HEALTHMATTERS

A PUBLICATION OF THE VANCOUVER WOMEN'S HEALTH COLLECTIVE.

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DEPO PROVERA — Would you take this drug?

The Health Protection Branch of Health and Welfare Canada is considering approving Depo Provera for unrestricted use as a contraceptive. We are seriously concerned about what approval will mean for Canadian women and have joined with other feminist health groups, consumer groups, organizations involving the physically and mentally disabled, and those working with immigrant and Native women's issues to form the Canadian Coalition on Depo Provera. The coalition's aims are to inform the Canadian public about the drug and its hazards, to urge the Federal Government to hold public hearings to assess its safety, and withhold approval of Depo Provera until more thorough and controlled studies are done.

Depo Provera (Medroxyprogesterone-acetate) is an injectable progesterone-like hormone. One injection can stop ovulation for 3-6 months, depending on the dose. It works by disrupting a woman's hormone regulating system. It also causes thinning of the uterine lining, making implantation of a fertilized egg unlikely or impossible. Many women stop menstruating entirely while taking the drug; after stopping the injections, women often experience irregular or excessive bleeding and temporary or permanent infertility. Short-term effects include weight loss or gain, depression, dizziness, hair loss, pain in the limbs, abdominal discomfort, vaginal discharge, darkened spots on the facial skin, and a loss of interest in sex. Long-term use has been associated with increased incidence of diabetes, severe mental depression, and birth defects. It is passed to nursing infants through breast milk in quantities proportionately equal to those of the mother. Its effect on infants is not known.

If Depo Provera is approved, we can expect a massive advertising campaign promoting its benefits as a contraceptive and pushing the drug at doctors and subsequently, women. We are afraid that the convenience of Depo Provera will be emphasized and that its dangers will be downplayed. We suspect that information about the drug will be incomplete and misleading, as has been the case for years with the Pill, and that women will be unable to accurately assess the risks vs. the benefits of using it.

As an injectable contraceptive, Depo Provera is particularly susceptible to abuse. The drug requires almost no cooperation on the part of the woman using it. Already in Canada, we have witnessed its use on mentally retarded and physically disabled women living in institutions, as well as on immigrant and Native women.

Though used widely in developing countries, Depo Provera is not approved for use as a contraceptive in North America. Upjohn, the manufacturer, has been trying to have it approved in the United States for 20 years and has been unsuccessful. The Food and Drug Administration has repeatedly turned Upjohn down, saying that studies done have been "haphazard" and "uncoordinated" and that public concern about the drug, expressed through groups like the National Women's Health Network, warrant taking a cautious approach to its approval as a contraceptive.

Historically, a number of drugs and medical devices have been allowed onto the market, have been advertised and accepted as safe, and years later have been banned because they were proven extremely dangerous. D.E.S., Thalidomide, and the Dalkon Shield are all examples of this. Will Depo Provera be added to this list, perhaps 10 or 20 years from now, after millions of women and children have been exposed to it?

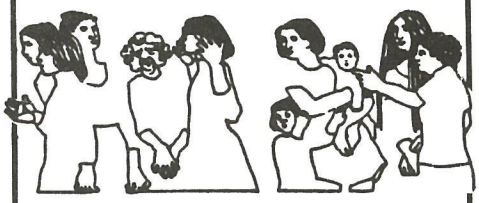
In Canada, we are being told that the matter is between the Health Protection Branch and the manufacturer, and that the government is not obliged to take public concerns into account. The Federal Health Minister, Jake Epp, claims that public hearings on the issue are unnecessary. He originally refused to meet with members of the coalition, but has agreed to a 45 minute meeting (most Ministerial meetings are 20 minutes) on December 18.

It is crucial that the Health Protection Branch look seriously at the implications of approving Depo Provera as a contraceptive. It is outrageous that in a so-called democratic society the concerns of those who stand to be most affected by the government decision, namely women, are denied input into that decision.

We are circulating a petition and encouraging people to write:

Jake Epp
Minister of Health and Welfare
House of Commons
Ottawa, Ontario
K1A OA6

No postage fee is required. For more information or if you want to help, call us at 682-1633.



INSIDE HEALTHMATTERS

POLYCYSTIC OVARIAN DISEASE—What is it?

Polycystic Ovarian Disease (also known as Stein-Leventhal Syndrome) is a condition characterized by one or all of these symptoms: irregular or absent menstrual periods, infertility, pain, abnormal hair growth, excessive weight gain, and diminished breast growth. Fifty years ago doctors Stein and Leventhal made a connection between these clinical symptoms and cystic changes in the ovaries. Since then, although the symptoms have become better understood, the cause has not. Various theories suggest that Polycystic Ovarian Disease is genetic in origin, or a result of an adrenal-glandular disorder in puberty which affects the amount of androgen (male hormone) in women.

In the normal monthly course of events follicles within the ovaries containing unripe eggs are stimulated to grow, develop, and move toward the surface of the ovary, where one of them matures, bursts open, and releases its egg. This process of stimulating the follicles is governed by hormones from the pituitary gland. After the egg is released at ovulation, the remnants of the burst follicle become the corpus luteum, which produces the hormone progesterone. The primary effect of this hormone is to stimulate the lining of the uterus to prepare for possible fertilization of an egg. The rising levels of progesterone also cause the pituitary to stop producing its hormones.

In women with polycystic disease, this normal progression of events does not take place. The follicles with the unripe eggs never reach the surface of the ovary. They remain beneath the surface, and since there is no burst follicle, there is no corpus luteum, and therefore no rising levels of progesterone to tell the pituitary to stop its production of follicle stimulating hormones. Thus, more and more follicles are trapped below the surface of the ovary. These follicles become fluid filled sacs called cysts. Eventually both ovaries become studded with cysts which can can cause them to enlarge to two or three times their normal size. The ovaries are enclosed in a thick shell, but it is unclear whether this is a result or cause of the presence of many follicle cysts.

The most common symptom of polycystic ovarian disease is the irregularity or absense of menstrual bleeding. This usually occurs shortly after a young woman begins to menstruate for the first time, but can also occur in women who have been menstruating normally for some time. The majority of women with polycystic ovaries grow extra facial and body hair, probably as a result of their ovaries producing more androgens than they normally would. The body converts androgens into testosterone. Although there may be male-type body hair patterns, most women with this disease do not have the more drastic masculinization effects such as decrease in breast size or balding.

Isis

Diagnosis is made by combining a physical exam with a careful history (with emphasis on when the symptoms started), and laboratory tests of hormone levels. A visual examination of the ovaries may be made, using either a culdoscope or a laparoscope, special instruments which are inserted into the body to view the organs.

If left untreated, polycystic ovarian disease is thought to increase the risk of uterine cancer, due to the action of constant, non-cyclic estrogen levels on the uterine lining. The oldest treatment is a surgical wedge resection of the ovary. In this procedure, a V-shaped portion of the ovary is removed. The theory is that the removal of ovarian tissue somehow causes a drop in androgen production, and therefore a resumption of ovulatory cycles. Although this treatment works 85% of the time, it is being used less because of the risk of post-surgical scar tissue preventing pregnancy

The most common treatments are hormonal. If regulation of the menstrual cycle is the goal, and the woman is not concerned with pregnancy, then a progesterone compound such as Provera is taken orally, once a month, usually for about five days. The progesterone causes the lining of the uterus to thicken and swell. When the drug is no longer present, the endometrial lining will break down and shed, simulating menstruation. Some doctors prescribe birth control pills instead of progesterone. The progesterone in the pill suppresses the pitutary hormones that keep stimulating the follicles. Using the pill cyclically, three weeks on and one week off, will allow the uterine lining to be shed.

If the woman wishes to become pregnant, fertility drugs, such as Clomid, are used. These hormones only work in the cycles in which they are given; they do not get the ovaries working again normally. If hormone therapy fails to induce ovualtion, surgical treatment may be considered. A woman with polycystic ovaries who has not decided whether she wants to get pregnant will probably be pressured to make a rapid decision because the longer the problem continues, the less successful is the treatment.

Apart from the question of whether she will be able to conceive, the other problems caused by the condition may be very stressful. The excessive hair growth can be very hard to deal with emotionally, particularly in a culture that has rigid standards for what is acceptable appearance in a woman. The hair can be removed by electrolysis, but the procedure is extremely time consuming and expensive.

Women may experience further stress because of the sorts of treatments doctors rely on. The emphasis of the medical profession seems to be placed on a woman's fertility, rather than her overall health. Both estrogen (used in the treatment of polycystic

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ANOREXIA NERVOSA—Compliance or Defiance?

In September of this year, the Canadian Pediatric Society general meeting announced that the incidence of Anorexia Nervosa among teenage women has doubled in the past ten years. There are growing numbers of eleven and twelve year old girls as well as a marked increase in the number of males - about 10% - suffering from anorexia nervosa.

Anorexia Nervosa was given its name in 1874 by William Gull; anorexia refers to a loss of appetite, nervosa refers to the psychological aspect of the condition. A.N. is a complex psychological disorder in which self-starvation becomes a symptom of emotional problems. It is characterized by an intense fear of becoming obese and a preoccupation with thinness. It involves a significant loss of normal body weight, loss of menstrual periods in women, extreme sensitivity to cold, numbness in the hands and feet, hair loss, poor concentration, dry or scaly skin, delay in bone development and in extreme cases hypoglycemic comas. In addition to eating less, women with anorexia nervosa may exercise compulsively, eat very slowly and cut their food into tiny pieces, weigh themselves several times a day, and deny that they are thin.

What anorexics share with other women is an uneasy relationship with food and body image. In a recent study, over 80% of adolescent women surveyed answered that they were dissatisfied with their body image

Health League of Canada

and wanted to lose weight. In another study almost ninety percent of those surveyed had been on a weight loss diet before they were eighteen. Many of us learned to eat to please and satisfy others, not to gratify or satisfy ourselves. Eating is hedged around a series of shoulds and oughts which have the effect of making it a penance rather than a pleasure.

Anorexics are sometimes viewed as being more susceptible to the power of mass advertising where women are flat chested and angular. Anorexics do not comply, they defy. In the face of social conditioning that teaches women to be passive, available and nurturing, anorexics defy what is expected of them. They make themselves unattractive and infertile, refusing to be warm or motherly. Their defiance has a double edge; they are strong yet helpless, controlled yet craving, slender yet repulsive.

Treatment for Anorexia Nervosa might include behaviour therapy - to encourage weight gain as well as psychotherapy and family therapy. Many anorexics are hospitalized for periods of time to gain weight, but their hospital visits rarely include the kind of emotional attention they need. To force or coerce an anorexic to eat - an act that she finds totally repulsive, may only reinforce her negative self-image.

Treatment type and success is very controversial but many anorexics point to the real advantages of self-help groups. Within the self-help group there is genuine understanding and an absense of the power struggle often exhibited between the anorexic and her doctor. The self-help group cannot take anything away from her. She can maintain her control, her independence and her self respect.

Most Anorexics have an extreme deficiency in zinc, thereby losing their their sense of taste and smell. Recent reports indicate that zinc supplements produce a marked improvement in their condition.

References:

The Anorexic Experience Marilyn Lawrence Women's Press, London, 1984

Prevention June 1985 pg 7

Self Starvation Spare Rib June 1979

Globe and Mail Sept. 11 1985

continued from page 2

POLYCYSTIC OVARIAN DISEASE

ovarian disease) and progesterone are known to have serious side effects, especially if used for a long time. Ironically some women develop polycystic ovarian disease once they stop using the pill.

Are women with polycystic ovaries expected to take these hormones for the rest of their lives? What are the long term effects of Clomid and the other fertility drugs? What are the effects of these drugs on the fetus?

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Womancare Lynda Madaras & Jane Patterson. Avon Books, New York, 1981 pg 443-448

The Experience of Infertility Naomi Pfeffer and Anne Woollett. Virago Press London 1983

Polycystic Ovarian Disease Diane Clapp and Paul Zarutskie RESOLVE Inc. 1981 fact sheet.

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WE WANT YOUR FEEDBACK

The article on Polycystic Ovarian Disease was written in response to a request from a reader. If there are health issues you would like to know more about then let us know.

"THE YEAST CONNECTION"—Candida albicans

THE YEAST CONNECTION: A MEDICAL BREAKTHROUGH by William G. Crook, M.D. Professional Books, P.O. Box 3494, Jackson Tennessee 38301

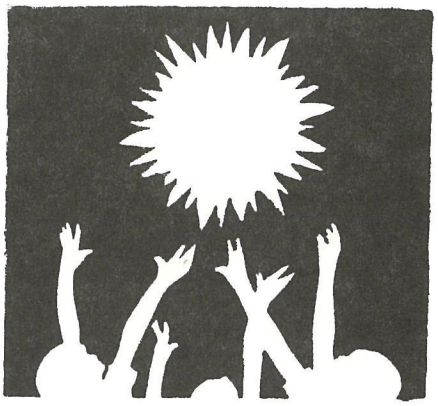
Is treating people for Candida albicans or intestinal yeast overgrowth for a host of seemingly unrelated chronic conditions a medical breakthrough? Dr. Crook thinks it is, based on his own clinical work since 1979 and his knowledge of the work of other doctors and researchers.

In 1979, after trying for over a year to help a woman with severe chronic hives, mental confusion, fatigue and depression, Crook put her on a yeast-free, low carbohydrate diet and the anti-fungal medication Nystatin. Within a few weeks, her hives had disappeared completely. She followed the diet and took Nystatin for almost a year and her other symptoms also gradually improved. She now feels perfectly well. Since then Dr. Crook has taken a particular interest in Candida albicans and has helped many of his patients with a similar program.

Why an overgrowth of a type of yeast which normally lives in the body, especially in the digestive tract? Other than pregnancy and the hormonal changes of the menstrual cycle (women are more prone than men to Candida), the promoters of yeast overgrowth are strictly twentieth century ones - antibiotics which destroy friendly bacteria in the digestive tract but not Candida, birth control pills and diets rich in sugar and yeast. The toxins released by the excess yeast weaken the immune system, leaving us vulnerable to a host of conditions.

Some of the major symptoms of Candida are fatigue, insomnia, muscle aches and weakness, digestive problems, loss of sexual feeling, premenstrual syndrome, endometriosis, infertility, anxiety, chilliness and irritability when hungry. Since tests for Candida are not yet too reliable, it is usually diagnosed by looking at a person's symptoms and her/his medical history, especially as it relates to use of antibiotics, birth control pills and cortisone-type drugs. The book contains a questionnaire and score sheet which can help the reader determine if her/his health problems are likely to be Candida-related.

Dr. Crook's treatment program involves a diet with no yeast, molds or fungi, sugar or honey, fermented



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foods, alcohol, cheese, fruit juice, dried fruit, processed food, dried or smoked meats. Meat, fish, poultry, eggs, vegetables, whole grains, nuts (except peanuts and pistachios), seeds, and occasional fruit and dairy products (if no allergy to dairy) are allowed. Vitamins in a yeast base must be avoided. Dr. Crook actually has four diets that he recommends, depending on the individual. The Candida control diet includes high carbohydrate vegetables, grains and fruit. More difficult cases may require a low-carbohydrate diet or a completely fruit-free diet. There is a fourth extremely restrictive diet which is fruit, grain, nut and milk-free. Controversies over some aspects of the anti-Candida diet (e.g. whether fruit should ever be allowed), are discussed in the book.

The other main aspect of treatment is an anti-fungal preparation. Crook uses Nystatin which he believes to be an unusually safe medication. (Some people are sensitive to Nystatin and get diarrhea, nausea and vomiting). He uses other drugs when Nystatin does not work or cannot be tolerated. Surprisingly, he only mentions in passing Caprystatin, a non-drug preparation containing a saturated fatty acid as the anti-fungal agent. Some health practitioners have found it superior to Nystatin. And, except for Taheebo tea, a herbal remedy, he does not mention other anti-fungal remedies that are being tried by various researchers.

An anti-Candida program may also include avoidance of known allergens and inclusion of vitamin supplements, especially vitamin C and Evening Primrose Oil (gamma-linolenic acid). Crook does not claim a cause and effect relationship between Candida and allergies, premenstrual syndrome, infertility, etc, but the fact that these conditions often improve or disappear after treatment for Candida indicates that there is a connection. In one of the most interesting chapters, the possibility of a link between Candida and conditions such as multiple sclerosis, psoriasis, Crohn's disease, systemic lupus erthematosus and arthritis are discussed. Some people with these auto-immune-related diseases have been helped with an anti-Candida program.

Crook makes it clear that he considers Candida as only one contributing factor to a weakened immune system; nutritional deficiencies, environmental toxins and molds, and food and inhalant allergies all can contribute, and so might emotional stress. Many people do find, though, that their allergies and chemical sensitivities improve when their Candida has been treated.

One chapter called "Labelling diseases isn't the way we should go" sums up the philosophy underlying the book. By dividing illnesses into "diseases" the interconnections between systems and organs are often overlooked, as is the interaction between body and environment. Understanding that there is a connection between the immune system, hormonal system and the brain makes some sense of the Candida connection since Candida can affect all of these systems.

For anyone interested in Candida albicans, this book is easy to read and has many useful charts and illustrations. For those wanting more technical information, the many references to other authors and studies are footnoted and there is a long reading list on related topics such as allergy, immunology and clinical ecology. Information on this subject is constantly being revised and updated and any book on Candida will become out of date quickly, but as an introduction to the topic, this book is fascinating reading.

ANNETTE CLOUGH

There will be a support group series for people embarking upon a remedial program, or allergy diet, beginning in mid-January at the Vancouver Health Enhancement Centre 1644 West Broadway. The group will meet once a week for six weeks to share experiences, food, and support, and receive practical information regarding nutrition, recipes, menu planning, and stress reduction. Fee is $30 for the series. For more information call Margaret Sinclair, 228-9275 (after January 4th)

HEALTH SHORTS

Abortion Tribunals

Concerned Citizens for Choice on Abortion (CCCA) are holding a public tribunal "Speak Out For Choice; Abortion Law on Trial" on January 25 at 2.00 pm at St. Andrews-Wesley Church in Vancouver. The tribunal is designed to shift emphasis in the abortion debate from the fetus to the woman. It will provide an opportunity for women to turn the tables round....instead of being on trial, women will put section 251 of the criminal code on trial. Women who are interested in presenting testimony about their abortion experiences can contact CCCA at 876-9920. Confidentiality will be assured.

Pushing Asbestos

Canada's Mines Minister Robert Layton thinks Canadians have the wrong attitude towards asbestos. As minister from Quebec, the home of most of what remains of Canada's asbestos industry, he is making speeches and having information packets put together in praise of asbestos. In the U.S. there are thousands of law suits pending against the asbestos industry. The U.S. Environmental Protection Agency has been trying for years to ban several products containing asbestos. Undaunted, Mr. Layton wants to double Canada's asbestos production and start marketing it in developing countries. With little information to assess asbestos, people in developing countries may have what Layton describes as a less "negative attitude" towards it.
What is the justification for Canadians' "negative attitude"? Inhalation of asbestos fibres causes asbestosis, a chronic progressive lung deterioration, and mesothelioma, a rare but deadly cancer in the lining of the chest and abdomen.
We will have more about asbestos in our next issue of Healthmatters.

Source: Globe and Mail Oct. 5 1985 pg 1

Biased Drug Testing

Bio-Research Laboratories Ltd. (one of Canada's largest drug research companies) does not want women in their study groups. The company tests new drugs on about 1000 Quebec students a year, advertising for "Young men, 18 years or over, weighing between 145-185 pounds, in good health". This version of the "medical norm" under represents the majority of prescription drug users, for example, 73% of all tranquilliser prescriptions go to girls and women. Yet, researchers want to restrict the variables; womens bodies threaten the clean curves of their graphs. A researcher at the lab said that "women have fluctuating hormone levels and different combinations of hormones, which makes studies more difficult".
These differences are precisely why women should be included in studies of drugs. In essense then, if the drug affects women differently than men, the effects are not apparent until after the drug is on the market.

Source: The Ubyssey Nov. 15 1985 pg 1

Hiccups

A doctor in southern China's Yunnan province has cured 350 cases of hiccups by pressing the ears of patients. Inspired by an ancient theory, Dr. Deng Guangwu of the Qujin Traditional Chinese Hospital began daily ear pressure treatments in 1974 on a peasant who had been hiccupping for three years. Apparently Deng cured the patient by applying pressure in his outer ears for up to three minutes daily.

Source: Globe and Mail Oct. 18 1985 pg 2

Abortion in Spain

In early November, 3,000 feminists openly defied Spain's abortion law at their national convention on Abortion Rights. During the conference two pregnant women had abortions in an adjoining conference room. The women did not meet the criteria set out in the August 1985 law which somewhat like Canada's law, legalizes abortion in pregnancies caused by rape, where the fetus is deformed or there is a danger to the mother. The inadequate law is also facing opposition of a different kind. Spain's National Council of Bishops has threatened to excommunicate anyone who co-operates physically or morally in an abortion.
the Roman Catholic church.

Source: Globe and Mail Nov. 11 1985 pg 1

Surgeon with Aids

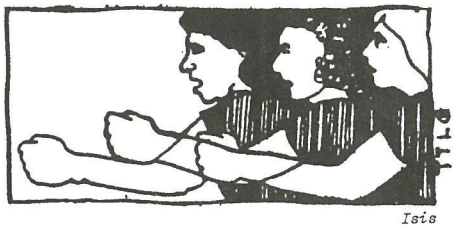
A Florida surgeon with AIDS operated on hundreds of patients without passing on the virus, supporting the belief that AIDS infected health care workers can safely treat patients. The doctor died two years ago and researchers attempted to contact all patients he treated between 1978 and 1983. The study of over 400 people 'found no evidence that transmission of AIDS to patients had occured and nothing to suggest that the surgeon should not have been practising! The study was conducted by the Florida Department of Health and Rehabilitative Services.

Source: Globe and Mail Oct. 17 1985 pg 9

Beeping Birth Control

A new birth control device called the "Bioself" has been released on the market in Canada this fall. The Bioself is currently selling for $97 in pharmacies in Ontario, Quebec and the Maritimes. The Bioself is a thermometer which a woman uses to take her Basal Body temperature every morning, combined with an alarm clock which beeps to wake her up, a computerized memory to keep track of temperature readings, and a light which shines green when she is least fertile, red when she is near ovulation, and blinks red around the time of ovulation when she is most fertile.
The Bioself, like any other basal body thermometer, measures the rise in body temperature which occurs after ovulation. It is no more accurate or effective than any other basal body thermometer but potentially much more profitable. The cost of all the Bioself's ingredients to a woman would be approximately this: Basal Body Thermometer $8; simple calculator $10; cheap alarm clock $10; paper and pen $2. The total would be $30 at most. Since women have most of these things around and could easily do the simple calculations needed the cost could be brought down to $8 for the thermometer. The additional $89 for the convenience and the gimmicks on the Bioself is a hefty price to pay.

Source: Globe and Mail Sept. 26 1985



Isis

MIDWIFERY IN BRITISH COLUMBIA

Midwifery is illegal in all of the provinces and territories of Canada except Newfoundland, where nurse-midwives can be the sole attendants at births in emergency situations. In spite of this, lay (unlicensed) midwives have been practicing both in B.C. and in other provinces for the last 10 to 15 years. Since the early 1970's over 200 women in Canada have worked as lay midwives. They have provided pre-natal care, support during labour and delivery, and post-patrum care for a relatively small number of women. Less than 1% of births in B.C. are attended by midwives.

Lay midwives risk being charged with practicing medicine without a license; a misdemeanor. If a death or injury occurs, they risk being charged with criminal negligence. Infant deaths that occur in a hospital under the care of a doctor are rarely investigated. The investigations that do occur are carried out privately by the College of Physicians and are limited to whether a person's license to practice should be revoked, and not whether he or she should face a possible jail sentence.

The midwives of Vancouver practice openly, even though their practice is illegal. They are known by hospital obstetrical staff and by the doctors who provide medical back-up to women planning home birth. The midwife must be known, and her experience respected by the client's doctor and by hospital staff, in case a planned home birth has to be moved to the hospital.

In the past, lay midwives have either received their training in countries where midwifery was legal or they have apprenticed under other practicing lay midwives. However, a school of midwifery opened in Vancouver in September 1984 to provide formal training. Sixteen women, most of whom were previously practicing as lay midwives, have just completed the academic portion of the program, and are beginning the clinical portion of their studies. The school has a midwifery instructor from England and a nursing instructor. It also solicits lectures and workshops from other health care practitioners. Funding comes entirely from students' tuitions. The school curriculum has been adapted from midwifery schools in other countries, particularly in the Netherlands and the Seattle School of Midwifery. It follows a 'direct entry' model of midwifery which does not require nurses' training as a prerequisite. The clinical portion of the program requires attendance at 50 births as an observer and attendance at an additional 50 as the primary attendant.

The school has applied for accreditation in Washington State, so that graduate midwives can obtain a valid license. A license to practice in Washington does not improve a lay midwife's legal standing in B.C. However, it does provide her with more credibility, both in a court case should she be tried for practicing medicine without a license, and in the eyes of the general public. A formalized system of training also ensures clients that they are hiring someone with skills and experience.

Midwives and their supporters created the school as one aspect of the fight for legalization. The Midwifery Task Force, a consumer group, has been lobbying the government and suggesting changes to the existing legislation. Although the Social Credit government is unlikely to legalize midwifery in B.C. in the near future, both the Quebec and Ontario governments are currently considering legislation to legalize midwifery.

Midwives have formed professional organizations in several provinces. The M.A.B.C.(Midwives' Association of British Columbia) is the professional body of midwives in B.C. The M.A.B.C. guidelines for the practice of midwifery are based on international standards. The association is currently discussing plans to make the guidelines binding, so that member midwives not practicing according to guidelines would have their membership revoked. An associated group, the M.A.B.C. Consumer Council, has recently been formed in order to provide input from the users of midwifery care.

The M.A.B.C. would like to be an independent, self-regulating profession. Should midwifery be legalized, there is no guarantee that the type of organization proposed by the M.A.B.C. would be accepted. Nurse-midwives practicing under the supervision of doctors and only able to deliver in hospitals would provide some measure of reform to the present system, without threatening the medical profession's control of the birthing process. However, a nurse-midwife system under the control of doctors may not significantly change present medical intervention practices. For example, in 1982-1984 a pilot midwifery project took place at Grace Hospital in Vancouver. Four nurse-midwives working with four obstetricians provided care for healthy low risk women. Midwifery care was less personalized than that provided by lay midwives, as women did not know which of the four midwives they would get during their labour, although they met them all during pre-natal visits. Intervention rates for the pilot group were lower than for Grace Hospital as a whole, but they remained relatively high. The project's forceps rate was 16% and the Caesarian section rate was 11%. This compares to a forceps rate of 19.8% and a Caesarian section rate of 21.5% for Grace Hospital during the same period. By comparison, of all planned home births attended by midwives in Vancouver in 1983, the forceps rate was 2% and the Caesarian section rate 4%.

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DEMYSTIFYING MENOPAUSE

Menopause is a normal developmental phase in the life of a woman. It is the permanent ending of a woman's menstrual cycles and her ability to bear children. We usually use the term to mean the entire period from the onset of the decline of ovarian function to the stabilization of the body at reduced levels of estrogen. It is the natural result of the changes in hormonal production that come with aging.

Menopause is not a disease, and menopausal women are not sick. The popular stereotype of the menopausal woman has been primarily negative. She is exhausted, irritable, unsexy, a burden to her family and irration ally depressed. Menopause is often seen as the beginning of the end. The period of change is gradual, usually starting when a woman is in her mid-forties and lasting 5-7 years. For some women their periods will stop abruptly, but most women will experience some menstrual irregularity before their periods end altogether. Menopause is said to be complete after one year without a period. It is recommended that sexually active heterosexual women use some form of birth control until this period has been completed.

The most common symptoms associated with menopause are hot flashes, night sweats, and vaginal dryness. These have been clearly linked to estrogen depletion. Other symptoms range from various physical discomforts to irritability, anxiety, and depression. It is hard to know if these states are related to hormonal changes in menopause, the aging process, or cultural conditions. Aging is difficult for women in a society that values youth and a youthful look.

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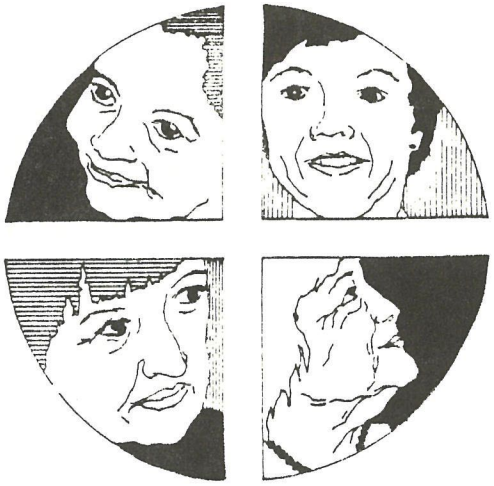
These are years of change for most women; family structures alter, children leave home and job opportunities are fewer. Some women find themselves widowed or divorced. It is possible that the depression and anxiety as well as the physical problems that many women feel at this time are caused more by the emotional distress and well grounded fears of getting older, than with the menopause itself.

Conventional treatment for menopause has been Estrogen Replacement Therapy (ERT). Although ERT has been helpful in relieving symptoms for some women, there are serious side effects that need to be carefully considered. These include an increased severity of symptoms when the drug is discontinued, increased risk of endometrial cancer, increased blood clotting, elevated blood pressure, post menopausal bleeding, benign liver tumors and more!

Non medical methods of dealing with menopause include exercise, diet, vitamin supplements, herbal therapies, and relaxation techniques. These treatments involve women being in control of their own health and the benefits they may experience are many. It is equally important for women to cut down on certain substances such as caffeine, alchohol, sugar, chocolate, and some prescription drugs, as these aggravate menopausal problems.

Many women have found the support of other women a great help. Menopause is not as strange or fearful to us if we can share information and offer support to one another.

Menopause does not have to signify a period of decline. It can be a time of self discovery, and a new phase of life full of challenges and possibilities opening up to us.



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MIDWIFERY

Whether or not legalization is desireable is a controversial issue within the midwifery movement. Some midwives and consumers oppose legalization; they feel that it would infringe on the spiritual side of midwifery and the ability of an individual midwife to independently determine her own style and mode of practice.

Currently, if most midwives consider a woman to be too "high risk" (too likely to have problems) to consider attending at home, the woman has the option to seek out another midwife who will attend her. Those who oppose legalization and licensing fear that this woman would be denied the choice to give birth at home should midwifery be legalized. Those who favour legalization fear that at present a woman seeking out a midwife has no way of knowing that her situation may be unsafe should she happen to contact a midwife who does not practice according to the M.A.B.C. guidelines.

The issue of the safety of home births is crutial because the medical profession has been very sucessful in convincing the majority of Canadian women that it is not safe to give birth outside of a hospital. Midwifery which includes home birth as an option will not become legalized unless it wins much wider support. The recent moves of the midwives of B.C. to bring in a formal system of training and a set of guidelines are important steps towards that support.

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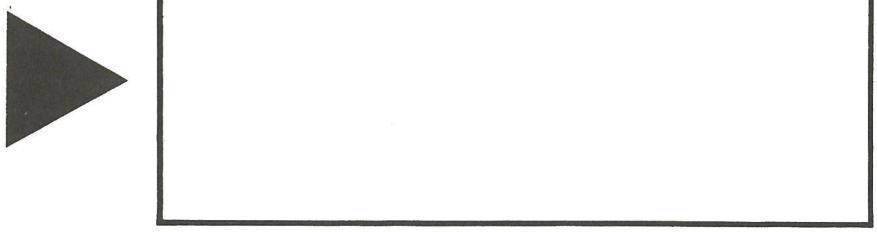

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