

Canadian Women's Health the network

spring-fall 2003

volume 6

number 2/3

Midwifery care in Canada continues to face challenges

Doulas create birth
memories worth cherishing

Prenatal technologies may
not offer reproductive choice

Health complications
from breast implant
surgery common

SPECIAL DOUBLE ISSUE

Canadian Women's
Health Network



Le Réseau canadien pour
la santé des femmes

Ta Da! *The Canadian Women's Health Network Unveils a New Logo*

In the spirit of birth and rebirth—the topic of several articles in this issue of *Network* magazine—we would like to present you with our new logo. We are not abandoning images many of you have come to associate with the Canadian Women's Health Network—our dancing women in bold purples, or our soft daisy in white hues; rather, we've simply added to our repertoire.

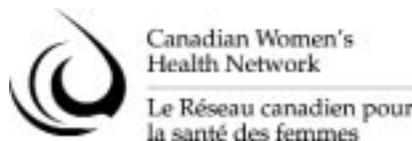
The logo, we hope, will act as a visual mnemonic device—something that will trigger individuals to remember who we are, a collective of distinct and distinguished women's health organizations, and what we do, women's health education, advocacy, policy influence and community networking; and above all, what we stand for, the improvement of health for all women and girls in Canada.

Of course, no single image can carry all of this easily, so we've opted for something abstract—something onto which we can project our meaning; something we can shape and form to our own image. Nevertheless the new logo conveys, in its very form, the activity, tenacity and vigour of a strong Canadian women's health movement. The spiral logo is thus no passive image, but a symbolic *fireball* of activity. When it is presented in full colour (we can't afford all the logo colours here in our magazine), the logo contains both a ruddy orange and red, and a powder blue: resonant of both the earth, to ground us, and the sky, to keep us looking forward.

Please welcome our new logo into the family of Canadian Women's Health Network images.

Sincerely,

Kathleen O'Grady
Director of Communications



WHAT'S INSIDE

- 3 Midwifery care continues to face challenges
- 6 Doulas create birth memories worth cherishing
- 7 Mothers in motion
- 8 Prenatal technologies may not offer reproductive choice
- 10 Degree of women's homelessness underestimated, study finds
- 11 Which tips for health really matter?
- 12 HRT claims challenged
- 13 Newspapers highlight benefits of new drugs, ignore risks
- 16 Drugs in our water
- 18 Health complications from breast implant surgery common
- 20 Women survivors of childhood sexual abuse reluctant to use health system
- 21 What we're reading
- 23 Women's health on the Canadian Health Network
- 24 About us: The Canadian Women's Health Network

Cover photo: Christina Gapic Photography / www.christinagapic.com

Editor: Kathleen O'Grady
Writer: Julia Allen
Margaret Laurence Research Assistant: Punam Mehta
Production Coordinator: Susan White
Design and Layout: Folio Design
Translation: Intersigne
Subscriptions: Léonie Lafontaine
Advisory Committee: Abby Lippman, Anne Rochon Ford, Susan White and Madeline Boscoe

Network/Le Réseau is published in English and French four times per year by the Canadian Women's Health Network (CWHN). Parts of Network/Le Réseau are also available on the CWHN web site: www.cwhn.ca

To subscribe to **Network** magazine, call 1-888-818-9172 or email cwhn@cwhn.ca for details and payment options. Receive 4 issues of **Network** a year for only \$20. Back issues are also available at \$5 each. We welcome your ideas, contributions and letters. All requests for information and resources, as well as correspondence related to subscriptions and undeliverable copies, should be sent to:

Network/Le Réseau
Canadian Women's Health Network
203-419 Graham Avenue
Winnipeg MB CANADA R3C 0M3
Tel: (204) 942-5500
Fax: (204) 989-2355
Toll-Free: 1-888-818-9172
TTY (toll-free): 1-866-694-6367
Email: cwhn@cwhn.ca
Website: www.cwhn.ca

Canadian Publications Agreement #40036219

CWHN Staff
Executive Director: Madeline Boscoe
Assistant Executive Director: Susan White
Director of Communications: Kathleen O'Grady
Web Site Manager: Ghislaine Alleyne
Technical Support: Tom Pieczonka
Administrative Services Coordinator: Léonie Lafontaine
Clearinghouse Coordinator: Barbara Bourrier-LaCroix
Health Educators: Alex Merrill, Manon Sabourin, Siobhan Kari
Outreach Coordinator: Mona Dupré-Ollinik
Library Technician: Charlene Jones

The opinions expressed by contributors are their own and do not necessarily represent the views of the Canadian Women's Health Network, its funders or its members. Articles are intended to provide helpful information and are not meant to replace the advice of your personal health practitioner.

The Canadian Women's Health Network gratefully acknowledges the funding support provided by the Women's Health Contribution Program of the Women's Health Bureau, Health Canada, as well as the support and donations of the individuals and groups whose work strengthens the Network.

Printed and mailed by union labour. Printed on recycled paper by Winnipeg Sun Commercial Print Division.

Midwifery Care Continues to Face Challenges

Canadian midwifery is still defining itself, one mother at a time

BY MIRANDA HAWKINS AND SARAH KNOX

DESPITE THE GAINS THE MIDWIFERY PROFESSION HAS MADE IN CANADA OVER THE PAST 10 YEARS, IT STILL FACES MANY CHALLENGES. SOME PROVINCES ARE STRUGGLING FOR FUNDING AND OTHERS FOR LEGITIMACY. MANY DOCTORS AND NURSES NOW CONSIDER MIDWIVES COLLEAGUES AND MAY RECOMMEND MIDWIFERY CARE TO THEIR PATIENTS OR CHOOSE IT FOR THEIR OWN BIRTHS. HOWEVER, IN SOME COMMUNITIES, INDIVIDUAL HEALTH CARE PROFESSIONALS MAY FEEL HESITANT OR EVEN HOSTILE ABOUT MIDWIFERY, THE WOMEN WHO PRACTISE IT AND THEIR CLIENTS.

Access to midwifery training is an issue for women who live outside major centres where education programs are based, or in provinces with no midwifery education programs at all. First Nations and Inuit midwives still face great challenges around training and regulation.

Advocates fight for funding on a yearly basis, even in provinces where midwifery has been established for years. Malpractice insurance remains one of the most difficult issues for midwives and for health care ministries; the premiums increase exponentially, at one time jumping by more than 400% in a single year.

The consumer movement so integral to the formation of professional midwifery remains strong in some parts of the country, while in others, having slept through the post-legislation years, it is waking up to the new issues of the day.

In some areas, midwives' increasing comfort with medical technology is causing concern. For example, will allowing midwives to administer epidurals change the core values of midwifery or will it support choice and continuity of care? Will schools continue to graduate midwives who are comfortable with homebirth, the roots of midwifery, and who are committed to care that is truly woman-centred?

A poster we spotted in practices around Toronto aptly proclaims midwifery to be “the oldest and newest profession.” Rich in history and with a solid philosophical stance, Canadian midwifery is still defining itself, one mother at a time.

Midwifery in Canada:

75% of the world's children are born into the hands of midwives. How does Canada compare?

- In Ontario, the Canadian province with the most midwives, 4.5% of children are caught by midwives.
- Five provinces/territories have no midwifery legislation or funding, 2 provinces have legislated midwifery but have not provided funding, and Quebec does not sanction homebirth, making this safe and inexpensive option nearly impossible for women who want reliable care.
- In legislated and unlegislated provinces, many women seek midwifery care but are turned away because of a shortage of midwives.

The result is a radically different picture of midwifery care depending on where you live in Canada and many barriers to accessing midwifery care. ►

PROVINCE	LEGISLATED	FUNDED	FEE FOR SERVICE	HOME/HOSPITAL/ BIRTH CENTRE	EDUCATION PROGRAM
Alberta	Yes	No	Yes	Home/Hospital/Birth Centre	No
British Columbia	Yes	Yes	No	Home/Hospital	Yes
Manitoba	Yes	Yes	No	Home/Hospital	No
Newfoundland and Labrador	No	No	No	Hospital (remote areas only)	No
New Brunswick	No	No	No	Home	No
Northwest Territories	No	No	Yes	Home	No
Nova Scotia	No	No	Yes	Home	No
Nunavut	Partially (one pilot project in 2002)	Partially	No	Birth Centre (only in Rankin Inlet)	No
Ontario	Yes	Yes	No	Home/Hospital	Yes
Prince Edward Island	No	No	Yes	Home	No
Quebec	Yes	Yes	No	Birth Centre	Yes
Saskatchewan	Yes	No	Yes	Home	No
Yukon	No	No	Yes	Home	No

Why we need accessible midwifery care across the country:

- By the year 2020, there will not be enough doctors to deliver Canadian children.
- Midwives provide a type of care that doctors cannot or do not.
 - Midwives can provide excellent prenatal care, operating on the principle of “informed choice,” which provides women with the information they need to make smart choices that work for themselves and their families.
 - Midwives provide excellent emotional support through longer appointments with their clients, offering on average, 20 to 30 minutes more time per appointment than medical professionals.
 - Midwives provide “continuity of care,” which means that mothers know that the people caring for them during their pregnancy will be the same people attending their births and making sure that they and their babies are off to a healthy start, including six weeks of postpartum care.
- Midwives are respectful of women’s choices to have their babies their way. Midwives offer the highest standards of practice and are supportive no matter what the outcome of the birth.
- Midwives are the only legislated professionals who routinely attend births outside hospitals.
- Midwives are strong advocates of birth without unnecessary

interventions (epidurals, continuous fetal monitoring, episiotomies), and are experts in helping women birth in health and happiness without requiring these interventions. While medical interventions do help women when used appropriately, they have become routine in many medically attended births, often at great cost to the woman and to the health system itself.

- Midwives provide care to women from every walk of life and are well trained to serve women from diverse religious and cultural backgrounds.
- Hundreds of women have told us that the care they received from midwives has allowed them to become strong and confident mothers that raise strong and confident children.
- In some areas of the country, a shortage of doctors means women cannot get proper, well-woman care, such as tests to detect cervical cancer or birth control counselling or prescription drugs. Midwives are capable of providing these services to their clients on an extended basis.
- In some communities, women require costly transfers to larger centres to give birth to their babies.
- Midwives have great success in aiding mothers to breast-feed, which has been proven to have long-term health benefits for children. The common problem of dehydrated newborns being brought into hospital emergency wards for treatment is solved by frequent home visits and nursing support from a known and trusted caregiver.

- Six weeks of regular check-ups for mother and baby, often in the home, means that potential problems, such as postpartum depression, can be avoided or detected early by someone who not only knows the signs of depression, but knows the woman well enough to note changes in her personality and behaviour.

Barriers to Universal Canadian Midwifery Care:

1) *Lack of government support (legislation)*

In provinces without legislation, very few midwives practice because of the difficulty of practicing in a quasi-legal way, and because of the difficulty in earning a living. In unlegislated provinces, the few midwives practicing cannot order routine blood and urine tests, or serve women whose particular pregnancies, or personal beliefs, would make a hospital birth a better option.

2) *Lack of government funding*

In provinces without legislation, or those where midwifery is legislated but not funded, women must pay for their midwifery care themselves. Even with the common practice of accepting payment on a sliding scale geared to income, many women cannot afford the cost of a midwife, leaving those already marginalized by society (the poor, new immigrants, young mothers) without access to midwifery care.

3) *Lack of midwives*

In provinces where midwives are legislated and funded, midwives are highly sought after and many mothers who seek care cannot be accommodated.

4) *Lack of training opportunities*

In order to get more midwives, you need to train more midwives. Though Ontario, Quebec and British Columbia offer university training for midwives, the aspiring midwives in other provinces need the opportunity to train in the areas where they currently live and work. Entering the existing programs is not feasible for many potential midwives, and ultimately means fewer midwives entering those already midwife-hungry provinces where the profession is already established.

5) *Lack of intra-professional understanding*

In our own care, we have benefited from respectful relations between midwives and physicians. However, there are many cases—some well-documented—of midwives being

treated as lesser professionals by doctors and nurses. When this happens, women's care is compromised.

In some legislated areas, individual hospitals grant—and deny—privileges to individual midwives. Should a hospital decide not to make privileges available to a midwife, she can be left unable to take clients who choose to birth in hospital, leaving these women without care, or forcing them to accept medical care instead.

6) *Inability to practice in a home setting*

Some medical professionals still refuse to acknowledge the safety of homebirth, and campaign against allowing midwives to catch babies at home, and stalling or altering the move towards legislating midwifery. This despite studies showing homebirth is a good option for many mothers and babies, including a recent study by the Canadian Medical Association.

What Still Needs to be Done?

Lobby the federal and provincial governments for:

- 1) Legislated and funded midwifery care in every province and territory, making this a truly Canadian option, available to the diverse populations of Canada.
- 2) Decentralized educational opportunities for potential midwives. This can be achieved through the creation of satellite schools and investing in on-line learning. Also, experienced midwives in areas other than those with existing university educational programs must be allowed to act as preceptors for future midwives. This means allowing students to apprentice and study away from their midwifery education programme.
- 3) Professional recognition of midwifery within the health care system through greater education about the benefits of midwifery care and the way in which midwives practice in Canada today. This will lead to better working relationships and increased privileges for midwives within hospitals.
- 4) Recognition of home birth as a safe and viable option for women in all provinces and territories, and permission for trained professionals to attend these women. 

Miranda Hawkins and Sarah Knox are the authors of the recently published, The Midwifery Option: A Canadian Guide to the Birth Experience (Harper Collins, 2003). For more information, visit www.midwiferyoption.ca

Doulas Create Birth Memories Worth Cherishing

BY JULIA ALLEN

WHEN MY GRANDMOTHER WAS PREGNANT WITH MY MOTHER IN THE EARLY 1950S, CHILDBIRTH WAS A PRETTY SCARY EVENT. HER EXPERIENCE GIVING BIRTH TO MY MOTHER, AND LATER, TO MY UNCLE, WAS VERY TYPICAL OF THE DAY—LONELY, COLD AND TERRIFYING.

But with the birth of my aunt, my Grandmother experienced something different. Though the birth itself was similar to her other birthing experiences, my Grandmother remembers this birth more fondly thanks to a visit she had from a young nurse when my aunt was barely a day old. My Grandmother vividly remembers that this woman brushed the newborn's silky hair, winding it into a beautiful kiss curl on her forehead. These few moments of kindness transformed what had been a typical birth into something special, and created a memory to be treasured throughout my Grandmother's entire life. Whether she knew it or not, this kindly woman was a *doula*.

The title "doula" originally comes from an ancient Greek word that means "a woman who serves other women." Today the term is used to describe a woman who helps couples go through the process of childbirth. Unlike the woman in my Grandmother's experience, doulas are rarely nurses, and in fact, are usually lay women who feel a calling to help women in childbirth. But similar to the woman in my Grandmother's story, doulas bring a kind and nurturing touch to the birthing experience whether it be in the hospital or the home.

Typically, doulas visit with the mother and her partner a few times before the birth of the child. These visits allow the couple and the doula to get to know one another and plan for the birth ahead. By the time the woman goes into labour, she knows her doula well, and her doula is familiar with the woman's hopes and wishes for the birth, as well as her fears.

When labour starts, doulas are available day or night. Doulas offer suggestions about how to speed labour and ease pain. As well, a doula provides an extra pair of hands, ready to do what needs to be done, from refilling a water glass to parking the car. Most of all, a doula's quiet presence communicates support, encouragement and reassurance—the "mothering" many labouring women crave.

For hospital-birthing couples, doulas are on hand to demystify terminology, procedures and machines that can seem quite intimidating to parents. Doulas also make sure that the couple receives all the information they need when faced with

unexpected situations.

The support a doula offers is not limited to the mother; in fact, one of the key aspects of a doula's role is to support the mother's partner. Whispers of "Why don't you try rubbing her back right here" or "She looks like she might like some more water" are common at doula-attended births, after which women will often marvel at how her partner mysteriously knew exactly what she needed.

After the birth, doulas return for one or two more visits to help with breastfeeding, process the birth experience and refer the new mother to other community resources if necessary.

The results of this type of continuous care are impressive. A landmark 1993 study by Klaus, Kennel and Klaus found a 50% reduction in Caesarean births, a 25% reduction in the length of labour and a 60% reduction in epidural requests among women supported by doulas.¹

Although doulas and midwives generally share a view of birth as a natural family event, they differ in that doulas do not perform any clinical skills or assessments. They are also different in that a doula's responsibility peaks during active labour when contractions are the strongest, whereas a midwife's responsibility peaks at the time of birth. This means that doulas can spend the bulk of their energy helping women from one contraction to the next, without having to save energy to monitor the delivery.

As well, doulas work with women that midwives generally do not work with, such as women who are classified as "high-risk," women who plan to undergo an epidural or a Caesarean, or in parts of Canada where midwifery is not yet legalized, with women who plan a hospital birth. A doula wants her client to have the most satisfying birth possible, however the woman defines it.

Training programs for doulas are varied; however, like the training offered by the 4,600-member organization Doulas of North America (DONA) (www.dona.org), many begin with an intensive three-day workshop focusing on the physical and emotional aspects of childbirth and pain-coping techniques.

Doulas usually work in private practice, charging anywhere

from \$250 to \$800. Nevertheless, most doulas are committed to DONA's vision of "a doula for every woman who wants one," and offer their services on a sliding scale or on a volunteer basis.

Although the scope of the role played by the woman who had such an effect on my Grandmother's birthing experience is far more limited than today's standards for doula care, her impact on my Grandmother is what today's doulas strive for. Kindness, support and recognition of the significance of childbirth are hallmarks of doula care, because, as in my Grandmother's experience, these are the factors that create a lifetime of positive birth memories. 

For more information, visit:

www.cwhn.ca/resources/faq/doulas.html

NOTES

¹ Klaus, Marshall H., John Kennel and Phyllis Klaus (1993) *Mothering the Mother: How a Doula Can Help You Have a Shorter, Easier, and Healthier Birth*. Reading, Massachusetts: Addison-Wesley Publishing House.

Nursing and Midwifery Exhibit

An exhibit on Canadian nursing and midwifery will open in 2005 at the Canadian Museum of Civilization. One section will be about midwifery, including traditional and contemporary practices in aboriginal midwifery. The organizers are seeking individuals or agencies willing to share personal stories and/or to donate artifacts (e.g., birthing mats, herbs), old pictures and newspaper clippings.

This is part of a larger initiative to create an interactive database on nursing and midwifery history, and find homes for donated material. Contact Dena Carrol and Cecilia Benoit at: (250) 472-3554 or dc Carroll@telus.net

Mothering, Religion and Spirituality Conference, Toronto

The Association for Research on Mothering invites you to attend our 7th annual conference, "Mothering, Religion and Spirituality," featuring keynote speaker, Starhawk. Atkinson College, York University, Toronto, Canada, October 24-26, 2003. For more details visit: www.yorku.ca/crm/ or call: 416-736-2100 x60366.

Mothers in Motion

Encouraging women to be active with their children

BY KRISTA BENOIT

GETTING NEW MOMS BACK INTO A PHYSICAL ACTIVITY ROUTINE or getting them active for the first time after giving birth is the goal of a new website called *Mothers in Motion*. Featuring a quick quiz called "Are you Ready to Become Physically Active?," the site features more than 80 pages devoted to encouraging women to lead a healthy, active lifestyle and to mentor their children to do the same. Statistics show that a mom's participation in sport increases her child's participation rates by 22%. Dad's participation in sport increases his child's participation rate by 11%.

Mothers in Motion is a program offered by CAAWS, the Canadian Association for the Advancement of Women and Sport and Physical Activity. Since its formation in 1981, CAAWS has been encouraging women and girls to get off the bleachers, onto the fields of play and into the boardrooms. CAAWS offers numerous programs that encourage females to be more active, but the Mothers in Motion program is the only one that is targeted specifically for moms and moms-to-be. The program was launched in July 2002—timely, given the new 12-month parental leave that became available to new mothers in 2001. Many mothers are now taking advantage of the extended time with their baby and are looking for activities to help break up the routine of diapers and feedings.

The Mothers in Motion website offers lots of practical tips and advice, and covers topics such as breastfeeding, nutrition, physical activity guidelines, exercise equipment, appropriate clothing and advice on safety. The program was developed with assistance from Elizabeth (Beth) Mansfield, MSc, RD, a registered dietician and exercise specialist with Peak Performance in Ottawa. She specializes in bridging the gap between the sciences of nutrition and exercise and the practices of healthy eating and active living. All of the content, advice and suggestions on the website were also reviewed by Health Canada to ensure the accuracy of the information.

Visit the Mothers in Motion website at www.caaws.ca/mothersinmotion or contact CAAWS at kbenoit@caaws.ca or 613-562-5667 to request a brochure on the program. Multiple copies of the brochure are available for distribution at doctor's offices, conferences, clinics, health and fitness centers, special events and anywhere else mothers gather. 

Prenatal Technologies May Not Offer Reproductive Choice

From the Prairie Women's Health Centre of Excellence

BY YVONNE PETERS AND KAREN LAWSON

THANKS TO THE WORK ON THE HUMAN GENOME PROJECT and the media reports it has attracted over the past several years, the public has received a steady stream of information on the latest gene to be discovered by science. Such announcements are generally greeted with enthusiasm, and the hope that genetic solutions will save us from our human frailties. But, this hope may be overly optimistic and ambitious. While genetic technologies may offer a few more keys to unlock the genetic puzzle, they have not necessarily produced the solutions required to solve the puzzle.

For example, although hundreds of human genes have been identified and mapped, in many cases, a corresponding cure or treatment regime has not yet been developed. Moreover, although many common diseases are suspected of being genetically linked, in most cases, the risk must be augmented by other genetic or environmental factors in order for the disease to occur. Nor does the detection of a chromosomal disorder, such as Down's Syndrome, predict the severity with which the syndrome will be expressed.

Advocates of new reproductive technologies, particularly prenatal technologies, argue that this technology will expand women's reproductive choice and decrease the incidence of disability in society. This argument is over simplistic at best, and belies the significant social and ethical implications underlying such technologies for women's reproductive autonomy and the equality rights of women and men with disabilities.

It is possible that prenatal diagnostic testing can offer women more control over the occurrence of the birth of a disabled child by providing relevant information about the genetic status of the fetus during pregnancy. However, because there are no therapeutic interventions available for the majority of conditions which prenatal testing detects, the options open to women following a positive diagnosis consist of preparing for a life with a disabled child or terminating the pregnancy.

Negative perceptions about a life with a disability, combined with the difficulties in obtaining adequate social supports may cause a woman to believe that her only real choice is to terminate her pregnancy.

Disability rights activists harshly criticize the intent of prenatal testing and the more often than not, follow-up procedure of aborting disabled fetuses. They are suspicious of the manner in which prenatal testing has been allowed to outpace therapeutic strategies. They argue that gene location is the means for a strategy of eugenics by eliminating defective fetuses.

The Medicalization of Disability

Given the rise of medical influence during the past century, the medical profession has been well-placed to exercise a powerful role over the lives of persons with disabilities. Medical professionals and scientists have historically characterized disability as a defect, deficiency, dysfunction, abnormality, failing or medical "problem" that is located in an individual. As a result, societal (and medical) attention is directed at fixing or curing the individual or returning the person to "normality." Where so-called "normality" is not achieved, attempts are made to make the person as "normal" as possible.

The "medicalization" of disability espouses an ideology of the individual in that it affixes the "problem" of difference to the body of the disabled individual. Under this ideology, the responsibility for any and all disability-related barriers is placed on the individual, rather than on the social institutions which have excluded persons with disabilities by maintaining barriers to their full participation.

Genetic technologies and the ideology of geneticization threaten to reinforce the traditional view of disability as a medical problem. Language such as defect, abnormality and congenital malformation is sometimes used to describe fetuses in which a disability has been detected. These labels demonstrate that once again, disability is being framed in the context of individual pathology, rather than in a social context.

Prenatal technologies will not eliminate disability from society. The Council of Canadians with Disabilities estimates that only 3% of genetic conditions may be affected by gene therapy. Eighty-five percent of adult disability is caused after the age of 13, and more than 90% of infant disability is because of social and not genetic causes. A person is far more likely to

become disabled because of situations such as ageing, illness, unsafe working conditions, toxic environments, violence, poverty, lifestyle choices, poor nutrition, etc. Consequently, despite the hype offered by the media and the scientific community, it is unlikely that gene identification will significantly reduce the incidence of disability or improve the social status of persons with disabilities.

Not only has disability been regarded as the problem of the individual, it has also been characterized as a medical problem requiring a medical solution; that is, the care and intervention of professionals such as doctors, social workers and rehabilitation counsellors.

Consequently many people with disabilities have been isolated from society, and forced to live in conditions of dependency and oppression. Framed as an illness or individual defect, disability has been ascribed a negative value.

People with disabilities are disturbed by prenatal testing because, to them, it represents a return to an individual-based, medical model of disability at a time when they have only just begun to experience the dignity of rights and the hope for a barrier-free society. Their apprehension about prenatal testing arises from a history of eugenic practices that have contributed to the brutal oppression of disadvantaged groups. For example, during the last century, people with disabilities were subjected to non-therapeutic sterilization, institutionalization, and, in Nazi Germany, mass killing.

It can be argued that historically, disability-based discrimination occurred because society was, to a large extent, uninformed and uneducated about the value of human diversity, and in particular, about the potential of people with disabilities. People with disabilities are concerned that genetic technologies and their capacity to be used by science to designate “good” and “bad” genes, run

the risk of replicating the discriminatory mistakes of our past.

It is conceivable that, in a respectful environment, prenatal technologies could offer positive benefits in the form of new treatments and increased support for reproductive choices. However, to preserve the integrity of our humanity, we must listen to the views of those most affected, and we must use the lessons of the past to guide us into the future.

The Relationship of Disability Rights and Women’s Reproductive Choice

It is women who are subjected to prenatal testing, and women who must make sense of, and cope with the results of such testing.

As more and more genetic conditions become amenable to prenatal diagnosis, it is not unreasonable to imagine that society generally, and the medical profession specifically, will place enormous pressure on women to undergo such testing and to follow through with an abortion when the results are positive. This process has the potential to subtly, but effectively, shift the responsibility to ensure healthy babies from society to the private choices of women.

Traditionally, women have assumed the responsibility of caring for the health of the family. Prenatal testing now conveys the message that women are also responsible for protecting the well-being of society by aborting fetuses found to be unsatisfactory. In other words, women who knowingly choose to give birth to a baby with a disability may be accused of weakening or burdening society. Prenatal testing, therefore, has the power to promote the compulsory abortion of disabled fetuses. Although no government would probably ever dare, at least not in the foreseeable future, to require the systematic abortion of disabled fetuses, the medical, social and economic pressures com-

elling such a practice are so powerful that refusing it may not be a realistic choice for women.

In fact, prenatal testing is often cast as a means of meeting a public health need. The economic costs that disabilities place on the social welfare and medical systems are relatively high, and testing and selective abortions are presented as a very cost-efficient way of reducing the incidence of disability on society.

Implicit in this formation is that making use of prenatal testing technology is the act of a responsible citizen and mother-to-be. Women who do not comply with testing, or who decide to continue with a pregnancy after a diagnosis of fetal disease or disability are viewed as socially irresponsible, irrational and selfish.

If a woman was assured that she would receive the emotional, social and financial support necessary to ensure the nurturing of her child, and if she was confident that her child would be accepted as a valued member of the community, whatever his or her genetic make-up, more women might choose to forego testing. These avenues of intervention, along with increased acceptance of people with disabilities, provide an alternate route for addressing the social and economic barriers that confront families of children with special needs. These alternative approaches would also address the issues in such a way that the responsibility for “curing the problems of society” would not rest on the shoulders of childbearing women. 

From The Ethical and Human Rights Implications of Prenatal Technologies: The Need for Federal Leadership and Regulation by Yvonne Peters and Karen Lawson. For a full copy of the study, contact The Prairie Women’s Health Centre of Excellence, (204) 982-6630 or visit: www.cewh-cesf.ca/PDF/pwhce/ethical-human-rights.pdf

DEGREE OF WOMEN'S HOMELESSNESS UNDERESTIMATED, STUDY FINDS *From Sistering: A Woman's Place*



THE FULL EXTENT OF WOMEN'S HOMELESSNESS IS SEVERELY underestimated, a new study finds. Commissioned by the charitable organization, Sistering, and funded by Health Canada and the Status of Women Canada, *Common Occurrence: The Impact of Homelessness on Women's Health* highlights homelessness as a significant women's health issue that seriously impacts women's emotional, mental, spiritual and physical health.

Building on the realization that women's homelessness has not been adequately represented in other studies, and that the continuum of homelessness for women has not been fully understood, researchers sought to incorporate both "hidden" and "visible" homelessness in their report:

Visible homelessness includes women who stay in emergency hostels and shelters and those who sleep rough in places considered unfit for human habitation, such as parks and ravines, doorways, vehicles and abandoned buildings.

Hidden homelessness includes women who are temporarily staying with friends or family or who bear staying with a person only in order to obtain shelter, and those living in households where they are the subject of family conflict or violence. Hidden homelessness also includes situations where women are paying so much of their income for housing that they cannot afford the other necessities of life, such as food; those who are at risk of eviction; and those living in illegal or physically unsafe buildings, or in overcrowded households.

"Homelessness has become a women's health issue," says Nancy Blades, the Director of Programming at Sistering. As advocates for the rights of homeless women, Sistering wanted

to educate key health care stakeholders about the lived experiences of homeless women in Canada's health care system, and the connection to women's poverty. "We wanted to quantify women's experiences to uncover how women's homelessness is often hidden," says Blades.

Using a gender-based analysis, researchers interviewed more than 125 homeless women in Toronto on their health status, and gathered input from 38 representatives of agencies in Toronto's health, settlement, social services and emergency housing sectors. "We interviewed women in 14 different languages, and of various ages, ethnicities, sexual orientation, disabilities, women with children, street workers, immigrants, women with psychological/emotional/mental illnesses, and more," says Blade. Of the more than 125 women interviewed, 93% of the women reported emotional and mental health issues as a result of their living situations.

In the study, researchers also address women's homeless-specific health concerns, including the barriers homeless women face in the current systems of support. The study finds that social and medical services are not fully responsive to homeless women's health care issues and needs, particularly because there has been little understanding of the continuum of women's homelessness. 🍷

Common Occurrence Research Action Report: The Impact of Homelessness on Women's Health is available from Sistering (\$20 each, plus \$5 shipping). Phone (416) 926-9762 ext. 227 or visit www.sistering.org for details.

To help improve the conditions of women's visible and hidden homelessness, we need to:

- Call upon provincial and federal governments to implement a National Housing Strategy.
- Call for an increase to income supports for women and children to halt the spiral from hidden to visible homelessness and increased poverty.
- Expand violence against women programs to provide support for victims of family abuse.
- Improve safety and access to emergency shelters.
- Increase collaboration between health care institutions and community based agencies.
- Increase involvement of homeless women in the health care sector, such as on committees and outreach programs.
- Enhance community-based services to address the concerns of homeless women.
- Network between community-based women's agencies to prevent isolation and loneliness of women experiencing hidden homelessness, and to protect women from falling into the spiral of visible homelessness.
- Increase government funding of disability support programs to enable visible and hidden homeless women and children to meet their basic nutritional requirements. 🍷

Adapted from Common Occurrence: The Impact of Homelessness on Women's Health (Sistering, 2002).

WHICH TIPS FOR HEALTH REALLY MATTER?

From The Centre for Social Justice

The politics of health are weighted with import, so finding a humorous take on a serious subject is rare indeed, but occasionally possible. Here, the Centre for Social Justice compares the politics of those frequent and helpful 'personal' health tips with the social determinants of health—and rubs the funny bone raw.

- Don't smoke. If you can, stop. If you can't, cut down.
- Follow a balanced diet with plenty of fruit and vegetables.
- Keep physically active.
- Manage stress by, for example, talking things through and making time to relax.
- If you drink alcohol, do so in moderation.
- Cover up in the sun, and protect children from sunburn.
- Practice safer sex.
- Take up cancer screening opportunities.
- Be safe on the roads: follow the Highway Code.
- Learn the First Aid ABC: airways, breathing, circulation.¹

or

- Don't be poor. If you can, stop. If you can't, try not to be poor for long.
- Don't have poor parents.
- Own a car.
- Don't work in a stressful, low paid manual job.
- Don't live in damp, low quality housing.
- Be able to afford to go on a holiday and sunbathe.
- Practice not losing your job and don't become unemployed.
- Take up all benefits you are entitled to, if you are unemployed, retired or sick or disabled.
- Don't live next to a busy major road or near a polluting factory.
- Learn how to fill in the complex housing benefit/shelter application forms before you become homeless and destitute.²

For more information on the social determinants of health, visit The Centre for Social Justice, www.socialjustice.org

NOTES

¹ Donaldson, L. (1999) *Ten Tips For Better Health*, On-line at www.official-documents.co.uk/document/cm43/4386/4386-tp.htm

² Gordon, D. (1999) *An Alternative Ten Tips for Staying Healthy*, Personal communication, October 10, 1999.

HRT Claims Challenged

New data show no role for hormone therapy in women without hot flashes. Combined hormones do not help with depression, sexual function, vitality or cognition.

From the U.S. National Women's Health Network

AS THE WOMEN'S HEALTH INITIATIVE (WHI) study results on long-term use of hormone therapy continue to be analyzed, the unfounded health benefit claims for hormones continue to be debunked.

Data recently released show that hormone therapy had no clinically meaningful effect on the general health, vitality, mental health, depressive symptoms or sexual satisfaction of women participating in the WHI. One small group of women, the subgroup of women 50-54 who had moderate to severe hot flashes, did benefit. They received relief from their hot flashes, and their sleep improved, but even they had no improvement in any of the other outcomes measured including depression, vitality and sexual satisfaction.

"Hormone manufacturers have been skilfully and effectively skirting drug promotion restrictions for decades, persuading women and clinicians that hormone therapy will improve the mental health, sex lives and overall well-being of older women. In the last year, the Women's Health Initiative has proven that the long-term risks of these drugs are life-threatening and that the short-term benefits are nowhere near what women and their health care providers have been led to believe," stated Cynthia Pearson, Executive Director of the US National Women's Health Network.

"These companies deserve to go to the advertising hall of fame for their unparalleled success at convincing generation after generation of women that they would and did improve their health and their lives by taking hormones. And they deserve to go to the

QUOTATIONS FROM ADS FOR HORMONE THERAPY THROUGH THE YEARS:

1969: A Premarin ad in the *Journal of the American Medical Association* quoted a physician saying that estrogen is "notorious for the sense of well-being it imparts."

1974: A Premarin ad in a medical journal read: "Mild to moderately depressed patients often begin to obtain benefit within a few days [...]. Anxiety [...] is also usually relieved in a relatively short time. And psychosomatic symptoms such as insomnia, crying spells, nervousness, feelings of weakness and fatigue may also be alleviated."

1997: A Premarin ad in a medical journal urged doctors, "PREMARIN: You knew it was right for her when she entered menopause, to help her feel like herself again. Now, we are discovering the true potential of PREMARIN throughout every phase of her menopause [...] and beyond."

2000: Wyeth spokeswoman, Lauren Hutton, told *Parade* magazine estrogen is "good for your moods [...]. If I had to choose between all my creams and makeup for feeling and looking good, I'd take the estrogen."

research hall of shame for putting those same women's lives at risk with unethical medical experimentation of an unprecedented scale," asserted Pearson.

Pearson suggested that taken together with the earlier WHI results showing that combined hormone therapy increases women's risk for breast cancer, stroke, blood clots and heart attacks, "what these findings mean is that the only women who should even consider hormone therapy are those who decide that their need to alleviate their hot flashes is

great enough to outweigh the health risks of hormones." The *New England Journal of Medicine* editorial that accompanies the publication of this data estimates that between 10 and 20% of women experience "very distressing" vasomotor symptoms (hot flashes), although about 2/3rds of women have some experience with them. The editorial recommends that "Women with vasomotor symptoms must weigh risks associated with treatment against the benefit of symptom relief." 🍷

Women's Health Initiative: One year anniversary

To mark the one year anniversary of the Women's Health Initiative study, which highlighted possible health risks associated with long-term hormone therapy use for menopausal women, the **Canadian Women's Health Network** has now made several documents on menopause, hormone therapy and healthy aging available online and free of charge. Visit our "Health Topics" section at: www.cwhn.ca

NEWSPAPERS HIGHLIGHT BENEFITS OF NEW DRUGS, IGNORE RISKS

Consumers aren't getting balanced information about new prescription drugs

From the Canadian Centre for Policy Alternatives

THE INFORMATION WE GET ON NEW PRESCRIPTION DRUGS FROM A MAJOR AND TRUSTED SOURCE OF INFORMATION—DAILY NEWSPAPERS—IS INCOMPLETE AND MAY PROMOTE UNREALISTIC EXPECTATIONS ABOUT THE BENEFITS OF NEW DRUGS, SAYS A STUDY RECENTLY RELEASED BY THE CANADIAN CENTRE FOR POLICY ALTERNATIVES.

The report, *Drugs in the News* finds that newspaper articles more often emphasize the benefits of new drugs, while little attention is paid to possible harms. Sixty-eight percent of the news articles examined in more than 20 major newspapers made no mention whatsoever of possible adverse effects, and when identified, these harms were usually downplayed and mentioned towards the end of the article.

The study also found that:

- a. The health effects of drugs are often presented using only descriptive terms, without also providing precise or scientific information about the drug's effectiveness.
- b. Basic information that quantified the benefits or harms of the drugs was reported in only one out of every four articles, and when it was provided, 30% of the time it was presented in misleading terms.
- c. When possible harmful effects were mentioned, they were more often described with language that downplayed the risk to patients ("minor" or "rare"), while benefits were more often described using language that emphasized the potential benefit ("proven remedy" or "highly effective").
- d. Contraindications—those conditions under which it is not safe to take the drugs—were mentioned in only 4% of the articles.

e. Only one in six articles mentioned alternative treatment options (for example, an existing, cheaper drug).

f. The financial interests at work behind the scenes—such as who funded a study about a drug's effectiveness, or the financial relationship of a patient spokesperson to the drug company—were noted less than 3% of the time.

Sixty-eight percent of the news articles examined in more than 20 major newspapers made no mention whatsoever of possible adverse effects

The study's authors agree, however, that reporting on pharmaceuticals isn't easy for journalists. "It requires an ability to interpret complex scientific information while resisting the pharmaceutical industry's aggressive marketing techniques," says Barbara Mintzes, co-author of the study. "Pharmaceutical companies make it very easy to write favourable stories about new drugs, while independent drug information is harder to find."

Dr. Joel Lexchin, an emergency department physician in Toronto and associate professor in the School of Health Policy and Management at York University, says he hopes the study will help journalists when they report on new medications. "The media needs to do a better job of following the money so that readers can be better informed." 🍷

The complete study is available at www.policyalternatives.ca or by calling the CCPA office at 604-801-5121.

What You Need to Know About Prescription Drugs – and What the Media Doesn't Always Tell You

Drug indications

What medical conditions has this drug been officially approved to treat? Regulatory approval of a drug for treating specific conditions ensures that there is evidence that the drug has some beneficial effect for that condition. If it hasn't been approved for a condition, there is no guarantee the drug can provide any benefit and patients may be needlessly put at risk for side effects.

Drug contraindications

Who should avoid this drug? Contraindications identify who could be more harmed than helped by a drug. (For example, atorvastatin should not be given to pregnant women or patients with liver disease.)

Clinical benefits

Do the claimed benefits of the drug have a tangible, meaningful impact on the health of patients? (Atorvastatin may lower cholesterol, but is there evidence that it lowers the chance of heart attack? Donepezil may produce changes on cognitive tests, but does it help patients with daily living activities?) Non-clinical benefits, often called surrogate or intermediate endpoints, can lead to an exaggerated impression of drug effectiveness.

Clinical harms

All drugs have risks as well as benefits.

Are the harmful effects of the drug mentioned? Is this information presented in as much detail as the benefits, to provide the potential user with a balanced understanding of all of the drug's effects?

Magnitude

Have numbers been included to unambiguously explain the degree of benefit or harm? (For example, without numbers to provide the magnitude of benefits and harms, how is a patient to know if the benefits are proportionally greater than the risks?)

Absolute numbers

Have magnitudes of benefits and harms been provided as "absolute" differences? For example, a medication may reduce the proportion of patients having a heart attack from 10 in 100 to 7 in 100. In "relative" terms, there is a 30% reduction in risk, while in "absolute" terms the risk has been reduced by 3%. Relative values can be very misleading and any numbers greater than 10% are usually relative numbers.

Time

How long do patients need to take the drug to achieve a benefit? Drug therapies for acute conditions are usually taken over a very specific period of time. Chronic and preventative therapies can be taken over an indeterminate

or extended period of time. Individuals should be informed if there is a minimum length of therapy necessary to achieve any benefit and whether benefit and harm profiles can shift during long-term therapy.

Drug and non-drug alternatives

Have drug and non-drug alternatives to the drug of interest been included in the story? There are often several treatments available for a specific problem, including both drugs and other options. Different drug treatments can have radically different benefits and harms or surprisingly similar characteristics depending on their mechanism of action. However, drug alternatives create options for patients when deciding upon a treatment with their physician. Non-drug alternatives such as exercise and diet changes should also be included in any discussion of drugs in the news.

Costs

What is the price of the drug therapy? In an ideal world costs would be relevant only when comparing identical drugs, but, as the public ultimately shoulders the burden of high drug expenditures, consumers need to know the costs. (For example, do consumers feel that taking oseltamivir to possibly shorten flu symptoms from 5-7 days to 4-6 days is worth \$45 or more?) The

cost of diagnostic tests needed to initiate or monitor a drug prescription should also be considered.

Study design

What kind of research method was used in the study? Research data on drugs is only as good as the study's design, and an opinion survey of 100 people is considerably less reliable than a clinical trial of 1,000 people. A randomized-controlled trial (RCT) is the study design that yields the most reliable drug data. In RCTs, researchers randomly assign patients to drug or placebo treatments with neither the patient nor the researcher knowing who received which. Studies involving more patients for greater periods of time also improve the strength of the data. Publication in peer-reviewed medical journals does not guarantee that the results provide meaningful information for evaluating the safety and effectiveness of new drugs. However, the quality of data presented only at meetings and conferences or published in non-peer reviewed journals is even less certain.

Follow the money

Has pharmaceutical industry funding of any studies and spokespeople been disclosed? Following the money trail in pharmaceutical reporting can be just as important as in political reporting. While regulatory safeguards are in place to minimize the presence of ineffective and dangerous drugs on the market, financial allegiances can strongly influence the interpretation of drug data. Likewise, pharmaceutical companies provide educational material and guest speakers for public information nights under the guise of patient groups or organizations. See our list of some drug information resources that are independent of the pharmaceutical industry. 🐟

Independent sources of drug information*

Australian Prescriber
www.australianprescriber.com
tel: 61 (2) 6289-7038
fax: 61 (2) 6289-8641

CMA Infobase (guidelines)
www.cma.ca/cpgs
tel: 1 (800) 663-7336
fax: 1 (613) 565-2382

British National Formulary
www.bnf.org

Cochrane Library
www.cochranelibrary.com
tel: 1 (888) 855-2555
fax: 1 (613) 236-8864

Drug and Therapeutics Bulletin
www.which.net/health/dtb/main.html
tel: 44 (20) 7770-7571
fax: 44 (20) 7770-7665

Drugs of Choice
tel: 1 (888) 855-2555
fax: 1 (613) 236-8864

Food and Drug Administration (USA)
www.fda.gov/cder

Medical Letter
www.medletter.com
tel: 1 (800) 211-2769
fax: 1 (914) 632-1733

Prescrire International
www.esculape.com/prescrire
tel: 33 (1) 492-372-65
fax: 33 (1) 480-787-32

Therapeutics Letter
www.ti.ubc.ca/pages/letter.html
tel: 1 (604) 822-0700
fax: 1 (604) 822-0701

Therapeutic Choices
www.cdnpharm.ca
tel: 1 (800) 917-9489
fax: 1 (613) 523-0445

Worst Pills, Best Pills
www.citizen.org/hrq
tel: 1 (202) 588-1000
fax: 1 (202) 588-7798

Excerpted from Drugs in the News: How well do Canadian newspapers report the good, the bad and the ugly of new prescription drugs? by Alan Cassels, Merrilee Atina Hughes, Carol Cole, Barbara Mintzes, Joel Lexchin and James McCormack (2003). The study is available at www.policyalternatives.ca or by calling the CCPA office at 604-801-5121.

*Source:

Therapeutics Initiative (based at the University of British Columbia). "Sources of Drug Therapy Information," *Therapeutics Letter*, Issue 35, May/June 2000. www.ti.ubc.ca/pages/letter35.htm

Female Sexual Dysfunction, *New View Campaign* under way From www.fsd-alert.org

Based on the success of Viagra, the pharmaceutical industry is now trying to tell women that sexual fulfillment can be found in an expensive pill, patch, cream, spray or pump. Reducing female sexuality to genital functioning is not progress. What do women need for good sex lives? They need accurate information, good sex partners, good health coverage, sexual safety and entitlement to pleasure—and not new experts with new diagnoses and dangerous medications. Visit the campaign website, www.fsd-alert.org or contact Prof. Leonore Tiefer, Campaign Coordinator, ltiefer@mindspring.com to learn more or join the campaign. The website provides information on the campaign book and a classroom/workshop manual on women's sexual problems and treatments.



DRUGS IN OUR WATER

Chronic Exposure to Chemicals in Water Supply May Be Harmful to Health

From Women and Health Protection

BY SHARON BATT

DURING THE PAST YEAR, HEADLINES ABOUT “DRUGS IN THE WATER” have alerted the public to an unsettling fact: our lakes, rivers, streams and groundwater contain trace amounts of pharmaceutical drugs that can enter our drinking water. The growing list includes plenty one would rather not down in a glass of water on a hot day: antibiotics and painkillers, hormones and tranquilizers, drugs to treat blood cholesterol, epilepsy and cancer, musk fragrances, and phthalates, a family of chemicals found in cosmetics, perfumes and hair products.

We don't yet know how these chemicals may affect human health but the animal previews include reproductive and brain function disorders. To its credit, the federal government has been working for the past two years on a plan to protect the health of Canadians from this emerging potential threat. A project with the acronym EARP (for Environmental Assessment Regulations Project) has been wending its way through the bureaucracy and will surface this fall. Unfortunately, EARP's focus has veered off the mark. If the project continues on its present path, the environment that sustains our health will garner less protection than the drug and toiletry industry's bottom line.

Because much of this form of pollution comes from personal (not industrial) use of chemicals, public awareness is key. Everyone needs to grasp the problem, see the range of potential solutions, and engage in a process of change. And because women have a particular relationship to the products in question, an awareness of gender differences must be central to

any analysis. Prevention should be paramount—a principle that gets only lip service in EARP documents. The easiest way to reduce the environmental burden of drugs and toiletries is for everyone to use them less often.

Oddly, EARP materials never mention reduced use. As someone who took part in several EARP consultations, I believe the reason for this is simple: the process was geared to assuaging industry fears of added costs and lost revenues. Health and environmental groups, when consulted at all, faced a pre-set, legalistic agenda, drafted by government lawyers for their industry counterparts.

Personal use chemicals get into the environment in the most prosaic of ways. Fifty to 90% of the active ingredients of a medication are excreted and enter the sewage system; from there they may pass to a water treatment plant that is not designed to remove them. Unused drugs get flushed down the toilet or sink (mothers have been told to do this, for the safety of children). Hospitals and nursing homes dispose of vast quantities of pharmaceuticals, untouched when residents change or discontinue medications, or die. Drugs taken in life's home stretch likely contaminate posthumously, leaching from cemeteries into groundwater. Farmers give veterinary drugs to their animals, including large amounts of antibiotics. Drug-contaminated sewage sludge is sold as farm fertilizer.

Drugs aren't the whole problem: soaps, shampoos, cosmetics and perfumes contain chemicals that disappear down the drain, but persist in the ecosystem.

Calling the result a “chemical soup” sounds over the top when concentrations may be as little as one part per trillion. But science suggests that chronic exposure to multiple bioactive substances may well harm human health, even at low levels. Drugs are designed to have effects in small quantities; they are not meant to be mixed, willy-nilly. Researchers are discovering “windows of vulnerability” when developing embryos are exquisitely sensitive to chemicals, even minute amounts. Since environmental tests for these chemicals are still in their infancy, the discoveries so far are baseline levels.

Women Should Lead the Debate

Because of cultural norms, women are the family members most often responsible for the purchase of drugs and food, food preparation, caring for sick family members and disposal of home-use products. Many drugs are gender-specific (e.g., birth control products, menopausal hormone therapy), or are prescribed more often to women than to men (e.g., anti-depressants). Many of these prescribing patterns reflect the unnecessary medicalization of women’s lives, that is, the prescribing of drugs to “treat” such healthy life stages as menstruation, pregnancy and menopause.

Women are also the main users of cosmetics, perfumes and hair products, many of which contain phthalates, a family of industrial chemicals linked in animal studies to permanent birth defects in the male reproductive system.

A study Health Canada commissioned as part of EARP found that women were more interested than men in learning about safe disposal of drugs and were more likely to state that they would act on such information, even if it were inconvenient. Women were also more likely than men to state that they

flushed unwanted drugs down the toilet or sink, a difference that probably reflects women’s role as protectors of the health of children. The survey didn’t ask how consumers felt about reducing drug use.

As its name suggests, EARP is mostly about new regulations. Beginning sometime in the coming year, Health Canada will require drug companies and other manufacturers to expand their product safety tests. New products will have to pass tests of toxicity *after* release into the environment, not just during use. Tests will be phased in for products already on the market.

**If my prescription drug
can end up in your
morning coffee, every
home medicine cabinet
is a public concern.**

Manufacturers are nervous. What if the new tests are expensive, slow down marketing, reduce international competitiveness, or keep some products off the shelves altogether? These are natural questions for manufacturers to ask, but they are the wrong questions to guide a program to protect health and the environment.

Women’s health and environment groups should be leading this debate, but few have taken on the issue. Most community-based groups opted out of the government consultations after one introductory meeting. And no wonder: the scientific and regulatory documents

were not prepared for activists. They were written for industry scientists, lawyers and marketers, who take EARP very seriously indeed.

If my prescription drug can end up in your morning coffee, every home medicine cabinet is a public concern. Fortunately, plenty can be done. In a series of wide-ranging papers published in the journal, *Environmental Health Perspectives*, scientist Christian Daughton of the US Environmental Protection Agency lays out a grand plan for the short, medium and long-term. His short-term suggestions range from curtailing ads that promote drug use to consumers, to restricting physician drug samples, reducing drug doses, developing smaller package sizes, exploring non-toxic alternative treatments, and recycling, rather than disposing of, some unused drugs. He cites an Ontario survey estimating that the province wastes over \$40 million in medications each year.

Eliminating inappropriate drug use, overuse and abuse will, Daughton argues, improve health, save money and help protect the environment.

We can all tape that message to the medicine cabinet mirror. ☺

Health researcher Sharon Batt lives in Halifax. She is active in Women and Health Protection, and Prevention First, two coalitions that advocate regulations to protect health and the environment.

The analysis in this article draws from a discussion paper on drugs in the environment prepared for Women and Health Protection, available online at www.whp-apsf.ca

A version of this article first appeared in the Globe and Mail (07/31/03).

Health Complications from Breast Implant Surgery Common

Follow up procedures from private cosmetic surgery draws on public health system

From the British Columbia Centre of Excellence for Women's Health

BY ALEINA TWEED

FOR DECADES, WOMEN WHO HAVE UNDERGONE BREAST IMPLANT surgery have reported high implant failure rates and general, unidentifiable illness. In 1992, silicone gel-filled implants were subject to government moratoriums in the United States and in Canada, until such time as their safety could be assured. In the years that have followed, researchers have tried to find answers. In the meantime, breast implantation continues to become more and more popular, with saline-filled implants taking the place of their silicone predecessors.

Many women who choose breast implantation are very happy with the results of their surgery. They report psychological and emotional benefit from their new body image. However, many women report side-effects and feel that their short-term and long-term health has been compromised.

In Canada, thousands of women have chosen breast implant surgery, including an estimated 25,000 or more in British Columbia alone. As in all of North America, approximately 20% of these surgeries are for reconstruction after cancer or prophylactic mastectomy, or to correct under- or non-developed breasts. The other 80% are performed as cosmetic augmentation. Such surgery is not considered “essential” and is therefore paid for privately rather than through public insurance. However, if there are health consequences to this surgery—ranging from the well established local complications to the very controversial systemic complications—these women enter the public health care system for their care.

Breast implant research is beset by challenges, not the least of which is the lack of a central registry allowing health care professionals or researchers to track women who receive breast implants or to do any follow-up. But we do know that a very high number of women have been affected by breast implant-related complications. A Mayo Clinic study in the United States, for example, found that 25% of women with breast implants suffered local complications requiring additional

surgery within five years. We also know that there were 103,343 adverse reaction reports associated with silicone breast implants and 23,454 reports involving saline implants received by the U.S. Food and Drug Administration between January 1, 1985 and September 17, 1996.

In a recent study, researchers at the BC Centre of Excellence for Women's Health have discovered relatively high complication rates for breast implantation in Canada as well. Data collected from a study group of 147 women who have undergone breast implant surgery were compared to data from a non-implant comparison group (583 women). Researchers found that women who have or have had breast implants visited doctors and specialists significantly more than women who had not undergone implant surgery. The study also indicated that women with breast implants were more than four times as likely to be hospitalized, and that the number of hospitalizations they experienced over the study period was significantly higher than among women without implants.

The researchers also found that over half (51%) of respondents from the study group reported at least one additional breast-implant related surgery subsequent to the initial implantation. Of those, half (49%) had undergone one additional surgery, 23% had undergone two, 11% had undergone three, and 17% had undergone four or more additional surgeries. For some of these women, the complications were enough to convince the women that they no longer wanted breast implants. 40% of respondents had had their implants permanently removed.

Breast implant surgery is not deemed medically necessary and is performed—and paid for—privately in the vast majority of cases. However, it appears to directly contribute to an increased need for public health care services among the women receiving these devices. If, as the literature suggests, serious local complication rates are at least 25%—and more likely are 50%

or higher—there are many thousands of women in Canada who are using greater health care resources as a result of this surgery, and whose health and well-being may be at risk.

Complications with Breast Implantation

There are three major groups of health complications associated with breast implants: local complications, systemic complications and psychological complications. Breast implant surgery also carries the same risks associated with any surgical implantation of a medical device. All aesthetic complications (dissatisfaction with size, position, etc., of the implants) are not funded by public health care; however, all health complications resulting from the implant, including the removal of the implants, is covered by publicly funded health care.

1. Surgical complications

Any surgery—and breast implantation is no different— involves risks such as complications of general anesthesia, infection, haematoma, hemorrhage, thrombosis, skin necrosis, delayed wound healing and additional surgeries.

A woman who receives breast implant(s) will likely require additional surgery or surgeries related to her implant(s) over her lifetime. These procedures may include treatment of capsular contracture, correction of the implant's size or position, infection control as the result of other local or systemic complications, or to prevent or treat leakage, rupture or other health problems.

2. Local complications

Local complications can range from very mild to very severe, and they affect a large percentage of women who undergo breast implant surgery. Capsular contracture is one of the most significant complications. Contraction of the wall of scar tissue surrounding the breast implant may cause hardness of the breast, discomfort and even severe pain. According to Health Canada, capsular contracture occurs, usually within two years of surgery, in approximately 25% of women who undergo breast implant surgery. Other researchers suggest the percentage is as high as 70%, and some estimate that 100% of women with breast implants will develop capsular contracture to some degree over the life of the implant.

Implant deflation and rupture caused by normal deterioration over time, breast trauma, undetected damage or shell weakness in the implant are significant complications; one study found that 70% of removed implants 11 to 15 years old were ruptured or leaking. In a U.S. government study, 2/3rds of 344 implanted women examined with MRI had ruptured implants. Deflation, leakage and rupture can result in the breast implant filling being spread through the body. The salt-water solution contained within saline-filled implants should

be harmless. However, partly because of the semi-porous nature of breast implant shells and partly because of faulty valves and difficulties inherent in the sterilization of breast implant materials, it has been suggested that the saline filler does not remain sterile. In one study, most explanted saline-filled breast implants, regardless of their age, had microbial growth in the implant and in the capsule surrounding the implant. If the filler was so contaminated, it would no longer be considered harmless upon deflation or rupture.

Other complications include change in shape or volume of the breast; change in breast sensation; calcium deposits; mammographic interference, and breast/chest discomfort or pain and nipple discharge.

3. Systemic complications

Systemic complications appear most frequently several years after breast implantation. These complications tend to present as a cluster of symptoms, including those associated with autoimmune diseases, connective tissue diseases, “human adjuvant disease” and/or fibrositis/fibromyalgia-like disorders. (The classic autoimmune and connective tissue diseases thought to be associated with silicone implants are scleroderma, systemic lupus erythematosus, mixed connective tissue disease, rheumatoid arthritis and Sjogren-Larsson syndrome.) Women with breast implants have also reported granulomas and lymph node involvement, chronic flu, respiratory problems and infections. The cluster of symptoms reported by these women often includes those present in more than one such disease. Cancer also remains a concern—albeit a smaller one—associated with breast implants.

The link between breast implants and systemic complications is still not clearly understood. However epidemiologic research has not shown a significant increased risk.

4. Psychological complications

Unfortunately, studies of the psychological consequences of breast augmentation have been largely anecdotal, consisting primarily of surgeons' reports of their patients' satisfaction. These reports suggest that typically 70% or more of patients report satisfaction with their surgical outcome. However, such investigations clearly have serious problems. Firstly, how many patients will admit, face-to-face with their surgeon, that they are not satisfied with the results of their surgery? Secondly, how many surgeons will admit, face-to-face with their colleagues, that their patients are not satisfied?

There are many studies that suggest cosmetic surgery in general leads to immediate post-operative improvements in body image, quality of life and depressive symptoms. Other studies, however, have found that women who undergo ▶

removal of breast implants (explantation) report higher levels of breast anxiety, upper torso dissatisfaction and depression both before and after implant removal, compared to women who have undergone other cosmetic surgery (surgical controls) and women who have not undergone any cosmetic surgery (non-surgical controls). These findings suggest that breast implant surgery leads to poorer psychological well-being, rather than better, for many women.

Policy Issues

In Canada the only breast implants now widely available are saline-filled implants (a silicone bag filled with salt water). These implants, however, have not been reviewed by Health Canada.

The Medical Devices Regulations were introduced in Canada in 1975. These required notification of devices within 10 days of being put on the market, but involved no evaluation. These regulations were amended in 1977 so that evidence of safety and effectiveness was required before marketing. The list of devices covered by this amendment did not, however, include breast implants. In October 1982, a further change to the regulations was implemented, which extended the pre-marketing review to all devices, including breast implants, designed to be implanted in tissues or bodies for more than 30 days.

The 1982 amendment required all implantable devices to

go through a premarket evaluation of safety and effectiveness data in order to obtain a Notice of Compliance and be allowed for sale in Canada. This evaluation included a review by scientists at Health and Welfare Canada's Bureau of Radiation and Medical Devices of animal and human test results and manufacturing data supplied by the manufacturer. However, the review was required only for devices introduced after the date the amendment became effective. Because most saline-filled implants were available for sale before this date, they were exempted from the pre-market review.

Currently, despite the moratorium on silicone gel-filled breast implants, Health Canada has begun allowing their use in certain circumstances. There are suggestions that their popularity is again growing. Even as these silicone gel-filled implants are being reintroduced, there has still been little evaluation of the effects of the saline-filled implants that are currently widely available. This represents a gap in public policy and should be addressed by Health Canada. 

From Health Care Utilization Among Women Who Have Undergone Breast Implant Surgery by Aleina Tweed, from the British Columbia Centre of Excellence for Women's Health. Full report available online at: www.bccewh.bc.ca/PDFs/hcubreastimplants.pdf or call 604-875-2633.

Made in Canada home-grown research on canadian women's health

Women Survivors of Childhood Sexual Abuse Reluctant to Use Health Care System

From the Prairie Women's Health Centre of Excellence

The numbers are staggeringly high: one of every three female children and one of every five male children in Canada will be sexually abused before adulthood, according to statistics from the 1994 National Clearinghouse on Family Violence. Researchers have long known that childhood sexual abuse (CSA) has profound long-term consequences that impact emotional, psychological and physical health well into the adult years. Victims of CSA report increased levels of interpersonal problems, self-abuse, chronic pain, gastrointestinal and respiratory disorders, and other chronic ailments.

More recently, studies have indicated that those who have experienced CSA are also reluctant to visit their health care practitioners and avoid health care until it is absolutely essential. Researchers believe that there may be similarities between CSA and the setting for most medical examinations, such as being left alone in a closed room with an individual who has great power, feeling lack of control over the situation, anxiety from physical touch or from physical examinations that may be painful, and the requirement to be undressed or partially dressed.

A helpful series of guides from the Prairie Women's Health Centre of Excellence urge health care providers to be aware of the anxiety that an examination may cause many individuals, and recommend changes to both the environment in which the examination takes place (such as providing music and artwork to ensure a feeling of comfort and safety) and reforming the procedures for conducting the examination (such as giving the patient options and a sense of control, and providing pamphlets that explain procedures).

For more information see: Getting Through Medical Examinations: A Resource for Women Survivors of Abuse and Their Health Care Providers at: www.cwhn.ca/resources/csa/ab_index.html

FROM BARBARA BOURRIER-LACROIX, CLEARINGHOUSE COORDINATOR, WITH DANIELLE ALLARD AND KATHLEEN O'GRADY

**Because I Love You:
The Silent Shadow of
Childhood Sexual Abuse**

Joyce Allan (VFH Press, 2002)

It takes courage to read this book, and nothing short of heroine-ism to have written it. Allan documents five generations of childhood sexual abuse in this autobiographical exposé of her own family, with her father—a pedophile who abused dozens of children, including his own—as the focal point.

Allan discloses, without anger, bitterness, fear or trepidation, the systemic sexual abuse she experienced at the hands of her father, and the great efforts that her family, neighbors, friends, and for a time, even herself, went to keep this abuse quiet. Now, decades later, after her own children were abused by the same man, their grandfather, Allan wants to shatter the silence that protects and perpetuates the exploits of child sexual abusers.

“Because I Love You”—the regular phrase her father spoke when abusing his daughter—explores the violence of childhood sexual abuse as it is passed from generation to generation, while polite society sits idly by, putting etiquette and family unity above the well-being of children.

In the seven years it took Allan to document this book, she found that numerous people had known about her father’s activities, that his abuse of children extended beyond herself and her siblings, to her child playmates and neighborhood children, and that because everyone kept a “respectful” silence, her father was permitted to continue his abusive pattern for more than 40 years. Allan offers her story in the hope that the time has come for others to speak loudly and clearly about the sad reality that is childhood sexual abuse. See her site: www.timetospeak.com

**Like Family: Growing Up in Other
People’s Houses, A Memoir**

Paula McLain (Little Brown, 2003)

Paula McLain is known more for her award-winning poetry than as a writer of memoirs, and it shows—but in the best possible way. The first thing that strikes the reader about *Like*

Family is that the author has chosen her words very carefully, fastening her story to a spectacularly stark but beautifully resonant prose. And with this poet’s voice, McLain reveals in waves of childhood memory what it was like to grow up in foster homes, buffeted from family to family, never quite feeling at “home.”

Like Family in many ways resembles the classic adolescent novel by Judy Blume, *Are You There God? It’s Me, Margaret*, full of nostalgia and tender tales of going through those awkward teenage years. Except punctuating what would otherwise be a fairly ordinary adolescence are McLain’s memories of being beaten by her foster-mother and her repeated sexual abuse at the hands of yet another foster-father.

But somehow *Like Family* does not reside only in the bleak terrain of foster families. Rather, it is the mixture of sweet nostalgia for growing up combined with the harsh emotional scars of neglect and abuse that makes this book remarkable. McLain leaves the reader with the knowledge that a child is not the sum total of the abuse she has experienced at the hands of others, but somewhere, between the neglect and mistreatment, a child is able to create a space and a life that is her very own.

**World Report
on Violence and Health**

Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi and Rafael Lozano, eds (World Health Organization, 2002)

Violence pervades the lives of many people around the world, and touches all of us in some way. Violence is also a major public health problem that has serious consequences, both in the short-term and the long-term, for individuals, families, communities and countries alike. This first *World Report on Violence and Health* aims to raise awareness about the problem of violence globally, and to make the case that violence is preventable, and that public health researchers have a crucial role to play in addressing its causes and consequences. This book examines the various types of violence that are present worldwide that have public

health consequences, including youth violence, child abuse, violence by intimate partners, elder abuse, sexual violence, self-directed violence and collective violence.

**The First Casualty: Violence
against Women in Canadian
Military Communities**

Deborah Harrison (James Lorimer, 2002)

In *The First Casualty*, Deborah Harrison argues that within the Canadian military an environment exists where violence against women is both encouraged and hidden. Because the military relies on aggressive male behavior, because it is based on a model where no one is permitted to question the boss, and because it values secrecy—a culture exists where military personnel often abuse their partners, with this fact remaining well hidden within the military community.

Drawing from extensive interviews with military personnel and spouses of military personnel, the author uses personal stories and first hand accounts to explore why violence against women occurs within military communities. The book begins by discussing violence against women and the military way of life. It then looks at the services currently available to spouses of military personnel, and determines that these services are inadequate, leaving military spouses isolated and vulnerable. It concludes by making recommendations to improve services. While the subject matter of the book is difficult, the tone is not hopeless. The author uses the courageous voices of women who have survived domestic abuse to end the secrecy and create positive change.

**Anorexia’s Fallen Angel:
The Untold Story of Peggy
Claude-Pierre and the
Controversial Montreux Clinic**

Barbara McLintock (HarperCollins, 2002)

Barbara Walters told *20/20* viewers that Peggy Claude-Pierre and her Montreux Clinic in Victoria, British Columbia, were “a last hope” for those critically ill with eating disorders. Oprah Winfrey tearfully described her as “an

angel on earth." This media coverage earned Claude-Pierre's clinic a worldwide reputation before allegations of force-feeding patients and patients being held against their will ultimately led to the clinic losing its license in 1999. In this book, journalist Barbara McLintock charts the rise and fall of Claude-Pierre's clinic, and in doing so, tells a compelling story of desperate families grasping at unrealistic promises for a cure in the absence of proof.

Eve's Rib: The New Science of Gender-specific Medicine and How it Can Save Your Life

Marianne J. Legato (Harmony Books, 2002)

Until very recently, women's and men's bodies were seen as essentially identical, except for the differences in our reproductive function. In fact, it was commonly assumed in medicine that it was necessary to study only men, and that the data collected from men could be extrapolated to women without modification. The rules, thankfully, are beginning to change. As Marianne Legato, an expert on gender differences explains, the medical community is finding that in every system of the body there are significant and unique sex-based differences in human physiology. This book explores these differences, looking at the brain, drug metabolism, the gastrointestinal tract, the lungs, the heart, the circulatory and immune systems, the skeleton and even the skin.

Abortion & Common Sense

Ruth Dixon and Paul K.B. Dagg (Xlibris, 2002)

"Abortion" is a word that, when uttered in public, elicits strong emotions, deeply held convictions and divisive debate. Yet about half of all unplanned pregnancies in the world end up in induced abortion, and four-fifths occur in developing countries. Some women end their pregnancies safely and legally, yet so many more are forced to do so clandestinely and often dangerously. The authors of this book offer a fact-based, common sense account of how and why women have abortions, and what can be done to make them safe. In the first section, they explore a variety of personal, social, economic and health issues affecting women and couples in their efforts to regulate their ferti-

lity, and the role that safe and unsafe abortion plays in this endeavor. In the second part, they look at the legal, medical and political institutions that shape the environment in which abortion occurs. The authors conclude with the need to ensure that all abortions are performed correctly, legally and humanely, and that it be understood as a normal part of good medical care.

Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning

Nicole Haberland and Diana Measham, eds (Population Council, 2002)

The recommendations of the International Conference on Population and Development, held in Cairo in September 1994, represent a radical change in the way population and reproductive health problems are conceptualized. Since then, however, the challenge has been to translate these recommendations into effective reproductive health services that satisfy the needs of women and men. This book presents 22 case studies that examine past and present practice in reproductive health and family planning programs, in a variety of setting, highlighting changes and work yet to be done.

No More Periods? The Risks of Menstrual Suppression and Other Cutting-Edge Issues About Hormones and Women's Health

Susan Rako, M.D. (Harmony Books, 2003)

Menstrual suppression, the cessation of a woman's periods using hormones, has recently become a hot topic in women's health. Many health professionals and drug companies are suggesting that it is a safe and preferable option for women to suppress their periods if they are not trying to become pregnant. In her book, *No More Periods*, Susan Rako argues that this is a dangerous idea that does not take into consideration possible increased health risks associated with menstrual suppression, such as osteoporosis, heart attacks, strokes and cancer. She is concerned that members of the medical community have not provided women with enough information about the implications of menstrual suppres-

sion, and that not enough research on menstrual suppression for large populations of healthy women has been completed. If this information was known to women, Rako suggests, it would cause women to think long and hard before choosing to stop their periods. This book discusses frankly and honestly the far reaching implications of what it means, not only to stop one's period, but also the implications of altering the whole menstrual and female reproductive cycle.

The Vulvodynia Survival Guide: How to Overcome Painful Vaginal Symptoms & Enjoy an Active Lifestyle

Howard I. Glazer and Gae Rodke (New Harbinger Publications, 2002)

Vulvodynia is a chronic vulvar discomfort or pain, characterized by burning, stinging, irritation or rawness, and painful intercourse. These symptoms are not caused by an infection or skin disease. As with most chronic pain conditions, it can have a profound impact on a woman's quality of life, affecting her ability to engage in sexual activity and interfering with daily functioning (e.g., sitting at a desk, engaging in physical exercise, participating in social activities, etc.). These limitations can negatively affect self-image and lead to depression. To make matters worse, when it comes to vulvovaginal pain disorders, there is a true lack of knowledge in the medical community. Many doctors do not yet even acknowledge the condition as a real problem with a physical component. As the authors contend, since the medical community is not yet up to speed on vulvodynia, those women who suspect that they have this condition must educate themselves. They present the reader with medical information and self-help solutions to identify and avoid triggers, modify diet to reduce symptoms, find knowledgeable medical help, reduce or eliminate debilitating pain, and begin to enjoy healthy sexual relations and daily activities.

Visit our website to see more new resources in women's health:
www.cwhn.ca

See also new resources in French on page 24.

What's new in women's health on CHN

BY ALEX MERRILL, CHN HEALTH EDUCATOR

Looking for health information for yourself or for a woman in your life?

Women form the largest group surfing the Internet for health information. But finding trustworthy sources of information is a tough task, given the vast array of commercial interests crowding the web.

The Canadian Women's Health Network (CWHN), as the women's affiliate of the Canadian Health Network (CHN) for the past three years, has been providing the CHN links to reliable non-profit, Canadian sources of women's health information. The CHN is a Health Canada-funded, bilingual website resulting from the partnership of over 1,000 non-governmental organizations, universities, and federal, provincial and territorial governments. Affiliates such as the CWHN benefit the CHN with our in-depth knowledge, expertise and networks. The credibility CHN derives from these partnerships is at the core of its motto, "Health Info for Every Body."

There are now over 1400 links to

women's health resources on the CHN, and the collection is growing. The CWHN has recently been focusing on seeking out web resources where few resources exist, in the areas of Aboriginal women's health, Black women's health, and the health of immigrant and refugee women of colour.

What's new on women's health on the CHN?

A year after the Women's Health Initiative study came out with groundbreaking findings on the health risks of hormone therapy, women are more than ever looking for effective alternative therapies for menopausal symptoms. Check out our latest feature on the CHN site, *Menopause without hormones: what are the alternatives?* (www.canadian-health-network.ca). CWHN co-wrote this with CHN's Complementary And Alternative Health affiliate.

We are also covering a wide variety of women's health topics, by adding to our

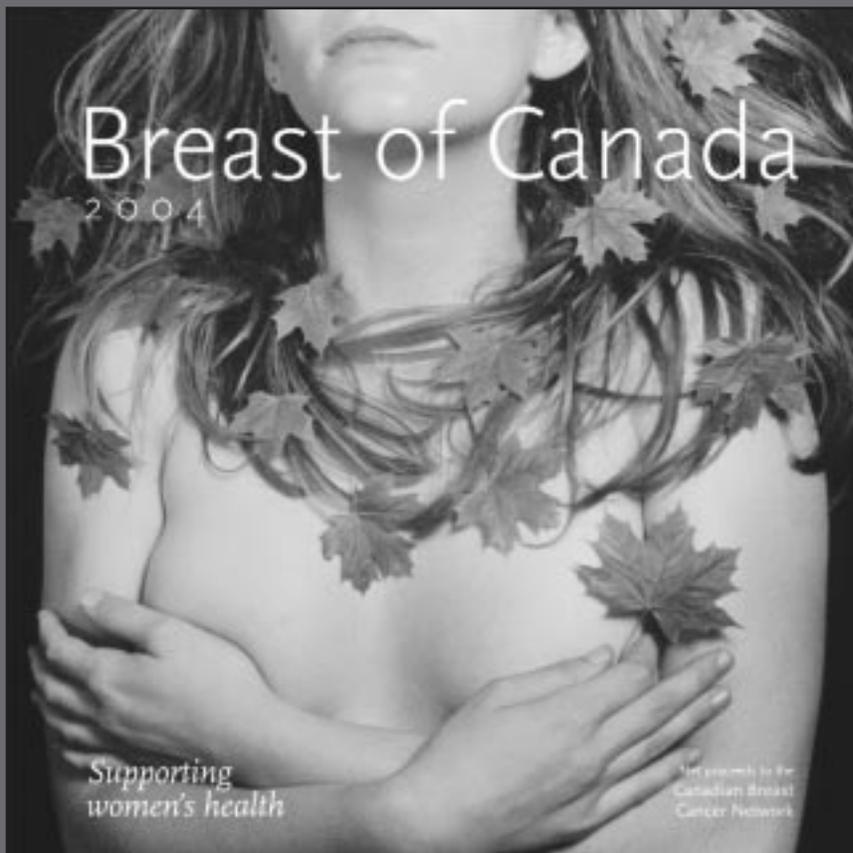
FAQs (Frequently Asked Questions):

- How can I help my daughter to have a healthy body image?
- What if I have fibroids?
- What is women's health?
(A look at gender-based analysis)
- How do I talk to my daughter about periods?
- As a woman who is a smoker, how can I make changes to get healthy?

We will be posting many new FAQs in upcoming months on lesbian health, menopause, women's health in the workplace, breast health, coping with care giving stress, vaginal health and much more.

New look and feel to the Website

The look and usability of the CHN has changed with new colours, and improved ways to search for resources. Check us out when you're looking for on-line women's health information! Click on "women" at: www.canadian-health-network.ca



Breast of Canada™ Calendar 2004

*Supporting
women's health*

*Fine art · 12x12" · 28 pages
Ideal gift for your breast friend.*

To order:

www.breastofcanada.com

Phone: 519-767-0142

Fax: 519-824-9289

**\$19.95 plus applicable taxes
and shipping.**

Net proceeds to Canadian
Breast Cancer Network
www.cbcn.ca

Independently published by Art Jam

about us:

Canadian Women's
Health Network



Le Réseau canadien pour
la santé des femmes

CANADIAN WOMEN'S HEALTH NETWORK

Networking to Improve Women's Health

The CWHN is a network of individuals and organizations from across Canada who believe that health is a human right that eludes many women because of poverty, politics and dwindling resources for health and social services. The CWHN is committed to enhancing women's health in Canada by facilitating information sharing, and building regional and national links among organizations and individuals who care about women's health.

Our programs offer easy access to existing health information and resources, as well as newly produced health materials specific to women's concerns. The CWHN also encourages community-based participatory research and provides forums for critical debate on women's health research and policy issues. We operate in English and French, and strive to provide materials in accessible formats.

CANADIAN WOMEN'S HEALTH NETWORK PROGRAMS

Website: Our website offers access to a variety of women's health resources, organizational links and databases, as well as breaking news on women's health issues and bi-weekly feature articles on important women's health topics. The CWHN website is visited more than 275,000 times each month, with more than 32,000 unique visitors each year. Check us out! www.cwhn.ca

Electronic Mailing Lists: Our monthly e-bulletin on women's health issues, *Brigit's Notes* reaches more than 1,700 individuals who want to know what's hot in women's health. Our thematic women's health mailing lists include, *The Aboriginal Women's Health and Research Interest Group*; *The Rural and Remote Women's Health Interest Group*; and *The Evidence Group on Women, Health and Caregiving*. Sign up for free today! webcoord@cwhn.ca

Women's Health Information Centre: The CWHN responds to health information requests in French and English from individual women, family members, community groups, health care professionals, researchers and students who contact us through our website or through our toll-free information line, 1-888-818-9172.

Databases: Our bilingual databases, available to the general public through our website, continue to grow. The databases now include more than 1600 women's health organizations, 670 women's health research specialists, 2500 published women's health resources, and 280 women's health research projects. We are always seeking suggestions for new materials or groups to include.

Media Referral Service: The CWHN continues to be contacted regularly by media personnel who regard us as a knowledgeable resource for information on women's health topics and organizations. We regularly direct the media to those individuals or groups in Canada who have expertise on specific women's health issues and who will offer a balanced women's health perspective.

Community Outreach and Networking: The CWHN regularly participates in numerous conferences, consultations and presentations, distributing credible women's health information materials at regional and national conferences, events and workshops. The CWHN also participates actively in a number of important policy and research working groups and institute planning committees, working hard to create a national presence for women's health in Canada.

Join Us!

Make an Investment in Women's Health Today.

Canadian Women's Health Network

Mailing Address: Suite 203, 419 Graham Avenue,

Winnipeg, MB R3C 0M3

Tel: (204) 942-5500

Fax: (204) 989-2355

Toll free: 1-888-818-9172

TTY (toll free): 1-866-694-6367

E-Mail: cwhn@cwhn.ca

Website: www.cwhn.ca