powerful article by Linda Lounsberry (Summer, 1985) describing the misery of working for long hours in a constrained position under pressure and isolation. The isolation and lack of stimulation make one more aware of pain and discomfort because they become the only stimuli. The refusal of the supervisor to pro-

vide a proper chair was disgraceful. All writing on VDTs stresses the importance of ergonomics, especially the chair.

I have wondered if there is another approach, one more within our control. Victorian ladies did not maintain their marvellous posture unaided; buttressed by whalebone, it was impossible to slouch. Liza Dalby in her recent study *Geisha* describes the difficulty of keeping the proper posture, sitting for hours on the floor with the back straight. She says that the wide, stiff obi sash supports the upper body and takes the strain off the back muscles.

Many women workers have jobs where they have to sit or stand for long periods of time. Surely there is a field open for research into developing clothing that would be light and comfortable to wear but which would provide support for the back. While I do not downplay the importance of having employers provide optimum conditions, all too often women are not unionized and have no clout. If we could turn to something that we could do ourselves we would have more control over our own health and comfort.
Rose Delap
Savona, B.C.

Tunnel Vision

I am annoyed with your tunnel vision of women and reproductive rights. In the fall, 1985 issue of *Healthsharing*:

1) a pregnant nude woman is on the cover; in light of the hue and cry of feminists in their nation-wide campaign against pornography, I wonder whether you feel you have a poetic license that has not been bestowed upon men such as Heffner simply because you are feminists?

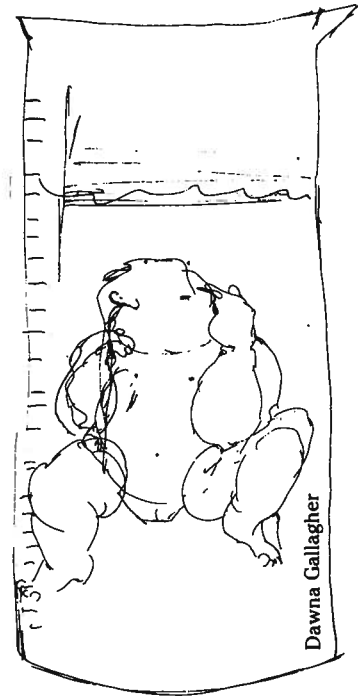
2) Connie Clement describes the understandable chill and alienation she felt when she read certain types of science fiction where "machines were humanized, humans were mechanized" (*Science Fiction/Science Fact*); I experienced such a chill when I read Nancy Adamson's article about self-insemination: how much further removed from humanity

can be the woman who inserts a needleless syringe/turkey baster full of semen into her vagina in the name of reproductive rights? Is adoption passé?

3) I disagree with Dianne Patychuk (*Ultrasound: The First Wave*) that "medical interventions in childbearing...provided new ways for medicine to take greater control over the management of pregnancies;" not only does this statement smack of feminist paranoia, it overlooks the fact that control in health care is taken only when it is *allowed* to be taken: implicit permission to take control is readily available in the passivity, submissiveness and fear rooted in the unnecessary, unenlightened state of the patient (male or female); regarding the issue of ultrasound overuse, Dianne may not be aware of the many women who pressure their physicians for ultrasound pictures to put in their baby books!

4) in your editorial you state: "to better understand the issue of reproductive technology, we must examine the motives of doctors, scientists and researchers who are developing and using the technology;" let us not forget to examine the motives of the women who, as patients or research subjects or lobbyists, promote the development of such reproductive technology - none of this occurs in an academic vacuum; let us also not forget that these same doctors, scientists and researchers gave us such valuable devices as incubators, fetal monitors and the science of neonatology.

In conclusion, I would like to mention that, in our present society, I hesitate to equate motherhood or mothering with power. The fact of the matter is that to bear children is to relinquish power. In a society where power is equated with money, where dependable day care services are scarce, where paternity leaves are considered frivolous, where employers are not concerned about whether little Suzie has the chicken pox, where nuclear family support systems are waning, where a woman's 'ongoing education' competes with hockey practice,



school outings, disposable diaper sales, laundry, housework and grocery shopping, I choose to be childless.
Mary Margaret Steckle
Toronto, Ont.

Proud Hamiltonian

As a Hamiltonian, I was proud and impressed by your information about the Occupational Health and Safety Centre (*Beyond Male Bias in Occupational Health*, Summer, 1985). Hopefully centres like this will continue to develop and stay ahead of the menacing industries which inevitably seem to find "loopholes" and dodge taking responsibilities.

In Clare County, Ireland, certain companies involved with dangerous chemicals have their workers sign forms which effectively prevent them from taking legal action against the employer if they become sterile or give birth to defective babies.

Renee Albrecht
Hamilton, Ont.

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



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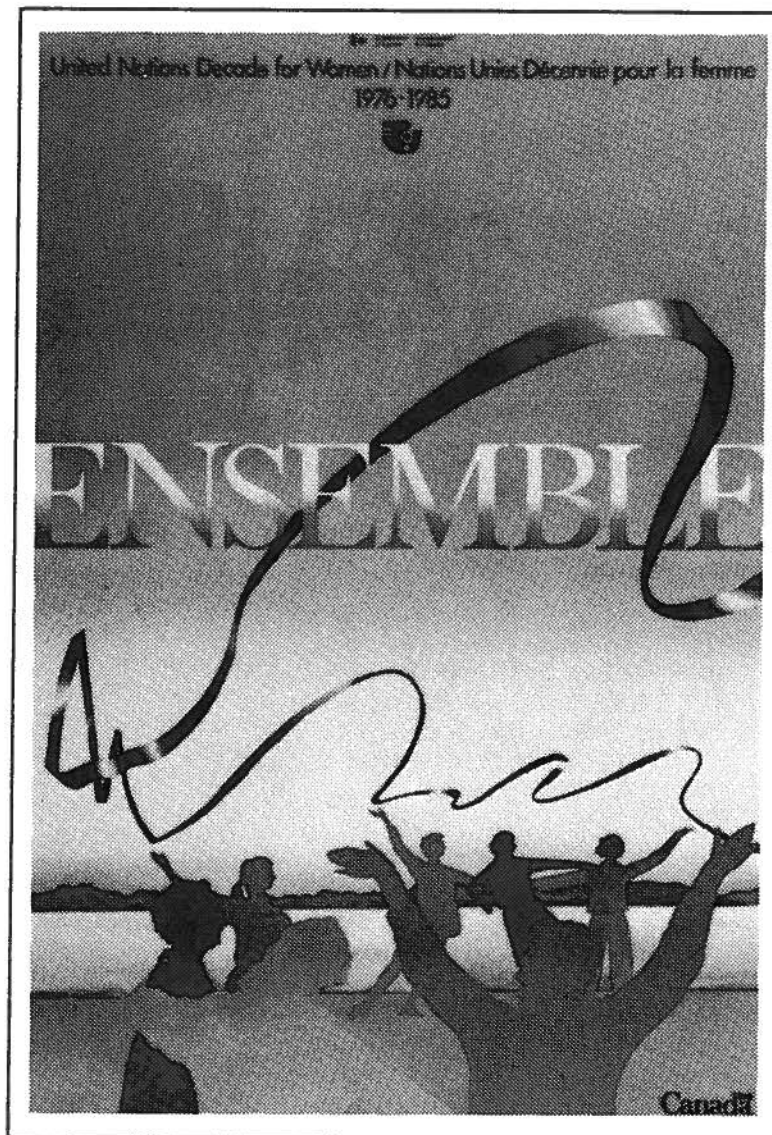
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UNITED NATIONS DECADE FOR WOMEN 1976-1985

The Decade for Women, proclaimed by the United Nations to eliminate discrimination against women will end in 1985. The co-operative efforts of women working to achieve this goal will however continue.

A poster in full color, acknowledging and celebrating the work of women over the past decade, has been produced by the Government of Canada and is available free of charge from:

Communications Directorate
Department of the Secretary of State of Canada
Ottawa, Ontario
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DÉCENNIE DES NATIONS UNIES POUR LA FEMME 1976-1985

La Décennie pour la femme, proclamée par les Nations Unies afin d'éliminer la discrimination envers les femmes, prendra fin en 1985. Toutefois, les efforts déployés collectivement par toutes celles qui cherchent à améliorer la condition féminine n'en resteront pas là.

Une affiche en couleur a été produite par le gouvernement du Canada pour saluer et célébrer le travail accompli par les femmes au cours de la dernière décennie. Vous pouvez l'obtenir gratuitement en écrivant à l'adresse suivante :

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RESOURCES & EVENTS

Assault and Immigrant Women

A 39-page manual, *Working with Assaulted Immigrant Women*, has been released in a revised form. Written by Monica Riutort and Shirley Endicott Small, this useful, easy to handle booklet is directed at para-professional counsellors working with immigrant women. It outlines the specific problems of wife-battering for immigrant women and offers an effective approach to providing help. It is also useful for professional counsellors.

Available for \$2.50 (plus postage and handling) from Education Wife Assault, 427 Bloor St. W., Toronto, Ont. M5S 1X7, (416) 968-3422.

Women's Summer Health Institute

The third annual Women, Health and Healing Summer Institute to help upgrade the teaching of women's health issues will be sponsored June 20-July 2, 1986, by the University of California, San Francisco.

The 40 participants will come from the community colleges, medical schools, universities, schools of nursing and women's studies programs from the United States and outside. Programs will examine minority health problems, doctor-patient communication, women's illness behavior, reproductive health, mental health issues and violence against women.

The Institute will be held on the

Berkeley Campus of the University of California. Application materials are available from the School of Social and Behavioural Sciences, School of Nursing, N-631-Y, San Francisco, Calif. 94143. Application deadline is March 15, 1985.

Preconception Health Kit

Planned Parenthood of British Columbia has produced an education kit for prospective parents and health care professionals. The kit contains information on fertility awareness, nutrition, tobacco, alcohol, stress management, expenses and many other issues.

The kit is available for \$10.00 (plus \$2.50 handling and postage) from Planned Parenthood Association of B.C., 204-5704 Balsam St., Vancouver, B.C. V6M 4B9, (604) 266-1381. Cheques payable to Planned Parenthood Association of B.C.

Community Health Tapes

The Ontario Rural Learning Association has produced four cassette tapes on community-sponsored community health centres as a part of its program to assist the creation of locally-controlled health services. The tapes contain clear action-oriented information on the purposes, structure and functions, funding base and start-up strategies for community-sponsored health centres.

The tapes are \$16.50 a set or \$4.50 individually and are available from the Secretary-Treasurer, Ontario Rural Learning Association, P.O. Box 1204, Guelph, Ont. N1H 6N6, (519) 863-9885.

N.W.T. Spousal Assault

The Task Force on Spousal Assault in the Northwest Territories has released its findings in a large report to the Minister Responsible for the Status of Women. The report contains an examination of the nature and extent of spousal assault, an analysis of the effectiveness of existing government responses and specific recommendations to improve present programs and to develop new ones. The report is comprehensive and would be valuable to anyone doing research on battered women in Canada's north.

Contact Dennis Patterson, MLA, Minister Responsible for the Status of Women, Government of the Northwest Territories, Box 1320, Yellowknife, N.W.T. X1A 2L9.

Unplanned Pregnancy Committee

The Manitoba Committee on Unplanned Pregnancy this summer launched a sophisticated media campaign aimed at raising public awareness of the growing problem of teenage pregnancies. About 60 teenage girls become pregnant every week in Manitoba. Using brochures, posters, press releases and a free information phone line, the Committee reached out to teenagers and parents. The problem was publicized and information was offered.

For more information on the program contact the Committee on Unplanned Pregnancy, 206-819 Sargent Ave., Winnipeg, Man. R3E 0B9 (204) 774-2501.