November, 1985 did not come quietly for me. It was a month of immersion in violence and conferences. It was also a month for Quiet Heroines.

The first two days find me in Amherst, Massachusetts at the “First Annual Nursing Conference on Violence Against Women” presenting a workshop on “Abortion: The Politics of Violence.”

The opening session of the conference sets the tone for two days to come. The audience is hushed and silent, the room dark. Familiar images rush past on the screen—click-click—a breast—a crotch—leather—guns—knives—little girls—sex and violence—Playboy and Hustler one after another. It goes on for almost an hour—the presenter’s voice overriding—calling our attention to the subliminal and not so sub-
Continued from pg. 1

liminal sexism in the cartoon images. Seeing this for the first time, the woman behind me moans and groans audibly. Later, she makes it a point to tell me she has two small children and from now on will be ever vigilant—insuring her children's eyes be protected. For myself, I had seen this show many times before. It could be a pornography workshop, battery, rape, child abuse—take your pick. It could actually fit in just about anywhere in a feminist conference.

At lunch, I make it a point to tell the two academic women beside me that I had recently purchased Hustler and Playboy. They are aghast. "You mean you actually bought those things?" I recount the story. It occurred in a small delicatessen beside a picturesque country road in upstate New York. They sold homemade lasagna, luncheon meats, detergents, cigarettes and newspapers. A little country store, open till 10 p.m. to give the houses nearby access to necessities. The magazines were kept behind the counter. You could just make out their titles. The cashier was blonde, young, and nervous. I bought three magazines—he could barely conceal his blushes. He started to put them in a brown paper bag. "That won't be necessary", I said, as I picked them up along with my newspaper. "Have fun tonight" he murmured as I walked out.

Going through those magazines was an adventure—something akin to reading Popular Mechanics. No real sensuality or sexuality—merely descriptions of events, orifices and mailing addresses. It occurred to me that this expression of sexuality was a particular genre of male mentality—didactic, dualistic and mechanistic. SEXUALITY AS CONSUMERISM WRIT LARGE.

The evening conference entertainment is a showing of issue films. There are only about eight women attending—mostly 50 and older—they sit quietly, watching shadows of young girls describing molestations—no comment, very engrossing. One of the videos doesn't fly. It depicts two women arguing while a man lies quietly on the couch seemingly impervious to them. The audience's impatience grows—"When is he going to get off the couch and do something?" "Change the tape—not enough action." This becomes extremely disturbing to me. It seems as if even in the study of violence and its devastation there is an underlying sense of excitement.

A particular image remains in my mind. It is the final day of the conference and I am standing in a long hallway. There is a T.V. camera and a reporter interviewing a woman. She is somewhat nervous. "Do I look all right? This is the first time I'll be on television. Don't ask me hard questions." He is reassuring. The assistant helps fix her hair. "Roll Cameras." Question. "Why are you attending this conference on violence? Answer—"I'm here because I'm working in the field and I wanted to network with other professionals to find out what everyone else was doing." Question—"Is it successful?" Answer—"Yes, so much so that I hope there will be one next year and the year after that."

I feel myself getting that familiar anxiety in my stomach—the anxiety I get when my reality directly conflicts with the collectives. Now, I thought, violence against women will be thoroughly institutionalized academically and professionally. There will be university programs, Ph.D.s in violence, and a new professional journal to house increasing research on the issue. There is, it seems an unspoken assumption that violence against women will continue, is an accepted part of our social reality and will be here today and for many tomorrows.

It comes to me that the women's movement is in therapy. The constant verbal and literary analysis that pervades much of the politics of the current feminist movement can be dangerous in its seductiveness. There is a possibility that the consistent collective expression of our oppression in prose and verse may obviate our individual responsibility for changing it. Anger, frustration and rage turned inward becomes depression. There is a pervasive sense of helplessness—augmented by media propaganda proclaiming the death of the women's movement that seems to permeate women's consciousness. The comeback of tight dresses, high heels, the touting of a 'style wars' as if it really mattered. The inescapable reality of the long duration and difficulty of the struggle. The realization that things may never change in your lifetime, the fear of growth, the anxiety of change, the loss of dependency, the challenge of responsibility, the pain of knowing you are alone. The coming of age and aging, the lack of concrete answers and the monotony of the same questions results in the movement too often reflecting on itself and diffusing its own energy.

It is a measure of the times and the social reality that makes for Quiet Heroines. She says she is 24 years old—very small, short dark hair worn in a punkish style—she had sat silently during the two hours of my presentation on abortion clinic violence; meeting my eyes for short intense moments. When she speaks, she is barely audible. The story she tells is not unique. She was 19 years old when she found herself pregnant, living in a small Catholic town—no one knew—not her parents, not her lover and certainly not the priest. Alone, all alone, she made an appointment at the nearest abortion clinic. She had no transportation, no support, no "significant other". After her abortion she had to walk alone for 10 miles to get back to her house. Alone, afraid, but not pregnant. She walked. And today at Amherst, in this small classroom—here with 15 other women—she speaks about it for the first time. She speaks, and I listen. Listen as her words break the silence. A Quiet Heroine—enough courage to put her life on the line—enough guts to go through the abortion alone. Walking through darkness, but unable to speak about it. Unable till this moment to say the words "I had an abortion." As if if the words verify the act—as if not speaking about it makes it go away.

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THE NUCLEAR THREAT
A Woman’s Perspective
By Betty G. Lall

Where are the women? It is an interesting fact that women have been shunted aside when high-level discussions turn to issues of armament—especially interesting since women have been at the forefront as activists where nuclear arms control is concerned. Yet when push comes to shove, we are the ones being shoved—away from the negotiating table.

For many months the United States and the Soviet Union have been negotiating on three separate armament issues, but on the large negotiating teams of each side, there were no women at the policy level. At the Summit meeting last October, one female policy maker appeared from the U.S., Ambassador Rozanne Ridgway, Assistant Secretary of State for Europe and Canadian Affairs. There was none from the Soviet Union.

Why? After all, women represent over half the populations of these two large, heavily-armed and mutually hostile powers. Can it be men are afraid of us? Afraid that women might be less inhibited in overcoming almost 70 years of mutual hostility and suspicion and be willing to negotiate reductions in our nuclear arsenals? Afraid that we would opt to cooperate peacefully to avoid the possibility of a world-wide holocaust?

President Reagan’s Chief of Staff, Donald Regan, puts down women by claiming we are not interested or knowledgeable about ways to avoid war and achieve a more stable peace. He told the press at the close of the Summit conference: “They’re not going to understand missile throwweights or what’s happening in Afghanistan or what is happening in human rights. Some women will, but most women...believe me, your readers for the most part if you took a poll...would rather read the human interest stuff of what happened.”

Women care deeply about preserving the values that are fundamental to the achievement of a more peaceful, secure, and just world, but we have not been given effective opportunities to inject our views into policy-making decisions. We have not been given choices.

Considering the facts, our participation certainly couldn’t hurt. In the past 13 years, not a single arms control agreement between the Soviet Union and the United States has been ratified by our government though there have been three important ones signed: the SALT II Treaty, the Threshold Nuclear Test Ban Treaty, and the Treaty on Underground Nuclear Peaceful Explosions. A fourth, a Comprehensive Test Ban Treaty, was in the final stages of negotiation before being abandoned by the United States.

Why do we tolerate our government spending so much of our money for destruction—over $300 billion dollars this year alone? Both sides insist on utilizing at least half of their best scientific and engineering talent to develop, test and produce weapons. Since 200 to 500 strategic nuclear warheads are enough to destroy most of the population and industry of each side, why are billions of dollars and rubles spent to produce over 10,000 such warheads each? Why don’t we complain that we are borrowing far into the future, saddling generations to come with this enormous Federal debt, to wage a wasteful and dangerous military competition with the Soviet Union?

The answer in part stems from the fact that we tend to trust the pronouncements of our government in Washington—a government that is populated predominantly by white males. When they describe our main adversary in the worst possible terms, we believe our leaders and tend not to question their “facts” or their judgment—to say nothing of whether or not our President and his advisers are telling us the full story.

It is a mad mad race. And it can be stopped; but not unless women are able to participate along with men. Women and men generally are socialized differently. There is no question that throughout history, with a few exceptions, it has been men not women who prepare for and wage wars.

In this nuclear age, we women have been frightened by our respective governments whose leaders control most of the information about the intentions and capabilities of the adversary. If we thought the other side genuinely wanted to reach agreements to stop building stockpiles, would we agree to support the expenditure of hundreds of billions each year for weapons and preparation for war? Did Soviet leader, Mikhail Gorbachev, stop the testing of nuclear weapons and anti-satellite weapons because he wanted to lull the United States into a trap or because he decided this might improve chances of reaching an agreement for both sides to stop the arms race? Wouldn’t our two countries be more secure if we stopped testing these weapons?

Despite the claim of the White House, data available from the U.S. Department of Energy and the Swedish National Defense Institute show that there was no sudden acceleration of Soviet nuclear tests in the months before the Soviet leader announced a unilateral Soviet moratorium and invited the United States to follow.

The Republican Chairman of the Senate Intelligence Committee, David Durenberger of Minnesota, remarked: “If the United States and the Soviet Union could not test their nuclear devices, neither country could make potentially destabilizing qualitative improvements in their nuclear weapons...A comprehensive test ban treaty would stop menacing Soviet developments while preserving the technological edge the United States enjoys in their nuclear warheads.” (Bulletin of the Atomic Scientist, October, 1985, page 9).

Should we believe our present President who claims such agreements cannot be verified or should we believe our past arms control negotiators who, under both Republican and Democratic Presidents, negotiated for such agreements? When we have such enormous over-
MASSACHUSETTS EMPLOYMENT AND TRAINING CHOICES PROGRAM—
on ON THE ISSUES exclusive interview
By Naomi F. Chase

Massachusetts Governor Michael S. Dukakis and Cheryl Liberatore, the 13,000th ET Choices Graduate.

Massachusetts' phenomenally successful Employment and Training Choices Program (ET) provides job training, career planning, job placement and critical support services such as day care and transportation for people on public assistance. Introduced in October 1983 by Governor Michael S. Dukakis, ET is particularly notable for the route out of poverty it has given single mothers.

As of June 1985, ET had placed 16,000 participants, 77 percent of them women on Aid to Families with Dependent Children in full-time and part-time jobs which pay at least twice, often three times, their previous welfare benefits. In May, 1985, the program received the Public Service Excellence Award from the Public Employees' Roundtable, for saving Massachusetts taxpayers nearly $48 million in welfare benefits, and for demonstrating, as Governor Dukakis says, that "good management and compassion can be allies in the administration of government programs."

For On the Issues, Naomi Chase, author of A Child is Being Beaten, interviews Cheryl Liberatore, ET's 13,000th placement, about her new life; Department of Public Welfare Commissioner Charles Atkins, who administers the program; and Division of Employment Security Director Kristin Demong, whose department provides job placement.

Atkins: ET is based on the premise that given the opportunity, people would rather work than be dependent on welfare. Poverty, in Massachusetts as in most of the United States, is increasingly a women's problem. Sixty percent of all poor families are headed by women. We believe that employment training can make a crucial difference to them. Specifically, it's their leverage out of poverty. It gives people, women and men, job skills and education. It teaches them how to look for a job. It makes welfare a temporary, rather than a permanent solution, a permanent lifestyle.

Chase: How is ET different in the way it serves women?

Demong: I think what makes it different and unique is that it offers women the support systems they need. For example, along with job training, it offers day care. That's terribly important.

Atkins: It's interesting that of the women who have gotten jobs through ET, 18 percent of them have children under six. Now, under current federal guidelines, these women with kids under six are the only welfare participants who don't have to sign up for some kind of jobs program—yet here they are.

Chase: Cheryl, you're 22 and your son is two and a half. You're one of those who didn't have to sign up for ET. Why did you?

Liberatore: I hated being on welfare. When I was a kid, I believed all those stereotypes about how those women really liked sitting at

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MAN-MADE REPRODUCTION
By Dr. Janice Raymond

Within the last decade, many new reproductive technologies have been developed. Indeed, doctors and scientists have claimed that a veritable biomedical "revolution" is underway.

What are the new reproductive technologies? The most well-known is in vitro fertilization, more popularly called test-tube babies, by which egg and sperm are joined in a petri dish, and the fertilized egg can then be implanted in a female body. Any female body can gestate the egg, not necessarily that from which the egg is taken. In vitro technology depends on man-made ovulation in which, through the use of powerful hormones, the ovaries are "coaxed" into producing numbers of eggs. With the development of even newer forms of reproductive technology such as the artificial womb and placenta, the fertilized egg can grow entirely outside the human female womb.

Another of these new reproductive technologies is sex predetermination. Techniques currently being developed separate x and y-bearing sperm (gynosperm and androsperm) to determine the sex of a fetus before conception. Sex predetermination can now take place after conception using amniocentesis or the new chorionic villus method, a prenatal diagnostic technique that can be used earlier than amniocentesis. The parent(s) can then choose to abort the fetus if the sex of the child is not the desired one. Research tells us what we already know, that in countries after country, preference for male children is the overwhelming first child choice. For example, in a Chinese study on the Anshan aspiration method of sex predetermination, 100 sex predictions resulted in 30 abortions. Of these 30, 29 aborted fetuses were female. Other studies confirm this preference for boy children in the West as well.

Then there are the new reproductive technologies of freezing sperm, and most recently embryos. Possibly, in the not too distant future, we will freeze unfertilized eggs. Melbourne, Australia, the pioneering site of embryo cryogenics, made headlines when an American...
of us. How can one continue a pregnancy only to birth a baby to die? Surely there is no point to it. But this thinking begs the most basic and unanswerable question of them all: what is the point, the ultimate meaning of life itself? How long must a child live for there to be a “point” to continuing a pregnancy?

Advances, or what we are continually told are advances, in prenatal diagnosis now allow for a far more detailed and sophisticated analysis of the fetus resulting in a much more sophisticated prognosis. Now we not only know about the fetus in utero but about the person it might become after it is born.

All of what we currently can learn is inherently, inevitably, ambiguous. Presently, the most common use of prenatal diagnosis is amniocentesis for Down’s Syndrome. A fetus with Down’s Syndrome will, we can be reasonably certain, grow to have some level of mental retardation, and some possibility of physical problems as well. But how much retardation, how severe the physical problems? That we cannot know.

Diagnosis of conditions like Down’s Syndrome present us with decisions which are difficult enough. But we are also facing these very troubling diagnoses of conditions that directly affect the length of life. Very soon we can expect to have prenatal diagnosis of cystic fibrosis, a condition which kills not in pregnancy or in infancy, but later in childhood or early adulthood. We now have available diagnostic tools for Huntington’s chorea, a hereditary condition which does not begin its killing until after the mid-point of the life expectancy; people with Huntington’s chorea usually do not become symptomatic until they are in their 30s or 40s. By the time it manifests itself, those with the disease have often produced offspring who may, in turn, have the disease and pass it on. Is there a point to continuing a pregnancy which will give the fetus only a few months of life? A few years? A decade? Half a life-span?

This is the kind of information, and these the kind of choices, that face women who would choose to be mothers in these times. It is not the kind of information or choice most of us in the reproductive rights movement envisioned as empowering women. In my interviews for...
In the U.S., as elsewhere, the poor health status of Black women cannot be viewed as genetic or as an individual's fault. It is a systemic problem, not in the medical sense of "total body," but in the social sense of "total society".

A person's race, class and sex determines their life, health, sickness and death experiences. The poor health of many Black Americans is due primarily to poverty. Access to health care is dependent on income level. When we consider female-headed families living below the poverty level, we see that 71 percent are headed by Black women. Indeed, in the U.S. one's race determines their class status. When a woman is forced to live in poverty by conditions out of her control, we can predict a poor health outcome.

CASE IN POINT: Access to Health Care

Prior to the legalization of abortion, in one year alone, 94 percent of the deaths in New York from illegal abortions were of Black and Puerto Rican women. In Georgia, during the years 1965-1969, the Black maternal death rate due to abortion was 14 times the white rate.

These appalling figures are an example of the fact that white women had access to abortion procedures by better-trained personnel, even if illegally performed; or were able to stretch the law and obtain "therapeutic" abortions; or had the financial resources to travel to other countries to obtain legal abortions. In all these cases, the stratification of women along racial and class lines literally made the difference between life and death.

In 1973, the Supreme Court ruled abortions to be legal and federal funding was set aside to aid the poor. But, in 1976, just three years later, funding was discontinued—altering poor and minority women most. In a situation where existing birth control is not always effective, the availability of abortion means a chance to continue school, to work—to build a quality life. Without a choice—it means no chance.

CASE IN POINT: Infant Mortality

An important indicator of the health status of women is infant mortality. A high infant mortality rate is the direct consequence of lack of prenatal care, poor maternal nutrition resulting in low-birthweight...
I took back the day: the NYPCC raise their fists in victory celebrating the successful turnout. January 22 is OUR day—and we proved it!

MONTHS OF WORK—DAY OF TRIUMPH. The hard networking of the New York Pro-Choice Coalition (NYPCC) produced these results on January 22, 1986. Nearly 1000 supporters for Choice attended the rally in Bryant Park, NYC. Media coverage was extensive. Also on the works: a national mobilization pro-choice march on Wasington sponsored by NOW on Sunday, March 9 and in L.A. March 16. Step-off for DC at 11 a.m., rally at Lincoln Memorial. For further details, contact your local chapter of NOW In New York City: 212/807-0721. Report on rallies in Volume VII of On the Issues.

West, and increasingly in other countries, the new reproductive technologies have been presented as therapy, preventive medicine, and as an expansion of options allowing women richer lives, lives free of the risk of producing defective or wrong-sexed children. We are told that in vitro technology, in particular, will enable women to exercise their “right” to bear babies. It will eliminate inherited diseases and birth defects by controlling which particular eggs and sperm meet in the petri dish. It will expand the choices and options open to parents as to sex of their child and the timing of birth, and it will upgrade the human species by upgrading the gene pool. In short, the technologies will improve life for all human beings but specifically for mothers and babies. However, the most benevolent image of the new reproductive technologies is that they give infertile women the ability to reproduce.

My work, and the work of the international feminist network on the new reproductive technologies previously called FINNRET (but now re-named as FINRRAGE—the Feminist International Network of Resistance to Reproductive and Genetic Engineering) calls upon women to take a more in-depth and comprehensive look at these technologies. FINRRAGE challenges the scientific and media portrayal of these technologies as beneficial to women and as part of the progressive picture of modern science moving ever onward and upward. Instead we are concerned about the ways in which they are damaging to all women.

What are the reasons for this concern? Primarily, it is based on the reality of how these technological “advances” remove from women control over their own bodies and reproductive processes. They do this by chronically medicalizing not only the processes of pregnancy and birth but women’s lives, often by intrusive and invasive procedures. More and more areas of a woman’s life become the territory of medicine, and thus subject to medical control—to medical ideas about how women should give birth and to medical mandates of a “good birth.” Finally, the case for concern about these technologies is based on their status as experimental. Thus they
Of Love and Loss: A Personal Remembrance of Judy Lee Klemesrud: 1939-1985

Only one moment of that Sunday, October 13, 1985 is imprinted on my memory: when I opened my New York Times to read “Judy Klemesrud, 46, Is Dead. Reporter for Times 19 years”. After that, the day disappeared into a black haze.

Judy, my dear, dear friend, was gone. But the loss of Judy was beyond the personal—it was a loss for women everywhere. Judy—who chronicled the women’s movement—Judy, who was the first to do a major feature article on abortion—on lesbian mothers—on so many topics of women’s health and social issues. Judy pioneered the reportage and others followed. But no one had her style.

Judy was a very special person. If you asked her to cover something with which you were involved, you knew you were taking your life in your hands. Judy had a way of telling it as she saw it, whether you liked it or not—and whether you were a friend or not. Strangely enough, this never lost her any friends—though there were times when I wondered why not! I suppose because she had such honesty, both in her writing and in her personal relationships, that once you were her friend, you were her friend forever, and that was that.

Judy received many awards for her reporting but she was always unassuming about it—self-effacing, almost shy—as if she didn’t believe that she was a top reporter for the major newspaper in this country.

On the other hand, Judy had a temper and made it felt if she thought she was being exploited, or if she definitely thought she was right and you didn’t see things her way. How wonderful that she wasn’t perfect. Because, to many of us, she seemed perfect—our Judy, the bright, the funny, the loyal—Judy, the radiant shining star.

Memories of Judy flash through my mind: Judy, wishing she could meet “Mr. Right” and talking wistfully about the many “Mr. Wrongs”; Judy, playing the guitar and singing in her high, sweet voice; Judy, playing hard at sports—and playing to win! Judy, making and breaking lunch dates with me—as I did with her—because we were both career women with demanding schedules and very busy all the time.

I knew when Judy went in for her mastectomy. I knew the pain she went through afterward with chemotherapy. I didn’t know she was going to die.

At the “Celebration” of her life on October 29, 1985, many people paid tribute to Judy—colleagues, friends... Betty Friedan spoke of how much was owed to Judy by the women’s movement....Nancy Newhouse, Judy’s editor, read excerpts from Judy’s pieces, some humorous, some serious, and all written in the inimitable Klemesrud style. Friends spoke of her warmth, her generosity. I was a little comforted, felt a little less guilty when I heard that no one knew she was going to die—Judy had kept it a secret from all of us. Perhaps we should have been warned by her last article, written shortly before her death. She wrote of families with terminally ill loved ones—cancer patients—and types of support groups available to them. Was she sending her family a message? Was she trying to soften the blow for all of us who loved her? I think so. It would have been her style.

Listening to everyone speak of Judy, I discovered that we all knew the same person. In a world of masks and undercurrents, Judy was right up front—there were no hidden corners. Something that can be said of few people.

Each day when I open my newspaper, I expect to see her byline and have to remind myself it won’t ever be there again. Each time my phone rings or I listen to the messages on my answerphone, I expect to hear that special voice. My
sixty-nine percent had their first sexual experience with a male partner between the ages of 16-19; of those, 19% had sex between the ages of 10-15. Forty-five percent stated that at some time they had been persuaded to have a sexual experience they didn’t want and 15% that they had been sexually abused. Of those who stated they were sexually abused, 80% indicated that the abuser was a family member, a friend or a friend of the family.

Ninety-six percent believed that “every woman has the right to have an abortion for whatever reason she chooses”; 77% of those stated they have always felt that way. Forty-four percent thought that men—through marriage, medicine, politics or the courts—should have no say in the abortion decision. However, 92% did tell the man involved they were going to have an abortion; 60% stated the decision was “basically mine” and 34% indicated it was a joint decision.

A high level of activism was evidenced by the fact that 64% stated that if abortion was made illegal in the United States, they would fight politically to retain their rights. Thirteen percent said they would try to activate other women by talking about it personally with them.

Ms. Hoffman thinks the activist response “can be attributed to the high degree of publicity given the abortion issue as anti-choice forces have resorted to more direct, violent, and overt tactics against women and abortion clinics.”

The questionnaire consisted of 70 multi-part questions. Additional topics covered attitudes toward second trimester abortion, birth control, men, and the medical establishment. All respondents were having first trimester abortions and were administered the questionnaire on the day of the abortion, after being seen individually by a counselor. Demographically, the majority of the survey population was Catholic or Protestant; Black: 44%; Hispanic: 22%; White: 26%. Other: 8%. The age range was 13 to 42.

**CHOICES PEOPLE**

**Cynthia Smith**

Intelligent, empathetic, capable, ambitious, pleasant—a perfect description of CHOICES’ Medical Records Supervisor. Cynthia Smith. Cynthia evaluates herself as “a feminist. A single parent doing my best. I look at myself as a woman struggling hard to make things better for my daughter than they were for me.”

Cynthia, eldest of seven children in a family she describes as “very poor”, was the only one to finish college.

“I pushed myself through high school and college,” says Cynthia. “My mother helped a lot. She always encouraged me to go on. She couldn’t go as far as she wanted without an education and she didn’t want the same thing to happen to me. She gave me emotional support all the way.”

Cynthia originally had wanted to be a nurse and took a number of courses in nursing. “But,” she laughs, “chemistry and biology did me in.”

With her usual adaptability, she “saw alternatives” and took her major in Community Health and Education at York College.

After college, in 1982, she came to work at CHOICES as a file clerk, with “hopes of advancement”. She advanced rapidly to an MPF (Medical Person Fri

**Of Love and Loss**

finger still dials her number when another number begins with the same three digits. I think of Judy and my mind replays the words of Edna St. Vincent Millay: “What’s this of death from you who will never die?”

Judy, from all women to whom you gave so much, “Thank you.”

Judy, from me who was your friend: the “Celebration” of your life was from 12 to 2 p.m. on a day that was very busy for me—the kind of day when I probably would have phoned and broken the lunch date.

Hey Judy, I made it... and my tears and my love are with you—wherever you are.

—Beverly Lowy
The Black infant mortality rate is a major concern during the critical first year of life. Babies, and poor infant nutrition during the critical first year of life. The Black infant mortality rate is more than twice the white rate. In addition to infant survival, low-birthweight babies have an increased risk of such handicaps as cerebral palsy and mental retardation. According to the Public Health Service, the incidence of low-birthweight babies stopped dropping in 1980. The proportion in the United States is 6.8 percent of live births—higher than the rate in at least 12 other developed countries. The Institute of Medicine of the National Academy of Sciences cites current financial restraints, including Medicaid restrictions on the number of allowable prenatal visits, as a major barrier to adequate prenatal care. Yet it is a fact that far from saving money by denying poor women and their babies adequate care, the entire cost of prenatal care is less than that of a single day of hospitalization in the intensive care nursery for a low-birthweight infant.

CASE IN POINT: Social Services—Black Women and Health

The current cutbacks in social programs—under President Reagan—have effectively eroded the quality of life for poor and, particularly, Black women. The right of all people of access to decent health care, education, and living conditions regardless of income has been taken away. Since women assume a heavier responsibility for childrearing and family maintenance, any cutback in social services that might begin to ease that burden constitutes a blow to women.

The provision of health care services to poor and minority communities is inadequate in the best of times. The programs that are designed to serve these communities are understaffed and underfunded—ill-equipped to maintain the health of the population at its current level, much less to improve it qualitatively. During economic crises like the current one, even these piddling programs get the axe. The gutting of the WIC program “Special Supplemental Food Program for Women, Infants and Children” is a case in point. WIC provides food supplements to about 2.2 million people, including low-income pregnant and lactating women who are at nutri-

A news item from the New York Times: The Massachusetts Supreme Court upheld the right of the Christian Science Monitor to dismiss a lesbian employee who refused to participate in a church-ordered healing. Church doctrine holds that homosexuality is a “deviation from moral law” and requires members or employees to “heal” themselves. The court held that the Monitor was a valid activity of the church, which adheres to a policy of employing “only members of the church”; therefore, the court said, “the decision to fire [Christine Madsen] because of her sexual preference can only be construed as a religious one, made by a church as employer.”

In a separate opinion, Justice Francis P. O’Connor said Ms. Madsen did not prove damages entitling her to a new hearing. He also contended that her dismissal did not involve religious doctrine, making use of the First Amendment argument inappropriate. It sounds like a double bind to us, and a no-win situation for Christine Madsen.

According to the United States Census Bureau, only 15 percent of America’s 62 million families fit the old-fashioned stereotype where father goes out to earn the bread while mother stays home to bake it. In fact, in almost 22 percent of families with children, both parents are wage earners; in 11 percent there is only one parent; the remaining families have no children in the home.

But what they all have in common is that the wage-earning woman still makes 62 cents on her male counterpart’s dollar.
Violence is often a family affair. Family members killing each other are responsible for 20 percent of all homicides. Nearly a third of the slain women are murdered by their husbands or boyfriends, according to U.S. Attorney General's Task Force on Family Violence. At least one of every five women treated for injury is battered. Wife beating, which切s across all ethnic, racial and social boundaries, affects anywhere from two to six million women a year—in fact, it's considered possible that as many as half of all married women will be assaulted at some time—and these are considered to be low figures. According to the F.B.I., battering is even more underreported than rape.

Why don't the women get out? For many the choice is between staying and being hit or, perhaps, killed, or leaving and being impoverished.

Thanks to the Reagan Administration, with employment-training programs that might empower women being cut, and equal opportunity employment being chipped away, women will have even fewer options.

From a variety of informants from California:

Medicaid funding for abortion is being threatened by two possible ballot measures that would amend the California constitution. The first, which is scheduled to appear on the June, 1986 ballot, is a proposal to prohibit the use of state funds for abortion except when the life of the mother is endangered and would direct those funds into programs to aid disabled children and premature babies. The second proposal, which anti-abortionists hope to get on the November, 1986 ballot, would not even include the exception to save a woman's life.

The measure states that public funds shall not be spent for "killing of innocent human individuals from fertilization until natural death".

Which means either that a woman's life is not a human life, or that a preventable death due to pregnancy is a natural death. Either way, this disregard for women's lives can only be considered inhuman.

Women can especially appreciate that national security is much more than raising and equipping military forces or developing and deploying large-scale nuclear weapons poised for instant attack. The strength of the economy, the degree of our social cohesion and domestic tranquility as a people, as well as relations with our allies in Europe and many other parts of the world are extremely important.

To define national security this way does not mean weakness. Women recognize that weakness cannot be tolerated when a well-armed adversary exists. But overarming and refusal to negotiate seriously, and trying to out-spend the opponent will be counterproductive in the long run and could lead to disaster.

Women participating actively in the national debate, using both knowledge and common sense, can make the difference in whether the United States moves safely toward arms control or dangerously toward the development of new threatening and destabilizing weapons.

One-third of the Senate and all of the House of Representatives are up for re-election in 1986—this coming Fall. The time for women to speak up is now and for the future and beyond. Otherwise, in the not-so-distant future, there may be no one left to speak at all.

Betty Lall, named by UNESCO as one of the world's three leading women experts on arms control, political economist, urban strategist, labor educator is Director, Urban Affairs and Public Policy Programs. Cornell University, NY. She is a director of the Arms Control Association and a dedicated fighter for the ERA, reproductive freedom and pay equity for women.
“I am writing about the short item on page 10, Vol. V of On the Issues. The writer is, of course, essentially correct about the oppression of animals and of women, a subject I explored in considerable depth in My Magazine (August, 1983). I must object, however, to the sweeping and undocumented statement that all religious fundamentalists oppose animal rights and that all feminists support them. This is simply untrue. I further object to what you have to say about the ‘Old Testament’, which we Jews call the Torah. The author of this item apparently never read the Torah or she would have seen the proverb, ‘A righteous person understands the soul of his animal’. The quote about dominion is from a very early source. By the time we get to the Prophets, that idea has evolved into stewardship of all creation. Kindness to animals is an important—though relatively unknown—part of the Jewish tradition.”

Aviva Cantor
New York, NY

On the Issues replies:
The item quoted was from “We’ve Come A Long Way???” Those items are printed verbatim from already published material, with sources cited. Only the underscored portion— the comments—are ours. The piece referred to was excerpted from an article on animal rights written by William Severini Kowinski for the Daily News Magazine (April 14, 1985):

“I am a 30 year-old woman, no children, and am looking for a feminist gynecologist in order to have a tubal ligation. I have just begun to ask questions (and to look up such information) for myself. I have never had any children (some women don’t WANT children). I feel that I have a right to enjoy my sex life without constant fear of pregnancy, or messy gadgets which upset the spontaneity, or dosing my body with unnatural chemicals. Why should a 30 year-old woman not be able to make a choice for sterilization without a hassle? Do doctors really believe that they will be sued several years later because the woman ‘really didn’t know what she was doing’ when she asked for the procedure?”

Nancy Nicholson
Brooklyn, NY

“I am against abortion, but I am compelled to tell the views of those who are for. I must know what opinions they are imparting to society in general. Normally, no woman with an unplanned or unwanted pregnancy is supposed to want an abortion if there is the normal respect and reverence for human life; and if society has a sensible understanding and pragmatic attitude toward such pregnancies. A morally sound society is one where unplanned pregnancies seldom occur and when they do, abortions are never sought. Tragically, our society is morally bankrupt. All of our institutions are under the control of sinister forces, allowing a legion of evils to be perpetrated. And the Moral Majority is a stupid and phony organization that does nothing but waste its members’ money!”

Lou Blackdyke
Columbia, S. C.

“I would like to thank you for a thoughtful review of my book Lillian Wald of Henry Street, Lillian Wald, the woman, remains locked away except that her public life became increasingly her private life. Personal letters have surfaced that might reveal the private person. There is about Wald, as about Jane Addams and the women of the period, a lack of hard facts about their inner thoughts. Perhaps scholars today are searching for illuminating material that will illuminate private conflicts and concerns.”

Beatrice Siegel
New York, NY

“I thank your publication is great! I’m passing it along to my daughter and her friends so they can find out the real truth and all attend a Catholic school and this is the only issue we differ on to date.”

Rhea Jane Diamond
Toledo, OH

“I thank the woman who gave me On the Issues. I generally find the media a heavy burden. I have no TV. The over-saturation of the printed word leaves little room for the imagination or the time to think things through and make choices on the issues. When O.I.I. is placed on the reading pile, somehow the words are different. It wasn’t easy finding a well-written work on the topic of women’s health.”

Leslie Katin, Director
The Feminine Cycle Workshop
New York, NY

“A friend gave me a copy of On the Issues with the Flo Kennedy interview. I haven’t heard anything from or about Flo in five or six years. I am so delighted to discover your publication—it is terrific.”

Margaret Levine
Flushing, NY

“I appreciate your sensitivity, feminism, education and good solid information on health care topics. It’s so bad most professional journals can’t offer what you do.”

Anne Warner, R.N.
Chico, CA

“Yours is an excellent, well-written publication. Coming from a lint-picking writer like me, that’s a real compliment.”

Charlotte Schwarz
New York, NY

“When I finish reading your publication, I give it to our librarian at the senior high school where I teach. She clips articles for a vertical file used for research projects.”

Marjorie A. Simmons
Cow Bay, OR

“I am a 30-year-old woman, no children, and am looking for a feminist gynecologist in order to have a tubal ligation. I have just begun to ask questions about finding a doctor to do the operation, and the initial responses have been most discouraging. I am too young (what do I have to do—wait until menopause??) I have never had any children (some women don’t WANT children). I feel that I have a right to enjoy my sex life without constant fear of pregnancy, or messy gadgets which upset the sp...
Man-Made

constitute unethical medical experimentation on women, even if women submit to them voluntarily.

Take the case of in vitro fertilization. Most of the women who seek salvation in clinics doing this procedure are so-called infertile women. By the time they reach the in vitro stage, they have already undergone multiple medical tests and exploratory procedures to determine and treat their (or their husbands') infertility. With many infertile women, tubal irregularities or obstruction are responsible for inability to conceive. So carbon-dioxide gas is injected into the uterus, or doctors often "blow out" the tubes every four to six weeks. This is a procedure in which pressurized liquid is forced through the tubes in order to maintain a limited opening. One woman, interviewed in People magazine, who had undergone this treatment, and who considered in vitro fertilization her last hope of conceiving and bearing a child, was quoted as saying: "When I have the therapy, I put a towel over my head and cry."

If a woman is accepted for treatment at a clinic, in vitro procedures follow upon years of infertility "work-ups". These procedures initially include laparoscopy to search for a mature egg. The doctor uses a laparoscope equipped with lens and light, and inserted through the navel, to look for eggs. The egg is then removed by suction from a needle. During laparoscopy and needle puncture, the ovaries are traumatized.

The egg is then fertilized with sperm in a petri dish after which it is implanted into the uterus of the woman. Trauma to the uterus can also result from the cannula, or small tube used to introduce the embryo into the womb. When the ovaries are surgically manipulated, as in the laparoscopy and suction procedures, they may not secrete the proper amounts of estrogen or progesterone required. Exogenous hormone treatments then become necessary.

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In addition to extraction and implantation, a number of other biomedical procedures are performed on women. Amniocentesis is most often done, as well as amniocentesis to determine the normality of the fetus. Ultrasound is often used to gain information and certitude about normal fetal growth. The final inter-
Choice Books

I had a number of problems with TRANSFORMING BODY IMAGE by Marcia Germaine Hutchinson, Ed. D. (The Crossing Press, Trumansburg, N.Y., $24.95 cloth, $8.95 paperback), although it would be difficult to disagree with the premise that we must learn to love ourselves as we are. Studies have shown that women distort their body images in a negative way, usually as far as weight is concerned—although those who are of normal or under-normal weight tend to feel overweight. Our all-American pastime of constant dieting, exercising and medicating ourselves to achieve what we consider the "ideal" body has for many women graduated into a dangerous obsession. Even those who don't feel "fat" often have negative body images: breasts too small, feet too large, nose too long, etc. Therefore, I had hopes of reading about some kind of positive breakthrough in this book which has the subtitle Learning to Love the Body You Have. Instead, I found what is to most of us "old news" mixed with pop psychology. What was most disturbing is that 100 out of 138 pages in the paperback edition are dedicated to exercises, worksheets, "self-discovery" exercises, etc. These exercises are not the usual "trying to tone up" kind—they are sensory, meditative, reflective, etc. But what struck me was both the time involved and the concentration on oneself that could become overriding unless handled very carefully by a trained professional. Dr. Hutchinson says, "It's a tragic waste of human potential... If you could harness one-tenth of the energy you spend being obsessed with your body and use it for something that furthered your personal development and goals, just think where you could be!" Yet this book creates its own obsession.

Yes, "it's a tragic waste of human potential," but why is the emphasis on "your personal development... where you could be?" (Underscores ours). Once again, the concentration on self. In a world that so desperately needs people working for change, a world where women and children are struggling simply to survive, just a small portion of the energies expended on these exercises could make a difference to so many. This can't happen as long as women view their mirrors as the whole of society. Someday, hopefully, a step-by-step worksheet book will be written on how to move away from the mirror, forget about self-improvement and self-help books to concentrate on the real issues.

Meantime, TRANSFORMING BODY IMAGE will join the proliferating ranks of similar books that are inundating bookstores nationwide.

—Beverly Lowy

We do not usually review fiction, but WINTER'S EDGE by Valerie Miner (The Crossing Press, $16.95 cloth, $7.95 paperback) is so different and so irresistible that we must recommend it. Although the plot is predictable, the characters are not—especially the two heroines who are active, vibrant women with distinct and very different personalities. It is a tribute to the writer's skill that although these women are in their 70s they never become "too old" or "too useless." They are supposed to be "never mind that they seldom are the way they're supposed to be." Age is not ignored—each woman has her own way of adjusting to it—but the crux of this novel is love: love that is sexual, love that is long-term, love that is pure and unfulfilling, much more so than Margaret's brief love affair turns out to be. It was also a pleasure to read of an older woman having a sexually exciting affair—something that few writers have considered as a topic. Most of all, this is a novel of humanist values, without fluff and with a lot of substance. Best of all, it's a good read.

WOMEN, DRINKING AND PREGNANCY by Moira Plant (Methuen, Inc., New York, N.Y., $32.00 cloth) is an up-to-date, comprehensive and critical review of information on the fetal alcohol syndrome. Ms. Plant points out that although both women physicians and patients of modern times, in fact it has been a problem and much debated since ancient times, with strong admonitions against drinking during pregnancy in writings from ancient Carthage and Sparta, the Bible, Plato, Aristotle—up to the present day. Although the book may be considered too in-depth for the average reader and geared toward health professionals and researchers, there is much fascinating information for anyone interested in this topic. The studies involved the results of smoking and drugs as well as alcohol—and the results should induce any pregnant woman to stop smoking! As for alcohol, according to these studies, moderate drinking does not appear to cause harm, but the question is raised as to what is moderate drinking. In the study cited, it would be one or two units a week—a unit is equal to a half pint of beer, a standard wine glass of wine or one shot of whiskey. Most drinkers would consider this "light" rather than moderate drinking—one of the dangers of drinking at all. This book is non-alarming, non-judgmental and very well presented. In its reasoned way, whether you're pregnant or not, it may keep you from reaching for that drink. And with alcoholism rising among women, that might not be a bad idea at all.

Room at the Top

WOMEN PHYSICIANS—CAREERS, STATUS AND POWER by Judith Lorber (Tavistock Press, N.Y., $22.50 cloth, $9.95 paperback)

Judith Lorber has ostensibly written a book about women physicians and indeed her piece is based on a 20-year longitudinal survey along with personal interviews with many women doctors.

But, in reading Lorber's book, I became acutely aware that this is more than just a study of ambitious, intelligent, accomplished women who face multiple kinds of overt and covert discrimination in their chosen professions. Women doctors may be viewed as a prototype of highly successful women who are trying to make it in a man's world—and the world of medicine is an especially bright reflection of the world itself—that is dominated by the system, politics and thinking of men.

It is Lorber's contention that women are systematically kept out of the power hierarchy of the medical establishment, and as result, have very little chance to impact positively (read feminist agenda) on the profession.

Lorber's analysis leads her to view gender discrimination as the root cause of the problem. She analyzes the established ritualized social interactions and professional patterns that result in limited career opportunities for women in medicine.

Quoting sociological research on career development to underscore her thesis that sexism in the male medical establishment (rather than any real gender or consciousness differences) is the cause of achievement differentials between men and women, we see that unfortunately, women doctors suffer from the same myths (both professional and non-professional) women face, i.e., the "good girl" phenomenon. They truly believe that if they are smart, brilliant or really accomplished, they will be and indeed should be rewarded. But, according to Lorber, "interactive processes, not individual differences between women physicians in their supposed 'appropriate place'. The 'male gatekeepers' do not believe that women are trustworthy colleagues—either due to their inherent feminality or their competing roles as wives and mothers.

Lorber writes that even though this current period in history has opened up many more career opportunities for women, they continue to be kept in the lower or middle levels of medical careers by both formal and informal barriers.

It seems that the male medical establishment—like any other established power structure (governmental, religious, etc.) has evolved and developed specific formulas to insure the maintenance of its position—"Power concedes nothing without demands."—there is no impetus for the establishment to change—and any opening up of opportunities for women is "a priori" threatening to the establishment. As a result, "Quoting sociological research, the two most powerful vehicles for achieving a prominent medical career, are withheld from women.

In every part of the analysis, the woman physician loses—she loses psychologically for she is always trying to be someone she is not, trying to please, to dance to the
right tunes so that she will be accepted. She loses family-wise—even in a two physician family—the woman is still expected to give more time to the children, and ultimately she loses as a careerist because no matter the level of her personal ambition, it is likely to be thwarted by the informal or formal organization of established medicine. In fact, it is Lorber's strong feeling that no individual woman doctor's career can be seen in a vacuum, but that each reflects the fact that professional development is as dependent on the actions of colleagues and superiors as on the individual woman concerned.

This is particularly evident in the choice of a specialty, one of the most common specialties chosen by women (pediatrics, psychiatry and anesthesiology) appear to be the ones that are most commonly recommended for them by others. The criteria used include: short training periods, non-competition, and women's inherent sensitivity to relate to others. Oddly enough, not one of the above really fits these specialists—too much sensitivity can be a negative in pediatrics, while psychiatry involves a rather extensive training period. Lorber contends that a woman's choice of a specialty is a result of "positive reinforcement and conflict avoidance"—rather than any real drive or specific orientation.

She goes on to demonstrate quite strongly that men are much more likely to follow their preferences in career choices while women are not. Even more interesting is a study quoted that shows there is "little evidence that women medical students are particularly nurturant and male medical students are particularly aggressive". In fact, one study found that when students evaluated their personalities—"females rated themselves significantly higher than males did on self-confidence, autonomy and aggression, while males rated themselves higher than did females on nurturance, affiliation and deference." But, as is the case so often in studying the women who have chosen to enter male-dominated professions, we are left with evidence of shattered dreams. Case by case is presented of women in their 30s and 40s who, even with good training and great ambition, did not have the rank or status that they desired. Comparatively, most men looking retrospectively at their careers could see the steps on the ladder leading very clearly to where they were sitting at the present time and had a much higher sense of satisfaction with themselves for achieving. The women physicians interviewed had to deal with working extra hard to prove to their male colleagues that having a newborn baby was not going to cut into their professional commitments, or, in the case of one woman who was not doing well, feeling she had been too "feminine" in medical school and as a result, had not been recommended for a post-graduate training post.

But it was Blackwell and other women physicians who organized clinics and hospitals to serve what they perceived to be the special needs of women patients. Much of the effort in the women's health field has been directed towards redifining the basic assumptions of organized medical practice, especially as it relates to reproduction and gynecology.

But for some women doctors, feminist concepts of medicine are not to their liking—and as a result, they do not ally themselves with the movement. For them, their M.D. is far more important than their Ms. Lorber strongly feels that for women physicians to achieve any real organized effective power base, they must create networks of support and sponsorship. She believes, as I, that personal solutions are important for individuals, as for society and systems to change. Collective, political, organized action is necessary. She fears, as I, that as soon as some women physicians enter high levels of the established power structure, they will be co-opted and forget their sisters. Lorber's ultimate goal is idyllic—men and women working together in a non-gender based culture where all that really matters is human issues and the search for truth. She is aware that the road of this revolution is long and not interminable, however, offers no insight as to how to prevent the leaders from getting lost along the way.

This is an issue for all of us to ponder.

—Merle Hoffman

Lorber quotes a woman physician in her 40s who said "I am encouraged by all the young women who are going into medicine, but..." Lorber says that "paradoxically" women must act politically as a group in order to defuse gender as a status. I do not find this to be a paradox at all—the power establishment itself has collected women, devalued and betrayed them even as they allow a few to rise. It should not be a paradox that women must recognize, reclaim and redefine their status as a GROUP and CLASS in order to effectively eradicate gender discrimination.

Lorber uses Elizabeth Blackwell and Mary Jacoby (women physicians at the end of the 19th Century) to elucidate the political choice for feminists. Blackwell felt that women should be in the profession not of the profession. A cultural feminist and separatist, she held that women had special responsibilities in evolving a higher social and moral order; while Jacoby, an integrationist and liberal feminist, believed that women and men should unite in the profession and work towards objective, demonstrable professional criteria in the search for truth.

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Well, it's terrible. Being on welfare makes you feel terrible about yourself. Everything I owned when I was on welfare, I got in second-hand stores. I mean, they were as nice as I could find, but everything was second-hand—my clothes, my furniture, my son's things. It was very boring, very depressing to sit home all day. And it's bad for kids when their mothers are obviously depressed—it gets them down, too. I remember one woman in the program said her child was really whiny and cranky. Well, I think that child was whiny because his mother was depressed.

So, I'd sit there saying to myself, "How can I get myself out of this situation?" And going into a store with food stamps—people look at you and say things under their breath, or they say it right out loud, things like, "They should have a special line for you people." I knew women who wouldn't use their food stamps because it was so embarrassing for them in the store. But on $75 a week, you couldn't eat and pay your bills.

Chase: What is the average welfare grant in Massachusetts?

Atkins: The average grant, in cash, depends on the size of the family. Cheryl got $75 a week. As she says, on $75 it's hard to eat and pay your bills. The cost to the state of the average annual AFDC grant, with food stamps and Medicaid, is some $7000, while the average cost to the state of an ET placement, including training, day care, transportation and administration, is $3000. In other words, we can get women back to work for less than half of what it costs to keep them state dependent.

Chase: Cheryl, you say you kept asking yourself, "How can I get out of this?" What actually made you get into the program?

Liberatore: Well, I saw the brochures for ET in the welfare office. I wanted something that would get me back to work quickly, and the program was short—it's 16 weeks. The most important thing, though, was the day care that ET offered.

Chase: Cheryl, why was day care so important?
Liberatore: Because there was no way I was going to leave my son alone at home, and I could never have afforded day care myself.

Chase: What was the group you trained with like?

Liberatore: Everyone became friends. There weren’t any cliques. We could sit down and talk about our problems. We had a reunion on May 15.

Chase: Could you describe some of the women you worked with?

Liberatore: Well, they ranged in age from about 18 to 50. A few were daughters of women on welfare. Some had attended college, like me. We were all in the same situation, though, of trying to improve our lives.

Chase: And your lives did improve?

Liberatore: Definitely. I'm working for Mass. General Hospital now, as a secretary to the Environmental Services Department, and they're going to pay for me to go back to college. I had to stop before, when I had my son. One of the other women is a secretary for a construction group. One works doing computer programming. Another is an assistant for a nutritionist.

Chase: What did you do with your first paycheck?

Liberatore: I bought a new dress and shoes, and bought my son toys. For a while, every time I got a check, I bought him a toy. My sister was saying that it looks like Christmas all the time.

Chase: You mentioned day care before. What are some other aspects of the program that were important to you?

Liberatore: Well, nobody I know who went through the program would have been able to get the job they're in without the skills training we got through ET. Most of them were planning to go back to school eventually, but this speeded up the process. Also, the career counseling—showing us what kinds of things we could do. I remember noticing how women around me in the program were feeling more and more independent, less depressed if they didn't have a husband or a boyfriend to help them out. ET gave us the confidence to go on to bigger and better things. And we all needed it. Without it, people can't better themselves.

Chase: How does ET fit into the general economic scene?

Demong: Well, we've been building up a real database here, and getting some figures on who is poor. As I said before, the answer is mainly women, and not only people on public assistance. Nearly three-fourths of unemployed teenagers in Massachusetts are women.

Chase: Does ET make your task of job placement easier?

Demong: It sure does. You see, women on AFDC develop some terrific management skills, which they can be trained to transfer to different areas. The fact is, a lot of poor women are excellent managers, but most of them don't think of themselves that way. Any one who can feed a family of three on $4300 a year is accomplishing a significant management task. ET channels personal talent into an employable profile. As you can imagine, that builds a lot of confidence in the participants, as well as giving them marketable skills.

Atkins: I think that's a crucial point. Programs like ET are the only route out of poverty that I know of in this country. Reagan claims that a rising tide lifts all boats. But there are no boats for the people who are discouraged job hunters because they don't have skills for jobs in the workplace. They have to get help so that when the tide rises, there's a boat to get into.

You asked me about the average grant a few minutes ago. Massachusetts is among the top 10 states in the amount of money it gives in welfare benefits. Despite that, we can only give $4,440 in cash, plus $1,800 in food stamps—that's $6,240 for a family of three. Meanwhile, the federal poverty level for a family of three is $8,850. That's why I think the only way out of poverty is ET-type programs which can help women get off welfare and into jobs. You know, the average AFDC grant is $4,400. The average ET full-time job pays $9700. I'm in the ridiculous business of running a poverty program.

Chase: What do you think is the answer?

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other they could not test. In the absence of full information the responsibility for choice had been taken away. If either twin was retarded, sick, disabled in some way, it would be sad, but it would not be Deborah's fault. She would cope with what came, accept the twins as they were.

Having the ability to make some choices about the condition of our children has begun to take away the choice to simply accept them as they come. If we can know that a child might suffer, or even die before its time, can we knowingly allow it to be born? We make ourselves in some sense responsible for its suffering. Once the information is there, choice is inevitable.

Many of the women having

ilized conveys the tell-tale message of racism. It is noteworthy that the federal government assumes 100 percent of the cost of sterilization under Medicaid, while, at the same time, federal, state and local abortion funds are cut off.

The fact that Black women and other women of color are in a qualitatively worse position than white women is easily proven, as is the relationship of this poor health status to life conditions of an individual based on race, class and sex.

As progressive health providers and concerned individuals, this awareness oftentimes makes us depressed, demoralized, and at a loss for what to do. Providing health services and patient education are important, but its impact on society as a whole is limited.

To effectively transform the existing social ills, we must support and participate in the growing number of organizations and self-help clinics that are addressing these social questions.

I encourage all of us to "Change the World."

Vicki Alexander, M.D., Obstetrician/Gynecologist with the Maternal-Infant Care-Family Planning Projects in Brooklyn; Consultant, Montefiore Family Health Center in the Bronx is a long-time women's health care activist. Her political organizations include the Black Women's Health Project, National Campaign to Restore Abortion Funding; Coalition to Fight Infant Mortality; Alliance Against Women's Oppression.

prenatal diagnosis used the rather strange phrase: "my only choice." Whatever choice they made, it was often experienced by the woman as an "only" choice—the choice one makes when all other choices are too terrible to contemplate.

Choosing to end a pregnancy one wanted, with a baby one had begun to prepare for and even to love as it moved within, is never an easy choice. One may do it to spare the baby suffering, one may do it for good and strong reasons, but one always does it in pain and sorrow. Choosing to continue a pregnancy, knowing the child will not lead a full life, this too can only be done in pain and in sorrow.

There are no solutions to these dilemmas, but there are steps we can take. Along with our work for informed consent and for more choices and for more information, we must also consider the rights of informed refusal, including the informed refusal of information. Deborah had amniocentesis to test for Downs Syndrome. Had she known a diagnosis such as Amanda's was possible, perhaps she would have chosen not to learn it. Some women would not want to know if their children were going to die of cystic fibrosis. Some would not want to know if their children were going to die of Huntington's disease. Not all of us would want to know if our children seemed slated never to see old age. Perhaps sometimes it is not knowing that frees us.

Many science fiction, fantasy and horror stories have been written about being able to tell the future. Most end with the crystal ball smashed, the power too terrible to use. Knowledge may be a certain kind of power, but foreknowledge can also be the very opposite. We birth all of our children into the passage to death. How much do we want to know ahead of time about their journey?

Barbara Katz Rothman, Ph.D., Associate Professor of Sociology, Baruch College and the Graduate Center, City University of New York, is author of The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood (Viking Press, 1986). Previous work includes In Labor: Women and Power in the Birthplace, published in paperback as Giving Birth.

Janice Raymond is Associate Professor of Women's Studies and Medical Ethics at the University of Massachusetts, Amherst. She is the author of The Transsexual Empire and A Passion for Friends, both published by Beacon Press.
Abortion, such a major part of my life for so long, so politically comfortable, yet still having the power to amaze me. Today at Amherst, this woman faced herself and the reality of her choice. I had helped make that happen, had been a catalyst, enabling her four-year secret to be told safely in this room among women—among peers. Hearing herself speak must have given her some measure of comfort, for her voice became stronger as her story unfolded. Nothing new here, the terror of the abortion itself, the sense of depersonalization, the medicalization of choosing, the profound relief. I had heard all of it many times before, but her telling made it special.

Quiet Heroines. Another voice. She had been a prostitute, on welfare—doing sex to get by after her second marriage. All screwed up, falling back on the only skill she did not have to learn or practice. She tells me this as we walk the quiet campus. Her eyes do not move from the road—her voice betrays no change in theme from politics to life. Matter of fact, on welfare—prostituting. I react inside and say nothing. Just listen. She says she is 40 but looks much older. Her life had left messages on her face for anyone who could read to see. Feminists are made, not born, churned and hewed in the fire, radicalized by life, not theory. Now she is political and bourgeois. Her son will make something of himself, "respect women." As for her, she sits on approximately four boards of directors—pillar of the community, blue skirt, blouse with a neck ruffle and tie. Sex for her now is politics. Not something that one does to survive, but something to be analyzed for the struggle. She, too, has had abortions. But hers were more of a type—an occupational hazard to be expected. Looking and listening to her, I feel a sense of awe and wonder.

On the plane to San Francisco. Going to the 70th Annual American Medical Women's Association Conference entitled: "Violence—DxRx." Physicians also now studying and analyzing violence against women. I pick up the New York Times and see Betty Friedan's "How To Get The Women's Movement Moving Again?". It occurs to me that I often experience the movement in black and white—the colors of depression, a kind of bloodless passion that kindles itself on small flames. A world of dualisms—of politically correct and incorrect behavior, of good girls and bad, of homo and hetero, of feminine and feminist. My consciousness exists in prisms—I am bound by a natural necessity to see events through multiple reflections, eventually allowing for even an understanding of my enemies.

The ultimate passivity of women finds its apex in the act of abortion without its acknowledgment. 1.5 million women have abortions every year. How many of them speak about it? How many keep this reality inside themselves like some dark bloody secret: something to be hidden, to be ashamed of? How many women defy their post-abortion instructions not to have intercourse for at least three weeks because their lover or partner knows nothing about it? How many submit to infection to keep their secret? Keeping quiet, like keeping your legs together, is a major part of the mythology of being a "good girl." Quiet Heroines—careful not to be too abrasive, too strident, too aggressive.

Todos Santos, California. I am to be the keynote speaker at a professional women's conference. The topic is "Women, Power and Choice." They told me this was heavy stuff for the West Coast—so much so that the main newspaper in the area refused to interview me or carry the fact that I was speaking. Fears of pickets and violent protests in front of the hotel do not materialize. I am ready. These women are hungry for inspiration. They came to their feminism from the hard way—not on college campuses or in consciousness raising groups but through marriages. Most of them are divorced. I am a lightning rod for these women—I "put my life on the line" after all. I get a subliminal message that they love and fear me for it at the same time—know they have to be awakened, need to hear the message, but some part of them wants to keep sleeping. One woman has driven an hour to hear me speak. About 35, she is thin, pale, with eyes that seem restless. She has been in the struggle almost 15 years and like me does not really remember when she hasn't been involved. She has been—still is—an executive in an abortion facility. Very matter of factly, almost abstractly, she tells me her car had been torched two weeks before by anti-choice fanatics. She doesn't seem terribly upset, not proud, simply accepting this fact as a "given"—as if coming home and finding your car in ashes is just something to be expected for a front line fighter. For a Quiet Heroine.

Dinner is a typical Californian vegetarian meal. I speak to them about abortion. Yes, I have had an abortion. Yes it was difficult. And to my left, a woman gets up and begins: "I've never told anyone about it, but five years ago I got pregnant and ..." I love every minute of it. I am into the politics and the power—the small awakenings and profound beginnings. THE PERSONAL IS THE POLITICAL.

Afterwards, I stand at the lectern, taking questions. They ask me how I deal with my opposition and the direct attacks. I respond by saying that I have come to judge my accomplishments more by the strength of my enemies than the force of my supporters.

Make no mistake, tell them, abortion is the buzz word, the banner, the visible cue for all who would oppose women's equality. Abortion is the fundamental freedom for women. The right to choose whether or not to be a mother, whether or not to bring a child into the world is the non plus ultra for the women's movement. Without reproductive freedom and access to safe legal abortion, any discussion of equality for women is groundless.

I am bringing the issue to life. I am the physical and political representation of the theory. By speaking, by testifying, I become. The others—the silent ones—are also heroines but cannot be counted in the ranks of the struggle, for they make no representation, demand no response, create no anxiety. The movement must challenge and create conflict—otherwise it exists only in dialogue.

Another voice breaks the silence—"It was such a difficult choice for me to make. The mother in me wanted so much to have it, to love it, to see it grow. The other part knew it was impossible." The "other" part, I thought. It occurred to me how very male defined our definition of mother has become—selfless and self-sacrificing. But I knew the truth—that abortion—"the act of choosing whether or not to have a child—is in and of itself a mother's
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act. Abortion is so often an act of love—love for oneself, one's family, for the children one has. An act of love and survival.

The next morning, I am on my way to a radio interview. The white limo moves smoothly throughout the Napa Valley—pastoral scenes—cows, horses, vineyards. The driver is quick to point out the likeness to Falcon Crest. I, dressed in white, sit in the back readying myself for the adventure—a kind of feminist lone ranger riding into town to lay my raps. She is about 28, a stockbroker, bright, attractive, intelligent—came to her feminism through an independent hard life. She is supporting her newly married husband in his studies. She will be my guide to Northern California. The radio station is expecting me. Heads snap up as we walk in. The D.J. is real tough. He has my literature in front of him—it looks well worn and well read. He thrusts the mike in front of me and we are on the air.

“Well Ms. Hoffman, how are the Mets doing?” “They’re some kind of ball team aren’t they,” I counter. He is completely nonplussed and can only respond with a question concerning whether or not Geraldine Ferraro had made promises to me in return for that he thought was my heavy financial contribution to her campaign. It is truly Reagan’s Amerika. His questions are not new nor is his attitude. “Aren’t women really being selfish? After all, they are killing babies for their own reasons.”

The last few minutes of the program I take calls. A woman describes herself as a “young 70”. Her question echoes in my mind. “Why are all these women getting pregnant in the first place?” Why indeed?

December, 1985 did not come quietly, either. The first week brought with it letter bombs in Portland, Oregon sending messages of hate and destruction to clinic personnel—more Quiet Heroines. December 10th brought a violent bomb attack against a New York City abortion facility. The bomber made three phone calls alerting staff to evacuate. The bathroom, waiting room and equipment were damaged. Violence...

It gets closer.

PATIENT POWER

In the early 1970s, Merle Hoffman, founder/president of CHOICES, developed the concept of Patient Power, based on the principle that patients (mainly women) are consumers of medical treatment rather than passive (and often victimized) recipients. As such,

1. Patient Power is the right to question your doctor.
2. Patient Power is not being intimidated by the medical establishment.
3. Patient Power is making medicine work for you.
4. Patient Power is knowledge of the power of your own will to health.
5. Patient Power is awareness of available medical choices.
6. Patient Power is assertive questioning of the medical system.

They are entitled to get what they pay for, know what they’re getting, and understand all their options for treatment. The following “12 Tenets of Patient Power” will help you understand this philosophy and ultimately practice it in your own medical care.

7. Patient Power is knowing all your options.
8. Patient Power is being informed of your rights and responsibilities.
9. Patient Power is comparison shopping for doctors and drugs.
10. Patient Power is being an informed consumer.
11. Patient Power is integrity and responsibility.
12. Patient Power is a discipline of self awareness.

Who’s Life Is It Anyway?

“Most women make the decision of abortion...out of love...for family, children...often a selfless decision.” —From Abortion: A Different Light produced by Merle Hoffman in 1982.

This 28-minute videotape explores the ethical, religious, political and sociological aspects of abortion with honesty and candor—even allowing equal time for the anti-choice activists to present their side. Seven former abortion patients at CHOICES are “silent no more”—they tell their stories movingly and honestly. Pro-choice activists and attorneys are interviewed in depth; there is a vigorous debate between Merle Hoffman and Moral Majority leader Dan C. Fore; a 13-year-old girl rattle’s anti-choice rhetoric, unthinkingly parroting what she has been taught; and much more.

This film puts the focus of the abortion issue back where it belongs—on women. It is the ethical rebuttal to “The Silent Scream” and a useful tool for pro-choice activists to use in their communities. Available in Beta, VHS or 3/4” cassettes. Purchase price: $350; rental; $75; in special cases of fledging or struggling feminist organizations we will waive the cost except for $25 to cover postage and handling.

Contact: CHOICES, 97-77 Queens Boulevard, Forest Hills, N.Y. 11374. 718/275-6020, Ext. 467.
We are CHOICES, one of the most progressive and comprehensive ambulatory women's health facilities in the nation. Since our founding in 1971 as an outpatient abortion center, we have become a role model in the field of ambulatory women's health and surgical care, and offer the following services:

- Pre- and Post-Natal Care
- Full GYN Services
- Family Planning
- Walk-In Pregnancy Tests
- Abortion
- Diagnostic Sonography
- Vasectomies
- Female Sterilization
- Full Laboratory Services
- VD Testing & Treatment
- Workshops for the Community
- Counseling
- Project Outreach

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