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Winter/Spring, 1992
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Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

The Politics of Breast Cancer

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ALWAYS IN HEALTHSHARING

Healthsharing

Vol 12:4 Winter/Spring, 1992

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HEALTHLINES

One in 10

We are facing an epidemic. One in 10 of us will be diagnosed with breast cancer at some point in our lifetime. Every one of us will know someone—a sister, an aunt, mother, grandmother or friend—that will be told they have breast cancer. This is frightening enough, but what is even more so is the fact that we still know very little about what causes breast cancer and how to prevent it.

Our cover story on "The Politics of Breast Cancer" confirms that what we do know is vague. We know that it *may* be related to a high fat diet, that we are at greater risk as we get older, that if our mother, sister or grandmother was diagnosed with breast cancer, we stand a greater risk of being diagnosed ourselves. We have also heard that late child birth or women who experience late menopause or even menstruation before age 12 are at risk.

But, even these are still unproven. What is conclusive is that if you are a woman, you are at risk.

Common sense tells us that if we want to find the causes and the preventive measures to deal with any illness, we need research. Such research will help us to find answers to the questions we have about a disease, but it will also help us to be more informed about our bodies, to be more in control.

Breast cancer has fallen victim to the misogyny in our society and, in particular, in medical research. It is a women's disease. It has not been given the priority and support for research that other types of cancers (such as lung cancer) have garnered. Increasing research dollars to determine the causes and ways to prevent breast cancer may not be a priority for government or the medical establishment, but it is for women.

Breast cancer kills more than 5000 women in Canada each year; one can add to this figure those women who have been diagnosed with the disease and currently undergoing treatment. While mainstream media is finally beginning to react to this statistic, to focus more on breast cancer itself and the women affected, as women we need to do more. First we need to ask: Why are so many of us being diagnosed with this disease? And why are so few research dollars directed to answer this question? How are the socio-economic conditions–the sexism, racism and poverty–that so many women experience in this country contribute to the chances of being diagnosed with breast cancer?

Second, we need to learn from our colleagues speaking out about AIDS. While there is still far to go in the struggle against AIDS, these activists have managed to call attention to their cause. What we need to avoid is a comparison of mortality statistics, arguing that one illness kills more and therefore should be given more attention. This only weakens our point, pitting one cause against the other. More AIDS research is needed AND more dollars should be spent towards breast cancer. Not one or the other, not less of one for more of the other. But both causes demand attention NOW!

Third, we need to rely on more than breast self-examination (BSE) and mammograms to save our lives. There is controversy around how effective mammograms really are in detecting different kinds of breast cancers; and, BSE, while useful in detecting breast lumps, is helpful only if we know what we are looking for, and, if we find a lump, if our physicians take our concerns seriously.

We did not originally intend to focus this issue of *Healthsharing* on breast cancer. But, as articles poured in, as we began to ask questions amongst ourselves, as we heard of women's experiences with the disease through our magazine and in other media, it became clear that we had to focus attention on this issue.

Pam Bristol's feature explores the politics of breast cancer and the need for research and activism. Sat Dharam Kaur offers, in our Healthwise section, an overview of all breast diseases and some holistic approaches to lower the risk of being affected.

With diagnosis, (write the members of the Burlington Breast Cancer Support Services in their pamphlet, "*What You Need To Know About Breast Cancer*," see Breast Cancer Resources), comes a variety of feelings: from fear, denial and anger to guilt, hopelessness and helplessness. Summoning the courage to deal with breast cancer, to make difficult choices and to learn to "LIVE" with the disease are related in this issue by two women: Rivka Phillips and Shirley Masuda. Each woman tells a different story. One about the frustration in dealing with an insensitive surgeon throughout a traumatic ordeal and the other about drawing on the support of family and close friends to deal with her diagnosis and finding strength from her history to feel content to live as a one-breasted woman. Both tell touching stories of survival and courage. Both stories inspired our cover illustration by Linda Nakashima depicting a one-breasted woman with a clenched fist where a breast had been—still a woman, still strong, but politicized further by her experience and her will to live.

Our special issue on "Immigrant and Refugee Women's Health" has drawn comments from across Canada. We are pleased that so many of our readers found the issue informative and useful in their own work. We wish to acknowledge the financial support of the Ontario Women's Directorate and the Department of the Secretary of State, Multiculturalism for this special issue. Copies are still available.

Hazelle Palmer

LETTERS

We encourage readers to write. Your comments are just as important as the original articles and columns published in the magazine. Please take the time to share your opinions with other readers.

Healthsharing *reserves the right to edit letters for length, and print them, unless they are marked "not for publication."*

In Praise of *Healthsharing*
Thank you for the information and resources provided by *Healthsharing*. I like the in depth research and information on women's health and how to move toward wellness. I also like the social analysis related to health.
B. MacLauchlan
Edgeley, Saskatchewan

Thanks for the Opportunity
Further to the publication of my article entitled "Traditional Healing Practices" in *Healthsharing* (Vol 12 No 3, 1991), I wish to thank you for the opportunity to have written for such an enlightening magazine and to tell you that I was extremely pleased at the wonderful way in which your editors were able to make the necessary corrections to the original text without changing the message I was trying to convey.

I hope that ..your magazine continues to receive the recognition and support it deserves.
M. Vargas,
Toronto, Ontario

Timely Issue
I would like to congratulate *Healthsharing* and your guest editorial committee for a timely special issue: "Immigrant and Refugee Women's Health."

The articles, features and profiles have surely raised the consciousness of local health professionals with respect to the problems experienced by immigrant and refugee women who have been victims of war, deprivation and loss, when they interact with members of the health care system. This calls for an encore!
M. de Souza,
Etobicoke, Ontario

Need to Work Together
Having been a long-time reader of *Healthsharing*, I was really excited to read your most recent issue, "Immigrant and Refugee Women's Health". The issue was an important contribution to the understanding of the barriers facing immigrant women and ways to work for change. It further underlined the need for all women to work together on improving the quality of care available to us. Hopefully, issues like this one will go a long way to resolving some of the deplorable inequities in our healthcare system facing all women in this country.

Keep up the good work!
Johanna Shapira,
Toronto, Ontario

Biased Account
As a long time subscriber to *Healthsharing*, I was deeply disturbed by the blatantly biased and irresponsible journalism exhibited by your managing editor Hazelle Palmer in the fall 1991 issue in her Update article entitled, "Health centre staff locked out by board"

Our centre, Women's Health in Women's Hands, faced and dealt with a management crisis last October and November which was the result of circumstances that were complex and long standing.

There had been multiple efforts on the part of both board and staff to resolve the conflicts which were eroding efforts to move the centre forward as a cohesive and productive service. Ms Palmer's reference to lack of staff input, to terminations, to a lock-out, to the status of our work with INTERCEDE, to the existence of any programs being offered at that time by Women's Health in Women's Hands, in fact to the entire situation, was filled with inaccuracies and misrepresentations.

Fortunately, the difficulties we were experiencing at Women's Health in Women's Hands have been resolved.

Unfortunately, what cannot be resolved is whether or not we can trust the publication to reflect accurately and without bias, any future story it might choose to report.
Carol Cayenne, President,
Board of Directors, Women's Health in Women's Hands

Thanks for Support
We are writing to thank you for your support during a critical time at our centre. When we picked up the special issue "Immigrant and Refugee Women's Health", we were gratified to learn that you took time to report on the situation at Women's Health in Women's Hands.

We feel that as a Community Health Centre for women, the community has a right to know what goes on in organizations that are funded by their tax dollars. Also for an organization such as ours, whose mandate is to provide holistic health services for women, it is important to communicate the types of problems that will occur, even in women run organizations. As a women's community we need to have a dialogue about women working with women, in order to devise better ways of working together, and working through issues.

As readers and subscribers to *Healthsharing*, we appreciate the voice you give to women in relation to their health and well being, and the articles as educational materials we use for workshop discussions.

Thanks again for your coverage of a difficult situation in our organization.
Staff,
Women's Health in Women's Hands

UPDATE

Waterlily needs your help

Waterlily, Newfoundland and Labrador's only feminist newspaper, needs public support to keep its voice alive in the province.

The paper has provided a forum for local writers and artists since its creation in 1989. However, last summer its main financial contributor, the Canadian Employment and Immigration Commission, pulled its support and the paper has not found a new primary source of funding. They have appealed to various government and private agencies for contributions but lengthy bureaucratic delays leave the paper's future in jeopardy.

In addition to its financial woes, the founding collective has dwindled to just three members. Those women, June Hiscock, Linda Evans and Angela Wilson will continue to run the paper, but they seek the direction of an advisory board.

To survive these obstacles *Waterlily* is asking women across the country to support a feminist voice in Newfoundland and Labrador by doing one or all of the following: send a letter of support to *Waterlily*, P.O. Box 367, Station C, St. John's, NF, A1C 5J9; subscribe to the paper or send a donation; and/or, send suggestions for possible sources of funding.

Colleen Ferguson

Estrogen linked to breast cancer

A long-term study conducted at Harvard Medical School has shown that estrogen replacement therapy (ERT) in postmenopausal women significantly increases their risk of contracting breast cancer during the course of the treatment. As reported in The DES Action *Voice* (Winter 1991), the Harvard researchers surveyed 118,273 nurses who were 30 to 35 years of age at the beginning of the 10-year study. They found no increased risk in those who had undergone ERT during the study period but were no longer taking estrogen; however, women currently using ERT were found to have a risk 36 per cent greater than that of women not currently undergoing the therapy.

The study supports a previous one that tracked 11,468 post-menopausal women for six years. That report, published in 1989, found a 69 per cent increase in breast cancer risk in women while they were taking estrogen.

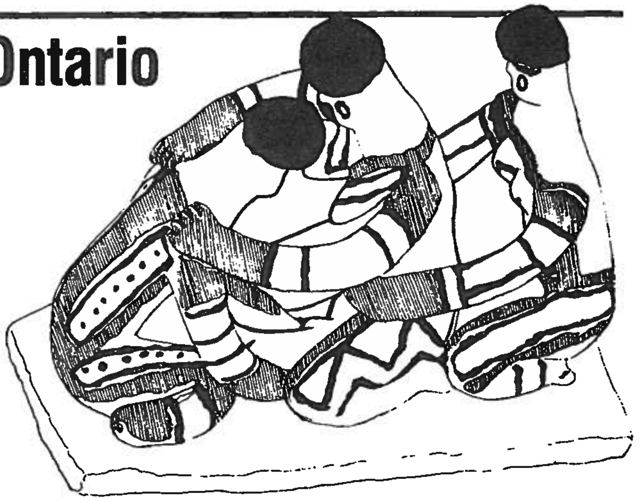
The Harvard researchers concluded that duration of use did not effect risk and that acute risk from current use was reversible within about two years of cessation of use. The data suggest that estrogen is a promoter of mammary tumors, they reported, but the beneficial effect of ERT on the incidence of cardiovascular disease and hip fractures still outweighs the risk for breast cancer.

WomenWise (Winter, 1991)

Lisa Huncar

Thousands of women marched through downtown Toronto, March 7th, celebrating International Women's day under the banner 1492-1992: 500 Years of Resistance, Women reclaiming and healing our peoples, our lands, our lives.

Midwives win legal victory in Ontario



Janet Isaacs Ashford

In November of 1991, the province of Ontario passed The Regulated Health Professions Act which included Bill 56, The Midwifery Act. This Act establishes midwifery as a distinct, self-regulating profession. Under the new legislation, midwives will be recognized to work as primary caregivers in all settings (homes, birth centres and hospitals) and the government is committed to funding midwifery services. The legislation is the result of 10 years of volunteer work (lobbying, research, writing briefs, making presentations and attending meetings) by hundreds of midwives and consumers dedicated to having midwifery recognized.

With the passing of the legislation, the integration of midwifery into the health care system has entered a new stage. The Act has passed, but it will take about another year to come into effect. For midwives currently practising in Ontario, a pre-registration program (an educational review and assessment to prepare them for registration) will begin in October 1992 at the Michener Institute in Toronto. The process will take anywhere from four months to one year for the individual midwife. As well, an education program for new midwives will be put in place. The government is studying proposals from educational institutions and will decide on the location for the program this spring. Also outstanding is a decision by the Ministry of Health on a method of funding to ensure continuity of care and choice of birthplace, essential elements of the midwifery model of practice.

In the meantime, women continue to seek out midwives and pay for their services privately. Why? It is natural for women to be with women during labour and birth. This has been the way worldwide throughout time. Women experience the pain and the passion of giving birth and midwives (meaning "with-woman") are there to assist. Midwives know that a woman needs to give birth her way, in her own time, and this is one of many reasons that women have been choosing midwifery care at their own expense. Having control over her body and her environment is an issue for most women who choose to give birth at home.

In Ontario, there are about 60 practising midwives. Throughout the childbearing year, midwives provide services such as prenatal care, childbirth education, primary care during labour and delivery, breastfeeding support, newborn assessment and postpartum care. Midwives usually practise in small teams which are on-call 24 hours-a-day. When doing home births, they are the primary caregivers. When their clients are in hospitals, they have been there as the woman's labour companion and advocate. The new legislation will enable midwives to have hospital privileges, allowing them to attend a woman in hospital whether it is a planned hospital birth or a transfer from home.

Midwives have been regulating themselves as a profession through the Association of Ontario Midwives (AOM), a voluntary body. Virtually all midwives practising in Ontario belong to the AOM. The Association's many committees (Practices and Standards Committee, Legislation Committee, Education Committee, Disciplines and Hearings Committee, etc.) have done a vast amount of work on the midwives' own, unpaid time. In the future, much of this work will be done by a newly created College of Midwives, similar to colleges of other health professionals, such as the College of Physicians and Surgeons.

With the passing of Bill 56, women across Ontario can expect much more accessible midwifery care in the near future. Midwives in the provinces of British Columbia, Alberta and Quebec have been in touch with Ontario midwives and are studying the Ontario situation. Midwifery is on its way to becoming an established profession, not only in Ontario but across Canada.

Currently practising Ontario midwives can call The Michener Institute at (416) 596-3147 for more information on the pre-registration program or they can write to The Michener Institute, 222 St. Patrick Street, Toronto, ON, M5T 1V4.

Women in Ontario needing assistance finding a midwife in their community will be able to call the Midwifery Task Force of Ontario Hotline starting in May 1992 at 1-800-387-9031. This service is being relaunched in honour of the 2nd International Midwives Day in May. The Midwifery Task Force of Ontario (MTFO) is a consumer group with chapters across Ontario. For membership information write to the: Midwifery Task Force of Ontario, P.O. Box 64, 260 Adelaide Street East, Toronto, ON, M5A 1N0.

Betty Dondertman
Midwifery Task Force of Ontario

American Convention on Human Rights

When Canada joined the Organization of American States (OAS), it did not ratify all the OAS Conventions. In particular, it did not ratify the "American Convention on Human Rights." The federal government is currently consulting the provinces about whether this convention should be ratified, and is working towards a target date of May 1992.

NAC is very concerned about Part I: State Obligations and Rights Protected, Chapter II - Civil and Political Rights, Article 4. Right to Life, which states: "Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life."

NAC is not completely familiar with this particular ratification process, but suggests that this information be passed on to all reproductive rights groups in your network. Those groups that are able to do more research and lobbying around this should contact Claude Demers, Senior Officer, Intergovernmental and Interdepartmental Committees, Secretary of State, Ottawa and/or Barbara McDougall's office, Ministry of Foreign Affairs, Ottawa. They should also express their opposition to the appropriate body in their provincial government.

ALICE DEWOLFE
NATIONAL ACTION COMMITTEE ON THE STATUS OF WOMEN

Health And Disabled Women's Project

The DisAbled Women's Network Toronto (DAWN) has received funding from the Health Promotion Directorate for a three year Health and Disabled Women Project. Today, many women with all types of disabilities have difficulty receiving proper health care. These women continue to struggle with inaccessible facilities and often feel neglected by women's health services.

The project will address the health care needs and issues of women with disabilities. Health care workers and planners will be encouraged to incorporate the needs of disabled women in their facilities and programs.

Regional workshops will be held across Ontario and a provincial symposium will take place October, 1992. By the end of the project DAWN Ontario will be formed.

If you are a disabled or non-disabled woman and are interested in our project, drop us a line at:

Health and Disabled Women Project, 4 Warner Avenue, Toronto, ON, M4A 1Z3, (416) 750-DAWN, Voice or TDD

THE DISABLED WOMEN'S
NETWORK TORONTO

Two regional animators named for health network project

Two women have been hired to facilitate the production of two of the six special issues *Healthsharing* will publish on women's health in six different regions across Canada. This is part of the Canadian Women's Health Network, a project coordinated by Women Healthsharing and funded by Health and Welfare Canada.

Vancouver resident, Anne Fraser, will coordinate the compilation of material for British Columbia and Alberta and Alexandra Keir, a native of Nova Scotia will cover the Atlantic region.

Each regional report will contain a resource list of organizations, groups and advocacy groups involved in women's health. The reports will also feature special projects or initiatives currently under way in the region. Space is limited, but the goal is to ensure that each issue paints a representative picture of the services and programs available for women from diverse backgrounds, ethnic groups, sexual orientations and abilities.

The first regional issue will focus on B.C. and Alberta and will be published in late May or early June 1992; the second, on the Atlantic provinces will be produced this fall. The remaining reports from the Prairies, Ontario, Quebec and the North will be produced, in this order, from early 1993. Regional animators for these four regions have not been named.

For more information on the project or if you are interested in applying for one of the regional animator positions, please contact Hazelle Palmer at Healthsharing, (416) 532-0812.

If you are a resident of B.C., Alberta or any of the Atlantic provinces and wish to contribute (graphics or written material) to those issues contact: Anne Fraser, 131 East 27th Avenue, Vancouver, B.C. V5V 2K5, (604) 879-1747 (B.C. and Alberta); or Alex Keir, R.R. #2, West River Station, Nova Scotia, B0K 1Z0, (902) 925-2049 (the Atlantic provinces).

WHS

Federal government's child care initiatives "despicable" say Ontario group

Child care advocates reacted with outrage at Federal Health Minster Benoit Bouchard's statement that the government's budget initiatives are a replacement for a national child care program.

"This is despicable," charged Ontario Coalition for Better Child Care President, Jane Bertrand. "Tax deductions do not create a single child care space."

Ms. Bertrand accused the government of taking money from moderate income families and giving it to upper income earners to help cover their child care costs. The budget initiatives do not replace any of the money the Conservative Party has removed from Canadian families since taking office in 1984, Bertrand pointed out. The de-indexing, then the claw-back of the family allowance, coupled with regressive tax changes have taken over $500 million out of the hands of Canadian families.

"Now the government has repackaged a shrinking pot, given more to the very poor, more to the rich, and left middle income families to fend for themselves," Ms. Bertrand charged.

Under the Tory scheme a family of four would have to earn over $100,000 to take advantage of the extra $1,000 tax deduction; a family would have to be earning under $20,000 to be eligible for the full $1,200 tax credit; and, a moderate income family would be ahead by only $44 a year.

Child care in Ontario costs on average $28 a day.

"The government initiated tax deductions as a means to "stimulate" child care in 1988," Bertrand said. "Today child care is in worse shape than ever."

ONTARIO COALITION FOR BETTER CHILD CARE


Dawna Gallagher

Sharing Health Information

We occasionally exchange our mailing list with other organizations. We are selective and choose organizations we think will benefit from learning about *Healthsharing* and which we think you might want to know about.

If you do not wish your name and address exchanged, please write us and we will withhold your name during exchanges.

Sistering celebrates 10 years!

Sistering, a non-profit women's organization that addresses the needs of isolated, poor and homeless women in Toronto is celebrating its 10th anniversary.

Jannie Mills, a worker at Sistering, says the organization serves over 900 women a year, offering support to 35 to 60 women daily. Services include an outreach program, a drop-in centre and a senior's independence program. The outreach program and drop-in centre offer information and referral services, advocacy support, social and recreational activities and life skills. A study recently completed by the Coalition for Feminist Mental Health Services in Toronto, found that 68 per cent of the women who use the services of Sistering are survivors of sexual abuse.

"The women who come to us are those who have fallen through the cracks. They are extremely isolated and when they do tell their stories of abuse, they are often dismissed or not believed by social service agencies," Mills says.

Sistering is publishing a book to be entitled, *Sistering Celebrates Women*, a compilation of stories, poems and quotations about women. In a unique fundraising effort, the organization is guaranteeing one page to each person who gives a donation of $100 or more, to write a tribute to a woman he or she cares about. If donors do not wish to write a tribute themselves, Sistering will use the page to write a tribute to a woman who has benefitted from the program. The book will be published in May 1992. Submissions and donations are welcome by April 10 to Sistering, 181 Bathurst Street, Toronto, ON, M5T 2R7. Call (416) 861-1954 for more information.

MEGAN WILLIAMS

Pam Bristol

The Politics of Breast Cancer

THE MORE WE LEARN ABOUT IT, THE MORE we fear it. We look to the media and the medical community for information on how to prevent it, detect it and if need be to cope with breast cancer. But we do not get many answers; and the answers we do get are often vague or contradictory.

For the one in 10 Canadian women who will get breast cancer during their lifetime, answers are crucial. Like women in the United States, more Canadian women with breast cancer are becoming activists. They are questioning the direction of current research and the effectiveness of detection and treatment, the adequacy of funding and education.

"AIDS activists have shown that the rewards are much greater if we speak out," says Pat Kelly of the Burlington Breast Cancer Support Services in Burlington, Ontario.

The incidence of breast cancer has been steadily increasing, according to data that dates back to the 1950s. Despite medical advances, the number of deaths per year has not declined and in 1991 reached more than 5,000.

Kelly and other breast cancer survivors expressed their concerns to a House of Commons subcommittee on the status of women which is examining breast cancer issues. It is expected to table its recommendations in parliament this spring. The subcommittee provided the impetus for some of these women to join together to form a national advocacy group.

Called Breast Cancer Action -Write Now, the organization intends to make governments and the public more aware of breast cancer issues in the same way AIDS activists have forced the AIDS crisis onto the public agenda. The group is encouraging women to write their Members of Parliament demanding more action on breast cancer; it is asking the National Action Committee on the Status of Women (NAC) to act as an advocate; and it is working to ensure that the subcommittee's report is taken seriously in the House of Commons and not lost in a shuffle of paperwork.

"We want to give the message that speaking out is not an indication of maladjustment to diagnosis," Kelly says, "We're not just trying to embarrass medical professionals; our complaints are legitimate." "Compared to men with AIDS, we've been incredibly passive about breast cancer," says Sharon Batt. She and other women with breast cancer are forming an activist group in Montreal. "It has to be politicized," says Paula McPherson, one of the women in St. Catharines, Ontario who have set up the Breast Cancer Information and Education Services to provide information, support and advocacy. Both Batt and McPherson have established contact with American activist organizations to help develop their groups.

"I remember walking out of the hospital at one point and saying 'it feels like I'm the only woman who has breast cancer,'" McPherson recalls. "It's a mystery, but it doesn't have to be this way."

These two groups, and the Halton Women's Self Health Project (see *Healthsharing* Summer '91), are some of the few grassroots activist organizations operating in Canada. However, there are numerous support groups across the country affiliated with the Canadian Cancer Society. As well, the Canadian Breast Cancer Foundation has grown in influence since its creation in 1986 and has raised $400,000 toward research so far. With a board membership that reads like a Who's Who of Toronto's elite, it is not exactly a grassroots organization. But the Foundation is working effectively to raise both money and awareness.

Research

One of the key areas under debate is research. In the past few years the medical community has increased its study of breast cancer. One Canadian researcher counted 4,561 articles listed in the international medical index in 1989 alone. But many important facts still elude us.

Although it is true that lung cancer kills almost as many Canadian women as breast cancer, more than 80 per cent of these deaths are readily preventable. Research clearly shows smoking is directly responsible for these deaths. Nothing tells us how to prevent breast cancer.

We know it is a systemic disease that can eventually spread through the body if left untreated. But we do not know why or how it spreads. We do not understand why some women remain cancer-free for the rest of their lives after surgery, while others suffer a recurrence within a few years. We know there are certain risk factors, such as a high-fat diet, late child-bearing and late menopause. But, except for a direct family history of breast cancer, none of these risk factors has been definitely proven to contribute to the disease. Even a direct family link only increases risk marginally. In fact, three-quarters of women with breast cancer have none of the risk factors.

Judith Rosner-Siegel, diagnosed with breast cancer four years ago and undergoing treatment, is a patients' rights advocate and a peer counselor with the Canadian Cancer Society. She is angered by attempts to provide simplistic answers, especially in the areas of prevention. "The only way to prevent it is to chop off your breasts when you're 16," she says. "And even that doesn't work because it's a systemic disease."

Women contacted for this article expressed concern about the under-funding of breast cancer research. According to the National Cancer Institute of Canada, which administers about 60 per cent of the country's cancer research dollars, they have reason to be concerned. Executive director Dr. David Beatty says Canada spends only one quarter the amount per person that the U.S. allots to cancer research and this holds true for breast cancer in particular.

However, Pat Kelly maintains that breast cancer does not receive its fair share of cancer research dollars. The Canadian Cancer Society spent about $45 million on cancer research in Canada last year, Kelly says, and about $2.5 million of that on breast cancer research. "Breast cancer represents 15 per cent of all cancers; yet it gets a smaller per centage of the research budget." (less than 6 per cent)

Kelly also believes that certain members of the medical establishment have too much control over which research projects are funded. "The Canadian Cancer Society is largely run by women volunteers who have no say on how the research money is spent."

Those contacted also questioned the direction of existing research. "So many groups are doing their own thing without talking to each other," notes Roy Clark, a breast cancer specialist with Princess Margaret Hospital in Toronto. "There's too much duplication between them."

Two areas especially need research. Despite several studies on the connection between high-fat diets and breast cancer, no link has been definitely established. However, it is well known that the incidence of breast cancer is much lower in Japan and other countries with low-fat diets. And when Japanese women move to a country with high-fat diets, their incidence rises.

It may take years before research discovers a definite link, but Clark feels common sense dictates that we lower our fat intake not only to reduce the risk of breast cancer but of other diseases as well.

The other area of research which could lead to a major breakthrough is the discovery of genetic markers. If we could pinpoint what inherited characteristics make certain women vulnerable to breast cancer, we could detect it much sooner than current methods allow and perhaps even prevent it.

Another complaint about research is that doctors often ignore its findings. Varying mastectomy rates across the country are the most graphic example of this. Since 1981 there has been solid evidence that lumpectomies (or partial mastectomies as they are sometimes called) provide the same chances of survival as mastectomies in the majority of cases.

A team of researchers from Princess Margaret Hospital and the University of Toronto, which included Clark, pioneered lumpectomy in North America in the late 1950s. Thirty years later 60 per cent of breast cancer surgery in North America is lumpectomy . But this per centage should ideally be up to 80 per cent or 85 per cent, he says. In certain parts of Canada, such as Vancouver, mastectomies still outnumber lumpectomies. The reason, according to Clark: "Doctors get hooked on doing a particular kind of surgery." On the other hand, Rosner-Siegel expresses concern that some women are led to believe that a mastectomy is never necessary, and this is not the case.

Support

Hundreds of women who have or had breast cancer volunteer their time for peer counseling through Canadian Cancer Society groups such as Reach for Recovery or CanSurmont. However, these groups are unable to reach many women.

Some hospitals don't allow the volunteers to set foot in their wards, says Rosner-Siegel, who works with the Reach for Recovery program. They have qualms about including 'non-professionals' in the treatment process. Other hospitals allow peer counseling only for women with mastectomies and not lumpectomies, which doesn't make sense, she adds. Rarely are patients told they can receive counseling

More Canadian women with breast cancer are becoming activists, questioning the direction of current research, the effectiveness of detection and treatment, the adequacy of funding and education.

support before surgery—a time when they are often the most confused and in need of reassurance from someone who has gone through it already.

"During treatment, need number one is peer support," Rosner-Siegel emphasizes. Some hospitals organize self-help groups for women who are recovering from surgery and undergoing chemo or radiation therapy. These groups, though helpful, are also flawed. Often they are organized without patient input. They are inflexible so if a woman misses the starting date she is unable to join.

However, stronger support seems forthcoming. After Rosner-Siegel and other cancer patients made their views known to the Cancer 2000 taskforce (whose mandate was to establish strategies for cancer management by the year 2000). The taskforce recommended the creation of a national cancer patient coalition. This coalition, expected to be organized by 1993, hopes to provide a telephone network for cancer patients across the country. This service will especially benefit those who don't have access to support groups or peer counseling. These people will be able to pick up a phone and be directed to someone who has undergone a similar experience with cancer.

Because breast cancer can be a long-term disease, support is needed after hospitalization.

Rosner-Siegel recalls an incident that illustrates this need. When her cancer recurred two years ago, she felt there was no hope. "I felt like jumping in front of a subway train," she says. But soon after, through her counseling work, she spoke with a woman who had suffered a similar recurrence 16 years ago and has had no further difficulties. It is this kind of personal experience sharing that can save someone from despair. The Toronto branch of the Canadian Cancer Society plans to start the first long-term support group for women with breast cancer in the spring. If it is successful, more will follow.

Although the Canadian Cancer Society provides needed support services, its mandate does not include political advocacy activities which could best be handled by groups directed solely by activist-survivors. "I think there should be groups across Canada which are survivor-directed," McPherson says. Such groups could push more aggressively to raise awareness.

Early detection

Early detection is key. About 80 per cent of women survive the five-year mark if their cancer is caught in the early stages. But early detection is relative. Most breast cancer is now detected by women themselves, usually about five years after the tumor first appeared. Mammograms are said to detect tumors about two years after they form. Obviously, a method of earlier detection is needed.

Despite the controversy surrounding it, mammography is now our only medical resource and has been proven effective in women 50 years or older. It's hard to reject something when there is nothing to take its place. But, unfortunately, many groups have polarized on the issue. Some call mammography a miracle of technology while others label it an ineffective smokescreen for the lack of progress in treating breast cancer.

There are problems with mammography. Most Canadians involved in the treatment of breast cancer believe the United States has created many of these problems by over-promoting mammography's use. University of Toronto professor of preventive medicine, Cornelia Baines, disagrees with the promotion of mammograms for women under 50 by both the American College of Radiology and the American Cancer Society (ACS). The ACS recommends a baseline mammogram between the ages of 35 and 40 and subsequent tests every one to two years between ages 40 to 50.

This recommendation contradicts evidence to date which shows no benefit from screening women under 50 in terms of reducing breast cancer mortality. Mammograms often do not detect irregularities in breast tissue of women under 50 because of the density of their breasts. However, they do help to diagnose breast cancer after irregularities have been detected through physician or self-examination. Could the self-interest of American mammography equipment manufacturers and radiologists who charge up to (U.S.) $250 per examination have anything to do with targeting women under 50?

In Canada, women under 50 are usually not screened unless circumstances, such as a family history of breast cancer, warrant it. But, influenced by American media, many Canadian women are asking for mammograms at relatively young ages. And some Canadian organizations, such as the B.C. Breast Screening Program, support the testing of women in their 40s.

On the other hand, women age 50 and up, who could benefit from regular mammograms, are often difficult to reach. Dr. Judith Weinroth is the medical coordinator for the Ontario Breast Screening Program. Under this program, centres have opened across Ontario to ensure that women age 50 and up have access to screening. She estimates that if these centres can reach 70 per cent of their intended clients, they can provide the early detection needed to reduce mortality in that age group by 40 per cent.

Screening programs have sprung up across the country. British Columbia started the first program two years ago. Alberta, Saskatchewan, Nova Scotia and Yukon are now offering similar programs, and others are planned in Quebec and Manitoba. However, these screening programs have to fight against fears of cancer and anxieties about mammography. "A lot of women are really afraid," notes Weinroth. "Intelligent women finally come in with huge lesions in their breasts. There's a lot of denial."

It is Shebina Amlani's job to alleviate these fears with education. In her role as health promotion officer for the Metro Toronto Breast Screening Centre, Amlani attempts to educate different ethnic communities within her region. She speaks to women's groups, multi-cultural groups and public health workers. She also writes articles for ethnic newspapers. The Metro Toronto Breast Screening Centre provides translators for several languages.

Holly Dee of the Southeast Asian Centre serves on an outreach committee Amlani formed for the screening centre. When Dee speaks to groups in the Asian community about breast cancer, she proceeds with caution. "Breast cancer is taboo to many in the Southeast Asian community." She aims her information session at the young, who she feels are easier to reach than older women. Because of the closeness of many Asian families, Dee anticipates that younger members of the family will inform their elders and encourage them to visit a screening centre.

Ontario's screening centres do not concentrate solely on mammography but embrace a more holistic approach. A nurse examiner checks a client's breasts and then spends at least 20 minutes demonstrating the techniques of Breast Self-Examination (BSE). Other provincial screening centres teach BSE to varying degrees.

Unfortunately, women rarely receive comprehensive instruction on BSE. Where would they learn it? BSE is not taught in schools and many doctors either do not know proper BSE techniques or do not take the time to inform women. Yet monthly BSE is the best means of detecting breast cancer in women under 50 and is also necessary for women over 50.

Activist groups can play an important role in this regard. The Halton Women's Self Health Project teaches BSE to any group which requests its services. Paula McPherson's group in St. Catharines plans to work with teachers to introduce BSE instruction in high schools.

No woman, regardless of age, should rely exclusively on mammograms for two reasons. First, mammograms are estimated to be only 85 per cent effective in detecting irregularities in women over 50. Second, the quality of mammography equipment and the qualifications of its operators vary. A woman has every right to check on the qualifications of both.

Fighting misconceptions

While women need information on breast cancer, we do not need the misconceptions that sometimes come with it. Rosner-Siegel is concerned about polarized views of the disease. The media often focus on either success stories or tragedies. The survival rate of 85 per cent for breast cancer caught in its early stages is often quoted. But in reality survival rates are much lower.

As well, the fact that a women's life is permanently altered is not always made clear. Instead, we're often presented with 'smiling celebrity' profiles of famous women who seem to be completely recovered. "We're talking about a chronic disease," Rosner-Siegel points out. "You're constantly monitored and facing the fear of it coming back."

Other aspects of the media's and society's treatment of breast cancer can be questioned. For instance, why are most articles about breast cancer accompanied by a picture of a young woman's breasts when the majority of women who get the disease are over 50?

Clearly, after years of neglect regarding women and breast cancer, we have achieved recognition of its seriousness. The next step is recognition of the need for more research funding and more support for women who are diagnosed with breast cancer.

Pam Bristol is the editor of a national food magazine and has volunteered with Women Healthsharing for several years.

This publication is regularly indexed in the Canadian Women's Periodicals Index.

The index is an early reference guide to articles about women printed in more than 80 English and French periodicals, for use by researchers, lecturers, students and anyone else interested in women's studies.

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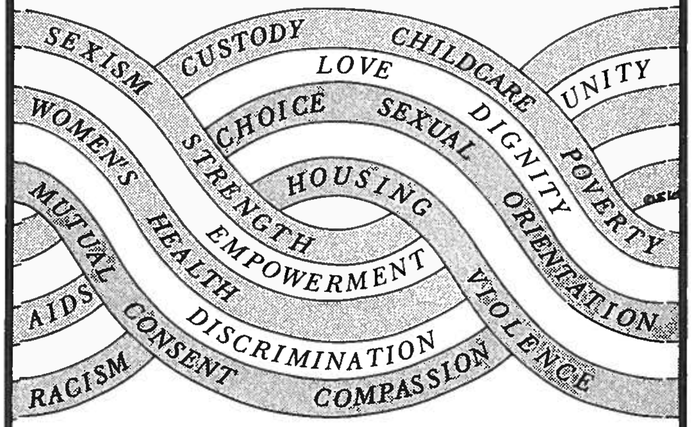

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HEALTHWISE

Alternative Approaches to Breast Disease

Sat Dharam Kaur

Many of us feel vulnerable about our breasts. Either they are too small, too large, handled too much or not enough. We may have experienced shame, confusion or anger at their budding during adolescence rather than embraced the rite of passage into maturity that their growth signified.

Perhaps some of us absorbed the discomfort and denial of our mother's relationship to her breasts. Thirty years ago women were discouraged by doctors from breastfeeding - the bottle and the cow replaced her flesh and blood. We lost contact with the source that was designed to nurture us and bring pleasure. Many of us who were not breastfed have more allergies and immune problems than those who were.

Society honours women's breasts as commodities rather than as givers of life. They pose with a pretty face in front of sleek cars, beer bottles and travel packages to sell products. The eternal tease, a woman's breasts have become a symbol of what we want but can never get. Ultimately, they represent the availability of pleasure and unconditional love.

Our society's discomfort with breasts is part of the pattern of women's oppression. We are taught to accept a submissive role in relation to our health and bodies — to leave it up to the "experts." But this pattern has contributed to the lack of awareness of and research into breast disease, especially breast cancer. The U.S. government spends only $77 million a year investigating ways to prevent breast cancer compared to $648 billion on heart disease prevention. Statistics on the proportion of Canadian government health prevention dollars spent on breast cancer research would look very similar.

As women, it is important that we take control of our breasts, that we care for them as well as find pleasure in them. We also need to understand the factors that cause breast disease. The conditions of our lives as women, surviving racism, sexism, homophobia, poverty, pollution and violence, lead to ill-health and disease. In conjunction with these social factors, there are specific physical and physiological causes of breast disease that I will discuss from the perspective of Chinese medicine.

All women over 20 should perform breast self-exam every month. It is one of the best ways to detect breast cancer in its early stages. It is also a way of accepting and validating our bodies, particularly where we feel most vulnerable. It shifts us away from being victims in the disease process to taking charge of our health.

Traditional Chinese Medicine and Breast Disease

In her book, *The Breast Connection*, Honora Lee Wolfe, a practitioner of traditional Chinese medicine, traces the progression of breast disease from premenstrual swelling to breast cancer.

She maintains that all breast diseases should be considered to be on a continuum and are not really separate entities. Premenstrual breast tenderness is the first stage of what may develop into other breast diseases. Appropriate therapies can reverse the process at different points along these routes. However, it is best done in the initial stages.

Traditional Chinese medicine has existed as a system of healing for over 2,000 years. It is believed that energy, or "qi" travels through the body along prescribed pathways called meridians. Each organ has its own meridian. Imbalances in the body are often related in terms of yin and yang, the great polarity of being. Yin refers to the blood, body fluids and body substance. It has a falling tendency and is relatively motionless. Yang refers to the heat and active functions within the body which cannot be seen hormonally. It has a tendency to rise in the body to produce, for example, headaches. The yang moves the yin, while the yin supports the yang. Both need to be in balance for there to be harmony in the body.

In Chinese medicine, the primary cause of breast disease from swelling to cancer is "stagnant liver qi" (stuck liver energy). This refers to a blockage (experienced as pain, swelling or a tumor) in the vital energy associated with the liver organ-meridian. The cause of this stagnation could be a traumatic injury, poor digestion or "excess dampness" in the body. However, the most common cause of qi stagnation is emotional stress. Anger, frustration, worry, fear and anxiety disrupt the smooth flow of the liver energy.

The organs are not solely large pieces of homogeneous tissue, but function as zones of highly concentrated electromagnetic activity within the body's energy system. Each organ-meridian is responsible for certain energetic functions which, in relationship to each other, keep the body healthy and in balance. Each organ also corresponds to a specific emotion. An excess or prolonged experience of that particular emotion can disturb the energetic function of the associated organ to cause disease. The heart is associated with joy or sudden fright; the spleen with worry and obsessiveness; the lung with grief; the kidney with fear; and the liver with anger and depression.

The liver is the most temperamental organ - stress affects it first. Normally the liver's energetic function is to promote the smooth flow of "qi" or energy, in all directions. When overwhelmed by emotional disturbance that is persistent, the liver qi loses its free flow and becomes congested or stagnant. Thus, prolonged periods of stress contribute significantly to breast disease.

This energy stagnation first manifests as pain and swelling, and will affect the pathway of the liver meridian, which traverses the lower abdomen and sex organs, chest and sides of the rib cage, the nipples, throat, gums and top of the head. Thus, liver qi stagnation may manifest as menstrual pain, chest pain, breast swelling, sore or swollen throat or headache on the top of the head.

A practitioner of traditional Chinese medicine would use herbs and/or acupuncture to "dredge" the liver when treating breast diseases. Every woman with breast symptoms would be wise to participate regularly in a form of relaxation so that her emotional disturbance is less pronounced. She should participate in frequent aerobic exercise, as this helps to release stagnation and circulate the liver qi freely.

Substances should be avoided which aggravate the liver. These include:

- Coffee and other caffeinated foods and drinks
- Alcohol
- Greasy, fried or oily foods
- Hot, spicy foods such as curries or chilies
- Meat in large quantities
- Smoking
- Recreational drugs

Categories of Breast Disease and their Treatment

There are a number of different breast diseases, each one requiring a particular form of treatment.

Premenstrual Breast Pain and Swelling

Roughly 35 per cent of all premenopausal women experience swollen, tender breasts before their periods. These women may also experience weight gain and abdominal bloating and swelling of the face, hands and ankles. The symptoms are caused by an increase in the hormonal secretion of aldosterone from the adrenal gland. The triggers for aldosterone production include stress, excess estrogen and a deficiency of dopamine, a brain neurotransmitter.

Nutritionally, these women may need magnesium and vitamin B6. Low magnesium in the body causes the adrenal cortex to enlarge and release more aldosterone, resulting in increased fluid retention and weight gain. Dopamine levels in the brain are depleted when there is a deficiency of magnesium. Low vitamin B6 levels in the body decrease the kidney's ability to get rid of sodium, and water is retained. Too much sugar can also cause water retention due to the increased secretion of insulin from the pancreas.

Thyroid imbalance and an overgrowth of intestinal yeast (candidiasis) can also cause premenstrual breast pain and swelling. These conditions should be checked into.

Fibrocystic Breast Disease

Fibrocystic breast disease commonly affects 20 to 40 per cent of premenopausal women between the ages of 20 and 50 years. The cysts are cyclic, vary in size, are often painful, freely moveable and multiple, occurring in both breasts. The condition is more severe before the menstrual period and is due to an increased estrogen to progesterone ratio. When estrogen levels rise from both internal and external sources, prolactin levels are also increased. Prolactin stimulates the enlargement of breast tissue.

Low thyroid function will also cause an increase in prolactin levels. When the thyroid gland needs a boost, TRH, a hormone from the hypothalamus, causes both a release in thyroid-stimulating hormone and prolactin from the anterior pituitary gland.

Thyroid function can be easily tested by taking the underarm body temperature before rising in the morning on days 2 to 7 of the menstrual cycle. Temperatures at or below 36.5°C or 97.8°F are indicative of low thyroid function.

Naturopathic methods are very successful at remedying a hypothyroid condition. If it is present, one should consume seaweeds and seafood which contain high amounts of iodine, or use dulse powder as a seasoning. Cabbage, brussel sprouts, broccoli and cauliflower may need to be avoided as they can block thyroid hormone production.

Since the liver is the main site for estrogen breakdown, any factor that interferes with proper liver function may lead to estrogen excess, which in turn may lead to breast disease. Many factors can get in the way of good liver function: chemicals in food, bowel toxicity, allergies, decreased immunity, polluted air and water, and a high fat diet. Liver-protecting substances include the herbs dandelion root, chelidonium, milk thistle, beet leaf and black radish. Nutrients that protect the liver are choline, inositol, methionine and glutathione, which are found in garlic, onions, sunflower seeds, broccoli, cauliflower, asparagus and brussel sprouts.

There is a strong association between methylanthine consumption and fibrocystic breast disease. Methylanthine is found in coffee, black tea, cola, chocolate and caffeinated medications and has been shown to promote the growth of cancer cells in the mammary gland of rats. Much improvement can be gained by avoiding these substances.

Fibrocystic breast disease and breast cancer have been linked to the western diet and bowel function. Women having less than three bowel movements per week have a risk of fibrocystic breast disease four to five times greater than women having at least one a day.

When fatty foods are eaten, a certain species of harmful bacteria is encouraged to grow in the large intestine. These bacteria are able to both synthesize estrogen compounds from dietary cholesterol and to split the complex molecule formed by the liver in its attempt to rid the body of the excess estrogen. The result is absorption of more estrogen through the intestinal wall. Women wishing to protect themselves from fibrocystic breast disease and breast cancer should virtually eliminate fat from their diet - specifically meat, dairy and fried foods. Women on a vegetarian diet excrete two to three times more estrogens than women who eat meat. Diets high in fibre, centered around starches are recommended since bowel movements will be enhanced. Fibre may also act as an intestinal barrier to reabsorption of estrogens.

One might rid the intestine of the harmful bacteria through nutritional substances such as grapefruit seed extract and the herb, goldenseal. Supplementation with Lactobacillus acidophilus would be helpful as it re-implants the favorable intestinal bacteria.

Women wishing to protect themselves from fibrocystic breast disease & breast cancer should virtually eliminate fat from their diet - specifically meat, dairy and fried foods

Other nutritional supplements useful in managing fibrocystic breast disease include vitamin E, B6, B complex, beta carotene, and essential fatty acids in the form of evening primrose oil, black currant oil, borage oil or flaxseed oil. These oils are beneficial to the body because they are unsaturated.

Homeopathic remedies have been used to help women with all types of breast disease. They act by stimulating the individual's inherent capacity to heal through the principle of "like cures like". Specific remedies for cystic breasts include silica, bellis perennis, thuya, phytolacca, calc fluor, kali mur and sepia. One should consult an experienced homeopath before using them because homeopathy is a complex science.

Fibroadenomas

This is a tumor commonly seen in younger women and is the third most frequent of all breast diseases after fibrocystic breast disease and breast cancer. Unlike in fibrocystic breast disease, the tumor is not cyclic, but is constantly present. It is not malignant, although its presence indicates the possibility of a higher risk for breast cancer later in life. The lump is firm, round and moveable, like a marble under the skin. If a fibroadenoma breaks down on its own it can develop into calcifications or microcalcifications. These may be associated with the development of breast cancer.

Mainstream medical treatment is removal under local anaesthetic. Naturopathic treatment would be similar to that of fibrocystic breast disease.

Breast Abscesses (Mastitis)

Mastitis is inflammation of the breast and milk duct system, usually due to infection entering a fissured or cracked nipple. It most often occurs in a first-time mother after childbirth and during breastfeeding. Symptoms are breast pain with redness, a hard swelling, fever and possibly swollen cervical and/or axillary lymph nodes. It may occur due to poor nipple preparation in the final two to three months of pregnancy, breast engorgement due to incomplete emptying, excessive sucking by the newborn or a blocked milk duct. Western medicine treats this by stopping breast feeding and using surgical drainage or antibiotics.

Alternative treatment would be to take the herbs echinacea and phytolacca in tincture form internally. The usual dosage of each is 25 drops diluted in water, five to six times per day. One could also use phytolacca in homeopathic potency. Hot compresses of calendula lotion should be applied to the affected breast every two to four hours. Massage the blocked duct with castor oil or apply a warm castor oil pack to the breast. Internally, take vitamins A, C and E and the mineral, zinc.

The breast must be emptied either by continuing to breastfeed or by expressing the milk manually or with a breast pump.

Intraductal Papillomas

Intraductal papillomas are relatively uncommon small, benign tumors occurring in the terminal nipple ducts of the breast. Frequently they are too small to feel. The main symptom is a watery, pinkish or bloody discharge from the nipple. Surgical removal of the affected ducts is the standard western treatment. The tissue must be biopsied since a bloody discharge from the nipple, especially if it occurs in only one breast, can be due to malignancy. Alternative therapies would be similar to those used for fibrocystic breast disease. Homeopathic remedies may also be helpful and include phytolacca and lycopodium.

Breast Cancer

Breast cancer is a leading cause of death for women 35 to 50 living in Canada. Approximately one woman in 10 will develop breast cancer at some point in her life and its incidence is increasing. Breast cancer is much less common in other parts of the world, implying that the conditions of our lives, diet and environmental factors play a large role in its occurrence. It seems that the biggest factor behind its rise is our high consumption of animal fat and low fibre intake. Breast cancer rates are highest in prosperous countries where people are "well-nourished." Studies have shown that dietary fat needs to be reduced to about 20 per cent of total calories for breast cancer incidence to decrease

What predisposes a women to develop breast cancer? In addition to the increased stress associated with living as women, as poor people, as women of colour, as aboriginal women, as lesbians and as disabled women, there are other factors that have a significant influence on our ability to prevent or survive breast cancer. If you have two or more of the following risk factors for breast cancer, you would greatly benefit from taking steps to prevent its occurrence:

Risk Factors for Breast Cancer

- **Age**

There is a higher incidence of breast cancer in women over 40. According to Chinese medicine, as a woman ages the fluid and blood (yin) in her body decline, while the heat and qi (yang) increase. The body tissues become dry and the stagnation of liver qi is exacerbated. After menopause, heat and toxicity are no longer discharged from the body with the menstrual flow, thus allowing their accumulation. Evidence shows that cancer cells are often present 10 years before the mass is finally detectable, having grown to a size one centimeter in diameter and consisting of one billion cells. The time one cell requires to divide into two cells is called doubling time and is about 100 days for breast cancer. Therefore, age simply allows more time for cancer to grow to a diagnosable stage. Immunity also tends to decrease as one ages.

Breast cancer is much less common in other parts of the world, implying that the conditions of our lives, diet and environmental factors play a large role in its occurrence

- **Family History**

The risk of breast cancer is two to six times higher if a mother or sister has had the disease. This may be due to adoption of similar diets and ways of preparing foods which are passed on from mother to daughter, exposure to the same environmental carcinogens and the inheritance of similar body types.

- **Diet**

A diet high in fat and low in fibre predisposes women to breast cancer. In Chinese medicine, high fat foods produce "dampness and phlegm" in the body which can lead to tumor formation. Fatty foods also encourage the growth of a specific harmful bacteria in the large intestine which is able to both produce estrogen and split the complex estrogen molecule that had been prepared for excretion. Thus, more estrogen is absorbed. Increased fibre helps to prevent estrogen absorption. The risk of breast cancer increases 1.35 times for every 77 grams of fat consumed daily. Fat is hidden in many common foods such as dairy products, meat, fried and baked goods and salad dressing.

- **Early Menstruation**

Women who have had the onset of menstruation at an earlier age have a slightly higher risk of breast cancer. The liver and stomach meridians flow through both the uterus and breast area. If the qi is excessive in these meridians menstruation will occur sooner. If unchecked, this excessive energy may persist into later years and contribute to breast disease. It is interesting to note that these two meridians pass through the upper outer quadrant of the breast where cancer is most likely to develop.

- **History of Benign Breast Disease**

Since breast diseases exist on a continuum and are caused by similar factors, a history of benign breast disease can predispose a woman to a higher risk for breast cancer.

- **Late or No Childbearing**

During pregnancy, the fetus and placenta mature, and with delivery there is a very large emptying of thick blood. This can be quite cleansing and healing for women with a tendency towards qi and blood stagnation. This is why many women's symptoms, including endometriosis, improve after childbirth. If the stagnation were not released, it could accumulate in the breasts to cause disease. Breastfeeding is protective for this reason as well.

- **Late Menopause**

A later menopause in some women can be a sign of good health, strong "kidney essence" and strong digestion. In others, however, it exists when there is an excess of liver yang energy, which causes the blood to flow more freely in an attempt to dispel the heat. Symptomatically, this often manifests as bleeding between periods, early periods or very heavy periods. When there is excess liver heat, often there is also an accumulation of heat and stagnation in the breast tissue, causing disease.

Another reason for late menopause is that the woman's spleen energy is not strong enough to keep the blood in the uterus. These women often develop a continuous dribble of uterine bleeding, which will lead to a blood deficiency. As the blood is lost, the yin energy is weakened. This disturbs the balance of yin and yang, causing the yang to rise and create excess heat, which can then enter the meridians flowing through the breast. The resultant qi and blood deficiency and excessive yang energy may lead to breast cancer.

- **Prolonged Stress**

Because stress aggravates the liver organ-meridian, decreases immunity and can weaken digestion which increases body toxicity - prolonged stress may be a deciding factor that triggers breast cancer in a susceptible woman.

PREVENTION AND MANAGEMENT OF BREAST CANCER

A woman's choice of treatment when confronted with the diagnosis of breast cancer should be her own, arrived at after self-examination, studying all available options and talking with other women and to different doctors. Alternative therapies work well with standard western procedures and can help prevent or moderate side effects. The best treatment is still prevention.

- **Diet**

Consume a low fat, high fibre diet, limiting your intake of meat, dairy, oils and baked goods. Restrict fat intake to less than 20 per cent of caloric intake. Consume more beans, salads and whole grains such as basmati and brown rice, millet, buckwheat, amaranth, quinoa and oatbran. Learn the principles of food combining so that your food is more completely digested and absorbed, thereby decreasing bowel toxicity and improving liver function.

- **Avoid Caffeine**

Caffeine helps to promote breast cancer and is found in coffee, black tea, cola, chocolate and caffeinated medications.

- **Keep Your Colon Clean**

Be sure to have at least one to two bowel movements daily. Keep your intestinal flora healthy by taking Lactobacillus acidophilus and other "friendly" organisms. Cleanse the colon with non-irritating fibre such as psyllium husks and oatbran if needed. Bowel toxicity can be assessed through the urinary indican test. If bowel movements are not frequent, check thyroid function by measuring underarm temperature daily.

Alternative therapies work well with standard western procedures and can help prevent or moderate side effects

- **Liver Detoxification**

Use botanical medicines such as milk thistle, chelidonium, dandelion and beet leaf, as well as nutrients such as choline, inositol, cysteine and glutathione which are found in a variety of foods, to improve liver function.

Use Chinese herbs and/or acupuncture to correct an energetic disturbance in the liver organ-meridian.

Exercise regularly to increase blood flow in the liver.

- **Immune Enhancement**

Herbs such as goldenseal and echinacea have long been used in the treatment of cancer by native cultures because of their immune-enhancing effects. Mistletoe has been used in Europe specifically for breast cancer. Protect against carcinogens with the use of antioxidants, which prevent cell membranes from being damaged. These include vitamins A, B6, C, E, as well as zinc, selenium and evening primrose oil. Avoid smoking and sugar as much as possible.

- **Vigorous Exercise**

Exercise burns fat and speeds up the circulation so that oxygen and nutrients can flow into the body cells and wastes can be removed. Movement decreases stagnation so that disease does not develop as easily. If your work includes some form of exercise, great. If not, exercise at least three times a week for 20 minutes at a time.

- **Lymphatic Circulation**

The lymph nodes under the arms play important roles in the body's defences against the development and spread of breast cancer by producing white blood cells that circulate in the blood and are able to destroy cancer cells. They do their job better with regular arm exercise and breast massage. Massage your breasts at least once a week and use your arms to scrub, hammer, punch, saw, skip, swim, flap, etc. daily. Take up yoga or Tai Chi. A classic herbal formula to break up lymphatic congestion is known as the Hoxey formula and is available in some health food stores.

- **Homeopathy**

Homeopathic remedies stimulate the vital energy of the individual to be directed towards establishing health. Choosing a homeopathic remedy requires careful examination of the individual's symptoms. Some remedies that are commonly indicated in breast cancer include conium, calc fluor, phytolacca, asterius, hydrastis, graphites and met album.

- **Relaxation**

Try to take time each day to relax. Experiment with using a guided relaxation tape so that you can induce a full body relaxation within minutes. Learn visualization techniques or meditations that encourage health and well-being.

Before embarking on these healing techniques, one should consult a licensed naturopath or alternative health care practitioner. We are all individuals and some things may not be appropriate or work for you.

Sat Dharam Kaur is a naturopathic doctor, wife, mother and yoga teacher. She teaches stress management at the Ontario College of Naturopathic Medicine and has a private practice in Toronto. She can be reached at (416) 923-4860.

Further Reading

The Breast Connection by Honora L. Wolfe, Blue Poppy Press, Boulder, Colorado, 1989.

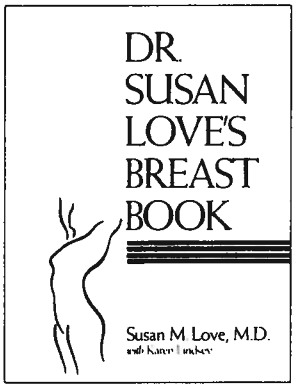
McDougall's Medicine by John McDougall, M.D., New Century Publishers, Piscataway, N.J., 1985.

BREAST CANCER RESOURCES

Dr. Susan Love's Breast Book

by Susan M. Love, MD with Karen Lindsey (AddisonWesley, 1990, $18.95).

A breast surgeon and feminist who is a member of the National Alliance of Breast Cancer Organizations Medical Advisory Board discusses all conditions of the breast, from benign to malignant. A balanced view of treatment options and controversies is clearly presented in a friendly, accessible style. Good as a general reference. 455 pages. Available at bookstores.



Keeping Abreast: Breast Changes That Are Not Cancer

by Kerry A. McGinn, RN (Bull Publishing paperback, 1987, $9.95).

A thorough overview of breast lumps and conditions that are benign in easy-to-read form: detection, treatment and need for further action. Includes a glossary of terms. 153 pages. Available in bookstores.

Every Woman's Guide To Breast Cancer

by Vicki L. Seltzer, MD (Penguin Books paperback, 1988, $7.95).

A lucid, informative and supportive book by a specialist, who discusses how the risks of developing cancer can be reduced by modifications of lifestyle and dietary habits. The author stresses the importance of BSE and explains screening and treatment alternatives in detail. 196 pages. Available at bookstores.

"If You've Thought About Breast Cancer..."

by Rose Kushner (1990 edition).

A general pamphlet covering all aspects of breast cancer detection and treatment by the National Alliance of Breast Cancer Organizations co-founder Rose Kushner. Includes a section of definitions and telephone numbers for resources. Order from Y-ME, 18220 Harwood Avenue, Homewood, IL 60430, or The Komen Foundation, 6820 LBJ Freeway, Suite 130, Dallas, TX 75240. 44 pages. Single copies are free of charge; order multiple copies at a bulk rate from The Women's Breast Cancer Advisory Center, P.O. Box 224, Kensington, MD 20895.

Winning The Chemo Battle

by Joyce Slayton-Mitchell (Norton, 1988, $16.95; paperback available).

A personal, sometimes angry, frequently idiosyncratic account of chemotherapy treatment from a woman who has "been there". Includes drug information and glossary. Available in bookstores.

Women Talk About Breast Surgery

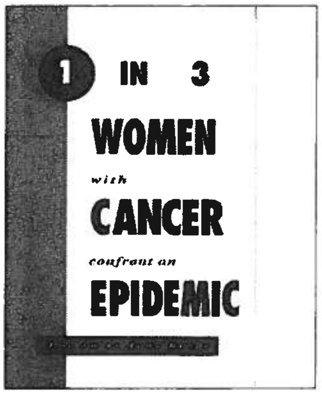
by Amy Gross and Dee Ito (Clarkson Potter, 1990, $22.95).

Virtually a women's network and support group between two covers, a helpful manual on how to proceed and the questions to ask when faced with surgery, revealed through conversations with women who have "been there". 352 pages. Available in bookstores.

Coping With Chemotherapy

by Nancy Bruning (Ballantine Books paperback, 1986, $4.95).

A matter-of-fact, objective and comprehensive overview of medical, physical and emotional aspects of chemotherapy treatment. Contains a list of standard drugs and their side effects and a glossary of terms. 329 pages. Available in bookstores or order in hardcover at $11.95 from Coping magazine, Book Order Dept., P.O. Box 1700, Franklin, TN 37065-1700.



1 in 3: Women With Cancer Confront An Epidemic

Edited by Judy Brady (Cleis Press Inc., Pittsburg, 1991, $10.95).

This book is described as going beyond cancer as a health issue and forces us to question the medical profession, the cancer establishment and the industrial, nuclear and agricultural polluters who hold our health in their hands.

Relative Risk: Living With A Family History of Breast Cancer
by Nancy C. Baker (Viking Press, March 1991, $19.95).

After a brief but thorough section on incidence and risk factors, the author presents a series of case histories describing how mothers, daughters and sisters have coped with a family history of breast cancer. 288 pages. Available in bookstores.

Low Fat And Loving It
by Ruth Spear (Warner Books, 1990, $19.95).

Over 200 recipes, plus information on the diet-cancer link, fat and cholesterol. Includes an easy-to-follow daily plan. 318 pages. Available in bookstores.

Invisible Scars: A Guide To Coping With The Emotional Impact Of Breast Cancer
by Mimi Greenberg, PhD (St. Martin's Press paperback, 1989, $4.95).

A useful guide which points out to women not only that they should be in joint charge of their treatment, but how to go about doing it. 204 pages. Available in bookstores.

No Less A Woman: Ten Women Shatter The Myths About Breast Cancer
by Deborah H. Kahane, MSW (Prentice Hall Press, 1990, $18.95).

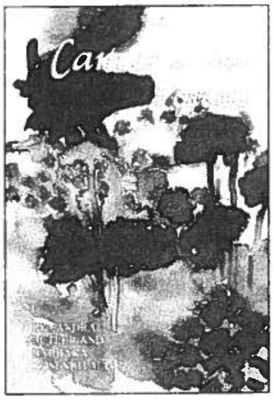
Ten women share their struggles, how they have confronted breast cancer and the emotional trials they faced. Each discusses how she coped with concerns about loss of femininity and sexual identity. 279 pages. Available in bookstores.

"What You Need To Know About Breast Cancer"
by the Burlington Breast Cancer Support Services (1991).

This informative booklet answers questions on cancer diagnosis and treatment and lends support to breast cancer victims by discussing the emotional trauma associated with the disease. A useful resource list for Ontario, particularly Burlington, residents of support and counseling services. For copies write to Burlington Breast Cancer Support Services, P.O. Box 85112, Brant Plaza Postal Outlet, Burlington, ON L7R 4K3.

Up Front: Sex And The Post-Mastectomy Woman
by Linda Dackman (Viking, 1990, $17.95).

A personal account, with frank details about the intimate challenges faced by a single woman in her 30s. 128 pages. Available in bookstores.



Cancer In Two Voices
by Sandy Butler with Barbara Rosenblum, (Spinsters Book Company, P.O. Box 410687, San Francisco, CA, 94141,1991, $15.95).

This is Sandy's personal account of coping with breast cancer. Co-authored with her lover, Barbara, Sandy speaks openly about the breast cancer, the politics of health care for women and the courage needed to cope with the disease. 183 pp. Available in bookstores.

Cancer As A Woman's Issue
Edited by Midge Stocker (Third Side Press, Chicago, Illinois, 60625-1802, 1991).

In this anthology, "voices of women whose lives have been deeply affected by the experience of cancer speak of pain and solace, of isolation and community, of fear and power. Essays and personal stories explore how cancer affects us as women, individually and collectively" and answers the question, "How do we keep our fear from overpowering our ability to act on our own behalf?"

MY STORY, OUR STORY

Two Experiences of Mastectomy

Becoming One-Breasted

Shirley Masuda

It was a long process. First the lump, then the mammogram, the attempted aspiration, the ultrasound, the needle biopsy, the removal of the lump and then, finally the diagnosis — cancer.

After consultations with my doctor and thinking things through on my own, I decided to have a radical mastectomy. The doctor said if I had the mastectomy, I might not need radiation; only after the surgery could they tell whether I would require further treatment. His statement confirmed that I had made the right decision. My daughters, one of whom is a doctor, also felt that this was the best route.

I was scared but I didn't panic. My three daughters, Val, Kim and Jill, were listening to me speak of nothing else, tolerating my mood swings and never objecting—they simply let me do what I needed to do. We were all scared but we knew that we would do what we had to do. We accepted the seriousness of the diagnosis, but it did not change or rule our lives.

Meanwhile, Joan, a co-worker and good friend, who had been through a similar ordeal with her sister just a year earlier, knew exactly what I needed. She went wheeling around her neighbourhood asking all her friends, men as well as women, to visualize rainbows around my right breast. Joan also got on the phone and set up a network of rainbows across Canada. A few men couldn't do the rainbow thing so they prayed, as did a few of the women; but prayers were just as welcomed as rainbows.

For my part, I searched for inner strength. I read books about people who had survived cancer and how they had coped. I learned that these people played an active role in their healing process and that the first step was to make a conscious decision to live and to heal. Next, I began a visualization process that I felt would work for me and would arrest the cancer. I went into surgery with a feeling of being surrounded by rainbows, prayers and a lot of positive energy. I felt that I didn't dare not be okay after all of that. I will even go so far as to say that it was almost a spiritual experience. My mother had her breast removed 25 years ago and remembering her courage then gave me courage now.

This was a very difficult time and I felt the need to be with the women in my life to whom I felt closest — my sister, my daughters and my friend, Joan. I had no energy to give to people outside this circle of women. I found dealing with other people's reactions over and over again was draining, dragging me down and using up the energy that I wanted to channel into my healing process.

I turned on the answering machine and my daughters protected my space by screening my calls and dealing with the things that needed to be done. Not everyone respected my request for privacy and some even managed to get through leaving their worries and uncertainties with me. I felt that I was dealing with their fears about cancer and their own mortality. I felt like a dumping ground and it angered me. The misunderstanding that was spreading throughout my community that I was seriously ill and could not work also angered me. It seemed that I was not only fighting the cancer, but a great mass of expectations for the worst possible outcome.

The surgery went very well. The cancer is gone. A lot of women have asked me: How I am? How am I mentally? I said fine. They wanted to know, How am I taking my loss? What about sex? What about feelings? What about...?

Sharing my room in hospital was one woman who was getting bilateral breast implants; another woman who was getting a new implant because of problems with the old one and another woman who had a lumpectomy and was waiting for radiation. The latter told me her husband was devastated.

All of these women agreed that the hardest thing for them was not their own fears but the fears and reactions of other people to the cancer and to the part of their anatomy that had been affected. I have been encouraged by other women to get a prosthesis so I will look "nice" again. I'm never sure any more when women ask me how I am, if they are asking whether the cancer is gone or how I can live with only one breast. I had expected more from my feminist sisters.

By whose standards are we judging whether or not we are women? What happened to our pride in the women we used to be when we burned off our right breasts so we could be better warriors in order to protect our children and better hunters to feed them. Amazons we called ourselves — women without breasts, but no less women. (The word amazon derives from "amastos, without breast, referring to the burning of the lacteal gland on all girls, through the application of hot irons, when they reached their eighth year. With some groups, the breast was merely limited in growth by being tied up with cloth..."— Helen Diner, *Mothers and Amazons: The First Feminine History of Culture.*)

On behalf of all one-breasted and no-breasted women, I say again that we are still women. We were born women, we grew up as women, our experience, our passions, our caring and our psyche are female. We are women because of who we are, because of our lives and our spirits, not because we have two breasts, 10 breasts or no breasts at all. We have never stopped being beautiful. We are still mothers, daughters, sisters and lovers. We are the same as we always were.

I do not feel that I have "lost" a breast. I lost a cancerous growth that would have taken my life away. There is no down side to that. I am a very happy, one-breasted woman. I am proud.

Shirley Masuda is a researcher and project coordinator for the Violence Against Disabled Women Research and Prevention Project for DAWN Canada: The DisAbled Women's Network. She is the mother of three daughters and surrogate mother to several dogs and cats. Diagnosed with breast cancer, Shirley had her right breast removed in October 1991.

Radical Mastectomy

Rivka Phillips

Twenty-nine years ago I had a radical mastectomy. It was 1963 and I was 46 years old. My husband had died six years after our marriage and I was the breadwinner for my young daughter and myself.

My family doctor, who had detected the problem in the lymph nodes, was a very fine doctor, a fine woman and human being. The surgeon, though he may have been an excellent doctor, as a human being rated zero on a scale from zero to 10. I hope doctors have moved closer to 10 since then.

At that time, a mastectomy, the removal of the whole breast, some of the chest muscles and the lymph nodes under the arm, was done as a one-step procedure. The patient was told that if the biopsy was positive—that is, if the lump was cancerous—a mastectomy would be performed immediately following the biopsy, without consultation with the patient about the results, alternative treatments or her wishes.

About 15 years ago, after persistent efforts from a number of breast cancer patients, their families and some doctors, a mastectomy became a two-step procedure. Actually, the two-step procedure was always available to women who thought of demanding it; however in the last 15 to 20 years it has become standard procedure.

Essentially, the two-step procedure means that even if the biopsy proves positive, no further surgery is done at that time. The woman then has time to discuss the next step with her doctor and decide whether to have a lumpectomy, mastectomy, radiation therapy or alternative therapies. The two-step procedure allows a woman to feel like a total human being, not just a lump of flesh without a mind, without emotions.

By participating in this consultation, a woman can take more control over what is happening to her. This feeling is extremely important, both in relation to one's self-image and to the recovery process. It helps to make the situation less traumatic and less devastating.

Twenty-nine years ago, we were still in the one-step era. When I came out of the anesthetic, I touched my chest area and found all of me still there. I naturally assumed that all was well. But that was not the case. My sister, who came to my bedside shortly after I awoke, told me as gently as possible that the biopsy had proved positive, but the mastectomy had not been done at the same time because I was a full-breasted person and there was some difficulty in locating the exact position of the lump. Therefore a second biopsy was scheduled. It was a terrible wait.

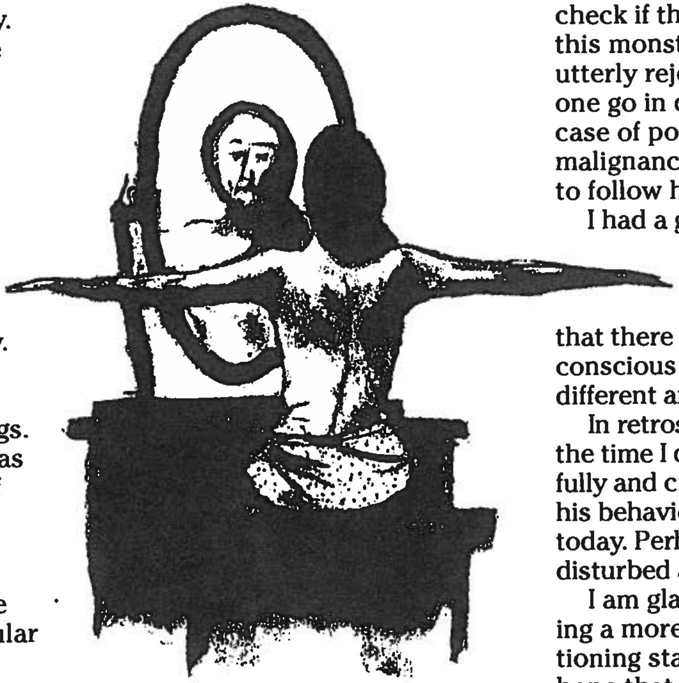
I was extremely depressed. It was double hell.

Later on that day, the surgeon came by. In less than two minutes he told me, in a most brusque and business-like manner, what I already knew. I do not expect a surgeon to burst into tears every time he or she has to present bad news o a patient and I understand why that is so, but there must be some evel of compassion or sympathy which can be conveyed from the doctor to the patient which shows some humanity. He did not convey this. He did not ask me if I had any questions. After the two minutes were up, he turned to walk away.

I called him back. There were a few things I wanted to know. He told me there was nothing had to concern myself with. should imagine I had to make a train trip from Toronto where lived, to Montreal. He was the engineer on the train and he would get me there. I was just a passenger on the train and I had no responsibility. To this day I find it completely ncredible that he could be so oblivious to my fears and feelings. He was the "man in charge;" I was this mindless, unfeeling mass of lesh, a non-person.

I did manage to ask what the area would look like after the surgery. "Like a man's chest!" he said. For him to use that particular comparison when talking to a woman about to undergo breast surgery was unbelievable. When I asked my family doctor the same question she said the area would ook like a child's body. This, I felt, was a softer, gentler response; an mage I could have more easily ived with.

My first visit to the surgeon after the operation was the first time I really saw the area without any bandages. It was deeply upsetting. It was on this visit that the surgeon suggested that I should have my other breast removed. I asked him why, thinking of course that he had discovered a malignancy there too. But he told me that was not it at all. I should have it removed in case it too developed cancer.



When you have had one breast removed the other becomes doubly precious. I had still not recovered emotionally from the surgery, and his advice, which by the way I did not follow, totally overwhelmed me.

He told me I had no idea how upsetting it was TO A SURGEON to do a mastectomy without knowing exactly where the lump was located (as in my case). So to avoid any further distress to him, he was advising me to remove the other breast. Not a word about me, my feelings, or how upsetting the idea was for me. Once again, I was a non-person. He was only focused on himself, not on me.

I then arranged an interview with another surgeon at Princess Margaret Hospital in Toronto to check if there was any validity in this monstrous suggestion. He utterly rejected it. How far does one go in dismembering oneself in case of possible future injury or malignancy, he told me. I was glad to follow his advice.

I had a good and quick recovery, not only physically but psychologically. Although, I do think that there is always a kind of subconscious awareness that I am different and in a way undesirable.

In retrospect, I am amazed that at the time I did not react more forcefully and critically to the surgeon for his behaviour. I know I would do so today. Perhaps at the time I was too disturbed and insecure.

I am glad women today are taking a more independent and questioning stand as patients. While I hope that the majority of doctors are more sensitive and human, I am aware that the level of callous insensitivity and the total disregard for the patient as a person still persists.

At 75, Rivka Phillips is an active member of the Housing and Environment Committees of the Older Women's Network, an advocacy and special interest group in Toronto. She is the only person in her family to be diagnosed with breast cancer.

Megan Williams

VAGINAL BIRTH AFTER CESAREAN

ALMOST 20 PER CENT OF ALL BIRTHS IN CANADA are by cesarean section, a report released last summer by Ontario's Ministry of Health revealed. This is the fourth highest rate of cesarean sections in the world, following fast on the heels of Brazil, Puerto Rico and the United States.

Our cesarean rates have climbed at an alarming rate over the past 20 years, rising from 5.2 per cent in 1969 to the present day rate of one in five. This is especially disturbing when one learns that 40 per cent of all cesareans are done solely because a woman has previously given birth by cesarean. In fact, nearly 90 per cent of all women who have had a cesarean, have an automatic repeat cesarean. Without repeat cesareans, the cesarean rate in Canada would be only 12-15 per cent, keeping numbers within the range recommended by the World Health Organization.

Why are so many women having cesareans in Canada? And why do so many women who have had a previous cesarean, automatically have others? If planned cesareans are riskier than vaginal birth as so many studies reveal, why are women continuing to have cesareans?

In examining medical intervention in women's bodies, one often finds that many interventions are sorely lacking in medical justification. The case of vaginal birth after a cesarean or VBAC, is no exception. High cesarean statistics tell far more about the patriarchal medical system than they do about women's needs or desires. A number of reasons explain why cesareans are so pervasive today, despite the risks.

Firstly, many doctors do not support VBAC simply because they are misinformed about its safety. Often older, more experienced and usually more conservative doctors have never been trained in the possibility of VBAC. As a result, many times VBAC is not even considered an option. In some cases, women encounter medical staff who are not only discouraging about VBAC, but highly antagonistic to the possibility. One woman who tried to have a VBAC at her hospital says, "I felt like I was asking for the impossible, I got such negative vibes from everyone."

In hospitals, women are often told they must discuss VBAC with their doctors "to see how he feels" and are not permitted labour support. It is not out of the ordinary for hospitals to place ridiculous restrictions on VBACs such as putting a very low cap on the labour time allowed before resorting to a cesarean, disallowing midwifes, insisting on removing placenta manually, offering women no choice of delivery position, and demanding women deliver in the cesarean section room. Needless to say, these regulations discourage many women from even contemplating a VBAC.

It is no secret that hospitals run on rigid schedules to which unpredictable processes such as natural birth, do not lend well. Consequently, women who have prolonged labour may be whisked into the cesarean section room prematurely, more as a matter of convenience than necessity. Time is money, and cesareans can be a great deal more efficient for the medical staff. Although doctors are paid only marginally more for a cesarean than a vaginal delivery, the latter can take hours. Cesareans are usually over within 45 minutes.

A further motivating factor lurking behind high cesarean statistics is again monetary in nature: doctors' fear of lawsuits. Last summer's report released by the

Ontario Ministry of Health called *Appropriate Use of Cesarean Section* cites fear of lawsuits as one of the primary reason doctors perform cesareans. Although in the past 15 years the frequency of malpractice claims against Canadian doctors have risen, studies show that fewer than 10 per cent of patients who have experienced health problems due to negligence receive any compensation. Despite the little benefit offered to those in need of compensation, in the late 1980s the medical profession considered the medico-legal situation to have reached crisis levels. Because the use of a cesarean section is seen as evidence that a doctor did everything possible to ensure the best outcome for a mother and baby when fetal distress is suspected, cesareans are considered "litigation-proof" and consequently done far more often than may be necessary.

Finding support for VBAC is particularly difficult for women with classical cesarean scars (see VBAC terms) or women who have had more than one previous cesarean. This is despite the fact that more than a thousand women have had VBACs after numerous cesareans. One Albertan woman, who delivered vaginally a healthy daughter after five cesareans, writes about her determination to have a VBAC. "I was told my first c-section was from failure to progress, but the more I read and thought about it, the more I knew it should have never happened...After 11 years of being told I couldn't even attempt a VBAC I knew I couldn't wait for 'permission' to try any longer."

Recently, however, it appears to be easier for women in large urban centres to find support for VBAC. Most hospitals in downtown Toronto, for instance, allow VBACs. Nonetheless, it remains a real feat for women in smaller communities to find the support and information they need.

Even doctors who appear willing to support a woman with VBAC, do not always follow through with it, backing out close to the due date. One woman who planned a VBAC had her doctor call her a few days before the due date to say he'd booked a room on the weekend and had decided to go ahead with another cesarean. "I had an absolute fit and said there is no way I'm planning a cesarean," she says. In her case, protesting paid off and she went through with a VBAC. Another woman's doctor who had agreed to assist her with a VBAC after one cesarean decided he too wanted to perform a cesarean - when she was only 12 minutes into labour! When she refused, he used forceps to pull the baby's head out, severely cutting her vaginal area, causing her considerable pain for months afterwards. "There is a lot of lip service paid to VBAC," says an Ontario member of VBAC Canada, "but the frequency with which doctors pull out at the last minute is alarming. Women not only feel betrayed, but they are stuck. It gives them very little time to find a new doctor who will go through with a VBAC."

The most common justification for cesareans is CPD or cephalo-pelvic disproportion (when the baby's head is supposedly too big to fit through the mother's cervix). Many women are told that VBAC after a CPD-caused cesarean is very dangerous because the second baby's head is usually bigger than the first and that supposedly the risk of the uterus rupturing will increase. Again, thousands of former "CPD women" have had VBACs.

The false belief that cesareans are easier than vaginal birth has further perpetuated the over-use of cesarean sections. Although a woman may not experience pain during the actual birth, a cesarean scar takes three months to heal. Coupled with the risks involved in the actual operation, planned cesareans are far from being a hassle-free option.

Interestingly enough, it is often because of the pain associated with cesareans that many women plan a VBAC. For women with toddlers who love to bounce on their mother's stomachs, the desire to avoid a stomach incision is particularly understandable, although for most women who plan VBACs, it

Why do so many women who have had a previous cesarean, automatically have others?

is simply a question of wanting to go through natural childbirth.

Faced with a barrage of misinformation and a dearth of medical support for VBAC, it is indeed a challenge for women to even consider delivering their babies vaginally after one or more cesareans. Nevertheless, there are some basic, yet important steps women can take to have more control over their deliveries. Firstly, expectant mothers must become better informed. By reading VBAC literature and getting in touch with other women who have had VBACs, many fears can be alleviated and questions answered. (See VBAC/AVAC Canada below in Resources) Secondly, if you decide to plan a VBAC, provide yourself with as supportive a birthing environment as possible. Many women have found midwifes to offer the best support, and an increasing number are having VBACs at home with a midwife. Hire one if you can afford to. If not, at least find a doctor who is actively supportive of VBAC. If your doctor changes his or her mind before the time of labour, change doctors. Until you are actually in labour, it's never too late. Thirdly, know your rights. Under Canadian law, you can refuse any medical procedure you consider unnecessary or unwanted. And finally, believe in your power as a capable, strong woman in control of your own body!

Dispelling the Myths about VBAC

"Once a cesarean, always a cesarean." E.B. Cragin, Conservatism in Obstetrics, *New York State Journal of Medicine*, July 1, 1916.

DESPITE OVERWHELMING EVIdence supporting the reality that vaginal birth is safer than a repeat cesarean, these words have had a vast and lasting influence on the way women with previous cesareans are treated by medical practicioners. Here are some of the central myths about VBAC that continue to linger, perpetuating the biggest myth of all, that "once a cesarean, always a cesarean."

Rochelle Rubinstein

It is a challenge for women to even consider delivering their babies vaginally after one or more cesareans

Myth#1 *Cesareans are much safer than VBACs.*

Although planned cesareans are safer than emergency cesareans, complications can arise due to anaesthesia and the surgery itself, affecting both the mother and baby. Furthermore, repeat cesareans are technically more difficult due to adhesions on the uterus caused by the first cesarean. Risks involved with cesareans affecting the mother include decreased fertility, urinary tract infection, and greater postpartum depression. Although babies who are electively removed from their mothers by cesarean may be mature, many experience serious respiratory problems. There is growing evidence that labour itself significantly reduces the risk of respiratory problems by mechanically stimulating lung fluid resorption. The baby's body releases hormones which help prepare the infant for life outside the womb.

Recent studies have found that women who undergo elective repeat cesarean experience more health problems after delivery (such as fever, infection, hysterectomy) than women who deliver vaginally after a cesarean. Long term health effects for mothers after cesareans can include a higher incidence of placenta previa (when the placenta blocks the cervix) and placenta accreta (when the placenta has penetrated the uterus), on following pregnancies.

Myth#2 *Rupture of the scarred pregnant uterus is one of the most serious obstetric complications.*

Rupture of the scarred uterus is rarely catastrophic for the mother or baby. Over 95 per cent of scars today are low transverse ones, with a rupture rate of 0.22 per cent in the past 7 years. The remaining scars are classical (higher up on the uterus), and although VBACs with classical scars are considered riskier, there is very little data to back up this belief. Often times, a rupture is detected well before labour and one study found that the incidence of scar separation appears to be the same whether or not a woman goes through labour.

Often in VBAC medical literature, no distinction is made between "rupture" (full tear) and "dehiscence", where there is only a partial separation of the uterine wall. With dehiscence, symptoms such as bleeding and fetal or maternal health problems are minimal or absent. It is also important to differentiate between the separation of a cesarean scar and a catastrophic rupture of the unscarred uterus. The latter, although a very rare occurrence, is an extremely serious problem.

Myth#3 *When a low transverse scar ruptures during a planned VBAC, the risk of the mother and baby dying is high.*

Over the past 40 years, more than 36,000 planned labours after cesareans have been reported without a single mother's death from rupture of a cesarean scar, regardless of the type of previous incision. Four women whose classical scars ruptured long before the due date have died. These deaths, however, occurred more than 30 years ago when emergency care was poor. Several mothers, though, have died as a result of complications arising from elective repeat cesarean operations.

In over 21,000 VBACs reported in the medical literature since 1984, five babies have died in association with scar rupture, three of whom died in developing countries where equipment is less sophisticated. For every 10,000 women in labour after previous low transverse section, two babies could die due to scar rupture. It is important to note that the infant mortality rate due to a ruptured uterus is about the same for women who have had no previous cesarean.

Myth#4 *Vaginal bleeding, abdominal pain, changes in uterine contractility and low blood pressure are typical signs of uterine rupture.*

Abdominal pain is a very unreliable sign of scar rupture and in several cases ruptures have occurred with no sign of pain in mothers who have not been anesthetized. Still, in certain centres physicians continue to refuse epidurals to VBAC women because they think it will hide the pain caused by a tear.

The most common sign of rupture has been found to be fetal distress (when the baby's heart tones become abnormal), which occurs in 78 per cent of ruptures, according to one recent study. Continual monitoring of the fetal heartbeat through a stethoscope is recommended by most midwifes. Although many hospitals use an EFM (electronic fetal monitor) to monitor the fetal heartbeat, those monitored by the EFM have a much higher rate of cesareans than those with midwifes or doctors who listen through a stethoscope. Furthermore, it has never been proven that EFM is anymore effective than a stethoscope.

Myth#5 *Women who have given birth by VBAC need "uterine exploration" or "postpartum transcervical manual examination" of the scar so that the doctor can see if the uterine scar is intact.*

No studies have shown any benefit from manual exploration of the uterus in VBAC women. Not only do most women find the procedure extremely painful (one woman said it "should be considered statutory rape"!), but the exploration itself poses the risk of introducing infection or of converting a dehiscence into a larger rupture. At least one woman is reported to have died from infection introduced by an unnecessary postpartum examination.

Doctors will know from bleeding, pain, and low blood pressure if a rupture has occurred.

Myth#6 *Even if a woman plans VBAC, it is not very likely to occur.*

At least 75 per cent of women who planned labour after a cesarean section gave birth vaginally between 1950 and 1990. Midwifes have a 95 per cent VBAC rate, and certain centres in the United States that actively encourage VBAC have a 90 per cent VBAC rate.

Myth#7 *Cephalo-pelvic disproportion (CPD) is a "recurrent" indication for cesarean section.*

The majority of women who

VBAC Terms

VBAC - vaginal birth after cesarean - this term was first coined in the late 1970s by an American woman, Nancy Wainer-Cohen, who started the VBAC consumer movement. Women who have already had a natural birth after a cesarean are still considered by doctors to be "VBAC candidates", and ensuing births are treated as VBAC.

CPD - Cephalo-pelvic disproportion - when the baby is considered to be too big to fit through the mother's pelvis. One of the most frequently used reasons to justify cesareans, many natural health advocates consider it grossly over-used.

dystocia/FTP - failure to progress in labour. Many women are diagnosed with dystocia when in fact they are experiencing early labour, rather than labour itself. "Average" figures for length of labour are often mistaken for "normal". Frequently women are not informed about the wide range of labour lengths that are still considered normal, and consequently agree to a cesarean.

electronic fetal monitor/EMF - equipment which electrically monitors the heart pulses of the baby to detect fetal distress. The monitor tends to pick up false pulses and a wide range of interpretation of the pulses exists. The mother is strapped down in one position which can cause considerable discomfort while in labour. Monitored mothers have a much higher rate of cesareans than those with midwifes or whose doctors listen to them through a stethoscope.

fetal distress - when the baby's heart tone becomes abnormal.

low transverse cesarean scar - the scar on the uterus near the cervix in the shape of a smile. Low transverse scars are on tissue with little muscle and few blood vessels, therefore bleeding at the time of the cut is minimal and healing takes place very quickly. For the vast majority of cesareans sections, the cut is low transverse. This scar is unrelated to the scar on the outside skin of the abdomen which may be vertical.

classical scar - incision in the corpus of the uterus (the most muscular part). Classical cuts are done rarely and in times of emergency. Outdated statistics indicate they rupture more easily than low transverse scars and generally doctors refuse to allow women with a classical scar a VBAC.

placenta previa - placenta which implants low in the uterus and covers the cervix. Placenta previa tends to occur more often in women who have had previous cesareans, and if it is undetected at the time of labour, there is a very small chance of the baby dying. Often times, placenta previa appearing early in the pregnancy migrates up away from the cervix, thus posing no risk.

trial of labour - currently the medical term for "planned labour". Carolyn Disler, the national co-ordinator of VBAC Canada and member of the Ontario Cesarean Birth Planning Committee recommended in the committee's report that "trial of labour" be changed to "planned labour".

ave had previous cesareans with PD can deliver vaginally if llowed. In fact, around 30 per cent f these women gave birth to abies bigger than CPD babies elivered by cesarean.

When women with a previous esarean for CPD were supported hrough their subsequent labour, p to 77 per cent had VBACs. BAC rates of over 85 per cent exist or women whose previous cesarean had been for reasons such as reech or fetal distress which is onsidered "non-recurrent."

yth#8 *If a cesarean scar ruptures uring birth, the best and safest hing to do is a hysterectomy.*

Because the vast majority of uptures occur along the clean line f the scar, it is very rare that such rastic a measure as a hysterecto-ny is required. The chances of a BAC woman needing a hysterec-omy due to scar rupture are 0.06 er cent. Only one study on hys-erectomies following cesarean elivery exists and it reveals that .7 per cent of women who have esarean sections need a hysterec-omy. Therefore, the chances of eeding a hysterectomy are 10 imes greater with a cesarean than ith a VBAC.

he above list of myths about aginal Births After Cesareans was ompiled from highlights taken rom a discussion paper by arolyn Sufrin-Disler (Co-ordinator f VBAC/AVAC Canada) appearing n International Childbirth ducation Association's newslet-er, August 1990. For a copy of the rticle with footnotes, write BAC/AVAC Canada, 8 Gilgorm Rd., oronto, ON, M5N 2M5.

egan Williams is a freelance riter and volunteer with Women ealthsharing.

esources and Further Reading

BAC/AVAC Canada, 8 Gilgorm Rd., oronto, Ontario, M5N 2M5.

Started in 1987 out of a growing umber of out of province informa-ion requests to the Ontario VBAC ssociation, VBAC Canada is a oose affiliation of women across the country offering information and support to those interested in VBAC. For a list of provincial contacts, write to the above address.)

Appropriate Use of Cesarean Section: Recommendations for a quality assurance program, The Ontario Ministry of Health, 1991.

For a free copy of this report in French or English, write to the Ontario Ministry of Health Information Centre, 9th Floor, Hepburn Block, Queens Park, Toronto, ON, M7A 1S2 or phone (416) 327-4327.

Birth After Cesarean - The Medical Facts, Bruce L. Flamm, Prentice Hall Press, New York,1990.

A Guide to Effective Care in Pregnancy and Childbirth, Murry Enkin, Marc Keirse, Iain Chalmers, Oxford University Press, 1990.

Ended Beginnings - Healing Childbearing Losses, Claudia Panuthos and Catherine Romeo, Warner Books, New York, 1986.

Open Season, Nancy W. Cohen, Bergin and Garvey Press, New York,1991.

Silent Knife: Cesarean Prevention and Vaginal Birth After Cesarean, Nancy W. Cohen and Lois J. Estner, Bergin and Garvey Press, New York,1983.

Transformation Through Birth, Claudia Panuthos, Bergin and Garvey Press, New York, 1984.

Une Autre Cesarean? NON MERCI, Hélène Vadeboncoeur, Québec Amerique, 1989. (To order, write Editions Québec Amerique, 1380D de Coulomb, Boucherville, sPQ, J4B 7J4.)

Chris Sternberg, a Toronto midwife, offers two full-day courses for women and their partners geared to help women feel more comfortable about having a VBAC and deal with their past experience with cesareans. For more information, write to Chris Sternberg, 91 Langley Ave., Toronto, Ontario, M4K 1B4. Phone (416) 466-6165.

Nancy Cohen will be speaking in April in Toronto on VBAC. For more information, contact: VBAC/AVAC Canada, 8 Gilgorm Rd., Toronto, ON, M5N 2M5.

Anne-Marie Conolly

Battling
Interstitial Cystitis

Barbara Pasternak

Joan knows every washroom on the entire subway line and they are few and far between. Riding the transit is a stressful endurance contest, with the constant fear that she will not make it to the next washroom in time. Joan has to urinate up to 50 times a day.

Linda can't sleep through the night without getting up four to five times to void. When she goes to a play or movie, she must sit in an aisle seat within easy access to the washroom.

Paula, a single career woman, used to have a great relationship with her boyfriend. But lately, because of her urinary frequency and urogenital discomfort, she avoids sex. Her doctor can't find anything wrong and suggests "it's a working girl's disease," implicating stress as the cause.

Imagine these women's nightmare. Many are initially treated with antibiotics for a urinary tract infection (UTI) despite the fact that there is no clinical evidence of an infection — no bacteria found in their urine specimens. When antibiotics don't help, and all other tests, x-rays and exams are normal, many physicians become frustrated and perplexed. Often at this point women are told their symptoms are caused by stress and/or psychological problems. Unfortunately, this does nothing to lessen their misery.

Sadly, this scenario is all too amiliar to the estimated 50,000 Canadians and between 20,000 to 0,000 Americans diagnosed with he disease known as interstitial cystitis (IC). Ninety per cent of the sufferers are women. And because he disease is now thought to be grossly under-diagnosed, there may be as many as 450,000 cases of IC in the U.S. alone.

Dr. Vicki Ratner, an orthopedic surgeon with the disease, formed he Interstitial Cystitis Association ICA) in 1984. Based in New York, he organization has single-handedly put IC "on the map." With Ratner as president, and many other hard working staff, there is now more information than ever on the condition. And finally, significant funds are being allocated owards IC research.

If you haven't heard of interstiial cystitis, you're not alone. Many physicians haven't heard of it either. Yet, IC is not a new disease. t has been known to medicine since 1830, when a physician by he name of Hunner found lesions on the inside of the bladder, a condition which became known as Hunner's ulcer. Current statistics now indicate the disease commony strikes women of almost any age, and that a small percentage of males (10 per cent) are diagnosed with IC.

What exactly is this disease? The prefix "cys" refers to the bladder; "itis" simply means inflammaion, and "interstitial" refers to a ayer of cells comprising a membranous wall—in this case, the wall or lining of the bladder. Therefore, C is a chronic inflammation of the bladder lining. This condition differs from regular cystitis and urinary tract infections, which are often caused by bacteria in the bladder.

What causes IC is still unknown. However, in September, 1991, at the ICA Annual General Meeting in Washington, D.C., urologists (physicians specializing in conditions of the urinary tract) and scientists considered various possible causes:

1. IC may be linked to a chronic nflammatory process involving certain cells (mast cells) which release substances into tissues which perpetuate the vicious cycle of inflammation.
2. IC may be related to a bacterial cause, but so far there is no conclusive evidence to support this theory.
3. IC may be the result of a defective mucous layer in the bladder lining.

An estimated 50,000 Canadians have been diagnosed with interstitial cystitis 90% of these are women

Symptoms

Dr. Kristene Whitmore, in her book *Overcoming Bladder Disorders*, cites the results of a 1987 survey by the Urban Institute in Washington, D.C., on the symptoms experienced by IC patients:

- 85 per cent reported waking at night two or three times (or more) to urinate.
- 84 per cent had urgency of urination (the need to void immediately).
- 80 per cent had urinary frequency of 15 to 50 times in 24 hours.
- 78 per cent reported pain in the bladder/pelvic region, urethra and/or vagina.
- 57 per cent reported their pain was relieved by voiding.
- 57 per cent experience painful intercourse.
- 51 per cent had difficulty in emptying the bladder.
- 47 per cent had difficulty in starting their flow.

Additionally, many IC sufferers report muscle and joint pain, allergies, asthmatic type wheezing and bowel problems, especially during flare-ups. Most IC patients with pain as well as frequency, report these common sensations: urogenital burning and pain, pelvic pain and/or pressure, sharp pains in the bladder and/or urethra and some report rectal pain as well.

These symptoms may be present all or some of the time depending on the severity of the disease. Many women with IC report their symptoms increase seven to 10 days before menstruation. In mild cases, the only symptom may be urinary frequency. Approximately 50 per cent of patients experience remissions, having flare-ups in between. Others suffer such unremitting pain and frequency that they cannot maintain a normal lifestyle. However, there is no evidence to suggest that mild cases necessarily progress to more severe forms.

Diagnosis

Statistics show that by the time the average IC patient has obtained a diagnosis, she has seen anywhere from 10 to 15 doctors in about five years.

Dr. Philip Hanno, associate professor of urology at the University of Pennsylvania School of Medicine maintains that failure to consider IC is the most common reason the diagnosis is missed. People with IC are often misdiagnosed as having a myriad of different conditions. According to Dr. Larrian Gillespie, in her book, *You don't Have to Live with Cystitis!*, some women have even had unnecessary hysterectomies to treat the pelvic pain associated with IC. (Men have trouble getting a diagnosis too and can have unnecessary prostatectomies for the same reason.)

Too often the symptoms of IC are erroneously attributed to a psychological cause. Historically, the male-dominated specialty of urology has clung tenaciously to a deeply ingrained assumption that chronic non-bacterial cystitis is caused by emotional and/or psychological problems. Gillespie quotes a paragraph from a medical textbook (published in 1979) which was required reading for medical students: "IC - a disease that is taunting in its evasion of being understood - may represent the end stage of a bladder made irritable by emotional disturbance... and,...the bladder had come to serve as a pathway for the discharge of unconscious hatred."

Clearly, this falls appallingly short of accepted scientific reasoning. There is absolutely no research evidence to support this assumption. Just words in a textbook, they can prove to be deadly enemies for women trying to get diagnosis and treatment.

What is the strategy for getting a correct diagnosis, if you think you might have IC? Since the symptoms vary considerably from individual to individual, and even from hour to hour, IC is difficult to pin down. Complicating the picture further, urologists do not necessarily agree amongst themselves upon the criteria for diagnosis.

The first step in getting a diagnosis is to make a list of your symptoms. An excellent checklist of IC symptoms is listed in Dr. Kristene Whitmore's book, *Overcoming Bladder Disorders*. The two most important questions are: do you have frequent, urgent urination but consistently get negative (no bacteria found) urine cultures and, do you have continual pain in your bladder, urethra or vagina that is relieved briefly by urinating?

The second step is to find a urologist who has a special interest in IC. Many urologists do not. In fact, because IC is often so hard to treat, many do not have the time or the commitment to work through a successful treatment regime. Call the urologist's office and ask the receptionist if the doctor has an interest in IC and treats many patients with the disease. Or, contact the provincial college or governing body of physicians and surgeons to get a list of urologists. If they can't help you, they may be able to tell you where to call.

Historically, the male-dominated specialty of urology has clung tenaciously to the assumption that IC is caused by emotional and/or psychological problems

Organizations such as the ICA have lists of support groups or affiliated organizations in your area. Members of these groups may have found a urologist with whom they have found success. Finally, don't be afraid to shop around; if one urologist can't or won't help you, find one who will.

The third step is to educate yourself about the disease so you can ask informed questions. Prepare for the office visit by writing out answers to the questions the doctor will ask: When did you first get your symptoms? Do you get pain relief when you urinate? (Pain or burning during urination is sometimes a symptom of a true urinary tract infection.) Have you had previous documented bladder infections? What kind of pain is it? And so on. One final tip— relate your history factually. Even though you may feel desperate and emotional, try to keep your feelings about what the symptoms are doing to you and your life out of the picture. The doctor has to know facts if she or he is to help you.

A urologist familiar with IC can usually be fairly certain of the diagnosis just by taking the patient's history and listening to the symptoms. She or he may want to do some tests to rule out other conditions. Diagnosing IC involves a procedure called a cystoscopy which allows the urologist to view the inside of the bladder by inserting a long, thin, tube-like optical instrument into the bladder. If you have suspected IC, this cystoscopy should be done under a general anaesthetic as patients with IC generally cannot tolerate the part of the procedure where the bladder is filled with water (over-distended) to enable the doctor to see the hallmark sign of IC, tiny hemorrhages on the bladder wall. A cystoscopy done without this distension procedure will not show these hemorrhages and the results may be reported as being "normal". Additionally, some urologists advocate taking a biopsy (a small tissue sample) of the bladder lining to substantiate the diagnosis of IC or to rule out other diseases. This procedure is usually done on an outpatient basis, although some people may stay overnight.

Treatment

Since the causes of IC are still unknown, current treatment focuses on the relief of symptoms rather than a cure. One common method of treatment is the instillation of various medications directly into the bladder by means of a small catheter. DMSO (dimethyl sulfoxide) is a solvent which has powerful anti-inflammatory properties. As well, it "carries" other medications, such as a steroid, heparin which may favorably act on the ladder lining) or an anesthetic. erformed in the doctor's office, his treatment takes 15 to 20 mintes and is done on a weekly basis ver four to eight weeks. Some atients can be taught how to dminister these treatments at ome. Because of its strong garlic-ike odour which persists for about 4 hours after a treatment, there ave been no controlled studies or linical trials with DMSO. Although he instillation of a very concentrated preparation of the drug has een linked to the development of ataracts in mice, no human model s available for comparison. To late, IC patients who received MSO treatment have not reported ny long term effects. However, it hould not be used if a woman is rying to conceive or is pregnant. ther medications can be instilled nto the bladder, but DMSO (alone r in combination with other lrugs) appears to have the most onsistent success rates. It is now standard treatment for IC.

Oral medications used to treat C can be administered alone or in ombination with other forms of herapy. Two experimental drugs urrently undergoing clinical trials nclude Elmiron and Nalmefene. nitial results suggest that Elmiron elps to reduce frequency more ffectively than pain. The ICA eports that 26 patients on almefene reported positive esults. Amitriptyline (Elavil), an nti-depressant drug, is used in ow doses to control the pain of IC nd reduce night time frequency. ther drugs used to reduce or control pain include non-steroidal anti-nflammatories (such as, aproxyn, Ibuprofen, Feldene, olobid) and Pyridium, a mild ladder analgesic. Minor tranquilzers and muscle relaxants have een prescribed to control some f the symptoms, but have the lisadvantage of being addictive nd have the side effect of drowsiess. Anti-spasmotics may be tried s well.

Diet modification has been nown to be helpful for some IC ufferers. It is commonly noted mong patients that acidic foods r beverages aggravate their sympoms. For this reason, many avoid coffee, tea, citrus drinks and foods such as tomatoes and onions.

Alternative therapies focus on pain control. The use of a TES (transcutaneous electrical stimulation) unit, a small device that electrically produces harmless sensations which "replace" the pain sensation, has reduced symptoms in some cases. Acupuncture, an age-old therapy, has also been tried with some success for some individuals.

Since the causes of IC are still unknown, current treatment focuses on the relief of symptoms rather than a cure

Home remedies such as drinking one-half to one teaspoon of baking soda in water take the "burn" out of IC flare-ups. However, caution is advised — if you have high blood pressure check with your doctor before taking this remedy; also the solution should not be gulped down rapidly. A simple heating pad placed on the pelvic or genital area can help ease symptoms. Several women in the Toronto IC support group report that sitting in a hot sitz bath brings some relief.

Relaxation, hypnotherapy and positive imagery are alternatives that can be done alone or with the help of a therapist. Psychological counseling and support can prove helpful for the anxiety and depression that so often accompany the disease. Support groups also assist in coping with the disease.

Finally, if all else has failed, surgery for IC may be considered. It is estimated that only five to 10 per cent of IC patients eventually need surgery. Because the procedures available are quite drastic and often have complications, surgery is not recommended except as a last resort. Two principle types of surgery are performed: The first, bladder augmentation, involves removing a portion of the diseased bladder and substituting in its place healthy tissue from a segment of bowel. This can be successful for a very select group of patients, but seems to have a high complication rate.

The second type of surgery involves diverting the urine away from the bladder and into an internal pouch made from a piece of bowel segment, or into a bag on the outside of the body.

Living With the Disease

According to a survey of IC patients conducted by the Urban Institute in Washington, D.C., 50 per cent of IC sufferers cannot hold full-time jobs. The survey published in *U.S. News and World Report* (September 21, 1987), also reported that these patients have three to four times the rate of suicidal thoughts compared to the general population. In fact, they rated the quality of their lives as lower than patients undergoing kidney dialysis.

Because of the general characteristics of the disease and because heterosexual intercourse is often impossible for those in moderate to severe pain, many women, if single, are afraid to enter into any kind of a relationship. Couples find they must modify their sexual activities accordingly.

Sheila Holmes, 28, has had IC

HEALTH WANTED

Surrogate Mothers
I am a female researcher interested in surrogacy. I am particularly interested in the experience of surrogate mothers. Women who have had or are having this experience please contact Fiona Green, University of Winnipeg, 515 Portage Avenue, Winnipeg, MB, Canada, R3B 2E9.

Lesbian Health Guide
Queer Press is currently working on a lesbian health guide over the course of this year. The guide will be Canadian-specific and be inclusive of race, age, class, religion, ability and rural contexts. They plan on having an extensive resource section and have already identified a number of health issues on which they wish to focus. The press wants to provide useful, factual and easy-to-understand information that can be used for preventative self care, as well as by lesbians who are ill or otherwise in contact with the medical establishment.
The press is inviting interested groups or individuals to:
1. Pass on this information to a person or organization you think would be interested in the guide.
2. Mail to the press any information about your organization's services which are applicable to lesbians so your organization can be included in the guide's resource listing.
3. Buy advance copies for your resource centre or resale to help fund the printing of the publication. A 20 percent discount will be offered off the cover price.
4. Write or compile a chapter on a topic (or topics) which interests you. Send a brief outline proposing what you would include.
A list of topics has been developed but the press is inviting further additions. For a listing of those topics and for more information on this guide, write to: Queer Press, P.O. Box 485, Station P, Toronto, ON., M5S 2T1.

since she was 14. "You can imagine what it was like trying to go through high school," she says. Her IC was not diagnosed at that time and she was told it was "stress." "I had a lot of anger, especially because I had it when I was so young, and because nobody told me there wasn't a cure. But what has really helped me cope is the work I've done with the ICA, helping others with the disease." Holmes does experience some pain, but her main symptom is frequency and urgency, forcing her to urinate about every 20 minutes.

Research

There has long been a gender bias in medical research. Despite the fact that women comprise 52 per cent of the population and make 25 per cent more visits to doctors, most organizations that fund research have ignored and neglected women's health issues. In response to this situation, the Women's Health Equity Act was legislated in 1990 in the U.S. to facilitate delivery of health care services to women and to ensure equity in medical research. The New York-based ICA has spent the past five years presenting their case to congressional hearing committees and investigating inequities in research funding. In the Spring 1990 issue of *ICA Update*, it was reported that the National Institute of Health which funds medical research, spent only 0.9 cents per person on female urological problems compared to $5.84 per person on male urological disorders. Through persistent efforts, the ICA has succeeded in obtaining significant research funding, and announced recently that the U.S. Senate has earmarked $2.5 million for IC research.

In Canada, however, there is neither the money available nor interest in convincing funding organizations to provide sizeable grants to research IC. Because IC is not a killer disease, the money that is available is allocated towards higher priority diseases, such as AIDS and cancer. The Kingston General Hospital, though, is one of seven designated sites in Canada currently participating in clinical trials of the experimental drug Nalmefene, sometimes prescribed to treat the disease.

Hope for the Future

If you think you or a loved one may have IC, there is now more reason to hope and to be encouraged than ever before. At least now, IC is finally being recognized by the medical profession. Hopefully, women will now be listened to, instead of being dismissed as hysterical or neurotic. We still have a long way to go, but the first step, if you need help, is to take responsibility for your own health and get information about IC. Research is being done in earnest and soon, we hope, the battle against interstitial cystitis will be won.

Anne-Marie Conolly is an exercise physiologist working in the cardiac rehabilitation program at the Toronto Hospital (General Division). She has a special interest in women's health issues including heart disease and interstitial cystitis. She is a member of the Interstitial Cystitis Association and actively involved in promoting awareness of the disease.

Further Reading

Rebecca Chaulker and Kristene Whitmore, *Overcoming Bladder Disorders*, Harper and Row, New York, N.Y., 1990. Available in paperback from bookstores or from ICA, P.O. Box 256, Woodhaven, New York 11421.

Larrian Gillespie, *You Don't Have to Live with Cystitis!*, Avon Books, Madison Avenue, New York, N.Y., 1988.

There are also many articles on interstitial cystitis in the *ICA Update* newsletter. Contact ICA, P.O. Box 1553, Madison Square Station, New York, N.Y. 10159.

The two branches of the ICA-Canada affiliate are ICA-Canada-Eastern Division, P.O. Box 5814, Station A, Toronto, Ontario, M5W 1P2 and ICA-Canada-Western Division, 10740 Fraserglen Drive, Surrey, British Columbia, V3R 8L9.

Diane Driedger and April D'Aubin

Women with Disabilities Challenge the Body Beautiful

Women everywhere feel pressure to conform to rigid beauty standards put forward by media and society. And these pressures are magnified for many women with disabilities who are perceived to be even less "perfect" than women without disabilities. As a result, women with disabilities experience low self-esteem and a sense that they are unattractive.

"I think it's far harder for women with disabilities because we just don't feel we're worth it. We see others making more. We see men doing better. Way down inside we are getting the message that we are not quite as good as men in general, or even the disabled men," says Gwyneth Ferguson Matthews, who uses a wheelchair.

Amy Edgington, reflects, "I have Scheuermann's disease. My spine twists into a pronounced S-shaped curve. I have seen trees shaped like me that look strong and graceful. Yet this is considered an ugly defect in humans and in a female, ugliness is the worst sin." There is an underlying assumption that sexuality is the preserve of the young and the beautiful both in Western society and beyond. As Rosangela Berman Bier, an activist in Brazil's disability movement points out, women with disabilities are seen as having "good heads," as if being rational and intelligent was mutually exclusive to being sexy and desirable.

Myths about disability lead to profound social, political and economic consequences for the women affected. Society's image of disability and the woman's own ideas about her body lead to a self-defeating circle of misconceptions. The greatest barrier is that there are few positive social role models, leaving women with disabilities feeling invisible and without goals.

Perceived as Sexless

"Disabled" often means that women are perceived as sexless and myths about their sexuality frequently present problems in marriage. Dr. Fatima Shah, a visually-impaired doctor and former senator from Pakistan, reports that in her country disabled women are perceived as "unmarriageable" because they are "damaged goods." Rosangela Berman Bier agrees that the problem is common. "When I met my husband

"Disabled" often means that women are perceived as sexless

Michael, I was disabled. People could not believe that an able-bodied man could fall in love with a disabled woman," she says.

People without disabilities often view disability as an individual's over-riding characteristic, the first and only thing they see. However, people with disabilities order their personal definition and world view in a different manner. "Disability is neither at the centre or the periphery of my life. It's just sort of there," says Adrienne Asch. "I'm not saying blindness isn't an important fact about me or that it doesn't affect a lot of things, but it's not part of my self-definition. If it's part of the world's definition of me that's the world's issue. I can't make it my issue."

"Blindness...is not part of my self-definition"

Low self-esteem begins at home. Some families present their daughters with limited choices and options. The family's expectations about the potential of a daughter who is disabled can limit a child from the start. While more and more able-bodied girls are being encouraged to aspire to more than traditional female goals, girls with disabilities may be defeated before they start. Jillian Ridington, a British Columbia researcher with a disability, suggests that a mother may lower her daughter's self-esteem by telling her that "she will never be attractive, that no man will ever want her, that she shouldn't go out and play because she might hurt herself, or other children might make fun of her. A child like this is doubly disabled, rendered powerless by her inability to see herself as an independent, separate being."

Women with disabilities are bombarded with low societal expectations and find little encouragement to strive for either personal or professional goals. "You must remember most people with any kind of disability are encouraged to take it easy, not to push themselves. They have a reason not to. This is basically what I kept hearing, 'You cannot do this. You drive every day? You should not be driving.' I really do not want to hear what I cannot do," comments Barbara Cole Appel, a jeweller who uses a wheelchair.

The education system may also damage the self-esteem and body image of a girl with a disability. In 1989, the DisAbled Women's Network Canada (DAWN Canada) conducted research in the area of self-esteem. The DAWN researchers discovered that "the school system turned an impairment into a handicap for many girls with disabilities." The researchers spoke with many women with disabilities who considered school to be one of the negative influences in their lives. Segregation into special schools or classes and an over-emphasis on life skills rather than academic achievement create obstacles which may take many years to overcome.

Double Jeopardy

In 1985, the median income for women with disabilities in Canada, was $8,360 compared to $19,250 for men with disabilities. (The figures for non-disabled workers were $10,000 for women and $21,000 for men.) People with disabilities leave school early. For example, 12.2 per cent of disabled females aged 25 to 29 had eight years or less of formal education while only 2.5 per cent of non-disabled females in the same age group. On the personal level, these figures translate into poverty, social isolation and unequal participation in community life for women with disabilities. "Women with disabilities feel doubly put down," states Matthews. "As women we don't expect what men get in terms of salary, and because we are disabled we don't expect what able-bodied women might make."

Poverty continues to be a fact of life for many women with disabilities. "Many women I know work when the act of working is almost physically impossible because they cannot afford anything else. Some women would love to work but no one will hire them. Some women are on welfare but hardly making it since, cruelly, the amount is so low," says Jean Winnow, a lesbian with a disability who is active in the lesbian health care movement.

Paula Keirstead and Liz VanReenan, two Winnipeg women with disabilities active in the disabled women's movement agree. They write: "Often women living in poverty don't have the resources to prepare themselves to meet the 'ablest' standards set by our materialistic society. ...Poverty propagates a negative self-image. For a woman with a disability this reality is magnified. ...she faces the limitations of poverty as well as [the] lack of access to the environment and society. And she is bombarded by the subtle and overt discrimination faced by all women in our society. The factors are all interrelated — finances, education, employability, appearance, self-esteem and productivity."

The messages about disability and gender which are projected by the job market and other sectors of society have a spillover effect influencing how individuals perceive themselves. Jillian Ridington explains: "The low self-esteem that is a critical problem for many, if not most, women with disabilities may make looking for a job overwhelming. If we are afraid of rejection, it may seem much easier to remain jobless than to write up a resumé, write letters of application...make transportation arrangements..."

> *"I really do not want to hear what I cannot do"*

Organizing for Change

In the 1970s people with disabilities in Canada successfully organized their own rights movement and by the 1980s had secured protection of their equality rights under the Charter of Rights and Freedoms. Most importantly, in this new movement, disabled people projected themselves as having the same inalienable rights as other citizens. In the early 1980s, Canadians with disabilities played a lead role in the founding of a global organization, Disabled Peoples' International, based in Winnipeg.

Despite an array of disability organizations at the national and local level, the issues of women with disabilities did not receive much attention until Gwyneth Ferguson Matthews published *Voices From the Shadows* (Women's Press, 1983) in which she talked about her frustration with a society that refuses to view her as a whole woman. It was the first time such an issue had appeared in print. Matthews researched the book by interviewing women with disabilities about their lives. They revealed that a lack of self esteem and good body image were number one concerns.

The book, originally commissioned by the Nova Scotia government, was shelved, because it contained "too much sex." Outraged, Matthews sought an outside publisher, and following the book's release, the disabled women's movement came into focus.

Women with disabilities began voicing their concerns about access to day care, the right to mother children and the importance of body image within existing disabled people's organizations. The unreceptiveness of these organizations to feminist issues led women with disabilities to develop their own organizations throughout Canada which nationally come under the umbrella of the Disabled Women's Network Canada (DAWN).

In countries such as Zimbabwe, the United Kingdom and Sweden, women with disabilities formed women's councils within disabled people's self help organizations. In Uganda, the disabled women's

organization takes part in the International Women's Day marches. The group pays for its activities by selling handicrafts.

In Australia, women with disabilities have confronted the body beautiful issue head on by decrying beauty pageants in Melbourne. They have organized protests outside the pageants and carried placards denouncing the promotion of "perfect bodies." The pageants outrage feminists because they raise money for disabled people's services in Australia.

"Beauty quests force on us a standard of appearance. Because of our disabilities this standard is impossible to attain. Every time we are judged against it we inevitably fail. We become second class women," writes Australian feminist Lesley Hall in her article, "Beauty Quests—A Double Disservice," in *Women and Disability* published by the Women with Disabilities Feminist Collective in Melbourne.

All over the world, people with disabilities have begun to develop their own resource centres, called independent living centres, to assist people with disabilities develop the services and resources they need to live full lives in their communities. Through peer support programs and independent living skills seminars, people learn how to manage their resources.

The Coalition of Provincial Organizations of the Handicapped (COPOH) has been involved in training and independent living programs in the Caribbean and Central America. COPOH is a national self help group of disabled persons which also runs an international program in solidarity with disabled persons in other countries. COPOH has also sponsored a literacy program for disabled women in Central America. While discussing literacy skills, the women also had opportunities to trade experiences about their bodies, sexuality and the oppression they face.

Peer support programs offered through independent living centres provide the opportunity to learn about different coping strategies and to test out ways of dealing with the world. This is an important resource for women with disabilities who have few socially sanctioned roles available to them. At independent living centres women can find mentors and begin to see themselves in a positive light. Success in a variety of social roles can help a woman with a disability readjust her self-image.

"One of the good things that has happened to me over the past few years has been my coming to better terms with my physical self," states Liz Blumber a lawyer with a mobility impairment. She explains, "For a long time after my ill-fated surgery, I felt extremely alienated from my body. Now I realize that there is much about my body that is right. I have splendid general health and I need a bare seven hours of sleep a night to function well."

Such realizations can create many positive changes in a woman's life. "The increase in my self-esteem about my physical self has had side effects. I used to buy clothes for work at discount stores — no polyester shirt was too cheap for me. Now I buy many of my clothes at specialty shops," says Blumber.

Keirstead and VanReenen, suggest the following ways women with disabilities can increase their feelings of self-worth:

- Talk to other women with disabilities and share success and things you would do differently.
- Focus on one issue at a time in manageable portions. This way you will guarantee success, not failure and poor self-esteem.
- Keep seeking information, ask questions, demand answers — refuse to be silenced by societal pressures to conform.
- Help others around you educate themselves about your situation.
- Reach out and become involved with women's organizations. Collectively, women have a powerful voice and wealth of experience when we work together..

The independent living movement and the disabled women's movement provide women with avenues for dealing with the negative effects of both ablism and sexism on self-esteem and body image. Women with disabilities have risen up and given a resounding "No!" to the body beautiful image. In an increasingly aging population, this action will prove important for the images of all women.

Diane Driedger is the International Development Officer and April D'Aubin is the Research Analyst with the Coalition of Provincial Organizations of the Handicapped (COPOH) in Winnipeg.

REVIEWS

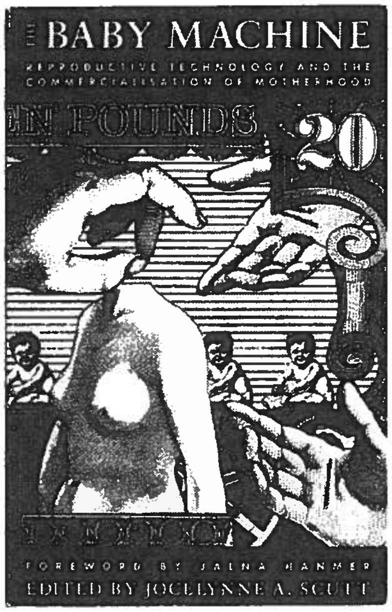
The Baby Machine: Reproductive Technology and the Commercialisation of Motherhood

Edited by Jocelynne A. Scutt, (Green Print), London, 1990, $19.95 ,342 pp.

Reviewed by Roberta Wedge

While alternative media have raised questions over the real intentions driving the development of new reproductive technologies (NRTs), mainstream media coverage is still limited to glowing write-ups of the latest medical achievement in "treating" infertility. In fact, in-vitro fertilization (IVF) and its spin-offs do not treat infertility at all, but attempt to circumvent it, and may cause other health problems. Women have good reason to be wary of the "solutions" offered by the same establishment that put our fertility at risk with DES, IUDs and misdiagnosed PID (pelvic inflammatory disease). This establishment now offers cuter acronyms such as GIFT (gamete intra-fallopian transfer), but is still not asking whether — or rather, how — the powerful drugs and invasive manipulations necessary for these procedures will affect our health and the fertility of the children conceived. Will they too have to return to the "technodocs" to try to undo the damage that we, unknowingly, have wrought upon them?

A recent book that examines these issues is *The Baby Machine: The Commercialisation of Motherhood*, edited by Jocelynne A. Scutt. It takes an uncompromising stand against all of the NRTs on the grounds that they take the control of reproduction away from women and put it in the hands of the predominantly male medical system. In the view of the contributors to this radical collection, the little good that is done by the NRTs — the relatively small number of healthy babies created — is far outweighed by the damages done to the women who join these experimental programs and even to the majority of us that don't. The attitude of this collection is not surprising, given that the book is from Australia, one of the countries most heavily involved in developing and promoting NRTs.



Most of the contributors are academics and their well-documented research has led them to make angry accusations and negative conclusions. They show how IVF programs debilitate women by using strong drugs such as Pergonal to force the ovaries to release several eggs at once instead of one, as is natural. These drugs cause weight gain, bloating, fatigue, nausea, depression and severe mood swings in the short term. No one knows for certain what their long term effects are; premature menopause and ovarian cancer seem distinct possibilities. Despite these physical dangers, it is difficult for a woman to leave IVF programs once she starts because they hold out the promise of a baby at the end of all the pain and misery. There is no easy way to get off the treadmill. The authors see all IVF-related technologies as failures, since, more than a decade after the birth of the first "test-tube baby" (Louise Joy Brown, born July 1978), fewer than 10 per cent of attempts at IVF result in a live birth. Some centres that claim to specialize in IVF have never "produced" even one baby! The babies that are born are often at high risk — multiple births, low birth weights, and delivered by cesarean. And, of course, no one knows how the chemicals and procedures to which the fertilized eggs were subjected in the laboratory will affect these babies as they grow to adulthood.

The editor is a lawyer, and contributes a piece demonstrating that the patriarchal principles of ownership already enshrined in law are being extended to cover reproductive and genetic engineering. The law tries to alienate women from pregnancy and giving birth by equating these lengthy and intimate processes with the quick selling of sperm. The assumption in law has been that motherhood is absolutely evident, but now the tide of opinion is turning against the gestating mother. The fetus she nourishes is somehow not really hers if she did not contribute its genetic material — no matter that she builds its blood and bone with her very own breath. Women are winning "paternal" rights of genetic ownership, but at the cost of losing the maternal rights which have always been theirs. For the first time in history we have a baby being taken away from the woman who gave birth to it with the claim that it is not "hers" and that no legal or moral ties exist between them. Why? Because she signed a piece of paper!

This is brought home in an essay by a contract mother. Therese McFadden explains that item four of the contract she was asked to sign required her not to "attempt to form a parent/child relationship" with the baby she agreed to bear. In the end, with her husband's support, she refused to relinquish her son, and comments dryly, "Those having had a child will realise that the parent/child relationship begins long before birth." Her conclusion could be the starting point for another book: "Maybe we should be shifting the emphasis away from parenting as necessary to fulfil us as human beings."

Gena Corea, has written extensively on the dangers of NRTs. In her submission, "Women, Class and Genetic Engineering: The Effect of New Reproductive Technologies on all Women," she argues that even now men are trying to direct human evolution by genetic manipulation. This is eugenics by any other name — and sometimes called bluntly just that — with a rationale of eliminating "low quality life." Amniocentesis is currently used widely in India, and no doubt in other countries, to determine the sex of fetuses and to justify the abortion of the female ones because their gender makes them unwanted.

The Baby Machine is unapologetically opposed to all NRTs. Those who are interested in this point of view may care to contact FINNRAGE (Feminist Network of Resistance to Reproductive and Genetic Engineering) at P.O. Box 20 19 03, D-2000 Hamburg 20, Germany.

Roberta Wedge was a feminist long before she got her degree in Women's Studies from the University of Toronto. She dates her interest in NRTs to the test-tube birth of Louise Brown. Roberta travels, writes, networks and collects utopias. She now lives in Montreal.

Sandra's Garden

Directed by Bonnie Dickie
National Film Board, 34 min.

Reviewed by Colleen Ferguson

Sandra is an incest survivor. Throughout her life she has been controlled, first by her father and then by the legacy of his abuse.

Sandra's Garden is a metaphor for the changes in her life. Now in her 40s, she can plan, nurture and blossom. She works in the garden with those closest to her — her friends, her dog and her lover. She tends devotedly to her garden, just as she tends to her relationships, and in return, she harvests the fruit of her labours.

The garden metaphor, a contrived and clumsy device, is this video's greatest weakness. Sandra's healing as an incest survivor seems to take a back seat, as the people in her life are paraded through her garden. She picks herbs for dinner when friends come to visit, she prepares vegetables for canning as her lover discusses their relationship and she sings folk songs on her lawn with the women in her community.

It is when Sandra gets out of her garden that this video begins to flower. During a discussion with other incest survivors, she emerges as a strong and confident leader. During this segment, Sandra's courage and intelligence are fully revealed. Her thoughtful voice takes the viewer through the hardships in her life, beginning at the time of abuse, through failed romantic relationships, to the torment of remembering.

Sandra talks about the guilt she still feels for living in her father's house with her young daughter, exposing her to potential danger. It is hinted the daughter was also abused and that it has come between her and Sandra. In fact, this is the most moving part of this video. Sandra's daughter never comes to her garden. It is clear they are isolated from each other, a result of the sexual abuse that Sandra has not yet been able to overcome.

Sandra's Garden takes a frank

and open look at the devastating results of incest. At the same time it offers positive images of triumph over hardship and a strong role model for other survivors. However, it errs in its efforts to be clever. Contrived scenes, like a woman singing a feminist folk song as she swims in a stream, lose all the film's subtlety and Sandra's deft dialogue.

Sandra's story is strong enough without such devices. Unfettered by film techniques, her courage, not her garden, would emerge as the real star.

Colleen Ferguson is a freelance writer living in Toronto.

DiAna's Hair Ego

Directed by Ellen Spiro, 29 min. VHS, U.S.A., 1990.

Reviewed by Hazelle Palmer

When you get your hair done at DiAna's Hair Ego you get more than just a new hair-do

When you get your hair done at DiAna's Hair Ego in Columbus, South Carolina you get more than just a new hair-do, you receive free condoms, information on AIDS and ways to practice safe sex.

DiAna, the salon's owner believes AIDS is something you have to pay attention to. And so in 1986, she decided to take action. She installed an AIDS tree at the entrance to her salon and decorated it with large- and small-sized skeletons to represent "the people and children that have died of AIDS." Then she began wrapping condoms in gift paper for her customers and handing out pamphlets about the disease.

Through the South Carolina AIDS Education Network (SCAEN), which she later founded and still operates from her home above the salon, DiAna conducts frequent information forums, "not lectures," on AIDS and hosts "sex parties" where men and women can discuss safe sex alternatives and sexual aids.

DiAna's Hair Ego chronicles the development of SCAEN and DiAna's tireless days spent raising awareness about AIDS in the African-American community. The organization's and her approach to grassroots health education challenges traditional sex and AIDS education which has historically focused on statistics and medical research.

DiAna and her SCAEN volunteers believe the only way we can spread information about AIDS is through education. And so, with their motto: Each One, Teach One, they are reaching out to community groups, women's organizations and even church groups to talk frankly about AIDS.

Director Ellen Spiro provides the audience with a comprehensive inside view, featuring interviews and comments from SCAEN volunteers, Hair Ego clients and a look at on-site community forums for young adults. The high level of dedication and commitment of the volunteers and their concern for their community is captured frame by frame in this video. It inspires you to take action. You realize that the first step in the struggle against AIDS is to become informed about the disease; then to speak to friends and family openly and frankly to breakdown all the myths associated with AIDS.

"One of the reasons I try to tell everybody to be prepared and know more about AIDS is that if you know more you wouldn't have to be so afraid because you don't catch it by going to work and doing your daily activities. But out of ignorance, when people are afraid, the first thing people want to do is get rid of whatever the problem is instead of working with it and dealing with it," says DiAna.

Over the past six years, SCAEN has reached more than 8,000 people through its AIDS education programming. Despite this success, the South Carolina State Health agency continues to deny them funding.

DiAna's Hair Ego is distributed by Dec Film and Video, 394 Euclid Avenue, Toronto, Ontario, M6G 2S9

Hazelle Palmer is the managing seditor of Healthsharing *magazine.*

RESOURCES & EVENTS

Creating Connections

Creating Connections presents *Sorrow & Strength: The Process*, their 2nd annual conference about childhood sexual abuse for adult survivors, professional helpers, teachers, and other support people. April 9-11, 1992, International Inn, 1808 Wellington Ave, Winnipeg, MB. Speakers include Louise Armstrong (*Kiss Daddy Goodnight*), and Shirley Turcotte (*To A Safer Place*).

For more information contact Sorrow & Strength: The Process, 1992 Coordinating Committee, 160 Garfield St. S., Winnipeg, MB, R3G 2L8 or call (204) 786-1971.

Womancare

Women's Health Clinic presents “Womancare” Conference '92, *Women and Cancer, Trends, Issues and Attitude*, April 25, 1992, 9 am-4 pm, Union Centre, 275 Broadway Ave., Winnipeg, MB., $25 (subsidy available).

For further information call Nori at (204) 947-1517.

Prevention Congress V

The Ontario Prevention Clearinghouse and the Foundation for Learning and Social Enhancement, are sponsoring Prevention Congress V, “Healthy and Supportive Communities: The Promise of Change,” April 27-30, 1992, London, Ontario. Workshop sessions will focus on health, social service and education, as well as housing, literacy, the environment and multicultural and native issues.

For more information, mail or fax your name, agency, address, and phone number to: The Ontario Prevention Clearinghouse, 984 Bay St., Ste. 603, Toronto, ON, M5S 2A5, Fax: (416) 928-5975.

“Freedom, Friends and Family! Celebration '92”

Gay and Lesbian Parents Coalition International (GLPCI) is holding their 13th Annual Conference in Indianapolis, Indiana, July 3 to 5, 1992. Workshops, guest speakers, a banquet, family picnic and much more. Child care is available for infants to age 5.

For more information write P.O. Box 50360, Washington, DC 20091, or call (202) 583-8029.

Strategies for Change: Part II

The 20th Anniversary Conference and Annual General Meeting of the National Action Committee on The Status of Women (NAC) is being held Friday, June 5 to Sunday, June 7, 1992 at Carleton University, Ottawa, ON.

CRIAW/ICREF Conference

CRIAW/ICREF's 16th Annual Conference, “Making the Links: Anti-Racism & Feminism”,will be held in Toronto, November 13 to 15, 1992. Issues of age, class, ability, sexuality etc. will be addressed within a framework of anti-racist feminism.

For further information write 151 Slater St., Ste. 408, Ottawa, ON, K1P 5H3, or call (613) 563-0681 or fax (613) 563-0682.

“Sexuality: New Visions”

The 14th Annual Guelph Conference on Sexuality, will be held June 15 to June 17, 1992. Current issues in human sexuality, teaching approaches in sexuality education and counseling strategies for sexual problems will be examined.

For further information contact Division of Continuing Education, University of Guelph, Guelph, ON, N1G 2W1, or call (519) 767-5000, or fax (519) 767-0758.

Breast Implant Registry

An international registry for women with breast implants has been established by Medic Alert. Registry members will be kept informed as new information on breast implants becomes available. You can join the registry for $25 (U.S.) plus an annual fee of $15(U.S.), to International Breast Implant Registry, Medic Alert Foundation, 2323 Colorado Ave., Turlock, CA 95381, or call 1-800-892-9211.

Breastfeeding Workshop

INFACT Canada, Women's College Hospital, La Leche League Canada and Humber College present “Re-creating a Breastfeeding Culture: A Workshop for Health Professionals,” June 4, 1992, 8:30 am-4:15 pm, 252 Bloor St. West, Toronto, ON. Topics range from Baby-Friendly Hospital Initiatives to Ten Steps for Implementing a Breastfeeding Culture.

For more information on this or the Evening Forum with Jackie Glover and others on June 3, 1992, 7:30-9:30 pm, contact Elisabeth Sterken at (416) 595-9819.

DAWN Office Open

DAWN Canada: Disabled Women's Network Canada has now opened a national office at 658 Danforth Ave., Suite 203, Toronto, ON, M4J 1L1. Voice: (416)406-1080, TDD: (416)406-1081, FAX: (416)406-1082.

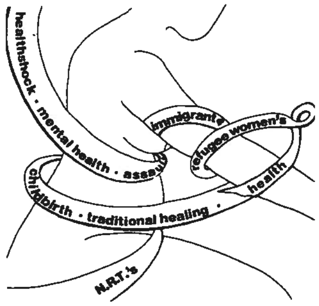
Resource Kit

The Cross Cultural Communication Centre in conjunction with other community groups, workers and activists has developed a resource kit, *Community Development with Immigrant Women*, that can be used as a training tool and resource for community education and organizing. Written by Judy Vashti Persad and Veronica Moreno, the kits are $12 per copy (plus 15% postage & handling; 7% GST) from Cross Cultural Communication Centre, 2909 Dundas St. W., Toronto, ON, M6P 1Z1, (416)760-7855 or FAX: (416)767-4342.

Midwifery Meeting

The Association of Ontario Midwives is holding their 1992 Annual General Meeting and Continuing Education Workshops May 30 to 31, 1992, at the Taoist Tai Chi Centre, Orangeville, ON.

Contact Jaylene Masaoka (416)466-7504 or Anne Egger (416)651-0520 for more information.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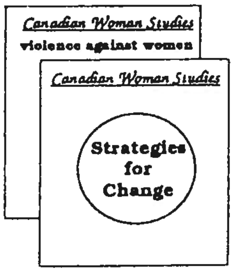

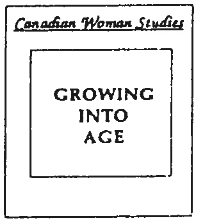

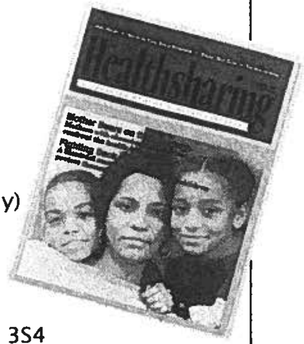
Healthsharing

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(29 minutes)

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These women describe their aspirations and accomplishments as well as the ongoing struggles they face in their personal lives and at work.

The film is a powerful call for an end to racism and for improved language and job skill training in Canada.

Closed captioned for the deaf and hard of hearing.
A decoder is required.

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