BIRTH CENTRES ▪ MIDWIFERY ▪ CERVICAL CANCER

Summer/Fall, 1992
$3.50

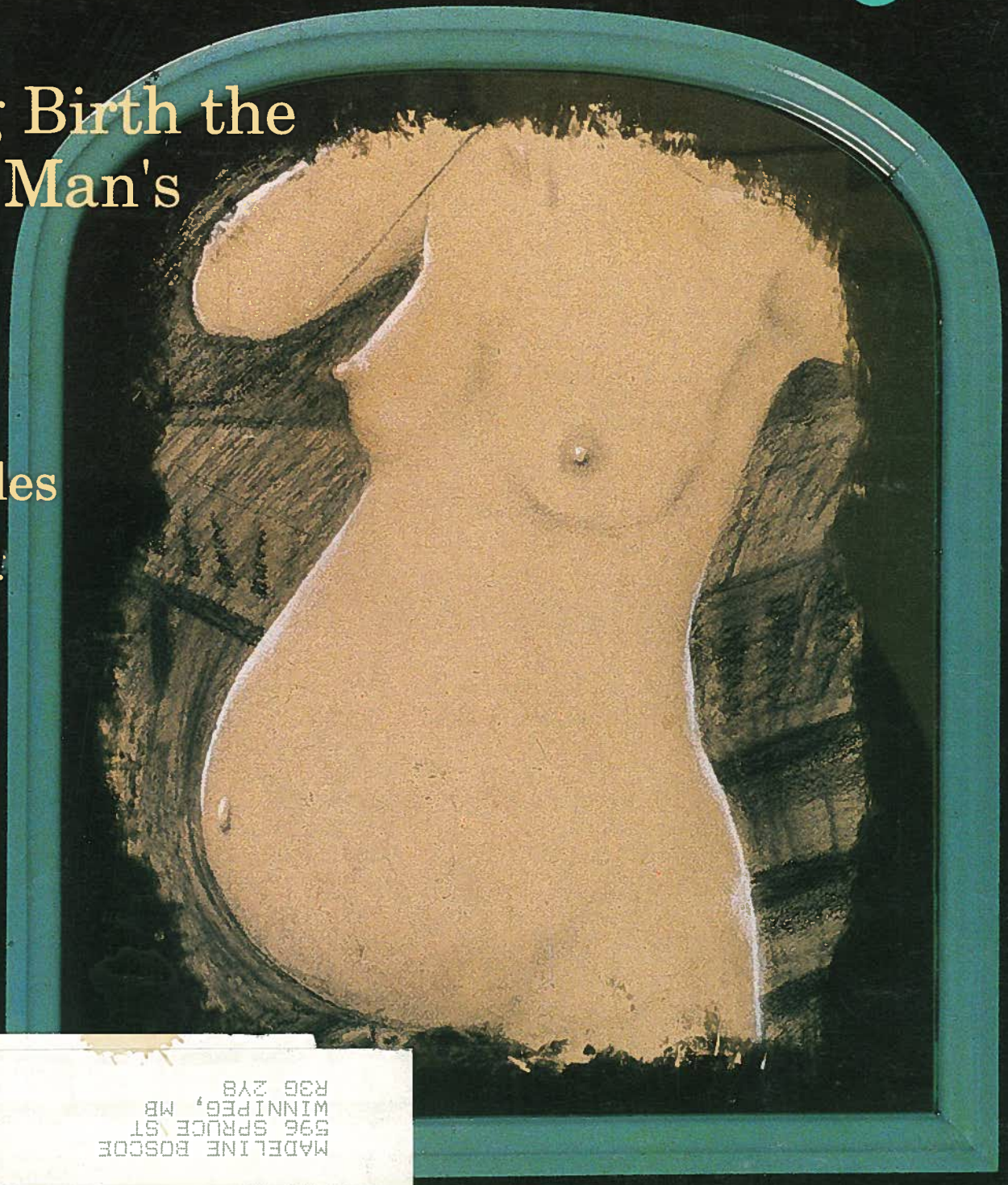
Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

Giving Birth the White Man's Way

Scenes from BirthTales

Padding the Bottom Line
an excerpt from *Whitewash*



Healthsharing

Vol 13:2 Summer/Fall, 1992

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Unsolicited manuscripts or artwork please include a self-addressed envelope. Writing guidelines available upon request.

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INSIDE

FEATURES

ALWAYS IN HEALTHSHARING

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Healthsharing *reserves the right to edit letters for length, and print them, unless they are marked "not for publication."*

Glad You're Surviving
I'm glad you're surviving. It's a wonderful "readable" magazine on women's health.
F. Correia,
Toronto, Ontario

More Useful
Your journal should be in every doctor's waiting room - a lot more useful than *Sports Illustrated.*
D.P. Harrison,
Penticton, B.C.

Up-to-date
I have been a subscriber to your magazine since 1984/1985....I've realized over the years that the magazine has had some tough times (financial, organizational) but I applaud the efforts of keeping it Canadian and up to date on women's issues. I am a registered nurse in a labour and delivery unit and your articles have kept me informed on what the consumer/patient wants these days. I look forward to receiving Healthsharing for another eight years. Keep up the grand work!
C. Johnston-Binks,
Lakefield, Ontario

Stimulating
Thank-you for all the stimulating articles - it's appreciated!
Movement Contre le Viol et L'Inceste,
Montreal, Quebec

More On Environment
Healthsharing needs more articles on our environment and public health, i.e. the effects of pesticides on people, lead and car fumes in our lungs, etcetera. Please encourage the bicycle and walking for (healthy) transportation. Your focus needs to be broadened, in view of the present environmental crisis.
H. Hansen,
Willowdale, Ontario

Delighted
I'm enjoying your magazine tremendously (and delighted you are still afloat!) and passing them along to friends.
D. Trimble,
Oak Park, IL., USA

Opportunity
I would like to thank *Healthsharing* for the opportunity provided to inform women about interstitial cystitis (IC). I was very pleased with the way my article was presented. Also, my compliments on the artwork....I would [also] like to compliment you on your very well done focus on breast cancer. [*Healthsharing* Winter/Spring,1992]
A.M. Conolly,
Interstitial Cystitis Association, Canada

Not Alone
I enjoy the magazine very much. I appreciate your point of view and I feel encouraged that I am not alone in my "odd" way of looking at the world, that is I don't see things according to the status quo.
B. Whyte,
Ormstown, Quebec

Spreading the Word
I have recently discovered the magazine *Healthsharing.* I would like to congratulate you and all those involved in producing such an excellent publication. As a staff member of the Consumer Health Information Service, I am often approached by women who have health concerns and are looking for information. Many times they want to read about the experiences encountered by other individuals who have faced the same concerns. Your magazine has provided this type of information on numerous occasions. The articles are always clear, well-written and informative. I wish to support your continued success.... You can be sure that I will help spread the word on this wonderful publication. Keep up the great work!
S. Taylor,
Toronto, Ontario

Special Interest
I have a special interest in the Winter/Spring 1992 copy. It contains an accurate article on "Interstitial Cystitis", a condition from which I have been a recent sufferer and victim. I have a support group in formation for other I.C. patients.
L.M. Reef,
Swift Current, Saskatchewan

Amazing
Your magazine is amazing - a feminist health magazine and it's Canadian! All of the volunteers here love to read it and await each issue. Keep up the good work.
J. Cunningham,
Co-Director, The Birth Control Centre,
Kingston, Ontario

The Pill and Breast Cancer
Thank you, *Healthsharing* is a special magazine. Does the "Pill" have any effect on breast cancer? That question never came up in ...the Winter/Spring issue. Why not? Please, ...,someone answer me.
E. Reynolds,
Charlottetown, P.E.I

There is still no conclusive evidence to link the use of oral contraceptives to the occurrence of breast cancer. However, as more younger women are diagnosed with breast cancer, a debate has been sparked as to the connection, if any, to the long-term use of oral contraceptives.

Let Your Voice be Heard!

If you would like to write a personal story or a researched article about women's health, we would like to tell you how to prepare it! Send us a note asking for our writing guidelines. These guidelines will answer all your questions about submitting an article, the types of articles we prefer, formats for submission, acceptance of articles and much more!

Your article will help contribute to women's empowerment over our own health!

HEALTHLINES

Choice Means Control

Choice. Control. Whether we are talking about abortion rights or childbirth, both of these words are recurring themes. They mean something when we are talking generally about women's health; they mean more when we are discussing childbirth.

Let's discuss choice first. Women need to know they have the right to choose what kind of birth they want —whether a natural or medical event; where that birth will take place whether in a hospital, home or birth centre. We can also choose to have a midwife, an obstetrician or both present during delivery.

However, there are things within the birth process with which we have less choice, particularly if we choose a hospital birth. Take the episiotomy for example. This surgical procedure involves a straight cut in the vagina to widen the birth opening and to supposedly prevent serious perineal tearing or trauma and pelvic floor relaxation. Women are not asked if they consent specifically to having an episiotomy. Instead the procedure is covered on the general consent form completed when admitted to the hospital.

A new study led by Dr. Michael Klein at McGill University in Montreal has concluded that there is no advantage to performing this surgical procedure. In fact, episiotomies may be harmful to women in the post-natal healing phase.

But there are other procedures we are not asked about—the use of forceps in delivery, fetal monitoring, the use of drugs such as epidurals and demerol. There are women who prefer a medicalized birth and welcome the availability of drugs to lessen contractions. But there are also women who don't. Having discussions with women about all of these procedures prior to the birth event will involve women in their own birth process, allowing them to make informed choices.

This process may help to eliminate the betrayal women feel after their hospital birth. In the meantime home births or birth centres may be the options for women who want to have more choice in their birth event.

Still the results of Klein's study should make us wonder why we continue to buy into the over-medicalization of childbirth. Why pregnancy is being treated more like an illness and less a miracle of life. Elders in the Inuit community are at least asking questions. They continue to watch Inuit women being evacuated, without consent, from their homes in the north to give birth in the south and then see them return describing their birth experience as including induction, episiotomies, epidurals and other drugs, and cesarean sections; a birth experience that has them lying uncomfortably on their backs with their legs in stirrups; a birth experience away from their families, away from their homes and far different from the midwife-assisted births the Inuit have practised in the past.

"Giving Birth The White Man's Way" is our central feature as we focus on childbirth in this issue of *Healthsharing*. Sheila Jennings Linehan speaks with Inuit women about their displacement from their homes to have a southern style birth. If there is a story which fully illustrates what little choice women actually have in childbirth, this is it. Throughout this piece, as we hear their stories, there is one common theme: no consultation, no choice.

And like other issues, from abortion to childbirth, when we have no choice we have no control.

Hazelle Palmer

On Our Cover

Pregnant Me
by Debbie O'Rourke
charcoal, gouache on
Der Wint paper
framed inside a mirror

A graduate of the Alberta College of Art and the Ontario College of Art, Debbie is a veteran of a decade in the low end sector of the design industry. Her passion for drawing led her to forsake more glamorous positions, for the privilege of spending 40 hours per week at a drawing board in a factory. Debbie is the curator of the BIRTHTALES exhibit shown in Toronto last spring. Some selected pieces from the show are presented inside this issue of *Healthsharing*.

UPDATE

Toronto's Morgentaler abortion clinic fire bombed

On Monday, May 18, a gasoline-fueled bomb ripped apart Dr. Henry Morgentaler's Harbord Street abortion clinic in Toronto. No one was injured, but the blast is the latest incident in the escalating violence surrounding women's freedom of choice.

Ontario's provincial government responded to the fire-bombing with a promise of $420,000 to be spent over the next two years in an effort to increase security at all of the province's 12 abortion clinics.

The explosion came weeks after the failed Operation Rescue in Buffalo, New York, a 10-day campaign which attempted to close that city's four abortion clinics. Morgentaler has speculated people from the United States may be behind the attack on his clinic, although no charges have been laid in the case.

Morgentaler has launched a fundraising campaign to help with the costs of repairing the clinic. The money raised will also be used to cover legal expenses in cases currently before the Supreme Court and to bolster security at all future clinics.

Donations can be made to The Morgentaler Defense Fund, P.O. Box 247, 238 Davenport Rd., Toronto, ON, M5R 1J6.

Mark Rozitis

Episiotomy unnecessary, study finds

One of the most common operations performed on women in Canada and the United States may not only be unnecessary, but disruptive and harmful as well, according to a new Canadian study.

Episiotomies, performed on 80 per cent of women giving birth for the first time, includes a surgical incision along the perineum. Ideally, the procedure widens the vagina to prevent tearing and ease childbirth. However, stitches are needed to close the wound: stitches that might have been avoided if an episiotomy had not been performed.

The study, released this summer in a new computerized medical publication called the Online Journal of Current Clinical Trials, found that women who had episiotomies ended up with the same number of stitches as women who had minor tears. In some cases, episiotomies led to even more tearing than would have occurred without the incision.

The study included 703 pregnant women randomly divided into two groups. In one group, episiotomies were performed regularly, in the other, their use was restricted.

Researchers found that women who were giving birth for the first time received the same number of stitches whether they had an episiotomy or normal tearing during birth.

Women who had given birth previously, received significantly fewer stitches without an episiotomy than women in the same position in the other group. And, women who gave birth without any tearing and therefore without any stitches, fared the best and felt the least amount of discomfort after childbirth.

An alarming finding of the study was that episiotomies may actually contribute to severe tearing. Out of 357 first births, 46 women who had episiotomies suffered severe tearing. By contrast, the restricted group had only one woman giving birth for the first time who suffered severe tearing.

Despite the findings of this study, many doctors continue to perform episiotomies routinely making the procedure the most common operation performed without consent on women in Canada and the United States.

COLLEEN FERGUSON

Maggie's

Maggie's, a Toronto resource centre for men and women working in the sex industry, has been recognized as a charitable organization by the federal government.

This important development, making Maggie's the only such organization in the country to achieve charitable status, will ensure their ability to issue receipts for tax-deductible donations.

Officially named the Toronto Prostitutes' Community Service Project, the organization is funded to provide AIDS-prevention education by getting information about safe sex and needle-use out to people in the sex trade and their friends and spouses. But Maggie's also provides an important network of other services such as the distribution of bad trick sheets, a list of men who have robbed or assaulted prostitutes; information about the law and legal referrals; and support for and by those that work in the sex industry.

A nightly drop-in centre, which provides fresh coffee, free condoms and a comfortable reprieve from the street also assists in keeping sex trade workers in touch with each other. Their concerns, opinions, and ideas are printed in Maggie's newsletter - a publication which offers friendly information, such as the regular column "STD of the Month," as well as dire warnings, like the article about a Toronto business man who specializes in conning prostitutes.

Maggie's is run by people in the sex industry who either volunteer at the coffee house drop-in centre, distribute condoms or buy a $10 membership. A membership-elected board of directors is made up of sex-trade workers and community members.

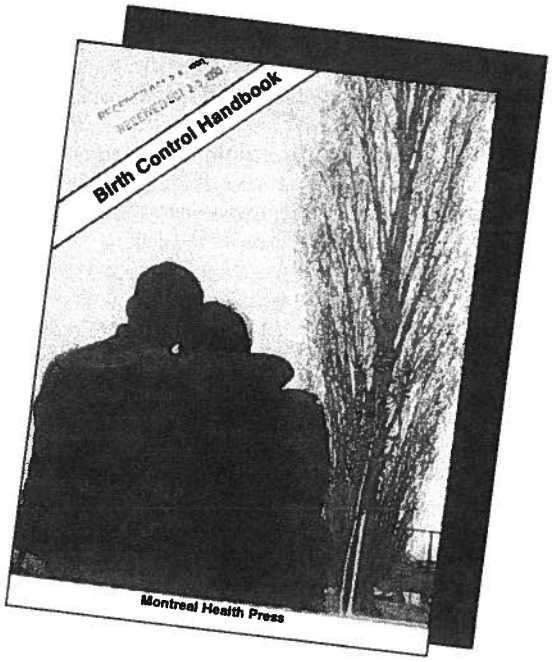
Interested benefactors can send their tax-deductible donations to Maggie's, Box 1143, Station F, Toronto, ON, M4Y 2T8. Please include a return address to receive a tax receipt.

COLLEEN FERGUSON

Support needed for birth control handbook

The Montreal Health Press, a women's collective who have been publishing books on health and sexuality for over 20 years, is in urgent need of funds to reprint the "Birth Control Handbook." First published in 1968, this handbook was published amidst great controversy, at a time when dissemination of birth control information was illegal. Over the years, the Montreal Health Press has published and regularly updated its four publications: the "Birth Control Handbook", the "STD Handbook", a book about sexual assault, and another about menopause. All of the books are recognized as excellent healthcare resources and are sold to clinics, colleges, women's groups, and individuals.

The Montreal Health Press is a non-profit group which has endeavored over the years to keep their prices as low as possible so that their information reach the largest number of people. However, due to recessionary difficulties, reprinting the Birth Control Handbook will not be possible without additional funds. If you would like to help, donations can be made to: A Votre Santé, the funding agency for the Montreal Health Press. Tax receipts will be available for donations over $10.00. Montreal Health Press, C.P. 1000, Station Place du Parc, Montreal, QC, H2W 2N1.



U.S. court ruling crushes women's right to choose

In July, 1991, WHAM! (Women's Health Action and Mobilization) decorated the Statue of Liberty with banners reading "No Choice, No Liberty" and "Abortion is Healthcare, Healthcare is a Right" to protest the Supreme Court's ban on abortion counseling at federally funded clinics. WHAM! P.O. Box 733, New York, NY, 10009

The following is an excerpt from a larger document prepared by The Centre for Reproductive Law and Policy in the U.S. analyzing the U.S. Supreme court's decision regarding Roe v. Wade on June 30, 1992 and its implications for abortion rights and reproductive freedom for women in the U.S.

On June 30, while a slim majority of Justices adhered in general terms to the principles of reproductive choice articulated in *Roe v. Wade*, the United States Supreme Court carved the heart out of the constitutional protection of the abortion choice that has been guaranteed to American women since 1973. In five separate opinions, the Court (1) upheld all of the governmental restrictions at issue, (2) opened the floodgates to further restrictions on abortion, (3) sanctioned the view that the government may act to protect "protected life" throughout pregnancy if it does not "unduly burden" the abortion choice, and (4) abandoned entirely any notion that the Constitution requires neutrality when government uses the force of the criminal law to regulate reproductive decisions.

Only two Justices voted to reaffirm *Roe v. Wade* in its entirety. Specifically, the Court upheld mandatory delay; biased counseling; "informed" parental consent; and a dangerously narrow emergency exception.

In upholding these provisions, the Court explicitly overruled two earlier decisions in which the Court applied Roe's standard of review vigorously. The only provision struck down by the Court was a husband notification requirement, which the Court found to be an "undue burden" on married women's right to obtain an abortion.

By upholding virtually all of the restrictive provisions while still claiming to reaffirm Roe, the Court attempts to deceive both the American public and the international community about the true import of this decision. Through this decision, the United States becomes the only country in the world to move towards lesser instead of greater freedom and equality for women.

For more complete analysis of the decision or for an analysis of the implications of this decision outside the U.S., contact the Centre for Reproductive Law and Policy at (212) 514-5534 or write to: 120 Wall Street, New York, N.Y. 10005, U.S.A.

Meryl Levin Photographer, Neil Demause, Designer

No More Fear - No More Ignorance: AIDS Awareness Week 1992

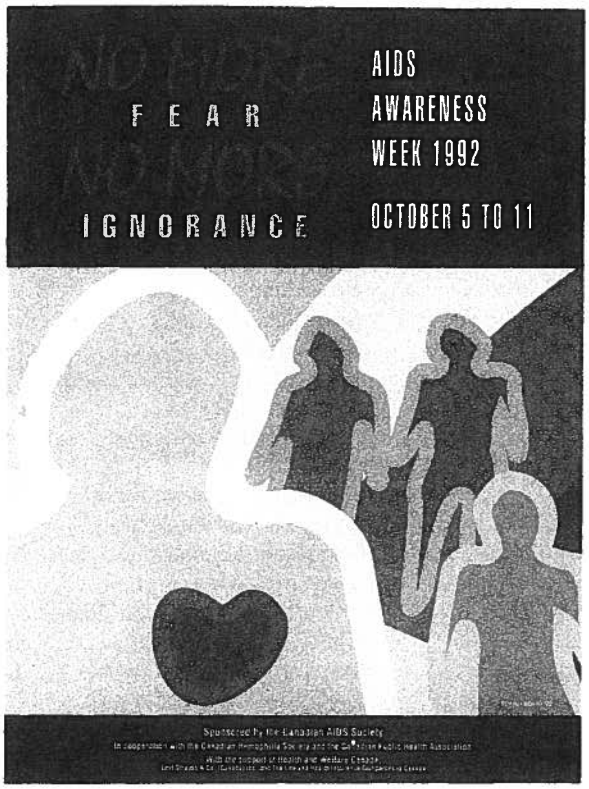
The HIV/AIDS virus is rising rapidly and so is the need for public education and awareness. AIDS Awareness Week provides the chance to put AIDS in the public eye and you the chance to play a role in AIDS education and the prevention of the spread of HIV.

The Canadian AIDS Society, a coalition of over 70 community-based AIDS organizations from across Canada, will once again sponsor national AIDS Awareness Week, this year in cooperation with the Canadian Public Health Association and the Canadian Hemophilia Society. The theme for 1992 is 'No More Fear - No More Ignorance'.

Local AIDS organizations across Canada, public health units, schools, associations who work with youth, and individuals committed to positive social change are invited to participate in the second annual national AIDS Awareness Week, October 5 to 11, 1992. This event, which originally began in the early 1980s through community action in a few cities, now has various partners from coast to coast actively participating.

This uniquely Canadian event allows for a wide variety of activities and creative educational endeavours as well as for multiple forms of partnership. If you and/or your organization would like to get involved in AIDS Awareness Week, please contact the local community AIDS organization nearest you.

WHS



Poster courtesy of Canadian AIDS Society, Ottawa

CVS test questioned

Researchers now say a test to detect birth defects well in advance may itself cause birth defects. The chorionic villus sampling or CVS test involves removing a small piece of tissue from the womb at 10 to 12 weeks to ensure the fetus is developing normally.

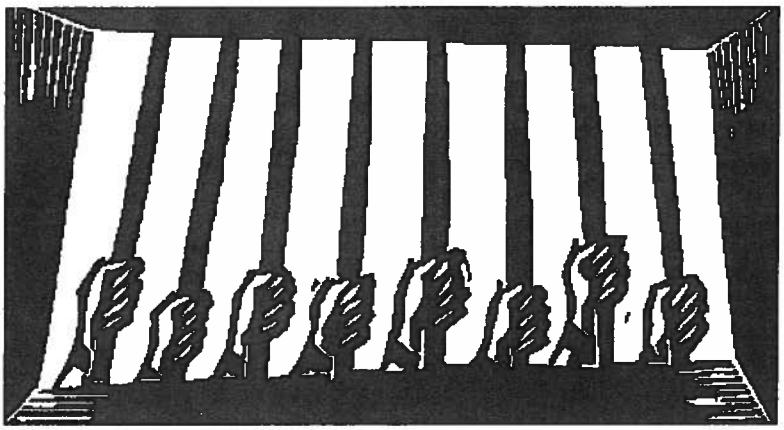
However a medical team at Britain's Oxford University reported defects among children whose mothers had undergone CVS. Five out of 289 infants had missing fingers, shortened limbs, or an underdeveloped jaw and tongue. Other medical centres have reported similar cases.

Expectant mothers concerned about their fetus' development can still opt for the amniocentesis test. It occurs later in the pregnancy between 15 and 17 weeks. Both procedures require anywhere from 2 to four weeks of laboratory testing to obtain the results.

Both tests can identify a wide range of disorders, including muscular dystrophy, cystic fibrosis and Tay-Sachs disease.

WHS

Protecting inmates from HIV infection



PASAN Brochure

The AIDS crisis in the federal and provincial prison systems is a result of government inaction claims a brief to the Ontario Minister of Correctional Services and the Ontario minister of Health last June. The brief was compiled by PASAN (Prisoners with AIDS/HIV Support Action Network) a coalition whose membership includes ex-prisoners and representatives from different community-based organizations.

PASAN advocates for the development and implementation of suitable provincial and federal policies on HIV/AIDS in prisons. The recommendations in the brief include comprehensive education and prevention programs, support and medical services and voluntary and anonymous testing for prisoners.

While comprehensive education for both inmates and staff is still the best prevention, PASAN says inmates do not have the information nor the resources to protect themselves. Federal institutions have started condom distribution programs for men and condom and dental dam distribution for women. However, provincial institutions have not made these or other safe sex materials available, creating a risky environment for men and women; but for women inmates the risks are even greater.

Prison officials in women's prisons continue to deny sexual activity between inmates and between prisoners and staff. This leaves women inmates unprotected and vulnerable to infection.

The majority of women in prisons are members of social groups that are even further marginalized on the basis of race, class, literacy, disability, sexual orientation, substance use and/or occupation (such as sex trade workers). In its brief PASAN stresses the need for education and recommends that all education and prevention information for women be culturally sensitive and gender specific, highlighting symptoms experienced by women, their reproductive concerns, and prevention such as barrier methods.

PASAN also suggests that needles, often used in prisons for intravenous drug use and tatooing, be replaced by needle exchange and bleach kit distribution programs to prevent HIV transmission. Tattoo equipment, they suggest, could be supplied for extra safety.

PASAN proposes the establishment of joint ministerial task forces at both the provincial and federal levels. In consultation with prisoners, community groups, and staff unions, these task forces would respond and hopefully take action on the recommendations presented in the brief.

NICCI COHNSTAEDT

Sheila Jennings Linehan

giving birth the "white man's way"

There is an ongoing discussion in the medical community on how to improve the delivery of medical services to the First Nations of Canada. Certainly Inuit communities want access to surgeons, ophthalmologists, pediatricians and general practitioners, for the times when they want or need medical care. Such communities actively solicit these services from physicians. However, the most aggressive "advance" of medicine into the North is clearly in the area of obstetrics. Most physicians have accepted the need for the "colonization" of childbirth in the North, and believe that Inuit women are in desperate need of "modern" medical management, and that they have been and continue to be grateful to be on the receiving end of it.

However, physicians are turning what the Inuit experience as a natural event into an event requiring medical intervention by forcing Inuit women to give birth in hospitals in the south. In doing this they are creating a market for their services at the risk of losing the Inuit's collective knowledge of birth.

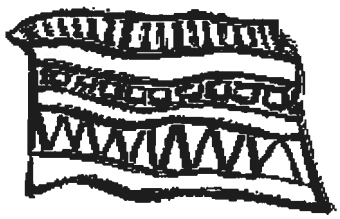
Flying in specialists and setting up a referral centre is one thing. But flying out all pregnant women, on their own, against their will and the wishes of their families and communities in order to force them to have southern-style deliveries in a hospital, is quite another.

This compulsory hospitalisation is not something that takes place only at a woman's due date; rather, the so called "evacuation" occurs for a time that ranges from two weeks to two months before the due date. When evacuated, Inuit girls and women are commonly billeted in boarding houses until delivery. Giving birth is a major life event that is definitely familial in nature. Forcing teenage girls, young mothers and mothers of large families to go it alone is cruel. Southerners would not tolerate this, why should northerners.

Years ago the Inuit resisted the effort to force women to deliver at nursing stations staffed by British-trained midwives instead of in their homes. Ironically, the government decided that while midwives were not acceptable for women in the rest of Canada, they could be tolerated for the purposes of preventing Inuit midwives (many of whom are men) from assisting Inuit women in the communities where they worked.

The legacy of quiet resistance by the Inuit to the medical co-optation of birth continues, manifesting itself in various forms. One form is when women delay reporting a pregnancy to create confusion about when they are due. Another is waiting to go to the evacuation centre until labour is so far advanced, it is impossible to get the woman onto a Medevac flight. These practices compromise the safety of the mother and child, but illustrate, at times the only way Inuit women can resist the practices being foisted on them.

Physicians are turning what the Inuit experience as a natural event into an event requiring medical intervention by forcing Inuit women to give birth in hospitals in the south



In 1987, I read an article by Drs. Pierre Lessard and David Kinloch in the *Canadian Medical Association Journal*, entitled, "Northern Obstetrics: A 5-Year Review of Delivery among Inuit Women." I remember feeling that there was something unpleasant about the article, but I could not put my finger on what it was. Now I know. Like all the literature I had read on Native healthcare it did not consult Native people —it simply put forward the wants, needs and opinions of the physicians. It smacked of paternalism.

After reading another article earlier this year in the *Medical Post* on the Stanton Yellowknife Hospital finding a new purpose as a referral centre, I sought literature on maternity care written by Native Canadians. I contacted the Ottawa offices of the Native Women's Association and the Pauktuutit (The Inuit Women's Association).

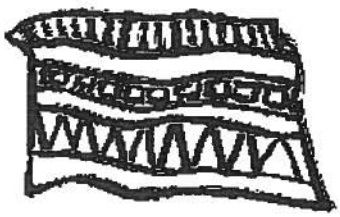
The Native Women's Association directed me to a book called *Gossip: A Spoken History of Women in the North*. It is a collection of works by Native and non-Native women involved in the North, and if there is any doubt that Inuit women are discontented with what the Inuit call "giving birth the white man's way," a quick reading of the book dispels it.

Says Marie Kilunik, an Inuk woman: "In the old days I thought I was going through a rough time. That was before the white man came, but now it's worse for the young girls because of the white man's ways. I worry a lot that girls go south into hospitals to have their babies. I felt so homesick. I didn't know what to do when I was away from home for so long. ....I was worried about my husband and kids. I think that women should have their babies in their homes, in their own beds."

Inuit Elders speak about their own experiences with birth in this book as well as their present concerns about the southern control of birth in the North. A major concern of the elders is the practice of their daughters and granddaughters being forced to lie on their backs with their legs up in stirrups (the lithotomy position). A further concern is their daughters' enforced isolation from family, friends and community. The elders also commented on the widespread use of drugs and anaesthesia during delivery in hospitals. Finally, the elders raised concerned that women return from "away" cut and stitched. They attest to a very low perineal tear rate from their midwife-assisted deliveries and do not understand why women fail to return home with an intact perineum.

I know two nurses and one physician involved in delivering Native women in the North. The nurses say, Inuit women frequently balk at getting into the lithotomy position because they prefer to deliver squatting and refuse to hand over their infants to be cared for by complete strangers. *Gossip...* quotes one Inuit woman as saying, "I'd always had my babies in the squatting position. But when I had my oldest son, they took me to Fort Simpson. I didn't like being on my back, I wanted to be in the squatting position, so I stayed in that position until just the last minute. They had to push me down on the bed to have my baby that way, even though I didn't want to have it that way."

"a pregnant woman is supposed to be in harmony. Pregnancy is not a sickness."



Martha Greig is the National Health Coordinator with Pauktuutit. She is Inuk and since 1987, she has been involved in the organization's annual meetings where resolutions have been drawn up on the practice of evacuation. I spoke to Martha about birth in her community (both her grandmother and grandfather were practising midwives). She told me "a pregnant woman is supposed to be in harmony. Pregnancy, she says "is not a sickness."

Greig emphasizes that Inuit women have a totally different perspective on pregnancy than the view held in the white man's world:

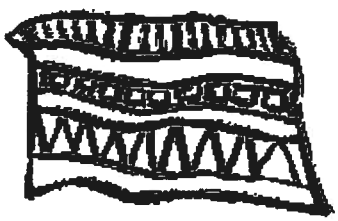
"In the 1940s, the Inuit lived at outpost camps and there were only Inuit midwife deliveries. In the late 1950s, the white man told the Inuit that they had to form into communities. The kids had to go to school and nursing stations were set up. In the mid-sixties some regional hospitals were set up, but occasional births still took place at home with the Inuit midwives delivering. In the early 1970s all women in their first or greater than fifth pregnancies were sent to regional hospitals, while all other births took place in the nursing stations. By the mid-1970s, all pregnant women were evacuated.

"Inuit women were moderately satisfied when the Department of Health and Welfare recruited British trained midwives who delivered in the communities. However, policy changed and suddenly new nursing graduates with little or no obstetrical experience were being sent up North. This was to promote Canadian nurses. All pregnant women started being evacuated. This practice is very hard for the woman's husband and other children; this was especially so in the winter because they could be gone for three or four months.

"Nowadays when a woman wants to remain in her community she must give birth in a health centre. This is hard because the woman is made to sign a waiver releasing the nurse from all liability for any faults on the part of the nurse or any problems if something goes wrong. This is risky. In view of this, some women choose evacuation instead and fly to a southern hospital even though they don't want to go."

Greig mentioned an alternative some Inuit women find palatable—a centre at Povungnituk in Northern Quebec where both local women and evacuees come to give birth. A team of three Inuit midwives works there year round. She said the aspect of having to live in a strange place and all the other attendant problems associated with evacuation still make Inuit women miserable, but the situation is tolerable since the women can give birth as they choose and can communicate in Inuktitut with their birth

Inuit people, specifically Inuit women, were not asked if they wanted southern obstetrical practice before it was foisted upon them



attendants.

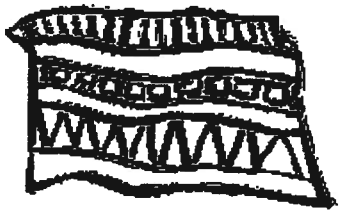
She says the Native midwives at the centre do not work in shifts —Inuit women like to avoid the stress of changing birth attendants according to the clock. The Inuit midwife remains throughout labour, no matter how long and is dedicated to ensuring a drug-free labour and delivery.

The Inuit of Povungnituk, Greig explains, are conservative in the way they want to preserve Inuit culture. When the community heard of the intention of the government to build a hospital in the Hudson Bay area, they got together and formed a committee that put forward their proposals for maternity care. Although midwifery is not legally recognized in Quebec, they got what they wanted— a birth centre where husbands, partners or family members could stay with the pregnant women, where the women could bring in a labour coach, and where deliveries were conducted by Native midwives.

Although there are many Inuit women who would describe themselves as home birth advocates, Greig says "I prefer a centre such as the one at Povungnituk. I think it is good to have medical back-up if an emergency comes up. My ideal birth is a birth centre like Povungnituk where Native midwives work and have received further training from southern midwives. The way things are going with midwifery in the provinces, I am confident that Inuit midwifery will become re-established in the North in the near future. When that happens Inuit women will reap the benefits of both worlds."

There are several Canadian academics conducting research in this area. Dr. Patricia Kaufert with the Department of Community Health Sciences at the University of Manitoba, has been tracking the erosion of Inuit childbirth practices and traditions for some time. Kaufert says that the trend towards southern control over childbirth is perceived in the North not only as a hardship for Inuit women, but as a threat to long-term cultural identity and survival. It is experienced by the Inuit in a political context even more than a medical one. Many Inuit are concerned when their children are forcibly delivered outside the boundaries of the North West Territories. Inuit worry about their children's future rights to special status entitlements, which have been important in the past in economic benefit determinations. Nothing a southerner can say can remove this concern.

The trend towards southern control over childbirth is perceived...as a threat to long-term cultural identity and survival. It is experienced by the Inuit in a political context even more than a medical one



One of Kaufert's studies examines the delivery of obstetrical care given to Inuit women in the Keewatin Region of the Northwest Territorities. The epidemiological component of this study included an audit of the obstetrical records for all women in the area who gave birth from 1979 to 1985. After examining the data, researchers concluded that there had been a misuse of the rates, numbers and statistics by policy makers to justify extending medical control over Inuit childbirth.

Betty Anne Daviss-Putt has been a consultant to the Inuit Women's Association since 1985 and has been a practising midwife for 15 years. In all that time she says she has not come across a single Inuit woman who prefers a hospital birth, and she also attests to a profound distaste of the medical approach amongst Inuit women.

In *Gossip...*, she notes that the Northern Obstetrics Conference of 1987 in Churchill, Manitoba also exposed the faulty epidemiological rationale that is the basis for the belief that evacuations are the only safe alternative for Inuit women.

Kaufert's studies show increasing rates of cesarean sections, inductions and forceps deliveries amongst the Inuit, at a time when many southern obstetricians are being chastised by the World Health Organization and Canadian health activists for overly interventionist and heavy-handed approaches.

Although physicians who have been involved in obstetrics in the North attest that Inuit women tolerate all the stages of labour well, reasons to "augment" are still being found. This should concern us all not just on humanitarian grounds but on fiscal ones also.

In one of Kaufert's studies, which took place over a seven-year span in the Keewatin region, not a single woman died in childbirth. Maternal mortality rates are quoted often at the Inuit in an effort to get them to see things the southern way. Kaufert points out that for Inuit women, maternal mortality rates are an issue only as an event which is feared, not as a reality. Stillbirths and neonatal deaths are the realities that the women face frequently. These serious problems point to the need for better prenatal care which could and should be delivered by Native midwives who speak Inuktitut. The need for medical advice for the neonate is self

evident. This could be given by a nurse or a general practitioner. The infant mortality rate clusters around the first four weeks of life amongst the Inuit—a condition labelled "northern infant syndrome." Labour and delivery are manifestly not the problems. Importing specialists in the pathology of labour and delivery is unnecessary.

The excuse given for evacuation is that it is a sure fire method to save maternal and infant lives. But, evacuation is not always going to save a woman should an emergency cesarean section be required. For example, women are evacuated to Churchill Falls regularly, yet c-sections are not available in Churchill Falls. The reasoning behind evacuation to this particular centre does not appear to be the availability of this service.

A second rationale could be the need for a blood transfusion in the rare event of a hemorrhage. But, as Betty Anne Daviss-Putt points out in *Gossip*..., it would make more sense to cross-match the woman's blood ahead of time and forward it to a nursing station, than to evacuate the pregnant woman traumatically and at high cost.

Finally, Daviss-Putt notes that there is the assumption that the personnel waiting for the arrival of the evacuee in the hospital are better qualified than the personnel the woman just left. This she says is not always true.

There is also a strong sense of what Kaufert refers to as a "civilizing mission" among Canadian physicians who go to work up North. In the article, "Reconstruction of Inuit Birth," Kaufert and fellow researcher John O'Neil say: "...preoccupation with perinatal mortality rates transformed the death of a baby from a problem only for the individual women, her family and her community, into a concern for the Canadian government...."

O'Neil and Kaufert further state that control over childbirth became essential to ensure constant proof of the advantage of power, and that when speaking with individual Inuit women, they found a recurrent theme: their loss of control over the place of birth, its timing and its process.

Both researchers feel this loss has now become a metaphor for the loss of political control by the Inuit people over their lives and their communities. They point to an ongoing campaign by the Inuit people to regain power over childbirth as having become as much an item on the Inuit political agenda as it is an issue for the individual Inuit woman.

Inuit people, specifically Inuit women, were not asked if they wanted southern obstetrical practice before it was foisted upon them. The reason for this is obvious—if consulted, they would have wanted input into its implementation or resisted its implementation altogether...

Gossip points out that some researchers have concluded that midwives are the most suitable providers of obstetrical care in the North for both pre- and post-natal care in healthy women. The question is: Why the muted response to this finding within the medical community? Until real communication begins, control over birth will remain a profoundly political issue in Inuit culture.

Sheila Jennings Linehan is currently clerking in the area of Intellectual Property Law at a law firm in Ottawa. She will be called to the bar in February 1993. She is married and has two children: Rory, age two and Chloe age one. Rory was delivered by a midwife and Sheila says she and her husband hope to have one more child and to have a home delivery with a midwife.

For readers interested in more information, the Inuit Broadcasting Corporation has made an excellent video entitled, "Ikajurti: Midwifery in the Canadian Arctic," produced by George Hargrave, Dorothy Kidd and Ruby Arngna'naaq. To order by mail call: (613) 238-3977; or contact Pauktuutit, 200 Elgin Street, Suite 804, Ottawa, ON., ($30.00 for individuals; $75.00 for institutions).

Karen Sampson

BIRTH CENTRES

give women another option

When their family doctor suggested that Deborah and Bob Peacock should consider having their first child at the Family Birth Centre at Peel Memorial Hospital, they were not sure what to expect.

They had already decided upon natural childbirth, and came to the centre with an open mind. After touring the regular labour and delivery unit, they were taken to the birth centre.

"The whole attitude was different," Deborah said. At the centre, "they focus on what you want, and in the regular delivery rooms they tell you what you will get."

It was 1989, just one year after the provincial government launched its four pilot alternative birth centres. Health ministry officials say that there was a demand for an alternative to conventional birthing methods, and women wanted the right to exercise control over their childbirth. In March of 1988, then minister of health, Eleanor Caplan, announced a provincial commitment to fund several demonstration project birth centres. It has been an experiment which has proven to be a huge success. There are two centres in the Toronto region, one in Ottawa, and one in Thunder Bay.

A health ministry official said that the office of the policy and support branch received 19 proposals from hospitals across Ontario for the demonstration project, and they narrowed it down to four. She said the ministry worked closely with the hospitals, all of whom have had experience with family-centred birthing, to develop guidelines for the centres. Hospitals were allocated $100,000 per bed, she said. The project, originally funded for three years, has been extended to four, and this is the third year, she said.

With six birth rooms and a staff of 14, the Family Birth Centre at Peel Memorial Hospital is the largest. The rooms are more like bedrooms than hospital rooms and are tastefully decorated. Two of the rooms have double beds and each room comes equipped with a basinette and a change table for baby.

More than two years after Deborah delivered their son, Jason, the Peacocks cannot say enough about what they describe as a "wonderful" experience. They are now members of Peel Memorial's Parent Advisory Committee, which meets once a month and regularly conducts information tours to

expectant mothers and their companions. Committee members have recently started going to community prenatal classes to let expectant parents know about the centre. It is basically a public relations body which supports the staff and eases the promotional workload for the nurses.

For the expectant mother contact with the nursing "team" begins at approximately 17 weeks of pregnancy. The expectant mother is assigned two staff members who will divide care for the duration of the pregnancy. Four to five prenatal visits are scheduled, alternating with visits to the family's obstetrician. The focus of the visits is education, and the women feel that this preparation is vital to their well-being.

For the Peacocks, the best thing about Jason's birth was the continuity and support they got throughout the pregnancy from their nurse-midwife, Ethel. "We were so prepared for the birth," Deborah said. "It was because of Ethel, she made me feel so comfortable and relaxed about the whole centre. I very strongly feel that it was a large, contributing factor to having a comfortable labour and delivery."

The nursing team is on call 12-hours-per-day each, and they carry pagers. Deborah said that knowing the support is there for any problem or question which comes up is very reassuring. The families develop a relationship with their nurse midwives, which goes a long way to help them relax when the moment finally arrives, and labour begins. The close contact continues after the birth, as the nurse midwife visits the family at home at least two times during the first week, and once or twice in the second.

Deborah said that the post-partum support was "unbelievable." In the first few days she had a great deal of difficulty with breastfeeding her baby, and her breasts were painfully engorged. At her wits end, and certain that she could never breastfeed, she called Ethel, who "came right over." Ethel spent a great deal of time with her, suggesting different positions she might try, and helping with hot compresses. "She was so wonderful. It made it so much easier. And I went on to breastfeed for 13 months."

Karen McKinnon was the managing director of the Peel Memorial's birth centre until mid-October. She is a registered nurse with midwife experience who firmly believes that women need to have options made available to them in childbirth and that the time of being told how to give birth is long past. She also gave birth to her second child two years ago at the centre. "Although healthcare professionals think they know what's best for people," she said, "we have to start listening to what [women] want." Not all women want the same things in childbirth, she said, and alternatives such as the four Ontario birthing centres are a big step forward for the healthcare system.

McKinnon stresses that natural birthing is not for everyone. "This is not the only way to have a baby," she said. "There are people who can't have this for a medical reason, and there are people that don't even want this option."

But she said birth centres fulfill a need for education. They also enable women to be actively involved in their labour and delivery, and to include whomever they want in the experience. Children are welcomed to attend the birth, she said. "We have had good experiences with children at the birth. We leave it up to the families because we believe they know their children best." McKinnon adds: "There is a whole group out there that are very interested in self-help. The women want to learn as much about pregnancy and birth as they can."

Not all women want the same things in childbirth. Alternatives such as the four Ontario birthing centres are a big step forward for the healthcare system.

Many of the routine factors of conventional childbirth, such as fetal monitoring, episiotomy, medication, and a hospital stay of several days are not always necessary, McKinnon said. "We tend to have a lot of things that are routine," she said. "Having worked in a high-risk prenatal centre, I'd be the first to tell you that they are useful things. It's when you apply them to the normal population that you have to wonder about whether it's the right thing to do."

Mother and child are discharged from the birth centre in less than 24 hours, McKinnon said. Because alternative birth requires less expensive machinery and a much shorter stay, she said, the costs are much lower, which is a bonus for our overburdened healthcare system.

Pain management is one of the big attractions of the birth centres. Women who have decided to have a drug-free birth need to know how to cope with pain, and prenatal classes begin around 16 weeks. Each birth centre is equipped with a jacuzzi, which McKinnon said is the most popular form of pain relief.

"It's extremely effective," she said. "We can do a lot with this room. We dim the lights, put on music, and get Dad in there rubbing Mom's back. The feedback has been marvelous." (Parents are asked to fill out a questionnaire after the baby is born, and the results are used for statistical purposes, as well as support material for small research studies.)

Some pain medication is available, said McKinnon, namely Demerol, for women experiencing a long, exhausting labour, and Entinox, a form of "laughing gas," used to relieve intense contractions. "[But] we don't push it," said McKinnon.

The decision to have an epidural, which blocks feeling from the waist down, is a personal one which may arise during a hard labour, she said. "We don't tell women they can't have one, if they really need it. But it's an anesthetic, which requires administration and monitoring at the labour and delivery unit. The mother is transferred out of the centre, but a staff member goes with her if at all possible," said McKinnon.

Although the mandate of the centre is to intervene in the birth process as little as possible, the safety of mother and child is, at all times, prevalent. The labour and delivery unit is right down the hall, and if for any reason a complication arises, the mother can be transferred out of the centre in three minutes or less.

Diane Morrison is the chairperson of the Parent Advisory Committee, and a two-child veteran of Peel Memorial's birth centre. Both of her children were delivered prematurely, which meant that she had to be transferred out of the birth centre. Even though her children were not delivered there, she said she

Phyllis Wong Kun

and her husband, Scott, still benefited from the support and comfort provided by the program.

In both cases, her water broke about six weeks early, and she was sent to the labour and delivery unit. "Even though I laboured three quarters of the time in regular delivery," she said, "our nurse, Margo, came with us, as a support person. As soon as she walked in, we both visibly relaxed."

Morrison said that the difference in experience at the birth centre and in labour and delivery was tremendous. "In regular labour and delivery, there was no support," she said. "The first thing they offered me was a sleeping pill. We saw our nurse maybe once an hour. Once Margo got there, I relaxed and it never crossed my mind to take something. My last few hours of labour were a wonderful experience."

Morrison advocates using the birth centre for couples who, like Scott and herself, want to experience "labour without interference." They turned to the birth centre after being referred to an obstetrician with whom "everyone ended up with a cesarean section," she said. They wanted to exercise their options. "Childbirth is a natural process, and shouldn't be tampered with," she said. After meeting the staff at the birth centre, they decided that it was what they really wanted.

Because the role of the staff at birth centres is central to their success, Lynda Pecora, a nurse at Scarborough Grace General Birthing Centre, said that dedication is pretty well a given in the program. She has some 25 years of obstetrical nursing experience, and says she and her colleagues believe in "pro-active-choice."

When she delivered her own children 21 and 22 years ago, she said, it was a "horror story." Like most women at the time, she said she delivered lying flat on her back, with little prenatal or postpartum support. "Some people need to be in general labour and delivery," she said. "They don't want control, and I believe they have a right to that. It's not like you can't have a good and happy birth that way. But it all comes down to choice," she said.

Giving families back the control over their births has "taken doctors off their pedestal," Pecora said, but in a positive way. The doctors who work with the birth centre are also pro-active, she said, and are meeting the demands of their patients for family control. Many hospitals are practising family-centred birthing anyway, she said, and they do "try very hard to accommodate the demand."

Dene Speers and her husband, Richard, chose their doctor from a list supplied by the Peel Memorial centre for the birth of their first child together, and they were thrilled with their doctor's support of their wishes. "She basically told us that anything you want, you can have," Dene said.

At the writing of this article, Dene was expecting her fourth child in a few days. She has experienced virtually everything when it comes to birthing methods. Her first child, a girl born 13 years ago from a previous marriage, was delivered at home by a midwife. She describes that experience as the "best." Her second child was born at a hospital, which she rates as the "worst."

"There was no comparison between the hospital and the planned home birth," said Dene. "It was wonderful to have a midwife, although 13 years ago that was something of a taboo. Had there been a birth centre," she said, "I may have chosen that route."

Her third child, and Rick's first-born son, was born at the birth centre, because he was not comfortable with a home birth.

She learned a lot from her first experience at the centre, she said, and will do some things differently this time. Her sister-in-law was there which prevented her from relaxing as much as she would have liked. This time, she says, it will be just her and Rick.

Karen Sampson is a freelance writer living in Toronto.

BIRTHTALES

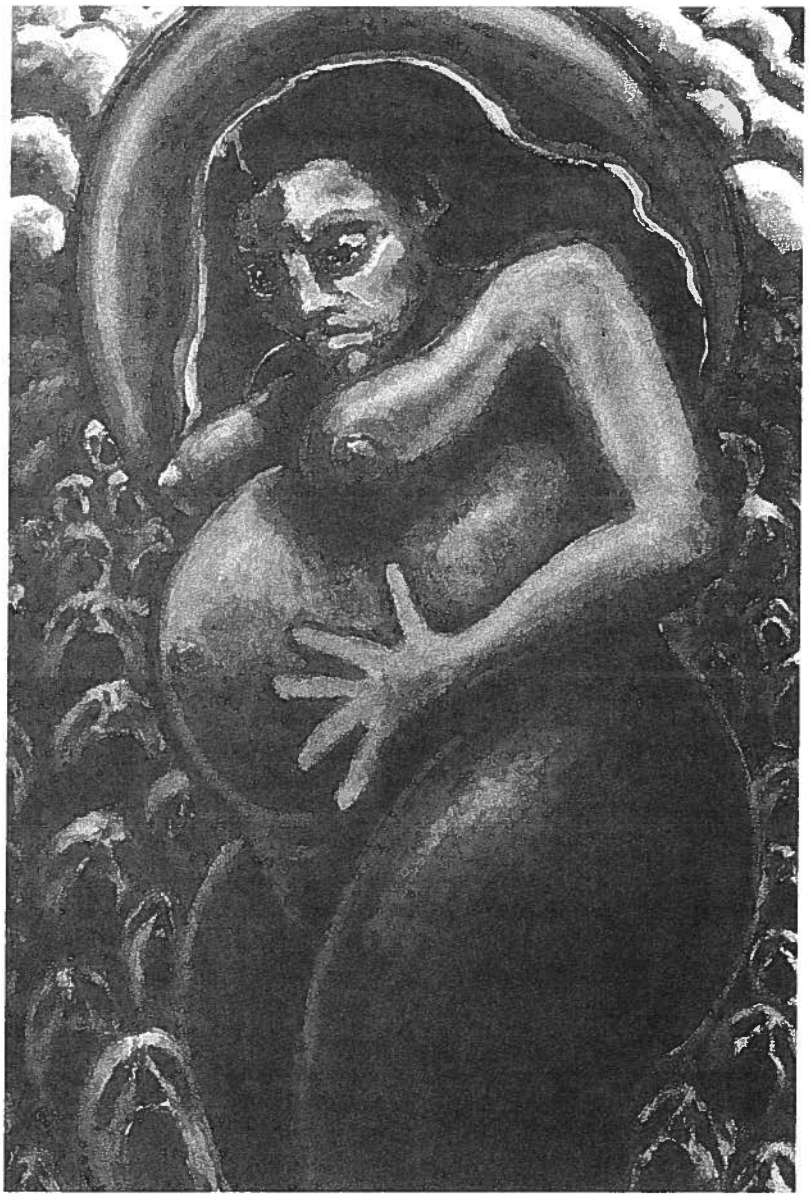
The artwork shown on these four pages is a small sampling of the evocative pieces featured in BirthTales an exhibit and workshop series on childbirth. Curated by Debbie O'Rourke and coordinated by Bonnie Burgess, BirthTales was specifically created to explore a new way of exposing medical students to information on the emotional effects of giving birth, as well as provide the public with a place to celebrate, marvel, or seek comfort in the wonder of birthing.

Forty-two artists were chosen from over 100 responses to a call for artwork dealing directly or emotionally with birth.

Work was selected to portray all the stages of pregnancy through lactation, covering both positive and painful experiences.

The exhibit was shown from March 14 to April 25, 1992 at A Space Gallery in Toronto and at the University of Toronto Medical School from March 23 to 29, 1992. In addition to the exhibit at the medical school, a "Caesarian Section Panel" discussion addressed the emotional aspects of this procedure and "Tradition, Technology and the Ecology of Giving Birth" spoke about indigenous and old-world midwifery traditions. The University of Toronto segment ended with a powerful afternoon of storytelling.

Video documentation of the event by Fay Cromwell will be available in 1993. The curator is presently searching for a publisher so that this collection of art and writing will become available in book form.



Sheila Hannon, Toronto, Ontario, Red Sky in the Morning oil on hardboard, 4' X 6'

I wanted to describe my first birthing experience. At first I tried to accurately document it. I finally decided to paint how I felt instead:

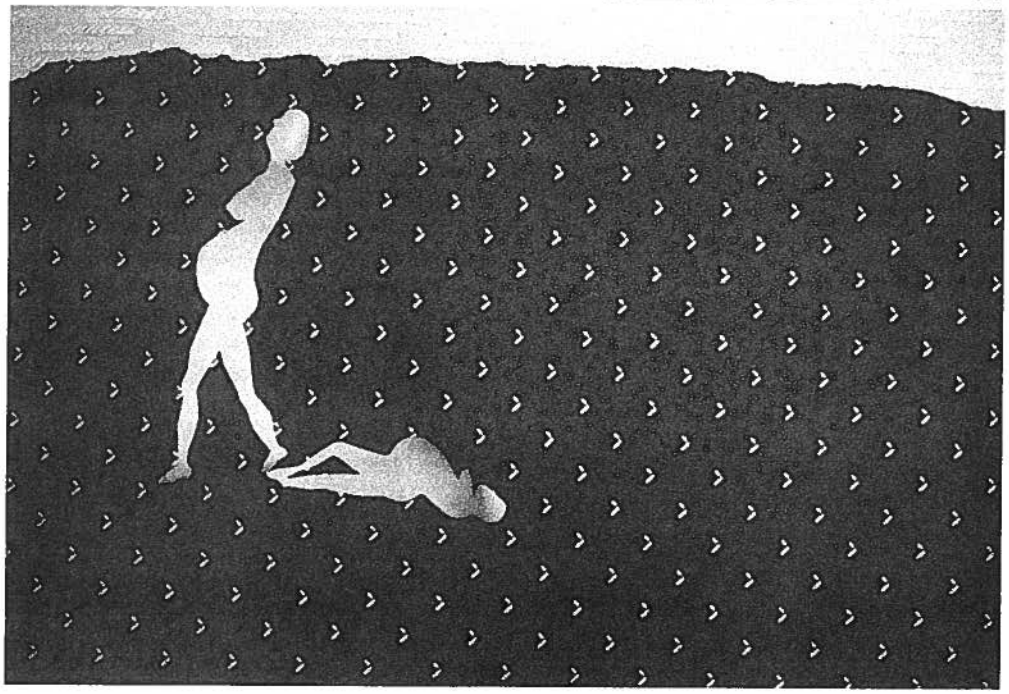
betrayed - my doctor knew I wanted a "natural" birth. I was not prepared for what happened to me.

silenced - it was assumed that I didn't know what was best for me and so I was never consulted. I was a naive, young girl. They knew what I really needed...

raped - spiritually, emotionally, physically, sexually as if my body was not mine anymore but somehow separated from my self lying there on the table to be used like some laboratory animal.

trespassed - what was the most sacred and intimate part of me was laid bare, exposed, made into the property of the doctor to be meddled with and taken from me without consent.

The works included here are part of a series dealing with pregnancy in two women —my mother and me.



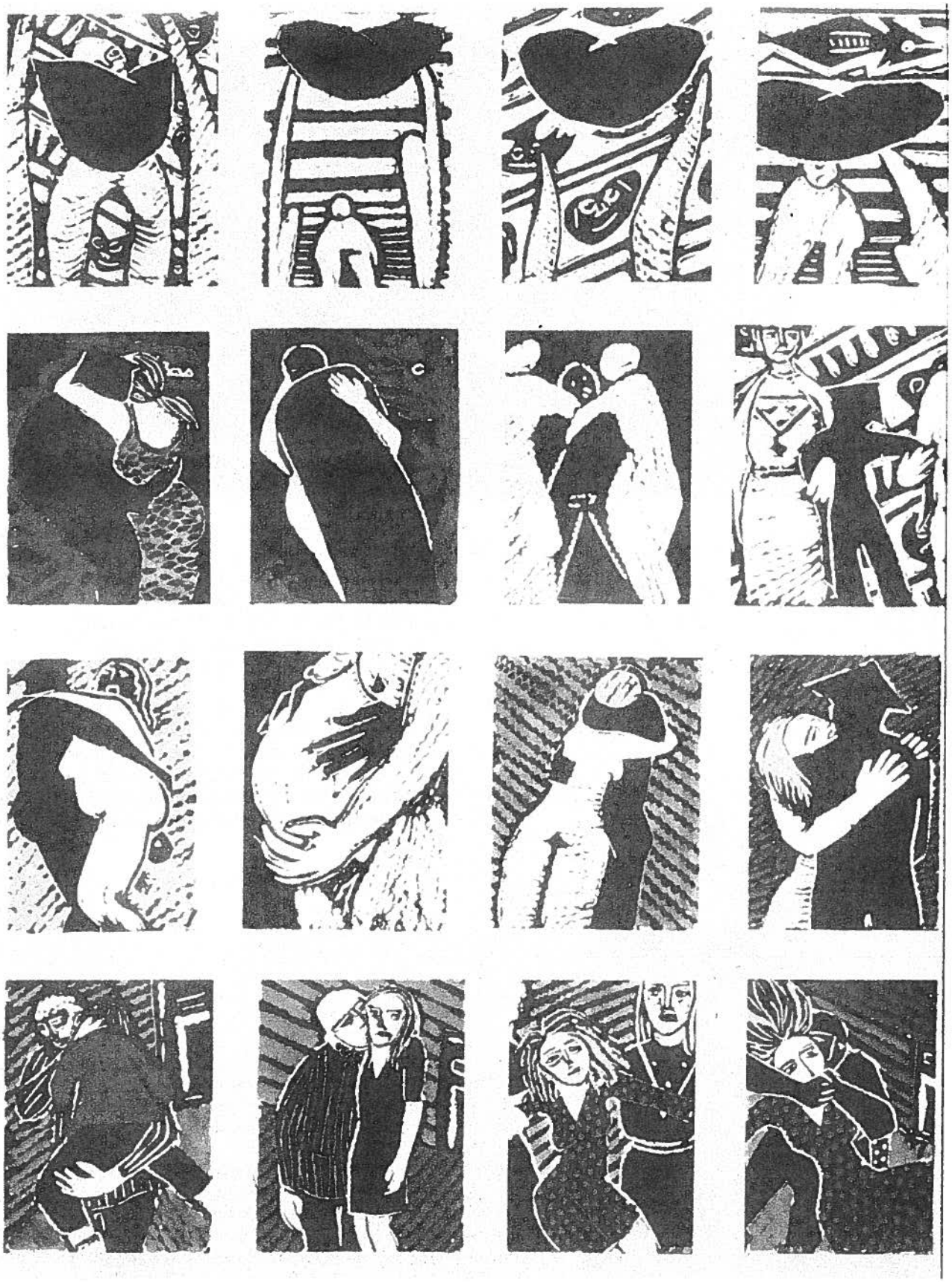
Doris Muise, Dartmouth, Nova Scotia, Necessary Detachment collage, gouache, wallpaper

▲ This is part of a series of collage pieces which examine my direct experiences with pregnancy. I was overwhelmed by a variety and intensity of emotions: isolation because of my sometimes negative thoughts about impending motherhood which are generally considered unacceptable in women; and sensations of wonder, of becoming two, of metamorphosis; or, in darker moments, feeling like my body was mutating out of control. Here the wall paper provides a backdrop against which the figure is thrown into an emptiness somewhere between an endless expanse of surreal landscape and torn fragments of wallpaper.

Doris Muise, Dartmouth, Nova Scotia, Breaking His Flask gouache on wallpaper

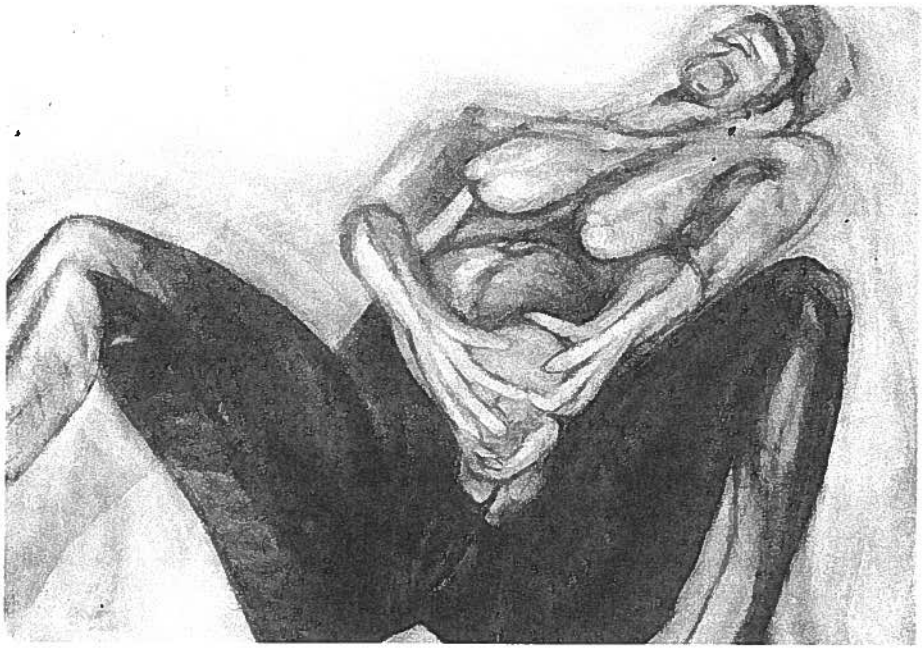
◀ Documents my struggle with the fact that for over a decade and a half my mother spent most of her life in pregnancy — with minimal support from my father.

Contemplating my own feelings about pregnancy led to a need to provide myself with a clearer picture of what it must have been like for my mother reproducing year after year. This involved dealing with the relationship between my mother and father where alcohol inevitably came into play. In trying to depict the confinement of her domestic situation, generic wallpaper seemed to provide an appropriate backdrop for the ordinariness of their situation in rural Newfoundland.



Rochelle Rubinstein, Toronto, Ontario, Black Heart
linocuts, dyes, 36" X 27"

Agatha's most recent drawings deal primarily with the themes of birth and motherhood. She exhibited some of these at a show entitled "All Things Confine" in Toronto and at the Lake Gallery as part of "The Secret History of Toronto Painting." She has been exhibiting professionally for over 20 years, her work ranging from pen and ink landscapes to installations of memory drawings. She currently teaches drawing at York University.



Agatha Schwager, Toronto, Ontario, Pain gouache, 95 X 130 cm

Shirley Cheechoo is a member of the Cree tribe and one of the most dramatic talents in the creative arts today. Shirley's paintings represent her personal documentation of childhood memories growing up within a warm extended family along the northern trap lines. Her art style, consistent with her concern to record this earlier lifestyle, is simple, clear and precise while evoking a richness of feeling.

This artwork consists of 16 linocut prints which can be read in a variety of directions to tell about a woman's seduction, repression, coercion, victimization, as well as the beauty and glory of her sexuality, her pregnancy, her labour, her birth. There is a black heart which weaves its way through the narrative, often changing form: from black heart to dark cloud to shadowy male figure to stern female figure in a black uniform. The form is always near the woman.

Shirley Cheechoo, West Bay, Ontario, Who's That? The New Baby and I Have to Watch Her acrylic on canvas, 16" X 20"

Jan Darby

Sex & Punishment

The Politics of Cervical Cancer

Cervical cancer is one of the most common reproductive cancers among women worldwide. Women living in developing nations, poor women and women of colour are at greatest risk of dying from this disease. In Canada and other wealthy nations, women are subject to mass screening, intrusive diagnostic procedures and destructive treatments in an attempt to "prevent" the disease. Therefore, the question of what causes cervical cancer has profound implications for women's lives and health.

Medical research has found associations between cervical cancer and a variety of possible causes, such as smoking, oral contraceptives, talcum powder, and the long-banned drug DES, a synthetic estrogen prescribed to pregnant women to prevent miscarriages which has been linked to the occurance of a rare form of cancer in women who have taken the drug and their children. In addition, feminist health activists have pointed out the potential role of other factors, such as Depo-Provera, a long-term injectable contraceptive, environmental and occupational carcinogens, nutritional deficiencies, and tampon use. Within the medical literature, however, the risk factor which receives the greatest attention is that of a woman's sexual behaviour.

This research focus has a long history. Contemporary medical literature often refers to a study conducted in 1842 by Rigoni-Stern, who compared the incidence of certain types of cancer between cloistered nuns and women in the general population. This study is said to have demonstrated the absence of cervical cancer among "virginal" women, and has given rise to the prevailing theory that the disease is caused by women's "promiscuity".

A great deal of effort has been expended by modern medical researchers in the attempt to substantiate this misogynist theory. Innumerable studies have been published which link cervical cancer to a woman having more than one (hetero)sexual partner or having intercourse before the age of 20. Liz, a white, heterosexual woman in her thirties, recounts her experience of being unwittingly recruited for one such study: "When I went in [to the clinic], I was asked to fill out a form. And one of the questions that really shocked me was how many men I had had sex with. And I thought - I mean, obviously this is a question that is going to be used to do a study. And I thought, how dirty! They get you in here to treat you for cancer and then use you for data. And I sat there trying to figure out who I'd slept with, and thinking, this is ridiculous and this is invasive! And so I just simply didn't answer that part, I just left it blank."

Rhoda, a white, lesbian, reported being asked similar questions about her sexual behaviour by the health professionals treating her for severe cervical dysplasia, a condition believed to lead to cervical cancer: "I go in there, and they ask me, "Okay, how often do you have intercourse?" "Well, I don't." "When was the last time you had intercourse?" And I have to think, "Oh, ten years ago - once." [laughter] And they still don't get

it, they don't even consider it."

Having collected their data on the number of male sexual partners and age of first intercourse of women with cervical dysplasia and cancer, medical researchers not only use this information to support their claim that cervical cancer is caused by women's "promiscuity," they also cite this data as evidence that cervical cancer is a sexually transmitted disease (STD).

Over the years, medical researchers have first proposed, then accepted, and later rejected, a succession of sexually transmitted disease organisms as the probable cause of cervical cancer. Early research centred on the "classical venereal diseases," gonorrhea and syphilis. When evidence for the causal role of these organisms waned, researchers were nonetheless reluctant to give up their theory that cervical cancer is a STD. Other STD organisms presented as possible candidates include trichomonas, mycoplasma, cytomegalovirus and chlamydia, all of which have been dismissed as unlikely causal agents.

In the late 1960s and early 1970s medical researchers argued that HSV-2, the genital herpes virus, was responsible for the disease. Indeed, many doctors accepted the evidence linking HSV-2 to cervical cancer as conclusive. However, in 1976, a new theory was presented which suggested that human papilloma virus (HPV), the virus which causes genital warts, was the cause of cervical cancer. This theory gained wide acceptance in the 1980's, supported by numerous clinical studies.

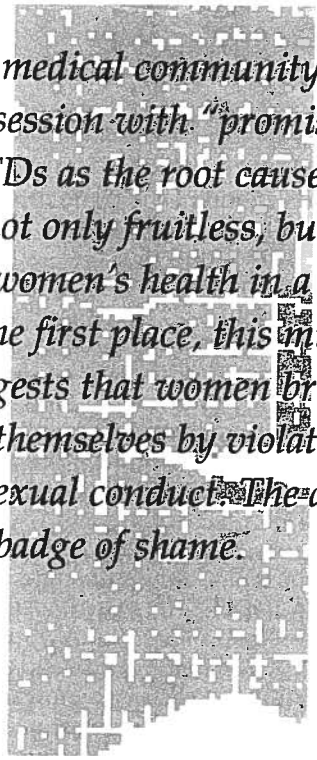
Sarah, a heterosexual, Jewish woman who has been diagnosed as a DES daughter, found her doctors more willing to assume that her abnormal cervical cells were related to HPV than to DES: "Another thing, too, that they told me initially, was that it was sexually related, and that it was papilloma. But there was no papilloma. So afterwards, I said, "Is this related to DES?" "Well, no. It's sexually related." "Are you sure?", "No." And there was no papilloma at all. So what is it?"

In fact, the HPV theory was so strongly supported in the medical literature that even some feminist critics accepted HPV as the cause of cervical cancer. For example, Toronto journalist Alison Dickie, in an article entitled "Scraping the Surface: Politics and the Pap Smear," which appeared in a 1989 edition of *This Magazine*, stated, "both dysplasia and cervical cancer are caused by a virus transmitted by men. For at least 10 years the human papilloma virus (HPV) has been targeted as the cause of dysplasia and, ultimately, cervical cancer."

Yet, recently, the evidence supporting this theory has been re-evaluated by some medical researchers. Muñoz and Bosch, in a 1989 WHO(World Health Organization) report, argued that the existing studies linking HPV to cervical cancer "were not planned as full epidemiological investigations and so none of them satisfies the usual criteria of design and analysis which would ensure the control of bias, confounding and chance in their interpretation." Clive Meanwell, a Swiss researcher, makes similar methodological objections to these studies, claiming the evidence is "severely limited."

Medical researchers remain undaunted, however, in their quest for a sexually transmitted cause of cervical cancer. As the HPV theory comes under critical scrutiny, new research now suggests a link between cervical cancer and Epstein-Barr virus (EBV). While EBV is not normally considered a sexually transmitted disease, at least one research team has argued that "the demonstration that EBV replicates in cervical epithelium raises the possibility of venereal transmission." Having run out of candidate STDs, medical researchers investigating the cause of cervical cancer seem content to classify any organism found in cervical tissue as sexually transmitted.

The medical community's stubborn obsession with "promiscuity" and STDs as the root causes of cervical cancer is not only fruitless, but also detrimental to women's health in a number of ways. In the first place, this misogynist model



The medical community's stubborn obsession with "promiscuity" and STDs as the root causes of cervical cancer is not only fruitless, but also detrimental to women's health in a number of ways. In the first place, this misogynist model suggests that women bring this disease upon themselves by violating social norms of sexual conduct. The disease thus becomes a badge of shame.

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For example, Paula, a white, bisexual woman in her early twenties, did not tell her family that she had had an abnormal pap test, because, as she explains: "I had an idea in my head that this was something that was my fault, something I'd done wrong. It was something linked to sex, which in my family is really repressed. So, it wasn't something to tell my parents about."

Similarly, Fran, a 23-year-old, white, lesbian, who had been heterosexually active at one time, stated: "I have an incredible guilt complex, because I was really promiscuous when I was a teenager. And he [GP] said this [abnormal cervical cells] commonly happens... in young women who have had a lot of intercourse, or whatever. So, I felt incredibly guilty, and I felt like, "Oh yeah, that's it, this is my sins being paid for, right - I'm going to die, I'm going to die for it."

These feelings of shame and guilt, as well as the self-imposed isolation which may result, put unnecessary additional stresses on the health of women trying to cope with cervical dysplasia and cancer. Furthermore, the medical model implicitly supports repressive patriarchal restrictions on women's sexuality, presenting women's sexual autonomy as a health risk.

The most dangerous aspect of this medical model, however, is its narrow focus. Some medical researchers have even attempted to explain the higher rates of cervical cancer among working-class women, women who smoke and women who use the pill, by claiming that these groups of women are particularly "promiscuous."

While the medical community has spent literally the last century and a half trying to prove the theory that cervical cancer is an STD, risk factors such as environmental carcinogens and contraceptive drugs have not been adequately researched. For example, Jean Robinson, a British women's health activist, presented compelling evidence in 1981 that linked cervical cancer to carcinogens in the workplace of both women and their male sexual partners. Medical researchers, however, have chosen not to pursue this area of research.

"Cervical cancer is the most common cancer among women in the Third World. Depo-Provera may be a factor for this occurence."

Similarly, the Vancouver Women's Health Collective, in their pamphlet, "*A Feminist Approach To Pap Tests*," point out that "Cervical cancer is the most common cancer among women in the Third World. Depo-Provera may be a factor for this occurence." Although the World Health Organization studies indicate that Depo-Provera may double the risk of cervical cancer, few other medical studies into the effect of this drug exist.

Clearly, medical researchers need to broaden their approach to the causation of cervical cancer to take into account the complex social and environmental influences on women's lives. The current model, which portrays women as predominantly sexual beings, and labels our behaviour with moral terms such as "promiscuity," is based on misogynist assumptions about women, our bodies and our sexuality. While sexual behaviour may be a factor in the development of cervical cancer, it must be investigated in a non-judgemental way, and other possible factors must be given equal consideration.

Jan Darby is a graduate student at York University. She has also been active in the anti-rape movement.

Mary Neilans

Midwifery: From Recognition to Regulation

THE PERILS OF GOVERNMENT INTERVENTION

Anne Maranta, a practising midwife in Kingston, always warns prospective clients that they are taking risks. But the risks she cites are legal not medical.

She cautions, "Since there are no clear legal provisions for the practice of midwifery, we practise in an environment of unknown risk." That's because in Canada midwifery is only now beginning to be officially welcomed into the fold of the medical establishment.

Last November, Ontario passed Bill 56, establishing midwifery as a recognized profession. The new legislation means midwifery services will be covered under provincial health insurance and midwives will have access to hospital facilities. A side effect of government recognition is public acceptance of the midwife's role in advising and supporting the expectant mother throughout their pregnancy and delivery.

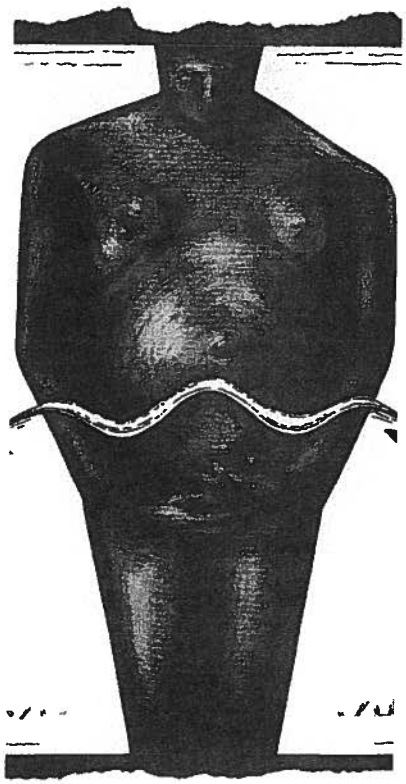
Since Bill 56, Ontario's subsequent decisions on how to regulate midwives are bound to have a precedent-setting effect on other provinces considering such legislation. As such, it is important to examine how any changes will affect the current role of midwifery.

History gives us reason to suspect the medical profession's newfound support for midwifery. Since the turn of the century, the medical profession has waged a concerted campaign to convince women that hospitals are the safest place to give birth.

Women eventually realized that access to medical intervention during childbirth is a mixed blessing. In the late 1970s, the demand for midwives increased largely due to a high medical intervention rate in the birthing process with uses of demerol, epidurals, episiotomies, forceps, and cesarean sections. Such intervention was more commonplace than many thought necessary.

As well, typical hospital practices did not meet the needs of most women: babies kept in the nursery to be bottle-fed, husbands or partners not made to feel welcome, and families allowed to visit only if garbed in gloves, gowns, and masks. As Anne Maranta wryly suggests, it was "not what you would call a family-centred birth experience." Women wanted more control over their child's birth. They wanted choices. And they wanted midwives.

The medical profession, however, was more than reluctant to acknowledge women's desires or meet their needs. In fact, in 1983, the College of Physicians and Surgeons of Ontario tossed statistics at women in an attempt to instill doubts about the safety of midwifery and home births. They referred to data from Great Britain



A controversy rages over the licensing of midwives

which suggested that the perinatal mortality rate for home deliveries was more than 60 per cent higher than the overall rate. A closer look revealed that these studies confused planned home births with the more general category of "out of hospital" births. Late miscarriages, premature births, taxi-cab deliveries, and unexpected births not attended by qualified caregivers were lumped together with planned home births. Ironically those same statistics demonstrated that births planned to occur at home with midwives in attendance were associated with lower rates of intervention and lower rates of complications than hospital births. In these cases, the perinatal mortality rate was extremely low, approximately two per 1000, compared to an overall rate of 14 per 1000.

Also in 1983, as a result of the need for greater public awareness on midwifery, a lobby group of health professionals and other supporters of midwifery formed the Midwifery Task Force of Ontario. The task force responds to any concerns about the qualifications of currently practising midwives by stating that the "midwife has always been a skilled practitioner. Modern midwives are trained through apprenticeships as well as in direct-entry training programs and in universities around the world. The negative image of the midwife as an unskilled and careless birth attendant was largely the creation of the medical profession."

Yet it seems the new legislation in Ontario responds to the myths rather than the facts. Newly-defined programs will replace traditional forms of training for midwives. The standardization of formal training for midwives would mean that all currently practising midwives would have to prove themselves, often going back to school for several years.

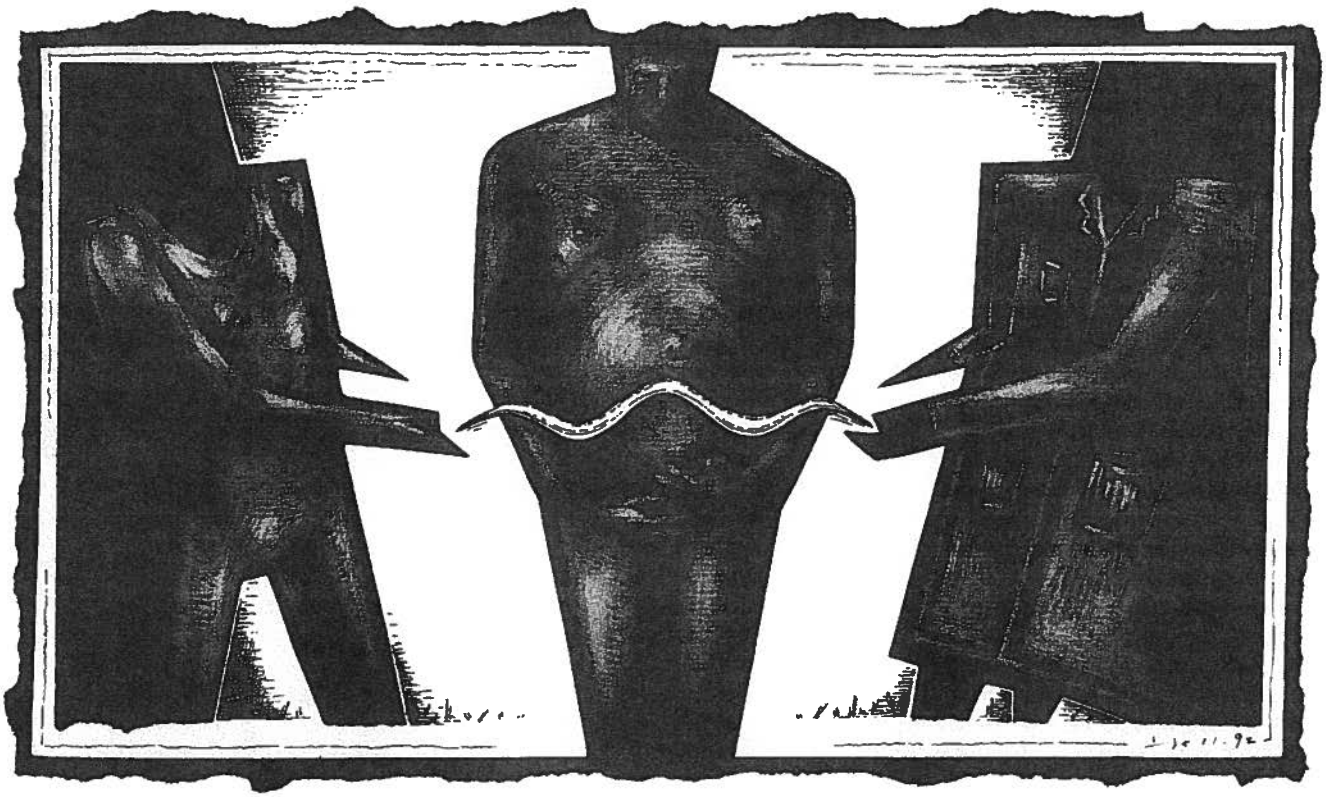
The approved schools, as well as meetings of any governing councils, would require attendance in large urban centres, most likely in Toronto. This would be difficult for many midwives, particularly those in rural areas. Yet, if the midwifery degree were not attainted and other routes of entry are deemed unacceptable, the midwife would risk criminal charges by continuing to practise as usual.

Anne Maranta spells out the potential loss for women in rural communities, if their midwives are required to attend school in urban centres for formal training. "Historically, midwives in rural communities had little or no formal training, but they were very capable. They simply learned on the job out of necessity. And if they weren't around to help the woman, often no one was. Before medicare, rural families often couldn't afford to pay a doctor to come to them. And they couldn't afford to go to the city to give birth. After medicare, most of the doctors wanted to stay and practice in the city anyway, so the woman was still on her own, unless she had a midwife."

If the rural midwife is threatened, the women who need midwives most may lose them.

Midwives who practice part-time, often while raising their own families, will also have to make some tough decisions. Potential problems surrounding funding may force licensed midwives to practice full-time or not at all. This will be a no-win situation for many midwives.

Are setting province-wide standards, evaluating all currently practising midwives, institutionalizing a formal education process, and enforcing a full-time commitment



Lori Dell

really necessary in order to recognize the role that midwives play?

Midwives are currently regulated by the Association of Ontario Midwives which provides professional standards for those practising. These standards include guidelines for mandatory consultation and transfer of care, codes of conduct and ethics, and peer review protocols. It hardly seems fair that midwives are now forced to seek legitimization from the medical establishment — the same body that has sought for so long to discredit midwives. Ironically, it is the medical profession and its impersonal and interventionist practises that have forced many women to turn to traditional midwifery.

The licensing of midwifery in Ontario should be viewed with caution. The mainstream medical profession is quite capable of undermining those that threaten its position. As one anonymous physician warned in *The Montreal Gazette*, "Midwifery is a turf battle, plain and simple."

Subtle changes in proposed policy demonstrate how midwives could end up losing their "turf." For example, in the *Guidelines to the Scope of Practice* produced by the Association of Ontario Midwives, certain medical conditions, such as pre-eclampsia (a toxemia of pregnancy characterized by increasing hypertension, headaches and swelling of the lower abdomen) or insulin diabetes, place pregnant women into a category of greater risk. Current guidelines state that if a woman falls into this category while under the care of a midwife, the midwife is instructed to consult with an obstetrician or specialist. She is then obliged to recommend to her client the advice given by the physician, which may involve transferring care to a specialist. Still, the final choice on what action to take remains with the pregnant woman herself.

The proposed guidelines brought forth by the new Interim Regulatory Council on Midwifery effectively eliminate that choice. If a woman were to fall into a high medical risk category, her primary care would be transferred automatically to a physician. No consultation or recommendations are required.

If the woman still desires to have a midwife as her primary caregiver, she is putting all three parties—herself, the midwife and the physician—at legal risk. In fact, it is up to the physician to give permission for any further involvement from the midwife. The physician can refuse the midwife's presence at the birth even if the mother desires it. Choice is therefore taken away from the expectant mother and given to her physician, often an obstetrician who the woman may not even know.

Since most women base their choice of a particular caregiver on trust, presumably they would follow the recommendations given by that caregiver, wanting to make the best choice for themselves and their child. But the proposed policy changes only reinforce the belief that the medical profession does not trust a pregnant woman to make the best decision.

In *The Trouble with Licensing Midwives*, Jutta Mason writes: "Part of our struggle has been to recognize that our support as women and as mothers, not particulary as experts, can help women in pregnancy and labour. [When I had my child], I didn't evaluate midwifery services—I found Mary, the woman who was willing to sit with me during the birth, through the advice of a trusted friend. No carefully-laid plans, no self-direction or prior information could have orchestrated this gift of strength and union."

Women should ensure that the unique and valuable role of midwives does not get lost on its way from recognition to regulation.

Mary Neilans is a feminist researcher and writer working in the area of women's health issues.

If you would like to find out more about the licensing of midwives in Ontario contact: The Midwifery Task Force of Ontario, Box 64, 260 Adelaide Street East, Toronto, ON, M5A 1N0, or Helen MacDonald, Midwifery Coordinator, Women's Health Bureau, Ministry of Health, Mowat Block, Queen's Park, Toronto, ON.

MY STORY, OUR STORY

Taming the Wolf: Learning to Live with Lupus

Anne Matheson

Lupus erythematosus means 'red wolf' in Latin. A French dermatologist gave this name to patients who had a rash on the bridge of the nose and across the cheeks in a mask-like shape — like that on the face of a wolf.

I am one of the 50,000 Canadians known to have lupus erythematosus, an immune system disorder that causes the body to attack itself. It can hit like a ton of bricks, or it can simmer for a long time, whittling away its victim's joy of living.

Although it is more prevalent than muscular dystrophy, multiple sclerosis, and leukemia, many doctors still know little about it. They often refer to lupus as 'the great impostor' because its symptoms mimic other diseases and make it difficult to diagnose. It may begin with vague symptoms that come and go — fever, rash, loss of weight, loss of hair, sensitivity to cold and sunlight, fatigue, or joint aches — or it may start with major system involvement.

No one knows why lupus affects women nine times more often than men, or why it occurs most frequently between the ages of 20 and 40.

I first got lupus when I was nine years old. It was 1952 and Howdy Doody, Kookla, Fran and Ollie, crinolines and bobby socks were in vogue, and lupus was considered a rare and fatal disease of the blood. Children who got it usually died. This is my personal story of my ongoing battle with this disease which has so far spanned 39 years.

My younger sister, Lynn, and I often were taken for twins since we were the same size although we were a year apart in age, and my mother dressed us alike. During our bi-yearly health checkups, our pediatrician would sit us together on the examining table and stand us side-by-side in the x-ray machine. Eventually he got us confused. He treated me for Lynn's sinus condition, and her for my kidney problem — a mistake which nearly cost me my life.

My kidneys became unable to filter body wastes and fluids. This made me so bloated and drowsy — it was like being slowly poisoned — that I could barely drag myself to school. One day, I put my head down on my desk and drifted into a deep sleep. The next thing I knew, I was being awakened by my teacher who was calling me 'lazy.'

Although I was hurt by his remark, in retrospect, this incident may have been a blessing in disguise. It led to my mother questioning me at lunch time when she saw my eyes were puffy from crying. Later that night my parents discussed their fear that there was something very wrong with me. They had noticed a drastic change in me; I was no longer the energetic child they were used to. I had put on a lot of weight quickly, and my feet were so swollen that I could not get my shoes on.

Although I was seeing our family doctor regularly, I was not getting any better. So, my parents, followed their instincts and found another doctor for me.

Dr. White was a pathologist, nearly 70-years-of-age, who came highly recommended. He seemed to know immediately what was wrong. He pressed a deep indentation in the putty-like skin of my leg, shook a knowing head, and left the room. Within minutes he was back with a colleague of his, a nephrologist, a specialist in kidney disorders.

A couple of hours later the results of urine and blood tests confirmed their suspicion that I had nephritis, inflammation of the kidneys. It had caused all my vital organs to become like sponges soaking up bodily fluids. Lupus was not considered as the underlying cause of my kidney trouble at that time.

Nature will take its course

My mother told me many years later that Dr. White had held very little hope for my survival. He had said that "nature will take it's course." My parents felt helpless because there was no cure for nephritis, and instead of medication I was given a diet of nothing but par-boiled rice. It was supposed to absorb the excess fluid in my body, and sure enough when I was discharged from hospital three weeks later, I was thirty pounds lighter.

Because I felt well, I was surprised at my doctor's prescription which was an entire year of bed rest. I had just turned 10, and as a mother now myself, I understand that persuading me to stay in bed was a monumental task for my parents.

A year passed and my doctor finally gave in to my pleas to go outside.

One day in July, I convinced my mother to let me accompany friends to a community swimming pool. The mile-long trek in the blistering sun tired us all, and we were looking forward to the cooling water. But at the pool, an inhospitable attendant shouted at me, "You've got some nerve expecting me to let you swim here. Go home until that rash clears."

The mirror in the change room revealed a mask-like, scaly rawness on the bridge of my nose and across my cheeks. (I now know that this butterfly configuration which itches and burns is a symptom of lupus caused by the sun. It meant that my lupus was not under control.)

My parents phoned the doctor immediately. He referred me to a dermatologist who discovered that I was anemic and arranged for me to have a bone marrow test.
We went back to the determatologist's office a few days later to hear the results of the test. He was convinced that my rash and kidney problems were caused by systemic lupus erythematosus.

There is no known treatment for lupus, but Dr. White hoped that in time my body would recover on its own, and he prescribed what he thought best — another year of complete bed rest.

(Long-term bed rest is no longer viewed as the cure-all that it was believed to be in the 1950s and earlier. In fact, 'weightlessness' is a factor in slowing growth and bone development in children.)

The following September I returned to school. I was excited but also nervous at the prospect of entering Grade Eight, a long way from Grade Five where I had left off.

I looked so healthy that my family and my doctor began to think that I might be over my kidney problems — and as for lupus it was never mentioned. My parents later said that they thought the diagnosis had been wrong. Nobody mentioned the probability of lupus being in remission which actually was the case. As for me, I simply reveled in the wonderful feeling of being back to normal.

However, soon I began to find the pace of high school exhausting. My eyes and ankles were puffy in the morning, symptoms of kidney problems which I tried to conceal from my parents. The thought that I might have to put my life 'on hold' again hung over me like a dark cloud, and I ignored the fact that I was in trouble again until I had no choice. One night, I awoke to find my parents standing over me. They were startled when I opened my eyes, and their reaction made me run to the mirror.

It was clear that my pretense of being well was over—the lupus, was back! We called Dr. White's office but he was out of town. This turn of fate brought us to meet Dr. Ronald Elliott and, in retrospect, I doubt that I would be here today if I had not. Dr. Elliott became my doctor, friend, and confidante for over 30 years.

After he examined me, he told my mother privately that I was close to death. He said if I were to recover from the near heart failure I was experiencing (from kidney damage), it would be the beginning of a long, difficult road ahead for all of us. Sympathetic to my fear of being hospitalized and away from my family, Dr. Elliott visited me daily at home instead. In fact, he kept me out of hospital for the next 20 years, although I had several severe flare-ups of lupus to contend with.

Lupus erythematosus means "red wolf" in Latin. A French dermatologist gave this name to patients who had a rash on

the bridge of the nose and across the cheeks in a mask-like shape — like that on the face of a wolf

Cortisone was hailed as a miracle drug

Dr. Elliott knew about cortisone from current literature, and he read everything he could find on lupus. Rather than 'non-treatment,' his approach was aggressive intervention. He used cortisone, antimalarials, and A.C.T.H. hormones which stimulated the adrenal gland's production of natural cortisone. In 1956, cortisone was being hailed as a miracle drug, but not much was known about the side effects it produced.

I was 13 years old, again feeling well, but embarrassed about a huge and rapid weight gain, a side effect of the medications. A.C.T.H. hormones and cortisone created what was called 'moon face.' My facial features changed so much that no one who had not seen me for a while recognized me. I was very sensitive about my appearance which I thought was freakish, and I dreaded having to pass other children on the street because they would make fun of me.

Finally, after a year and a half, I was 'weaned off' cortisone and most of the side-effects disappeared. I was well enough to return to high school, graduating without any further interruptions. I had learned to avoid demanding situations whenever I could and I decided against university. Instead, I accepted a secretarial position at a company in Hamilton. I entered this stage of my life full of hope.

However, one year later, the joints in my legs and arms were

stiff and painful again. My sister, Lynn, had to help me get in to and out of my clothes. Although a hot bath and some aspirin in the morning got me through the work day, by early evening I was in agony again. I generally went to bed very early for some relief from the pain.

My hair started falling out too. It was a shock to find clumps of it on my pillow in the morning. Although I did not actually go bald as I feared might, my normal abundance of long, thick auburn hair thinned out to barely cover my scalp. Of course, this completely sabotaged my attempt to hide my illness. I felt I had no choice but to quit my job to recuperate.

After just six months, my hair returned to its natural state, and once again I looked the picture of health. I found a new job and returned to work.

In 1970 I met my husband, Ian. When our daughter Jennifer was born in 1973, I was happier than I had ever dreamed I could be. I thanked God for a healthy child, and we felt truly blessed. I knew I was lucky to have come through this pregnancy without any problems in view of the long-standing and severe episodes of lupus I had endured in the past. I was less fortunate two years later with a second pregnancy.

I had a miscarriage, something that occurs frequently in women who have lupus and who have an anti-coagulant factor in their blood. Such women may also have problems after a successful pregnancy due to hormonal changes. Up until the 1970s, women with lupus not in remission were advised against becoming pregnant.

(There are now obstetricians who specialize in 'high-risk' pregnancies and specialists in lupus to monitor a woman throughout her pregnancy and afterwards.)

Jennifer was just over two years old when my world began to fall apart. Once again, I became a victim of a long and vicious assault of lupus. Physical exhaustion was so great that I had no energy to look after her, and managing my home became an insurmountable task.

I went to bed as early as I could, and got up as late as I could. In between I was a zombie. It was all I could do to get through to 5:30 p.m. when Ian returned from work to take over. He became surrogate mother, cook, cleaner, nurse, as well as father in our home.

As I began to learn more about the disease, I had to come to terms with its full impact: I have an illness with no known cause and for which there is no cure

I was prescribed high doses of prednisone, in place of cortisone which created an irregular distribution of fat cells called 'cushingoid syndrome,' a factor in the development of early osteoporosis. I was in a catch 22 situation. I needed the prednisone to hold back my immune system's attack on my own cells and defend me against foreign invaders, such as viruses and infections, but the drug had such devastating side effects.

As the months passed and I didn't improve, I feared I might never regain my energy and feel well again. Dr. Elliott knew that my lupus had gotten terribly out of control, and he located a specialist for me: Dr. John Bienenstock, an immunologist at McMaster Medical Centre in Hamilton, who was interested in lupus. I hope I never have to go through anything like that traumatic time from 1975 to 1981 when I was rushed to the Emergency Department time after time in virtually life-threatening situations.

The strain of those stressful seven

Continued on page 37

HEALTHWISE

Sanitary Napkins: Padding the Bottom Line

Liz Armstrong and Adrienne Scott

The following is an excerpt from the book Whitewash: Exposing the health and environmental dangers of women's sanitary products and disposable diapers - and what you can do about it *by Liz Armstrong and Adrienne Scott. Published by HarperCollins Ltd. ©1992 by Liz Armstrong, Adrienne Scott and Women and Environment Education and Development Foundation.*

As women, we're big consumers of one category in particular of pulp and paper merchandise - the so-called sanitary protection or feminine hygiene products. We are the market for tampons, sanitary napkins and panty liners. We buy them by the billions every year.

And talk about a captive market. Our biological fate is to menstruate nearly a week per month for about half of our lives. A total of eighty-five million Canadian and American women currently fall into the average menstrual age range, from about twelve to fifty years. We've been thoroughly conditioned to using disposable sanitary products. And we rarely discuss them. Add it all up and it's no wonder manufacturers are confident about the steady market for their merchandise, even in recessionary times. "The demand for Tampax products is not affected by the vicissitudes of the economy," proclaimed the 1990 Tambrands Inc. annual report, in what surely must have been the understatement of the year.

Until the 1920s, women used washable bandages or "diapers" made from materials with quaint-sounding names such as "bird's-eye" and "outing flannel" for sanitary protection. Bulky and uncomfortable, these homemade menstrual pads weren't much of an improvement over the basic bandage used many centuries earlier by women of the Roman Empire, or the grass and vegetable fiber contrivances made by women in Australia and Africa.

After a failed attempt by Johnson & Johnson to market a disposable sanitary napkin in the late 1890s - the moral climate of the day ruled out advertising - French nurses experimented during the First World War with cellulose surgical gauze and discovered it made an efficient, comfortable menstrual pad. In 1921, the Cellucotton Products Company - now Kimberly-Clark Corporation - marketed the first disposable in the United States under the trade name Kotex.

And the rest is history, a true rags to riches story, if you'll forgive the pun. Today, North American women spend close to two billion dollars a year on disposable pads and tampons. French nurses may have started the trend 75 years ago, but multinationals control nearly all of the action now.

Fortune 500 companies Procter & Gamble, Johnson & Johnson, Kimberly-Clark and Tambrands have a complete stranglehold on the menstrual products market. And men virtually run the whole show. Scanning the 1990 annual reports of these four U.S.-based corporations, we found only one woman in upper management who was well-placed to influence key product and marketing decisions.

About 1.3 billion sanitary pads were landfilled or incinerated in Canada in 1990. In the United States, the figure is even more staggering -11.3 billion. A woman throws away ten thousand pads or tampons in her lifetime, quite a bundle if you had to dispose of them all in your own backyard. Women rarely talk about these disposable, single-use products, but it's past time we had a closer look at them, especially their environmental implications. Menstrual pads aren't complicated products. There's an absorbent, cotton-like core made from wood pulp, a plastic, moisture-proof liner on the bottom to prevent accidental staining and a softer material, usually rayon or cotton, sheathing the product. Wet-strength agents that keep the pad from falling apart when holding menstrual fluid and surfactants to improve absorbency may also be part of the manufacturer's formula. Glue holds all of these "ingredients" together.

Slim "maxi" products such as Johnson & Johnson's Sure & Natural and P&G's Always Ultra include another component. Both are impregnated with synthetic gelling crystals that can absorb many times their weight in liquids. The safety of these super-absorbent polyacrylates was hotly debated when companies began using them in ultra-thin disposable diapers in 1986, but their presence in sanitary pads is almost unknown and is rarely questioned.

In the United States, the ingredients in "beauty products" such as shampoo and nail polish, as well as a host of other items far less intimate than feminine hygiene products, must be fully listed on their packaging. But this is not a legal requirement for menstrual pads or tampons in either Canada or the U.S., and the companies don't disclose their contents voluntarily.

Despite the competitive nature of the sanitary protection market,

with a few major manufacturers and a handful of independents scrapping for a relatively fixed number of consumers, sanitary napkins didn't change much in the 50 years after the first Kotex pads hit the shelves in 1921. The first major innovation appeared in 1970 when Johnson & Johnson introduced its Stayfree mini-pad, a beltless product with a self-adhesive strip down the middle. Beltless pads are now the standard.

Since the number of menstruating women in North America is apparently growing by a meager 1 per cent per year, manufacturers are always looking for new ways to increase sales. One is through aggressive expansion into "underdeveloped" markets for disposable sanitary products, such as Eastern Europe, the Soviet Union and the Pacific Rim.

But the industry has also managed to convince North American women we need even more "protection." Marketing data indicate that demand for externally worn sanitary products has climbed in recent years by about 5 per cent annually, much higher than the increase in total customers. Yet how can we possibly need more protection for a biological function limited to a few days per month? What's the trick?

Enter the panty liner. This thin pad with the non-biodegradable backing has captured a third of all sanitary napkin sales. Initially designed to help women through the waning days of their periods or to supplement a tampon, panty liners are now being advertised as an essential part of a woman's hygiene every day, all month long. "To keep you feeling clean and fresh every day. As part of daily hygiene," says the package of Johnson & Johnson's Carefree deodorant panty shields. Procter & Gamble's booklet, "Periods and Puberty: a practical guide for girls," tells teenagers that its Always panty liner is "great for very light flow days (like the last day of your period or between periods to absorb vaginal discharge). Many teens also like to wear pantiliners right before their periods are due, so they won't be caught by surprise."

And we've bought their ploy, hook, line and sinker. Sad to say, this sort of "information" feeds the notion that women are in a perpetual state of uncleanliness. Some vaginal discharge is natural between periods, but unless a woman is suffering from an infection, she should never produce a discharge heavy enough to warrant a panty liner, even when pregnant. The everyday panty liner ranks up there with deodorized sanitary pads, vaginal sprays and douches as unnecessary products devised by companies hungry to boost their sales.

The authors of The Curse: A Cultural History of Menstruation say that sanitary protection companies go to great lengths to push their wares. "Manufacturers have relied heavily on gimmickry to liven up sales (the manufacturers first created the need and then rushed to fill it) inspired napkin and tampon makers to capitalize on the odor mania and 'deodorize' their products. What passes for deodorant in most napkins is, of course, perfume."

In the United States, menstrual pads are considered "medical devices" and so are subject to government regulation. Scented or deodorized pads are deemed medium-risk medical devices because government concerns about the safety of fragrance additives used by manufacturers, and sanitary protection companies are subject to the American government's Good Manufacturing Practices Code. The Food and Drug Administration is required to inspect their facilities every two years.

In Canada, tongue depressors, bandages and dental floss are considered medical devices, but not women's menstrual pads. Interesting. Sanitary products can be placed on the market without prior evidence of safety or efficacy. Testing or monitoring of these products before they're sold in Canada is done entirely at the discretion of manufacturers, mostly for the purpose of quality control. Worse, there are no formal mechanisms in place for monitoring negative health effects once they're on the market.

When it comes to environmental friendliness, sanitary napkins are real losers. Pulping processes dump tons of organochlorines into the atmosphere and waterways, they're overpacked and impregnated with plastic and they get discarded by the billions into incinerators and landfill sites.

Nearly all disposable sanitary products on the North American market are made from chlorine gas or chlorine-dioxide bleached kraft pulps. When Greenpeace released confidential paper industry documents in 1987 showing that traces of the most toxic dioxins and furans were present in everyday paper products, the media was soon hot on the story's trail. The Canadian Broadcasting Corporation's television program Marketplace asked analytical chemist Thomas Tiernan of Wright State University in Dayton, Ohio, to conduct independent tests. He found 2,3,7,8-TCDD (the most potent dioxin) in facial tissues, paper plates and paper towels, and 2,3,7,8-TCDF (the most potent furan) in women's sanitary pads, disposable baby diapers and coffee filters.

The American pulp and paper industry has sponsored risk assessments of the dioxins and furans in these products and assure us they are safe. The U.S. Environmental Protection Agency has also concluded that trace levels of dioxin are "no cause for alarm," a verdict echoed by Canada's Department of Health and Welfare.

In our opinion, industry risk assessments aren't necessarily reassuring. Their conclusions are based more on assumptions and speculation than on concrete data. "Safe levels" of dioxin (and its toxic equivalents) were calculated to be 2.5 times higher in sanitary napkins than in toilet paper. This is a puzzling result. Women who use pads are exposed to the products for hours and even days, compared to an exposure time measured in seconds for toilet paper. An additional note: calculations for disposable diapers included a special correction factor for babies' sensitive skin. No such consideration for women!

Nowhere in any of these product risk assessments, of course, is there any mention of the impact of manufacturing these chlorine-bleached products on the environment around pulp mills. And nowhere is there any mention of all those other oranochlorines about which science still knows so very little.

George Petty, past chairman of the Canadian Pulp and Paper Association, is not known for mincing words. Here's how he dismissed concerns in 1989 about toxic organochlorines: "Dioxins are a non-issue. A baby would have to eat seven thousand diapers a day to get sick from dioxin, never mind wear them. What [environmentalists] managed to do in Europe is to get people paranoid about using white paper, not on any factual analysis, but on scare tactics. I think it is important that we as an industry don't let the Europeans show us this kind of leadership in this country."

Frankly, the kind of leadership we'd like to see in North America is one that doesn't descend to silly arguments about "eating diapers" to defend unnecessary bleaching of paper products with chlorine compounds to make them bright white.

Bright white products, of course, create the impression of hygiene and cleanliness. But consumers should know that whiteness does not equal sterility - neither sanitary pads nor tampons are sterile products. Nor is "whiteness" or "brightness" usually necessary for the paper product to function better. Removing some of the lignins and resins is required if the pulp is being used for sanitary products like facial tissue, toilet paper and menstrual pads - the pulp becomes more absorbent. It is not essential, however, to bleach pulp to a very high brightness to achieve adequate absorbency. And treating pulp with chlorine-based chemicals isn't the only answer. Renate Kroesa of Greenpeace says hydrogen peroxide effectively removes the resin acids without the negative side effects of chlorine bleaching. She points out that fluffing and special drying techniques can also increase the absorption potential of pulp.

The continued use of chlorine-bleached pulp is a sign that environmental concerns are not high on the list of priorities of North American sanitary protection companies. Nor has disposability made much of an impression. Walk down the aisle of any supermarket or drugstore and survey the sizable sanitary products section for a moment. You'd never know we have a serious solid waste disposal problem on our hands. Environmentalist Marjorie Lamb says in her book, Two Minutes a Day for a Greener Planet , that aside from chlorine bleaching, her major complaint with sanitary products is "the excessive and unnecessary use of plastics, which never break down in the environment." And there are plastics both inside and out. Synthetics and plastics are part and parcel of the napkins themselves, virtually nullifying their already slim chances of breaking down in a landfill site. The bottom liner is made of non-biodegradable polypropylene, and the soft, non-woven coverings may also be plastic - Procter & Gamble's Always pad, for example, uses a "breathable" polyethylene. Other producers have opted for materials such as woven rayon, polyester and cotton, each having its own environmental drawbacks.

Let's not forget there's still more plastic on the outside. It's called "polybagging," the latest trend in product packaging, which has overtaken cardboard. Not one of these thick outer wraps mentions any recycled any recycled content. (Most of these purchases are probably bagged yet again in plastic at the checkout counter, for "discretion's sake.") A few brands, including Tambrands' Maxithins and Johnson & Johnson's Stayfree and Sure & Natural Prima, are still boxed in cardboard but, as of this writing, only Johnson & Johnson stated that their cartons were made

from 100 per cent recycled paper.

The advent of individually wrapped sanitary pads is another product "innovation" that thumbs its nose at the solid waste crisis, a case of overpackaging gone mad. An industry trade journal says individual wrapping - even though the product is not sterile - has been a boon to the major brands and the private label manufacturers who claim that "today's consumer is more active and therefore more concerned about discretion."

Industry analyst Bonita Austin of Wertheim Schroder & Co. in New York believes that environmental considerations don't figure prominently when a woman is purchasing sanitary products. Tambrands Canada agrees. A company spokesperson told us that while a lot of women are concerned about the environment, the "number one consideration is whether a product meets their needs."

How about meeting our needs and striving to satisfy environmental concerns?

It's obvious that women who are concerned about the environmental impact of their use and disposal of sanitary protection products are faced with a dilemma. We're offered more and more plastic wrapping, and still more plastic, in the name of feminine discretion. We're being kept in the dark about organochlorine discharges from the production of wood pulps used in the products even as they're unnecessarily bleached to a bright white.

We find the total lack of "environmentally friendly" options offered by brand-name manufacturers unacceptable. Why aren't producers moving to incorporate recycled pulp in all of their packaging? Why aren't they eliminating petroleum-dependent plastic rather than rushing to it ever more enthusiastically? Or - most important - why aren't they cutting out chlorine gas and all related compounds - chlorine dioxide and hypochlorite - in the bleaching of pulp used for feminine hygiene products? As we were finishing this book, one private-label manufacturer told us that other major pulp producers were following Procter & Gamble's lead by planning to introduce low chlorine fluff. Even if this is true, we say "get the chlorine out" altogether. We can cope with off-white sanitary pads. We also think most women using disposables would be willing to settle for a little less "performance" in their sanitary pad as an inconsequential trade-off for a cleaner environment. (Still, women shouldn't have to settle for less. Surely if manufacturers put their minds to it, they can develop a chlorine-free product which matches the quality of their "whiter-than-white" pads. If they can put a man on the moon...)

We also find the industry far more secretive and proprietary than it needs to be. Far too often our questions were answered with silence, and sometimes as if we had no damn business asking. One Kimberly-Clark employee in Toronto curtly sidestepped our queries about environmental issues: "When we're ready to share things with the public, we'll do that," he said. That kind of paternalistic attitude we definitely don't need.

So far, it seems that most of the North American sanitary protection industry is immune to the new environmental ethos. But in our opinion - and a growing number of women agree - there's no reason why we should put aside our environmental concerns when we make decisions about sanitary products. Disposable products should only be used sensibly and sparingly. If sanitary protection companies are not going to provide us with more environmentally sound options, there are alternatives.

Copies of *Whitewash...* can be ordered directly from WEED (Women and Environmental Education and Development Foundation) 736 Bathurst Street, Toronto, Ontario, M5S 2R4, (416) 516-2600, $12.95 (plus postage and handling). A grassroots campaign has been launched around this issue called 'Stop the Whitewash.' A kit is available for individuals or groups wishing to join the campaign to pressure sanitary protection companies and government to respond to the need for more environmentally-conscious policies and products. Copies of the kit are also available from WEED.

Continued from page 32

years on my husband is still evident today. He carried a heavy load and was too proud, I suppose, to accept 'home care,' and he turned down the offer to talk with a social worker or have our daughter counseled. I believe this was a mistake.

There are others with lupus

In 1978, I heard for the first time about other people in Hamilton who have lupus, and I joined with them to become a founding member of The Lupus Society of Hamilton. Later, I served as the society's president from 1981 to 1984 and often spoke to groups about lupus. As I began to learn more about the disease, I had to come to terms with its full impact: I have an illness with no known cause and for which there is no cure. I have learned much about lupus from experience, from literature and from my doctors, and I know the symptoms that signal a flare-up for me.

I'm often asked, "What is lupus?" to which I say: Think of your immune system as your personal internal army, constantly on the look-out and ready to fight off foreign invaders (colds, viruses, germs, for example.) If you have lupus, your army might mistake the self as foreign and send the troops to attack it. Or it might issue an order to do battle with something which truly is foreign, but continue to send soldiers to the scene long after they are needed. In lupus, this surplus of antibodies causes damage.

Dr. Elliott died in 1989. I had the chance to tell him before he died how much I appreciated having his care and encouragement over the years. He was ahead of his time in understanding the importance of educating patients and making them part of the team treating their illness.

I have survived lupus for nearly four decades. I have come through a single doctor's care and the care of a medical team; through a time when there was a lack of a prescribed medications, to an era where there is an overuse of so-called miracle drugs.

I have been in remission for more than 10 years now. You could say I'm living in harmony with an enemy I've learned to respect. I'm aware that lupus is unpredictable and recurrence is a constant threat. But I choose to be optimistic and enjoy life to the fullest, though there are bound to be some hurdles in my path.

Now most of my problems are related to long-term lupus and a result of past use of prednisone. I've recently learned the pain in my hip joints is from osteonecrosis (dead bone) caused by insufficient circulation of blood to these joints. While my overall lupus is well under control, this new disheartening problem dictates limits which have altered my lifestyle. Unlike the other unpleasant stages of lupus, this one is not reversible and total hip replacement surgery is a certainty in my future.

Immune system disorders have been the subject of intensive research for over a decade. This has resulted in better management and has improved the survival rate to 95 per cent. But the cause of lupus remains a mystery. Researchers are investigating hormonal, environmental, and viral factors in search of the answers which will bring about a cure. Although lupus is not inherited, they believe there may be a predisposition for getting it.

It seems like a world ago when my daughter, who was seven years old at the time, asked in a worried voice, "Will I ever get lupus, Mom?" I answered what I honestly believed, "You shouldn't worry about that, Jennifer. There will be a cure for lupus soon." I'm happy to say that current literature speaks about the possibility of a cure in my lifetime.

Anne Matheson works as a secretary on a part-time basis for the McMaster Medical Centre. She is still an active member of The Lupus Society of Hamilton where she has counseled patients, helped create awareness of the disease and raised funds for further research. She can be reached at 617 Brigadoon Dr., Hamilton, ON, L9C 6E2.

For more information, contact the Lupus Information Hotline at 1-800-661-1468.

HEALTH WANTED

Pen Pal Network for Adult Survivors

Thirteen months ago, two American women formed a Pen Pal Network for Adult Survivors of sexual, physical and verbal child abuse. Says Pat, one of the founders: "Kathy and I started it because there was very little available to survivors in our area and what was available was extremely expensive."

They began by posting flyers in cities and towns in their area asking for submissions for a newsletter and for other survivors to contact them if they wanted to start a support group. "We now have weekly support groups in town," says Pat, and "the newsletter... is actually more of a journal with writings by and for survivors." The bi-monthly newsletter costs $4.50.

The Pen Pal network supplies members with a list, updated quarterly, of other survivors. With over 100 members in U.S. and Canada, the network is one way survivors can contact others and help break the silence around abuse.

Because the network is entirely self-supporting, there is a $2.00 charge to cover the printing and handling of the pen pal lists.

The network invites survivors to break the isolation, connect with other survivors and "help each other heal."

For more information write to KLPF, Pen Pals, 738 Main Street, Box 171, Waltham, MA 02154, U.S.A.

REVIEWS

Revolution From Within

Gloria Steinem, (Little, Brown and Co.), Toronto, 1992, $27.95, 377 pp.

Reviewed by Lorrayne Anthony

Gloria Steinem's *Revolution From Within*, is a tough, but worthwhile read. It is a time-consuming book, because each sentence explodes with insights and truths about why people, especially women, second guess their own self-worth.

For the past two decades, Steinem has been one of the most visible leaders of the feminist movement. Through, *Ms* magazine, which she co-founded in 1972, and one of her books *Outrageous Acts and Everyday Rebellions*, Steinem gave impetus to a revolution which challenged and eroded many sexual barriers. With this, her latest book, she comes full circle with the revolution by linking the social and political with the emotional and spiritual.

Steinem's reason for writing *Revolution from Within* came from meeting intelligent, brave and valuable women who did not think they were intelligent, brave or valuable. She wondered why so many women, including herself, suffered from low self-esteem.

The early chapters of her extensively research book, traces the birth of self-esteem back to childhood. It is now accepted that if you tell a child she is not bright often enough, she will believe it. But, Steinem uses her own childhood as well as examples from other people's lives to show the subtle ways in which self-esteem is starved.

But subsequent chapters assure the reader it is never too late for a happy childhood. Steinem also advocates being critical of the Anglo and male-centric education Western society dictates. Two chapters deal with unlearning the aspects of education which tell us we are not up to standard and how to relearn what makes us valuable.

Unlike many books on self-esteem, *Revolution from Within* does not read like a self-help guide. Instead, the first half of the book strings together success stories from people around the world—making it just as relevant to Canadians as it is to Americans.

Steinem writes about Mohandas ("Mahatma") Gandhi and how he was unable to lead the Indian people in their struggle for independence until he stopped trying to be "superior like the English" and raised his people's self-esteem by being one of them. She compares the famous life of Gandhi to the less famous life of Marilyn Murphy, an American mother and wife turned feminist lesbian.

She explains how both Gandhi and Murphy spent much of their time living through a false self. Only through their independent movement that enhanced the lives of others did they discover their true selves.

By condensing many of the ideas presented in Naomi Wolf's attack on the beauty industry in *The Beauty Myth* and drawing on her own experiences, Steinem eloquently outlines the link between body image and self-esteem.

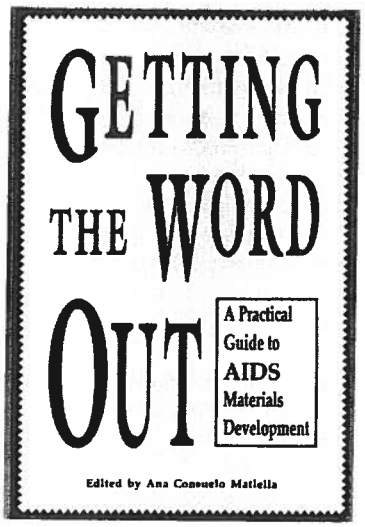
Steinem is less convincing than Wolf. Although she identifies the problems with society's unrealistic demands on female beauty, specifically examining eating disorders, racial preferences and aging, when she discusses cosmetic surgery, she does not fully explore or analyze the pressures which lure women to put themselves under the knife for beauty's sake.

Perhaps this is so because she has given in to these pressures herself by undergoing what she calls a "simple office procedure to remove some of the fat" over her eyelids. She claims that the "office procedure" allowed her to wear contact lenses and get rid of the large glasses she wore to hide what she thought were "chubby" cheeks. Her reasons seem, at first, self-affirming, but an eyelid-tuck at age 58 smacks of submitting to society's obsession with youth.

With the exception of her leniency on cosmetic surgery and the industry itself, Steinem attacks a society which continually forces women to think of themselves as second best. *Revolution from Within* provokes the reader into looking in a mirror and seeing a much strong self.

However, with the book selling at $27.95 per copy (it is not in paperback as yet), women who might benefit from its message may never get a chance to actually read it.

Lorrayne Anthony is a journalist living in Toronto. She most recently finished a four-month contract editing copy on the city, national and foreign desks at The Globe and Mail. *She has a special interest in women's issues and science.*



Getting the Word Out: A Practical Guide to AIDS Materials Development

Edited by Ana Consuelo Matiella, (Network Publications), USA, 1992, $19.95, 232 pp.

Reviewed by Toni Lauriston

Getting the Word Out is written by community AIDS educators skilled in developing education materials in ethno-cultural communities.

This book focuses on AIDS materials development, but is by no means restricted to one health issue. If your goal is to produce health information materials relevant to the target population, the approach will apply.

A central theme runs through the book: given the opportunity to define their needs, people are able to develop materials that best serve their educational goals. This book highly regards people's capabilities and especially participatory community efforts.

Each chapter stands on its own. This allows the readers to choose what information best suits their needs. Filled with examples and "how to" suggestions, the book covers the specifics of the materials development process.

The first chapter "Laying the Groundwork" states that AIDS education materials are developed as part of a larger community program. Intended as support materials, they do not replace but complement the benefits derived from face-to-face communication, which is the primary form of human communication.

Of particular interest is the chapter "Creating Culturally Sensitive Material." There are three components to this chapter:

First, the authors liken the process of developing education materials to using all your senses to create a dialogue with the community. The education materials produced become part of that dialogue.

Next, the chapter lists questions you need to ask to better understand your community.

The rest of this chapter examines the experiences gained from three communities: San Juan in Puerto Rico, Juarez in Mexico and Bridgeport, Connecticut in the United States. These communities encouraged women to come to the program's centre for education, support and counseling on HIV and AIDS.

In San Juan the main question was "What do we have to offer women in the community?" The community chose a poster that included a child since women would do things for a child they wouldn't do for themselves. Project staff also had to ask what this poster would say to men. The final poster showed a man shooting-up with a pregnant woman and a child on the bed. The caption reads, "An addict can give many things to you and your children."

A community needs assessment in Juarez identified a range of needs not related to AIDS education. The issue that stood out was people wanting to learn to read. Combining AIDS education in a literacy curriculum, the community developed a photo-novello.

In Bridgeport, the major concern was testing. Community workers found that people were not returning for their test results due to fear. Low literacy was also a problem. As a result, the workers produced audio tapes for people to take with them when they left the testing centre.

Successful AIDS education came from the community asking relevant questions, generating ideas and then taking the action needed. Giving people the chance to develop a product reflecting their needs is the essence of community empowerment.

This book brings together a variety of expertise to create an approach to developing culturally-appropriate AIDS information materials. The areas of expertise include marketing, cross-cultural communication, community development, literacy, empowerment and print, video and audio production.

The authors have written a book that is easy to follow for the beginner as well as advanced readers. Previous to this book, few guides on this subject existed.

Getting the Word Out is a gem of practical information with a theoretical framework. It includes three case studies in its appendices and bibliographies in many chapters. Written in the United States, the book lists agencies that can be substituted by their Canadian counterparts. For organizations, community groups or agencies that are starting out or reviewing their approach to health information needs of their communities, this is an excellent resource.

Copies of *Getting the Word Out* are available by mail or telephone order from Network Publications, Post Office Box 1830, Santa Cruz, CA, 95061-1830, 1-800-321-4407.

Toni Lauriston is a Communications Consultant who has produced AIDS education materials in ethno-cultural communities for the last four years.

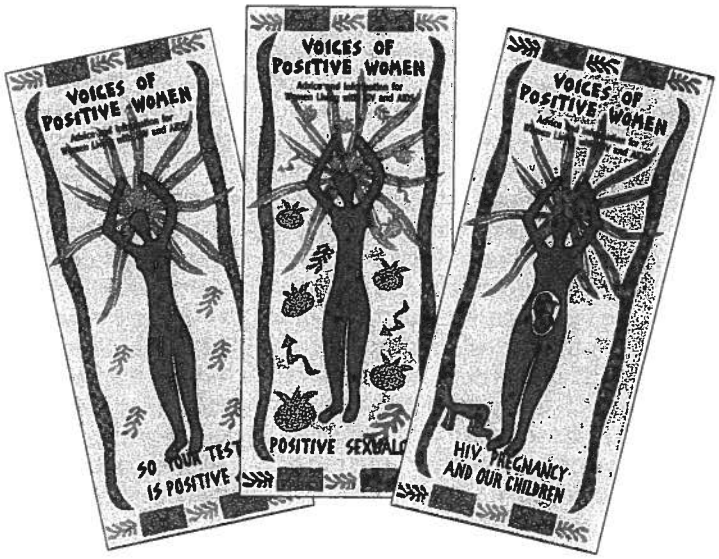
RESOURCES & EVENTS

Birth Stories
One Mother to Another is a Fifth House publication by Winifred Wallace Hunsburger who is the past director of the International Childbirth Education Association. Readers have the opportunity to share in the stories of Canadian women talking about pregnancy and childbirth. $9.95, 130 pp. U of T Press, 5201 Dufferin St., Downsview, ON, M3H 5T8.

Lesbians and Cancer
"What Lesbians Know About Cancer" is a newsletter put together by lesbians in the U.S. as a forum for the exchange of ideas and experiences about cancer. For further information write to: Louder Than Words, Box 90934, Washington, D.C. 20090.

Women and HIV/AIDS Phoneline
TELELINK is a telephone self-help network for women living with HIV and AIDS in Ontario. The support group is available to women of all ages at no cost. For information call (519)748-5556. Collect calls are welcome.

Breastfeeding
There are several chapters, affiliate groups and resources available across Canada to provide support and promote infant and maternal health through breastfeeding. To find out about activities in your area contact both national offices: Infant Feeding Action Coalition (INFACT)



10 Trinity Square, Toronto, ON, M5G 1B1 (416) 595-9819
La Leche League P.O. Box 2918 C Industrial Dr, Chesterville, ON, K0C 1H0 (613) 448-1842.

Donor Insemination
Donor Insemination: An Overview by Rona Achilles is available from: Royal Commission on Reproductive Technologies, P.O. Box 1566, Stn. B, Ottawa, ON. K1P 5R5.

Aborginal Women's Legal Fund
There is a call for contributions to the Aboriginal Women's Freedom Fund to support Kathy Mallet, an aboriginal woman being sued by a Manitoban chief because of comments Mallet made in a press interview about the violence against women on the reserves. Help end the silencing of aboriginal women. Tax deductible receipts can be issued for cheques made out to the Ikewak Justice Society Mallet Defence Fund, 356A Stella Ave., Winnipeg, MB, R2W 2T9.

ASPO/Lamaze Certificate
American Society Psychoprophylaxis in Obstetrics /Lamaze Certification program will start in November 1992 at the University of Toronto. Contact The Childbirth Educator Programme, Continuing Studies, 158 St. George St, Toronto, ON, M5S 2V8.

Call for Abstracts
The International Council on Women's Health Issues presents the 1993 North American Congress on Women's Health Issues in Toronto, ON, Oct 7-9, 1993. Deadline: January 15, 1993. For theme and guidelines contact: Rita Schreiber, 10 Badgerow Ave., Toronto, ON, M4M 1V1, (416) 466-8014.

HIV Positive Women
Voices of Positive Women is an Ontario group organized by and for women living with HIV and AIDS. They produce a regular newsletter and have just published a brochure series on: HIV, Pregnancy and Our Children; Positive Sexuality; and So Your Test is Positive. Available in English and French. Order from: P.O. Box 471, Station C, Toronto, ON, M6J 3P5.

Violence Against Women
Violence Against Immigrant Women and Children: An Overview for Community Workers is a manual that provides information to increase awareness of the issue of violence against women and children and to recognize the additional factors which have a particular impact on immigrant women. Women Against Violence Against Women, Rape Crisis Centre, 102-96 East Broadway, Vancouver, BC, V5T 1V6.

Abuse in Lesbian Relationships
Is the topic of a booklet written by L. Chesley, D. MacAulay and J. Ristock. Now in its second printing, the booklet is available free of charge from the Toronto Counselling Centre for Lesbians and Gays, 308-517 College St., Toronto, ON, M6G 1A8.

Menstrual Health Education
New Cycle Products - cloth menstrual pads and accessories that are woman-kind and earth-gentle. For a free catalogue 1-800-845-FLOW.

Incest Survivors
Beyond Survival: Psychosynthesis and Healing the Incest Wound - is the theme of residential weekend workshops and retreats for women survivors of childhood sexual abuse and those working with survivors. For 1992/1993 dates and information contact

Rosemary Sullivan - Pigeon Hill Bruideen - Peacemaking Centre, St. Armand, QC J0J 1T0, (514) 248-2524.

Current Trends '92
Current Trends in Maternity and Newborn Care '92 Oct. 19 & 20, Ottawa, ON, Box 203, Stittsville, ON, K2S 1A3 and Nov. 16 & 17, Halifax, NS with guest speaker Penny Simkin. Contact: 269 Richmond St. W., Toronto, ON, M5V 1X1. (416) 596-8680.

Creating Connections
is a group concerned with the incidence and impact of childhood sexual abuse. They will be presenting fall workshops with Shirley Turcotte, Nov. 4-7, 1992. For more information contact them at 160 Garfield St. S, Winnipeg, MB, R3G 2L8.

Pre-natal Education for Teenagers
Special Delivery Club Kit - is a program and resources directed at teenagers and single women. This innovative approach to pre-natal education was developed by the North Kingston Community Health Centre. The cost is $237.50 incl., 400 Elliot Ave., Kingston, ON, K7K 6M9.

Conference for Midwives
International Confederation of Midwives 23rd International Congress of Midwives, May 9-14th, 1993 Early registration encouraged. Secretariat c/o Venue West Ltd.,645-345 Water St., Vancouver, BC, V6B 5C6, (604) 681-5226

Child Care Conference
National Child Care Conference and Lobby - A Child Care Agenda for the 90s: Putting the Pieces Together. October 15-19, 1992 Ottawa. Registration - Eileen Condon, Ontario Coalition for Better Child Care, 500A Bloor St. W. ,Toronto, ON, M5S 1Y8.

Infertility
Infertility Awareness Association of Canada (IAAC) 1-800-263-2929. The Toronto chapter is presenting a series of seminars for infertile couples and associated health professionals until December, 1992. Information: Diane Allen, 160 Pickering St., Toronto, ON, M4E 3J7, (416) 691-0699.

No More Secrets
Community Resources and Initiatives (CRI) will present The No More Secrets conference, Oct.16-19, 1992, Toronto. This is a training conference for professionals working with women who have experienced the childhood trauma of emotional, physical or sexual abuse. Registration Co-ordinator, 285 Markham St., Toronto, ON, M6J 2G7 (416)924-8998; or fax (416)924-8352.

Childbirth Educators
The Ontario Childbirth Educators Association are planning their inaugural meeting, October 1992 in Toronto. Contact: Diane Gwartz 2022 Cedarwood Court., Pickering, ON, L1X 1V1, (416) 420-3890.

Call for Submissions
The Disabled Dyke Anthology is looking for poetry, essays, drawings, and stories from disabled lesbians/two-spirited women. Work may be submitted either in printform, or on audiocassette tape. Do not send orginals. Submissions cannot be returned. Send to: P.O. Box 41, 4700 Keele St., North York, ON, M3J 1P3, deadline: Feb.1, 1993.

Breast Screening Program
The Ontario Breast Screening Program (OBSP) has opened the first mobile breast screening centre in Ontario. The centre provides services throughout Northwestern Ontario and is administered by the Thunder Bay Regional Cancer Centre. Women may be referred by a physician or may make their own appointments by calling 343-1690 in Thunder Bay, 1-800-461-7031 from within the "807" area code district, or 1-800-668-9304 from anywhere within the province.

Birthing Resources

Association of Canadian Midwives - 251 W. 20th Ave. Vancouver, BC, V5Y 2C5

Association for Safe Alternatives in Childbirth: ASAC - Box 67, Armdale, NS, B3L 4J7 or **ASAC** - Box 1197, Main Post Office, Edmonton, AB, T5J 2M4

Calgary Association of Parents and Professionals for Safe Alternatives in Childbirth - #310, 223 12th Ave. S.W., Calgary, AB, T2R 0C9

Manitoba Association of Parents and Professionals for Safe Alternatives in Childbirth - 26 Kairistine Lane, Winnipeg, MB, R3R 1N9

Alberta Association of Midwives - Box 1177, Stn.G, Calgary, AB, T3A 3G3

Midwifery Task Force of Alberta - 507 Tavender Rd. N.W., Calgary, AB, T2K 3M3

The Midwives Association of BC. - 244 810 West Broadway, Vancouver, BC, V4Z 5C9

Midwifery Task Force of BC. - 926 School Green, Vancouver, BC, V6H 3N7

The Midwifery Coalition of NS - 1967 Bloomingdale Terrace, Halifax, NS, B3H 4E7

Vaginal Birth after Cesarean (VBAC) Association of Ontario - 8 Gilgorm Rd. Toronto, ON, M5N 2M5

Association of Ontarion Midwives - Box 85, Stn.C, Toronto, ON, M6J 3M7

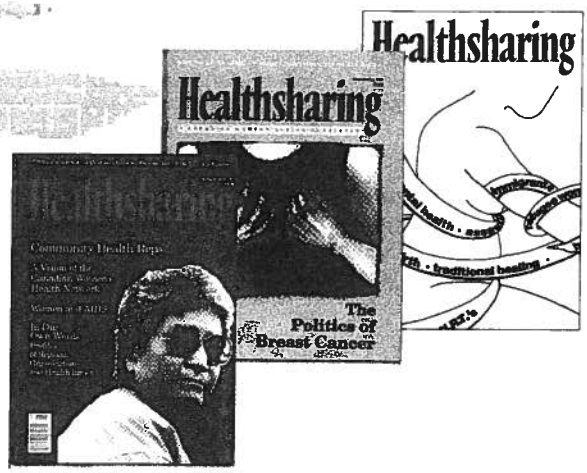
Midwifery Task Force of Ontario - Box 64, 260 Adelaide St.E., Toronto, ON, M5A 1N0

Naissance Renaissance - CP 249, Stn. F, Montreal, QC, H2T 3A7

Shattered Dreams - (a publication dealing with miscarriage), 2672 Hickson Cres.,Ottawa, ON, K2H 6Y6

Maternal Health News - Box 46563, Stn. G, Vancouver, BC, V6R 4G8

Have you missed something?



The following back issues are for sale. Don't miss out! Check your selection.

- ☐ Winter 1979, (Vol 1 No 1) Birthing options, the unhealthy cloth ing business, nurturing politics and health
- ☐ Summer 1980 (Vol 1 No 3) Pain killers, UI for pregnant women, well-being interviews
- ☐ Winter 1980, (Vol 2 No 1) No Love Canals here, sex without science, toxic shock & tampons, post partum depression
- ☐ Spring, 1981 (Vol 2 No 2) Power of science and medicine, endometriosis, radiation
- ☐ Winter, 1981 (Vol 3 No 1) Herpes, doing your own medical research, resisting womanhood
- ☐ Spring, 1982 (Vol 3 No 2) Infertility, VDTs, the politics of artificial lighting
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