The PUBLIC i

The *Public i*, a project of the Urbana-Champaign Independent Media Center, is an independent, collectively-run, community-oriented publication that provides a forum for topics underreported and voices underrepresented in the dominant media. All contributors to the paper are volunteers. Everyone is welcome and encouraged to submit articles or story ideas to the editorial collective. We prefer, but do not necessarily restrict ourselves to, articles on issues of local impact written by authors with local ties. *The opinions are those of the authors and do not reflect the views of the IMC as a whole.*

THE PUBLIC I
Urbana-Champaign IMC
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COMMUNITY SHARES OF ILLINOIS

The UC-IMC is part of the Community Shares Program.

Get Involved with the *Public i*

You don't need a degree in journalism to be a citizen journalist. We are all experts in something, and we have the ability to share our information and knowledge with others. The Public i is always looking for writers and story ideas. We invite you to submit ideas or proposals during our weekly meetings (Thursdays at 5:30pm at the UCIMC), to post a story to the web site (http://www.ucimc.org), or to contact one of the editors.

- Become a citizen journalist; write a news story or opinion piece.
- Make a tax-deductible contribution.
- Help distribute the *Public i* around the Champaign-Urbana area.
- Help with fund-raisers.
- Join the editorial board.

Habari Connection Awards Dinner

Habari Connection Inc. is hosting an Awards Dinner
SUMMER CAREER SUCCESS TRAINING PROGRAM
Tuesday, July 18th from 6-8pm at the Park Inn
Free Dinner. Donations Appreciated. Open to the public.
Contact us to RSVP By July 10
Contact Tanya Parker, Habari Connection Inc.
217-766-6374, or habariconnection@gmail.com

Join us is in honoring the youth that have successfully completed the Career Success Training Program, and learn more about Habari Connection Inc. and its vision for our community. Through our not-for-profit efforts we aim to provide solution based programs and services, and to promote healthy self-sufficient families and self-empowerment. We strive to make a positive effort to improve education, judicial, health, and the employment crisis. We have established a collaboration with Independent Media Center, to help create an even more dynamic impact. We have several awesome events coming soon!

From June 19 through July 15, Habari Connection Inc. sponsored a 4-week Career Success Training Program. They experienced career exploration, learned sales presentation skills, entrepreneurial development, guest speakers, and field trips. The youths are making a dedication to themselves to strive to achieve their personal success. Our program was featured in the News Gazette on June 23, 2006, by Amy Reiter.

We are looking forward to seeing you at the dinner. If you cannot make it to our dinner, but would still like to be informed of our activities or make a contribution to Habari Connection, feel free contact us.

Mail donations to:
Habari Connection
P.O. Box 6684
Champaign, IL 61826

Please make checks payable to Independent Media Center, Memo Habari Connection. A percentage of donations support the IMC.

Thanks for helping us to strengthen the Champaign-Urbana community.
Invited Guest Speaker:
Gloria Thompson-Brown, Civil Rights Activist
Please call today, SPACE IS LIMITED: 766-6374 for more information.
WE CREATE LEADERS FOR LIFE.

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The *Public i* wishes to express its deep appreciation to the following sustaining contributors for their financial and material support:

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If you or your organization would like to become a sustaining contributor to the *Public i*, or would like more information , please call 344-7265, or email imc-print@ucimc.org.

The PUBLIC i
A Paper of the People
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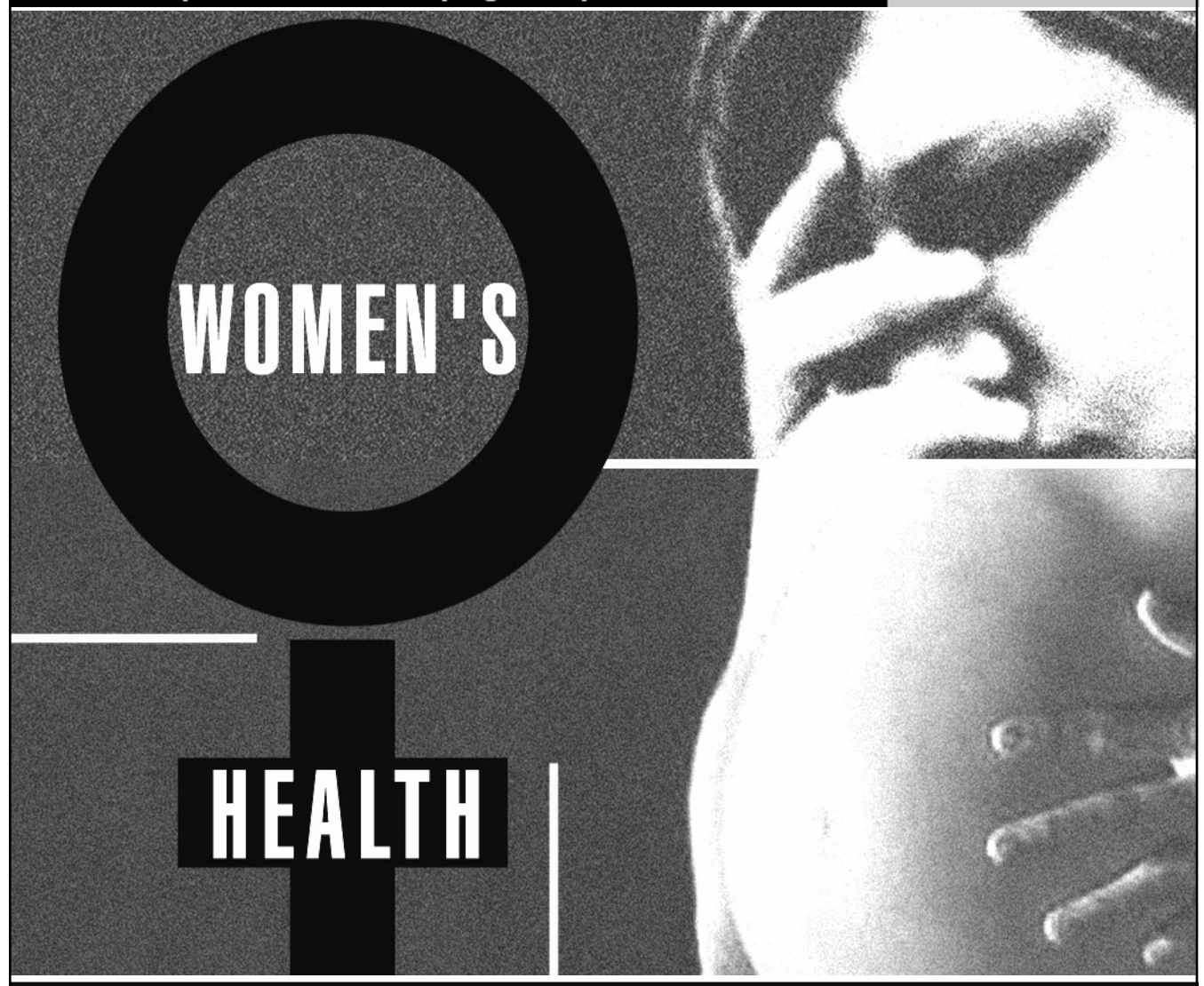

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A Paper of the People

HPV: Prevention of Cervical Cancer Through Vaccination

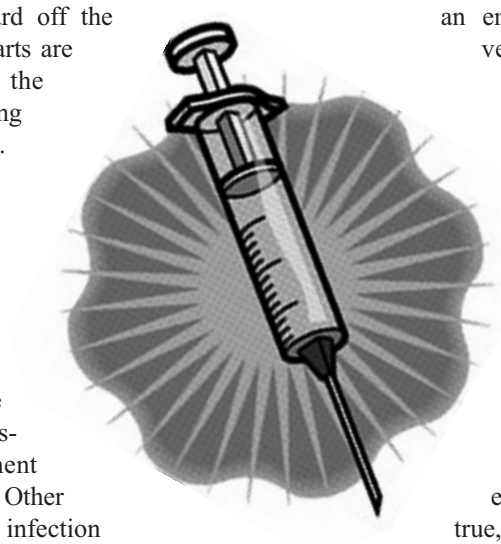
By Suzanne Trupin, M.D.

Suzanne Trupin, M.D., F.A.C.O.G, Owner & Chief Executive Officer, Board Certified OB/GYN, Women's Health Practice, Champaign, IL; Clinical Professor, Department of OB/GYN, University of Illinois College of Medicine at Urbana-Champaign.

A HPV VACCINE has been hailed by gynecologists as the most significant breakthrough in Women's Health of the century. The first HPV Vaccine has been approved by the FDA. HPV is a DNA virus that infects skin and mucosal tissues and causes cell changes that lead to what is known as cell proliferation (overgrowth) and conversion to neoplastic changes (premalignant and malignant). These vaccines have the ability to prevent the majority of cervical cancers, a cancer thought to be virtually 100% preventable. Two vaccines are: one, the newly-approved Merck quadrivalent vaccine Gardasil®, targets four types of the HPV virus: 16, 18, 6, 11. It is a vaccine that gives the individual a fairly rapid immunity to one of four types of the HPV virus. Merck has targeted the HPV 16 and HPV 18 viruses because they together are the responsible for 70+% of cervical cancer cases. They included 6, 11 because they cause genital warts and abnormal pap smears, and the vaccine has the ability to prevent 90% of those. There are over 100 identified types of the HPV virus. A second vaccine was developed to target only HPV 16 and 18, called Cervarix®. FDA approval is still being sought.

The quadrivalent vaccine that has been approved is a series of three shots, with the second shot administered two months after the first, followed by a final shot four months later. The injection is not that of a live virus, but that of the proteins of the outer shell that are called VLPs or virus like particles, that are perceived as the virus by the body, and robust antibodies are formed to that particle. With this antibody formation, for at least the few years that the vaccine has been studied, there is virtually complete immunity formed against HPV. The immunity means that persistent infections are absent. There is almost complete protection against the virus acquisition in those not infected, even in those that didn't adhere completely to the study protocol.

Cervical cancer has been a world wide epidemic for generations. Over 500,000 cases are diagnosed world-wide; over 250,000 women die. They die in the midst of America too, but the numbers pale, and fewer than 4,000 American women die each year here of this disease. This is due to the wide availability of pap smears, accurate tests to diagnose the primary causative agent, referral to gynecological treatment and effective elimination of most pre-invasive cervical disease. We in the United States also do fairly well at preventing the diseases of anal cancer, vaginal cancer, vulvar cancers, the rare penile cancer and laryngeal papillomous growths as well. Yet, even with our medical system of track and triage the burden of genital warts has continued to grow: 20 million infected Americans, and most unknowingly. Since only 4,000 die and 20M are infected, its not cancer that is the real American Tragedy of the disease here. It is the ever increasing numbers of young women who have contracted the virus and have to deal with the consequences: financial, emotional, physical and mental. Take the medical scenario of the only treatments of pre-invasive disease being surgical excision. There are legions of young women who have had large areas of the cervix permanently removed in an attempt to ward off the cancer. Genital warts are treated in much the same way, removing the affected tissue. Since elimination of the wart is not always accompanied by elimination of the viral infection causing the wart, recurrences are common and resistance to treatment common as well. Other consequences of infection are depression, lower sex drive, lower self esteem, anxiety, and the issues of "pre-existing" i.e. "not-covered" conditions on your next insurance policy, which causes economic burdens for those in treatment.



A focus group of girls and women with the HPV disease might have a 17 year-old who's had abnormal pap smears for many years, has had two procedures to remove the dysplastic tissue, and is at risk for consequences such as cervical incompetence in pregnancy resulting in miscarriage; a 40 year-old with multiple excisional procedures of the vulva to remove abnormal tissue who is at risk for sexual dysfunction; a 52 year-old with cervical cancer; a 26 year-old with multiple genital warts, who will likely require at least 3-4 visits just to remove this round of the infection, and a 28 year-old pregnant woman with an abnormal pap smear. In addition to the numbers of young women with the infection, we now estimate 80+% of us will acquire the HPV infection by age 50, and 20% of women who have contracted the disease have had only one partner. This group will ask where they got the infection: unable to say, as tests for HPV are so newly available we can't say how long an individual has harbored her infection; how likely they will resolve the infection. About 70% will clear sometime after 6 months, closer to 90% of infections clear by 2 years, and by 5 years if it's going to clear at all. Questions remain: when is sex safe again and what should I tell my partner? Disclosure issues are troublesome since there's no real test for the men.

Who will need the vaccine? We know that about 50% of adolescent women will contract HPV within three years of becoming sexually active, so the vaccine is most likely to help those women prior to their debut into sexuality. Administering an STD vaccine to a child, in a sheltered life, with monogamous parents who married when they were virgins, is looking to be a very hard sell politically. No one has an emotional problem preventing small pox, or mumps, or whooping cough, or polio, but when it comes to the S word topic, apparently that is a NIMBY discussion. Abstinence has been called 100% effective 100% of the time, and for the straight genital-to-genital contact disease that is probably true, but for variations in sexuality, not so good. So young people of both sexes probably need vaccinations. The Merck vaccine has been tested in girls and women from 9-26.

Condoms don't work effectively to protect against HPV disease. They aren't used consistently, aren't used with appropriate microbicial concentrations of spermicide, and plain and simply do not cover the potential odd wart or two that sits on the male body instead of the shaft, or the rectum, or the skin of the scrotum, or the rectal areas, or the female perineal areas. Latex condoms do help to block transmission, but if any skin-to- skin contact occurs in an affected area transmission will occur. Suffice it to say, even a body bag wouldn't do it, because slippage, breakage, and plain old holes let alone the lax application of said bag would not work, does not work. Now those of us in the business do need to add they do drastically reduce the rates of other infections: gonorrhea, Chlamydia (a cofactor in the cervical cancer cases), herpes (another cofactor of cervical cancer) and the rates of HIV infection, and by the way, are very effective at preventing unwanted pregnancy. Yet in the midst of an STD epidemic the Congress has been set on legislation designed to highlight condom's failures rather than on strategies that would increase their use.

Vaccines, if effective, are the only way to go when preventing a case of a sexually transmitted disease, or an outbreak, or an epidemic, or a pandemic. Years ago our CDC decided that it's only logical, that if gonorrhea is spread through sex, and you find an individual with said case, treat the partner who gave it to him or her and you'll stop the chain of events. With rules, regulations, laws, troops of more-or-less-informed public health workers, and a patchwork of policies and procedures, where has it gotten us? We see pretty stable rates of most of the common sexually transmitted diseases within the US. In the year 2000 we had over 19 million new infections reported. We have done a good job of decreasing syphilis by the way, but still HPV itself is responsible for about 50% of new STDs. And we forge ahead with these policies, as it still 'seems prudent', but there's not a single well done prospective study to say this is effective.

The HPV vaccines have the ability to prevent disease, save money, and save lives. This is not debatable. Many of the available vaccines we do take are for diseases that are frankly rare; this one is not. What is debatable is how to overcome the significant political and social obstacles to accepting the vaccine. Is getting vaccinated a ticket to loose or so-called unsafe sexual behavior? Moral extremists have been heard to say that STDs are just payment for out-of-wedlock sexuality. Both sexes will need to be vaccinated, but will public distrust of vaccine safety allow boys to be vaccinated to prevent diseases in women? Will vaccinated women stop getting pap smears when we know this will not prevent every HPV infection or every cervical cancer? Will the vaccine reduce condom use and inadvertently increase unwanted pregnancies? We'll need to be administering more of those morning after pills if condoms decline and that will be another topic for future discussion.

It is unlikely that legislation is going to rubberstamp HPV vaccination policies or protocols. It is most likely that the vaccine's acceptance will rest largely with individual providers, patient education and discussion and maximal understanding of the disease's serious consequences, the consequences of avoidance of vaccination.

Dr. Trupin is a paid research consultant for Merck & Co., Inc. and other women's health companies.

COMMUNITY FORUM

Vigil For Quentin Larry and Terrell Layfield

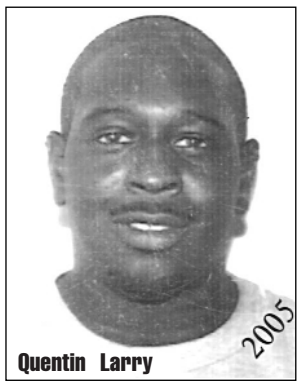
by Brian Dolinar

ON SATURDAY, July 22 at 8pm a vigil will be held for Quentin Larry, Terrell Layfield, and others who have died while in police custody at the Champaign County jail. Bring a candle and meet us at 204 E. Main, downtown Urbana, in front of the Champaign County Sheriff's office.

This vigil is first to honor the individuals and their families. Secondly, it is a call for an independent investigation into the five deaths that have occurred within the past two years. We plan to go to the Champaign County Board with the demand that an independent investigation be conducted into all five deaths.

Public concern arose in 2004 when three suicides occurred within six months. IMC reporters made contact with Twymenia Layfield, the wife of Terrell Layfield, the last of the three alleged suicides. It was through conversations with Mrs. Layfield that they found out about the restrictive and arbitrary visitation rules, as well as the high cost of phone calls from the Champaign County jail. After these were exposed, Sheriff Walsh allowed for more than the cut off number of fifty visitations. Sandra Ahten and Champaign-Urbana Citizens for Peace and Justice successfully rallied to get the County Board to renegotiate a contract awarding $14,000 a month kickback to a phone company.

IMC reporters accompanied Mrs. Layfield to the coroner's inquest and all left feeling they had not been given a full explanation of Terell's death. The public hearing involved Urbana officer Mike Metzler giving an account of the alleged suicide. No evidence was presented, no photographs, no bed sheet claimed he used. No witnesses testified, not the officer who found the body. The matter was quickly settled in under ten minutes.



Quentin Larry

This coroner's inquest was the culmination of an investigation that was far from independent. The Urbana police force was assigned to investigate the Champaign County jail. In a small town such as Urbana-Champaign, the authorities are a small circle of friends who know one another on a first name basis and have lunch together.

From the beginning, the Sheriff could not start his investigation until the Champaign County State's Attorney determined that no criminal charges were to be filed. If the Sheriff was to be sued, State's Attorney Julia Reitz would be his lawyer. In this scenario, as Sandra Ahten writes, "the State's Attorney would be both prosecution and defense" (ucimc.org 2/11/2005).

An independent investigation into the five deaths is the final piece in the puzzle to find out what is going on in the Champaign County jail. The repeated incidents suggest that these deaths are not "accidental" but systemic and procedural. In the words of Mrs. Layfield, "In my opinion, suicides are not only the fault of the jail system, but also the justice system." To police officers, jail guards, lawyers, and judges, inmates are not people who have loved ones, wives, and children. Terrell Layfield was charged with cocaine possession. He took it to trial and was found innocent. Yet he was found guilty on the trivial charge of obstruction of justice for lying to the police about his name. The heavy sentence of more than five years given by Judge Heidi Ladd should be seen as retribution for his beating the drug charges and lying to an officer. Layfield was obviously distraught about the long sentence. When he was denied a routine phone call to his wife, he became upset and began to make noise in his cell. He was not responded to for several hours. Committing suicide was his final act of protest against an unfair justice system.

According to the Department of Justice, drug offenders were found to have the lowest suicide and homicide rates of all inmates. Terrell Layfield was not suicidal before he entered the Champaign County jail. The inhumane condition in our jails and prisons do not correct, but only create more death and destruction. Those who administer justice become jaded and themselves become dehumanized. In the courtroom, Judge Heidi Ladd said Layfield received several years because he was "living like a bum."

On the ucimc.org web site, Mrs. Layfield responded to these comments saying Terrell was also a father, husband, friend, and son. She blamed the authorities who failed to take the first suicides seriously, "What did they change to prevent this from happening again to me – it seems nothing!" Her words were prophetic. While steps have been taken by Sheriff Walsh, not enough has been done to prevent two more deaths in the jail. How many more before we have a restoration of the public trust?

The individuals and their families are the real victims in this country's War on Drugs. Quentin Larry, who died of a heart attack the Sheriff is calling drug-related, is the latest victim. Larry died over Memorial Day weekend and his case is still under investigation. The City of Champaign police have been assigned to investigate this incident, another inside job.

The families of Quentin Larry and Terrell Layfield are supporting this vigil and asking for a full explanation of the death of their loved ones. Join us on July 22 at 8 pm in front of the Sheriff's office, 204 E. Main Street, downtown Urbana. The vigil is being sponsored by the Urban League, Champaign Urbana Citizens for Peace and Justice, Visionaries Educating Youth and Adults (VEYA), and Anti-War, Anti-Racism Effort (AWARE). For more information see the June issue of the *Public i.*

LOCAL

You Were Told *What* ?

A SHORT HISTORY ON THE REFUSAL OF INSURANCE PLANS AND PHARMACISTS TO FILL PRESCRIPTIONS FOR BIRTH CONTROL AND EMERGENCY CONTRACEPTION

By Kathy Spegal

THROUGHOUT THE US, women have been at the mercy of insurance carriers and employers who have refused to include contraceptive options as part of their health plans. Women who have been prescribed birth control for medicinal purposes other than contraception have had to petition their providers to make an exception. Permission was given grudgingly after many phone calls and documentation.

In 2001, a University of Illinois employee, whom we will call Sandra, got fed up with her insurance provider's refusal of coverage of birth control for endometriosis. Sandra called the Champaign County Health Care Consumers to see what she could do. While the doctor and the insurance provider duked it out, a call went out to other health care agencies to meet and discuss what could be done to address the issue. The Women's Health Task Force (WHTF) was formed and this issue was the first one to be tackled. It is ironic to note that U of I students had easy access to most birth control options at McKinley Health Center through student insurance.

This same problem was being addressed in several other states with law suits being filed in Washington state for discrimination based on gender. Men had no problem getting Viagra but women could not get birth control. Title IX was invoked and the first domino fell, soon followed by others. The EEOC ruled in the favor of women and employers began to take notice. WHTF requested an audience with the Chancellor to discuss broadening coverage to faculty and staff for birth control. After several months, U of I announced that faculty and staff could pick up birth control at McKinley, a first step. Meanwhile, efforts were being spearheaded by Planned Parenthood at the state level which would require employers and insurance companies to include birth control in plans that included pharmacy coverage. This provision was passed into law with exceptions for small businesses, businesses that were self-insured and businesses that have corporate offices in states where coverage is not required. Thus the U of I was required to offer the benefit while Carle Hospital was not.

The next project of the WHTF was to spread the word about Emergency Contraception, a low dosage of regular birth control that prevents pregnancy when taken within 120 hours of unprotected sex. Presumably, pharmacies that carried birth control would also carry Plan B, a brand of emergency contraception. Not so! The list for Champaign County showed that some pharmacies did not or would not stock Plan B, and some pharmacists refused to fill a prescription. Additionally, Catholic Hospitals would not even give information about Plan B to victims of sexual assault.

The WHTF spent many hours at rallies, dispensing information and collecting signatures for legislators who were discussing another law to make EC available. Planned Parenthood worked with the Governor's staff to encourage him to pass a rule making it illegal for a pharmacist to refuse to fill a prescription for EC or birth control. This rule became law in January of 2006.

Pharmacists have refused to fill prescriptions, to refer to pharmacists who will fill the script and in some cases, have taken the script and refused to return it to the patient. They have lectured and shamed patients coming in for the drug. A recent decision by Wal-Mart to carry Plan B heralded the end to a series of requests to stop their discriminatory behavior. Many smaller communities only have one pharmacy and it is often a Wal-Mart which meant that women had to drive many miles to a provider who would dispense Plan B.

In Illinois, several pharmacists have been terminated as a result of their refusal to fill the prescription. The excuse is their moral objection to birth control and they would like to invoke the conscience clause used by medical providers. Planned Parenthood and most physicians do not consider pharmacists health care providers. Several Right Wing groups have taken this issue as their "cause celebre" and are suing the State of Illinois for not allowing pharmacists to pursue their career with their own moral interpretation. The governor has recently submitted a rule that would make a posting of information on access to birth control and emergency contraception mandatory. Citizen input is being solicited by June 5.

When practitioners and professionals begin to use their own moral compass to control women's health care access, women invariably lose. Planned Parenthood and its allies are ensuring the future of women's health through excellent health care, medically accurate education and advocacy.

Here in this Place: Anarchism and Christianity In Our Context

AUGUST 4-5, 2006, ILLINOIS DISCIPLES FOUNDATION, 610 E. SPRINGFIELD AVENUE

Champaign, Illinois Contact: jesusradicals at jesusradicals.com

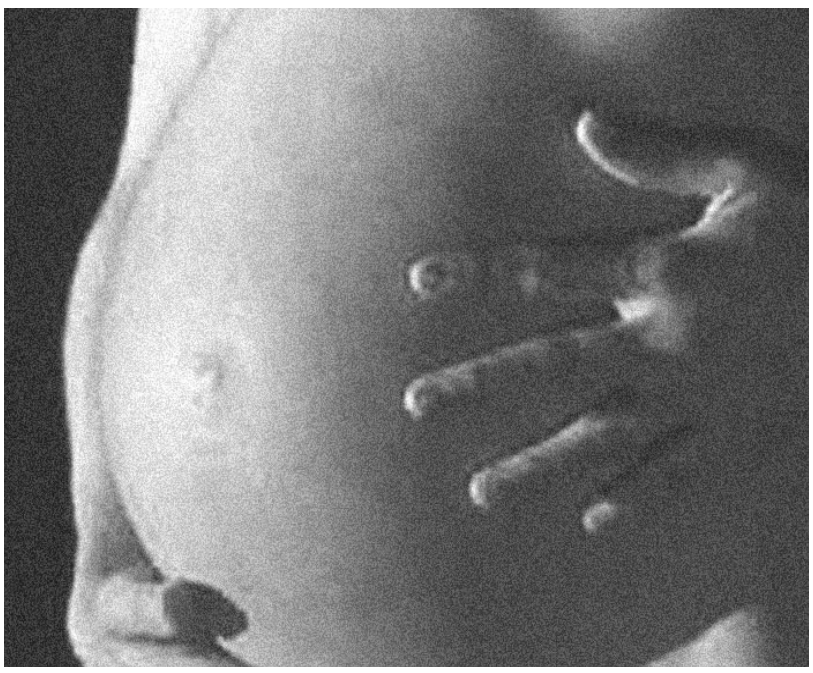
Anarchists and Christians in America share the tension of living in a kind of limbo. We know that life can at the very least be different, and at best be radically transformed, yet we are also overwhelmed by life in a society steeped in the status quo. If you ever wonder whether it is possible to put your faith and ideas into practice in the belly of the Empire, the answer is, "Yes." Here in this Place: Anarchism and Christianity in our Context will show you examples of people doing just that.

This year's two-day conference builds on last year's theme of Anarchism and Christianity in word and deed, with sessions that provide concrete examples of radical living within the United States. With topics such as Living in Community 101, The Problem of Policing and In Our Backyards: Urban-Rural Environmental Sustainability, speakers will not only share their theological/ideological reasons for the work that they do, they will also share strategies for how they do that work. The aim of the event is to both give a glimpse of Anarchism and Christianity in action and spark ideas on practices that may apply to the various situations we find ourselves in.

LoCaL

Childbirth: Hospital vs. Home

By Anonymous



IN MY FIRST CHILD'S BIRTH, I was led to believe throughout the prenatal period that my O.B. and the hospital staff would be supportive of a natural birth. When it came time to actually labor and deliver, the idea they seemed to have of "supporting" a natural birth was not to physically force you to have (most) interventions. (I say "most" because the use of the vacuum extractor WAS physically forced on me.) There was no alternative offered to any of the interventions, no actual "support". The two options for dealing with the pain and difficulty of labor seemed to be 1) drugs, or 2) nothing whatsoever. I think it's dishonest to allow a woman to think you're going to support her in natural birth, when the entire system is set up against it.

I was sent to the hospital by my OB after about 24 hours of unproductive labor, so they could start me on pitocin, an artificial version of the hormone that gets labor going and keeps it moving along. I had indicated that I didn't want pitocin, and had researched ways of getting labor moving, but none of these measures were encouraged. Because of the pitocin, continuous fetal monitoring was required. After several hours strapped down to the bed with the fetal monitor on one side and the IV on the other, I finally gave in and started Nubain (a narcotic). The nurse came in to turn up the pitocin periodically, despite my protests. After several more hours, when I was fully dilated but had stopped feeling contractions for some reason, I was told I had to push. The baby was still very high up, and it was really too early to push. He went into fetal distress and was then pulled out by vacuum extractor without any explanation or giving me even 10 seconds to get mentally prepared for the insertion of the vacuum extractor. (Traumatic birth has been compared to rape, incidentally, and I suffered flashbacks and nightmares about the birth for weeks.) I later read in a medical journal that having the mother push when the baby is up too high can cause fetal distress. So basically, my OB actually created a medical emergency. The term for this type of situation is "iatrogenic", meaning that the physician's actions actually do more harm than doing nothing at all would have done.

In the whole "emergency vacuum extraction" fiasco, part of my vaginal wall was caught in the thing, causing damage that took many months to heal. This caused much stress in our marriage, as we were not sure we would ever be able to have another child. When I went back to see my OB at about eight months postpartum to make sure everything had healed right, she said it looked fine and told me to use KY Jelly. I only found out after requesting (and paying for) the birth record from the hospital that my vaginal wall had been caught in the vacuum extractor. Another example of dishonesty. I also believe that I was given a "honeymoon stitch", because things felt tighter down there than before.

In contrast, my homebirth was a different experience entirely. I realize that some of this is due to the fact that this was my second baby, but not all of it. I am convinced that if I had had my first child in the care of the homebirth midwives, everything would have turned out completely different than in the hospital. In my homebirth, I was able to move around freely throughout the house. I was able to work with my body, getting into different positions depending on what felt better. We had planned to use a birthing tub, but couldn't get it filled up in time. If I had had the baby at the hospital, they would not have allowed me to push the baby out in the birthing tub because of my weight. I am heavy but not morbidly obese or anything.

My homebirth midwives never did a single cervical check. I didn't want them, and they don't do them unless requested by the mother. Cervical checks don't really give much useful information, and can lead to the mother being told to push when it's not really time yet. They can also be disheartening for the mother in a labor that is not following the classic "one centimeter per hour" pattern.

The homebirth midwives used a Doppler periodically to monitor the baby's heartrate. This allowed us to have that information without interfering with my labor, as the continuous fetal monitoring had at the hospital.

When the baby was born, he was handed to me immediately, and the cord was let be until it finished pulsating (giving the baby that valuable, oxygenated blood). I was allowed to sit and hold him while waiting for the placenta to come out. There was no rush. (At the hospital birth, the cord had been cut immediately and the placenta was pulled out by the OB right away.) The midwives had pitocin on hand, in case it became necessary to encourage the placenta to come out that way.

While I experienced more pain at the time of the actual birth with the homebirth (because of not having any shots in my bottom, as had been done in the hospital), the recovery time was not comparable at all. I didn't have any stitches, despite a 2nd degree tear, and experienced no discomfort. My bottom actually feels BETTER now than it did before the delivery. I had never felt the urge to push with my first child because he was up too high. In contrast, my second child was able to move down on his own and put pressure on my perineum, making me push without even realizing it. I felt like I was on a runaway train. My body was just doing it on its own. The mind-body connection was allowed to happen. Very, very different from the over-medicalized first birth.

If I had had my first child in the care of the homebirth midwives, everything would have turned out completely different than in the hospital.

Here are the interventions I had during my first birth and the consequences they can have (off the top of my head):

• IV with fluids: Can cause labor to slow because the mother's hormone levels drop. Can also cause swelling in the birth canal, making it harder for the baby to work its way out. Can cause baby to be overhydrated at birth, making for a larger weight loss in the early days before nursing is well-established, which can cause unnecessary concern on the part of parents or doctors.

• Pitocin: Can cause overzealous contractions, which are harder on the mother and can cause fetal distress.

• Nubain: Makes the mother loopy and makes for a sleepy baby, who can have a harder time getting started nursing.

• Episiotomy: They are done to avoid tearing or to get the baby out faster, but many tears end up being WORSE because of the episiotomy. They cut through muscle, which takes longer to heal.

• Vacuum extractor delivery: Can be a wonderful tool if used sparingly, but damage can be done to the mother. I think it is also painful to the baby's head.

There were no interventions like these in the homebirth. I had good perineal support and only had a 2nd degree tear, despite the baby being born very, very quickly, not allowing things to stretch.

Birth Doulas

(PROFESSIONAL LABOR SUPPORT)

by Suela the Doula

THE BIRTH OF YOUR BABY will be a lifelong memory and yours will be changed forever. Inviting a doula into your birth space will help you have the most positive birth experience possible.

A doula…

• Recognizes birth as a key life experience and as a fundamental right of passage.

• Understands the basic physiology and the emotional needs of a woman in labor.

• Compliments and works with the woman's partner and care provider.

• Allows the partner to participate at his or her own comfort level rather than as the "labor authority."

• Stays with you throughout your entire labor.

• Provides emotional, physical, and spiritual support.

A doula is not…

• Your voice, she can however help you find your voice, helping you to form your thoughts and questions.

• A medical professional. A doula stays within her code of practice and will not perform any medical procedures such as vaginal exams, blood pressure...etc.

• Someone who tells you how to give birth.

A doula will work to educate you in simple ways:

• Trust your body first.

• Ask questions. Know what your provider's standard procedures are and if they don't agree with your thoughts and desires for birth, shop around and find someone who does.

• She will support you at home and/or in the hospital.

• If you choose to use medication, know and remember that all women can give birth without it as long as there is not a medical reason to use it. Know the facts about medication before you choose to use.

• Trust is the key.

Studies done by Marshall H. Klaus, M.D., John H. Kennell, M.D., and Phyllis H. Klaus, C.S.W., M.F.T. indicate that **doulas help…**

• Decrease overall cesarean rates.

• Decrease length of labor.

• Decrease the need for epidurals.

• Decrease the use of oxytocin.

• Increase the confidence of the partner's participation.

• Decrease postpartum depression and levels of anxiety.

It breaks my heart to hear a woman say that her birth was the most horrible and painful experience in her life. That legacy was passed to me by my mother and I swore I would not pass it to my daughter. I wish I could help just one woman understand that birth is the hardest work she will ever do in her life and, although it hurts, it will teach her how powerful and strong she is! We as doulas cannot keep unwanted things from happening in your birth but we can stand with you and hold your spirit in our heart as you go through this part of your life. Birth is not something to fear; it is something to respect and honor. And *you can do it!*

If you would like to know more about doulas and my alternative birth sessions, Birth with Courage and Power, visit suelathedoula.com.

Of the US births in 2002,

• 34-38% of the mothers had little or no understanding of their rights to refuse procedures or ask for more information

• 44% were induced

• 63% of the mothers used an epidural

• 17-53% of the mothers were aware of various epidural side effects

• 6-8 % of the mothers used water therapy (the most helpful non-medical intervention)

• 29% of the mothers walked during labor

• 12% of the mothers ate during labor and 31% drank

• 5% of the mothers used a doula

• 10% resulted in vacuum or forceps delivery

• 24% ended in a c-section

• less than 1% had no interventions (almost all were home births)

(from childbirthconnection.org)

LoCaL

Reducing Postpartum Depression the Village Way

by Marcia Zumbahlen

IN JUNE 2001 the country was shocked to learn how Andrea Yates killed her children during an episode of post partum psychosis. The "eye for an eye" folks wanted her electrocuted. The "spare the rod, spoil the child" folks wanted her punished with a harsh sentence that would deter future killings. The "there but by the grace of God go I" folks wanted the world to wake up to the reality of how postpartum mood disorders (PPMD) can change a woman's life.

In the aftermath the *New York Times* began shedding light on the tragedy. Allegedly, Andrea's "controlling" husband limited her free time to two hours per week (despite the fact that she was isolated and also caring for and later grieving for her Alzheimers-ridden father), her church discouraged treatment and encouraged baby-making, her psychiatrist minimized her condition and failed to prescribe an anti-psychotic medication, and Andrea was previously discharged from clinics prematurely because insurance wouldn't pay for extended services (i.e., "coverage maxed out"). Knowing that these were things we could change, everybody wanted to fix the system so such tragedies would never happen again.

Three Common Types of Postpartum Depression

TYPE	RATE	SYPTOMS	ONSET	TREATMENT
Baby Blues	80%	tearfulness, worry, lack of concentration	Within first week after birth	Time (lasts a few hours to several days)
Post Partum Depression	10–20%	baby blues for 1 month, difficulty coping, too much/too little sleep, lack of pleasure (even toward baby)	Gradual within first year	Exercise, social support, cognitive-behavioral therapy, antidepressant medication
Post Partum Psychosis	.1–.2%	hallucinations, delusions (about infant's death, denial of birth), delirium or mania	Within 2 weeks after birth	Anti-psychotic medication given at onset

**% of post partum women; for a complete listing of PPMDs see www.postpartum.net*

HOW HAVE ATTITUDES TOWARD PPMD CHANGED SINCE ANDREA YATES' CASE?

Five years later people are still downplaying the reality of PPMD and its impact on children (see Julia's vignette this issue). Just three months ago a woman told me, "My husband doesn't believe post partum depression is real. He thinks I should just get over it. You know, 'Just do it!'" How unfortunate because PPMD generally responds to treatment (see sidebar on PPMD). When family members or professionals minimize a mother's concerns, or fail to acknowledge the reality of her depression, a mother is hard-pressed to get treatment. Rather than getting over it, individuals with PPMD can easily spiral downward in negative thinking that worsens their condition and distances support. Consequently, it is hard for them to give the attention their infants need to be happy and to build solid relationships (Field, 1997).

Five years later the "system" is still aggravating PPMD rather than preventing it and depriving women access to quality treatment. Beck (2001) identified 13 significant predictors of PPD (listed in order of effect size): prenatal depression, low self esteem, *childcare stress*, prenatal anxiety, *life stress, low social support*, poor marital relationship, history of previous depression, *infant temperament problems/colic*, maternity blues, single parent, *low socioeconomic status*, and *unplanned/unwanted pregnancy*. Although there is a subgroup of women who are vulnerable to hormone changes during pregnancy, radical hormonal changes did not make it to the list. Rather, pregnancy seems to trigger PPMD in women who have one or more of these risk factors, half of which, if not more, are affected by social policy (italicized items).

Social support is the factor that intrigues me the most. We now have ample evidence connecting it to PPMDs, even a causal role (O'Hara 1985, Field et al. 1985; and Gotlib et al. 1991). According to JAMA (2002), the hormone oxytocin (produced during natural labor and breastfeeding) "activates an evolved biological system underlying mammalian mother-infant attachment behavior…However, under conditions of high stress and inadequate support, this emotional reactivity may increase vulnerability to depression by rendering a woman more susceptible to stress."

The powerful impact of poor social support following the birth of a baby leaves men vulnerable to PPMD as well (see Hagen 1999). From an evolutionary perspective, reduced social support increases the costs borne by caregivers relative to the benefits of offspring, especially when infants already have problems. Reducing investment in the child reduces the costs. Hence, PPMD is less of an individual's mental illness, and more of a population dysfunction: community-based interventions are needed.

CALL FOR IMPROVED FAMILY LEAVE POLICIES

The current federal Family and Medical Leave Act protects parents against job loss for up to three months after a baby's birth. However, protected leave is limited to individuals who have worked at least 12 months for a company with 50 or more employees. For newly hired workers, workers with insecure jobs or jobs lacking fringe benefits, or workers who don't meet the legal definition of "family", taking a leave often means quitting and finding a new job later. Consequently, most parents return to work well before three months. Of families who wanted a longer leave but did not take it, 88% would have taken the time if income replacement were available (Cantor, Waldfogel, Kerwin, Wright, Levin, Rauch, Hagerty, & Kudela, 2001). In short, millions cannot afford to take an unpaid leave when they need it the most.

Current family leave policies don't offer families ample time to recover and support each other following a birth. A leave gives the mother time to physially recover and adapt to her infant. It gives parents time to adjust their relationship, balance family chores, recover from sleep loss, integrate the baby into the family, learn their baby's cues and patterns, and feel effective in soothing their baby and organizing her day. Three months is too short for many families to accomplish these tasks let alone give their babies' development solid grounding. Most infants are not socially responsive until three to four months of age, and many parents need longer to feel the rewards of parenting. Most infants do not have the capacity to sleep through the night until four months of age, and parents need time to make up lost sleep.

Early return to work can disrupt the adjustments that families must make after the birth of a child. When a mother is at risk for depression, early return to work, especially when caring for a child with special needs, could push her into depression. Developmental research shows that shorter leaves are associated with increased depressive symptoms in mothers and with more negative affect and behavior toward infants at 4 months. When a family has a significant stressor (e.g., depression, poor physical health, infant with special needs or difficult temperament), longer leaves are associated with increased positive affect, sensitivity, and responsiveness and decreased negative interactions toward infants at four months of age (Clark, Hyde, Essex, & Klein, 1997; also see Julia's vignette this issue).

It is unacceptable that employees feel lucky if they have a few weeks of paid leave after a baby's birth. Ask your state representatives to support flexible equal-opportunity family-work policies that recognize individual differences and vulnerabilities in families' needs and values. Consider pushing for HB 3470, the Illinois Family Leave Insurance Program (FLIP), which has been sitting in the House Rules Committee since March 2005 (see sidebar), or the socialist models used in Scandinavia (see sidebar on page 6).

PUSH FOR FAMILY SUPPORT PROGRAMS

In several places around the world women are pampered for 40 days after they give birth. Usually the grandmother comes to make special soups that will replenish the mother's blood supply and to tend to household tasks so the mother can sleep and bond with her baby. In the US, many women give birth in a community far from family or friends who might be willing or able to stay by their side for 40 days. Unless a woman is wealthy enough to hire a post-partum doula, she likely spends long hours at home alone with her infant. This lack of social support is the last thing she needs.

Recently I asked a local mother who lives with her spouse and two children, a 4-year-old and 3-month-old, how she spends her day. She told me that on the six days per week when her husband works, she spends 10 hours/day alone with her children (not counting night-time feedings while her husband sleeps), because, as she said, "Most of the people around me work during the day and my husband takes our car so it's hard to get out."

In a 2002 survey, 35% of women reported feeling isolated in the months following birth (childbirthconnection.org). Isolation prevents early detection and deprives women of the support they need to combat stress. Our current solution: wait for depression to happen and train pediatricians to screen women for PPD during well-baby visits. There are more proactive approaches.

Individuals could mobilize their neighborhoods to take care of their families with new babies (checking on them, helping them laugh, offering respite, connecting them with other families, listening to their stories, and referring them to the Crisis Nursery, Family Service, Healthy Families, or http://helpbook.prairienet.org when necessary). Early Childhood Care and Education providers could join the Strengthening Families Illinois network (strengtheningfamiliesillinois.org) to learn how to care for families,

Continued on next page

HB 3470, the proposed Illinois Family Leave Insurance Program (FLIP)

WHO?

For employees who have earned at least $1600 and worked at least six months during the employee's qualifying year for the employer from whom the employee is on FLIP leave.

WHAT?

An insurance program that provides a partial wage replacement for 1) an employee's serious illness, 2) to care for the serious illness of a family member, or 3) for new parents (birth or adoption).

- Benefit amount capped at 67% of wages or $1,500 per month (max $380/week) for employees working at least 35 hrs/week, prorated otherwise
- Maximum leave of 4 weeks per year
- Job not protected, so the employee must decide if paid family leave is necessary.

HOW?

Funded by modest employee premiums of 75 cents/week via a payroll deduction matched by employer contributions

- Prorated according to number of hours worked weekly
- Paid to the Department of Employment Security
- Employers can request certification regarding the employee's need for a leave at the employer's expense

WHEN?

Requested to be effective January 1, 2007.

(from womenemployed.org)

not just children. Hospitals and public health officials could add programs like the Nurse-Family Partnership (www.nursefamilypartnership.org) that send highly educated nurse home visitors or infant mental health specialists to visit families bi-weekly during pregnancy and the first two years after birth. These programs can save 4 times the money spent on them by improving the lives of mothers and their children up to15 years down the line (including reduced arrests and negative adjudications).

PUSH FOR UNIVERSAL ACCESS TO QUALITY HEALTH CARE

In my recent search for health insurance I discovered that many health care packages do not offer maternity care, let alone coverage for pregnancy related conditions like PPMD. Policies with maternity care come at a very high premium and/or are difficult or impossible to add after a woman becomes pregnant. Texas, where Andrea Yates lives, ranks near the bottom in the U.S. for mental health care (healthyplace.com). A doctor referenced on this site said that even though "improved drug therapy and outpatient care have reduced the need for long hospital stays…the time authorized by most managed care plans, often just 10 days…still isn't nearly enough" (also see Julia's vignette this issue). "Managed care selectively and deliberately cut the funding and the benefits for people with mental illnesses and addictive disorders in this country," says Dr. Peel. "It's deliberate corporate practice….resulting in drive-by hospitalizations."

To bolster these programs let your representatives know that you want to invest your tax dollars in wrap-around programs for families with infants instead of funding things like war. Shared responsibility for family care cycles back so that children, families, employers, workers, and citizens all benefit. It really does take a village to raise a child.

Life in Scandinavia

"There is just a completely different level of acceptance among employers here. It is not uncommon to put a telephone conference on hold, because you can hear a baby crying in the background." (Norwegian female executive, http://news.bbc.co.uk, 28 March 2006).

- Mothers or fathers can choose childbirth-related leaves (including adoption) up to a year and a half with full or near full wage replacement
- Fathers are required to take 1 month of leave following the birth of a child or forfeit 1 month of leave for the entire family
- Families can extend leave until a child is 3 years old with a lesser allowance or part-time employment during the entire leave
- Universal home visiting after childbirth is a routine, widely accepted component of a more comprehensive system of care provided to and expected by both rich and poor
- Birthrates still hover at 1.8 children per woman and only Norway has shown an increase in children with more extensive leave programs: among more educated women who previously weren't having children
- 40% of the parliament is female compared to 15% in the US

(from childpolicyintl.org)

Julia's Story

MY NAME IS JULIA. I moved to C-U 10 years ago after finishing my post-baccalaureate education. I'm now 33-years old and live with my husband and son in a comfortable, upper-class neighborhood. I've always known that I had a genetic risk for anxiety and depression. But when I had my son I didn't think it would affect me. Soon after the birth I began worrying about how I was nursing him and complained about his piercing cries. I'm sure he could see my annoyed face and feel my tension as I tightened my hold in these moments. I tried my best to get help.

STOP 1: BREASTFEEDING CLINIC

I said, "My baby's tongue is always in the way." They said, "Don't worry, he is gaining weight."

STOP 2: PEDIATRIC WELL-BABY VISIT

I said, "My baby sleeps only 45 minutes at a time and I can't soothe him. My husband and I have tried forcing a pacifier into his mouth, rocking him, driving him in the car, running the vacuum, water, and hairdryers, playing static on the radio, ocean wave CDs, and saying "shh" close to his ears. We're exhausted." They said, "Don't worry, he just has colic."

I'm sure my baby could see my frustration. By three months he looked away when I looked at him and I didn't look at him very much. I didn't play and I stopped going to him when he cried. I suspect he wondered in those moments if I would ever come. I wondered if he felt unloved. But I still did not consider depression.

I drained my vacation/sick leave to pay my salary during the three months of Family Leave I was entitled to take so it was time to return to work.

STOP 3: MY EMPLOYER

I said, "I need more time to be home." They said, "Sorry, we can't give you extra leave."

I cried as soon as I hung up the phone. I'm sure my baby felt it then and at the times I lugged him off to another house for care during the day because he started crying more during the night at that time. One night I was so frustrated by my baby's cries that I "flung" him onto the bed. Out of desperation I finally sought a doctor for myself.

STOP 4: HMO PRIMARY CARE PHYSICIAN

I said, "I have a problem." She said, "You meet the criteria for depression. But I can only give you two more weeks of additional leave." With the diagnosis I was able to pay for these two extra weeks through short-term disability. I returned to work when my son was 3-1/2 months old.

By the time my baby was four months old he started sleeping better. This gave me room to think more about myself. Fortunately, my doula found a support group for depressed moms that had just begun in the area and I was able to attend.

Within weeks I noticed my baby and I started to play, but traces of our rocky start lingered in his screams for attention and his clinginess beyond the norm. I wondered if he might have still been a bit mad for being ignored or remembered how it felt to wonder if I would ever come back. Six months later the facilitator for the support group moved to Seattle. My search began again.

I found some playgroups but things didn't really change until Illinois' Early Intervention system diagnosed my son with Sensory Processing Disorder (explaining the piercing cries and difficulty with sleeping and calming) and our family began to receive SOME of the services we should have received in the beginning. By my son's second birthday I was playing lots of spinning and tummy-time games to help him and I was being properly treated for depression and anxiety. We were finally happy.

NaTioNaL

Homeopathy—the Choice of More Women

by Barbara Raska Antisdel

Barbara has practiced homeopathy for over 25 years. She currently co-teaches a local homeopathic study group and presents for the Illinois Homeopathic Medical Association.

HOMEOPATHIC MEDICINE uses extremely small doses of substances prepared in a special way to re-vitalize a person's health. The choice of the medicine, referred to as a "remedy," is individualized for each patient according to the symptoms and characteristics of that patient. In true homeopathy it is possible for several women with the same diagnosis to each receive a different remedy. So homeopathic treatment is not "one size fits all." Furthermore, it is even possible for a patient with an undiagnosable problem to receive effective treatment. When used correctly, homeopathic healing is gentle and long lasting, because the remedies work with the body's symptoms and other defense mechanisms instead of against them.

In the early 1800's Samuel Hahnemann, a German-speaking medical doctor, first systematized contemporary homeopathy. He found that if he prescribed holistically-not just for the patient's main complaint(s) – that the patient would experience a deeper healing. In some cases even life-threatening and "incurable" diseases have been cured without the usual side effects. A homeopath treats each woman as an individual and as a whole, taking into consideration all of whom she is and all of her history, not just her chief complaint. Homeopathy is a method of treatment available to lay persons for acute self-care, as well as a medical specialty prescribed by licensed practitioners.

TREATING THE WHOLE WOMAN, NOT JUST THE DIAGNOSIS

Homeopathy like many other "complementary and alternative" modalities is a form of energy or vibrational medicine. Thus, it views disease as an imbalance in the person's energy or life force (like ki or chi in Oriental medicine). More specifically, homeopathy sees disease as an "untunement" of the life force, as if each of us were beautiful, sensitive, yet strong musical instruments in need of tuning. The correct homeopathic remedy then helps to "retune" the life force, putting us back into balance, so we can once again sing or play "on key," achieving our full potential.

Like other energy modalities, homeopathy recognizes that a person out of tune (vibrationally, energetically) is more susceptible to disease. Being "tuned up" means being in balance: mentally, emotionally and physically. So to be truly healthy a woman needs to be in balance on all of these levels. Since the remedies work in an integrated way on all these levels, homeopathic healing is truly holistic with a general improvement of all symptoms. Even those symptoms that may have seemed unrelated may improve. The healing not only restores physical and mental health but also generates better attitude and enjoyment of life. Long suppressed or repressed emotions are often released, sometimes in dreams. Sometimes major shifts in significant relationships occur. Everything is related and connected in the holistic homeopathic perspective.

In order to find the correct remedy, the homeopath must understand the patient as a whole: all her noteworthy dreams, fears, and patterns, as well as symptoms. She must be able and willing to reveal all these, while the homeopath listens for two to three hours. The homeopath must learn about every major event and trauma of the woman's life as well as how they have contributed to any imbalances in her eznergy, in her life force. The homeopath looks for how this woman's life experiences and symptom manifestations are different or special compared to other women with the same diagnoses. Since the process is holistic, the woman does not "take her uterus" to one practitioner and her joints to another. Thus, in many cases only one medicine heals both the reproductive system as well as the joints.

Although the interview process may seem like a counseling session, it is not. The homeopath's purpose is to listen and to discern indicators for the woman's correct remedy. The homeopath will generally not offer advice or make judgments, but only ask questions to get more relevant information, indicating the correct remedy.

MENOPAUSE & HRT

Homeopathy acknowledges that menopause is a natural transition in a woman's life, just as puberty is. Since we do not try to avert puberty with special treatments, why should we try to avert the transition at the other end of the spectrum? Most women in good health with appropriate diet and exercise should be able to complete this transition with little discomfort, without hormone replacement, and live gracefully for years beyond menopause. Research has not verified that hormone replacement is consistently a preventive measure for bone loss. On the other hand, many studies have shown that calcium loss and bone weakness are life-style related (excess ingestion of meat, coffee, sugar and alcohol, as well as lack of proper exercise and lack of natural calcium in the diet). Last but certainly not least, hormone replacement may contribute to a higher risk of cancer.

During menopause if a woman is "out of tune," she may experience bleeding, fatigue, headaches, hot flashes, insomnia, lower sexual energy, vaginal dryness and other symptoms. The conventional treatment of hormone replacement can be avoided by homeopathic treatment which gradually transitions the woman through menopause, as the symptoms wane and disappear.

In the words of a popular homeopathic doctor:

> "The current trend in medicine is to give hormone replacement at the first signs of menopause as indicated by decreasing hormone levels on lab work. This reflects an empty rationality. Menopause is no more a disease than puberty is a disease. In homeopathy we do not treat the lab work; we treat the patient. Menopausal women experiencing discomfort with menopause are treated as unique individuals the same way all patients are treated with homeopathy. Homeopathy has an excellent record of treating women through this transitional time without the use of exogenous hormones."
>
> A number of natural plant hormone-like substances are promoted as alternatives to synthetic hormone replacement. These may be preferable in many instances to synthetic replacement, but they still reflect a disease-oriented approach to what is, in reality, a natural process." (Timothy Dooley, MD, ND in *Homeopathy: Beyond Flat Earth Medicine*, p. 72)

Dr. Dooley concedes that very few women may benefit from HRT, but this must be individualized by their history and by the potential risks of hormone replacement therapy.

Finally, in the words of the late Dr. Maesimund Panos:

"Unless you are going to take estrogen for the rest of your life, sooner or later you must experience the shifting of the hormone balance, and some of the symptoms that accompany this change. Our own defense mechanism is well equipped to make the necessary adjustments without the interference of a drug whose purpose is to block the normal action of the body. Taking estrogen is a risky and expensive way of postponing the inevitable readjustment that Nature has decreed." (Maesimund Panos, MD in *Homeopathic Medicine at Home*, p.229)

HOMEOPATHIC MEDICINES OR "REMEDIES"

Homeopathic remedies work at the energetic level. They can, therefore, stimulate the recurrence of old symptoms or the worsening of current symptoms. This phenomenon is called "aggravation" and can also occur with treatment by any other deep-acting energy medicine or modality. Aggravation may last a few minutes or hours or a few days, but it is a small price to pay for reversal of symptoms that have lasted years. No pain, no gain! There are methods of administering the remedies that make the aggravation process more gentle. So if this is of concern to you, be sure to ask your homeopath about this.

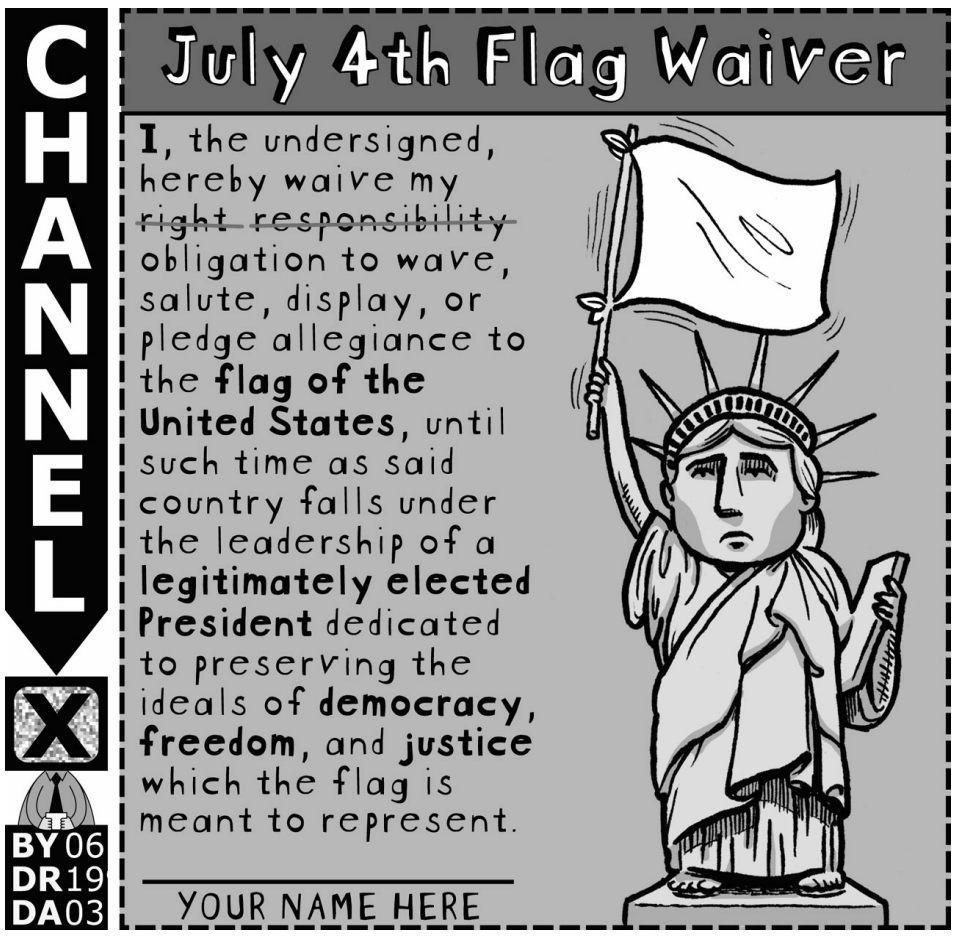
After the preparation of a homeopathic remedy, the original substance is usually so highly diluted that there is little or no molecular substance left in the remedy, hence the accusations of quackery ("just sugar pellets or water"). As the king in *The King and I* stated to his children: "If we only believe what we see, what is the use of school?" What is left in the remedy is the healing "energy" or healing vibration of the original substance, acting as a stimulus to a woman's life force, helping the woman to re-tune, re-balance, re-vitalize, and thus cure herself.

In my own life menstrual cramps, premenstrual symptoms and later hot flashes were relieved. More significantly, disabling headaches due to food allergies are 90% improved! My daughter who is quadriplegic due to an accident is at a very high level of health and has excellent quality of life partially due to homeopathy. Unlike most quadriplegics – who are very susceptible to respiratory infections and to those infections turning into bronchitis and pneumonia – she rarely catches "colds." When she does, they never turn into bronchitis or pneumonia. She only had pneumonia once, during the first months after her accident and recovered within a week with homeopathic treatment and without hospitalization. After her accident, which included a closed head injury, the doctor anticipated swelling of the brain. To the doctor's astonishment, there was none.

FINDING A HOMEOPATH

Think divinely, drink good water, eat well, keep good company and get exercise. These are prerequisites for health. Stay "in tune" and stay healthy. If you find that these are not enough, know that a good homeopath may help you.

The best way to find a good homeopath is by personal referral. Helpful hints about finding a homeopath and criteria for determining if a homeopath is good can be found at the website www.homoeopathic.com. There are also directories of homeopaths on the websites of the National Center of Homeopathy www.homeopathic.org and the North American Society of Homeopaths www.homeopathy.org. For local info contact visit www.homeopathyillinois.org.



Cartoon by Darrin Drda. Channel X celebrates its tenth year with 2 compilation books, "The Early Daze, 1996-2000" and "Recent Re-runs, 2000-2004". Email d_drda@hotmail.com for details.

HuMaN RiGHtS

Anarchism and Christianity:

Re-Viewing the Politics of Jesus

by Eric Anglada

LISTENERS WERE OFTEN SCANDALIZED when Dorothy Day—devout Catholic, co-founder of the Catholic Worker movement, and, notably, a U of I dropout—described herself as an anarchist. Indeed, the terms anarchist and anarchy conjure images of disorder, chaos and bomb throwers. This perception however is for the most part a distorted notion of anarchist thought, and has nothing to do with the anarchism of Dorothy Day.

Surely, to talk about a likeness between Christianity and anarchism is to risk being thought absurd and oxymoronic. Some would argue that to use the label "anarchist" is to encourage misapprehension, even hostility. But the same case could just as cogently be made in accepting the label "Christian." For, after all, to be a Christian is to be a right-wing conservative, right? So, while acknowledging the dangerous territory of both these terms, I wish to show the essential congruity between these two lines of thought—if we properly understand them, of course. Hence this essay.

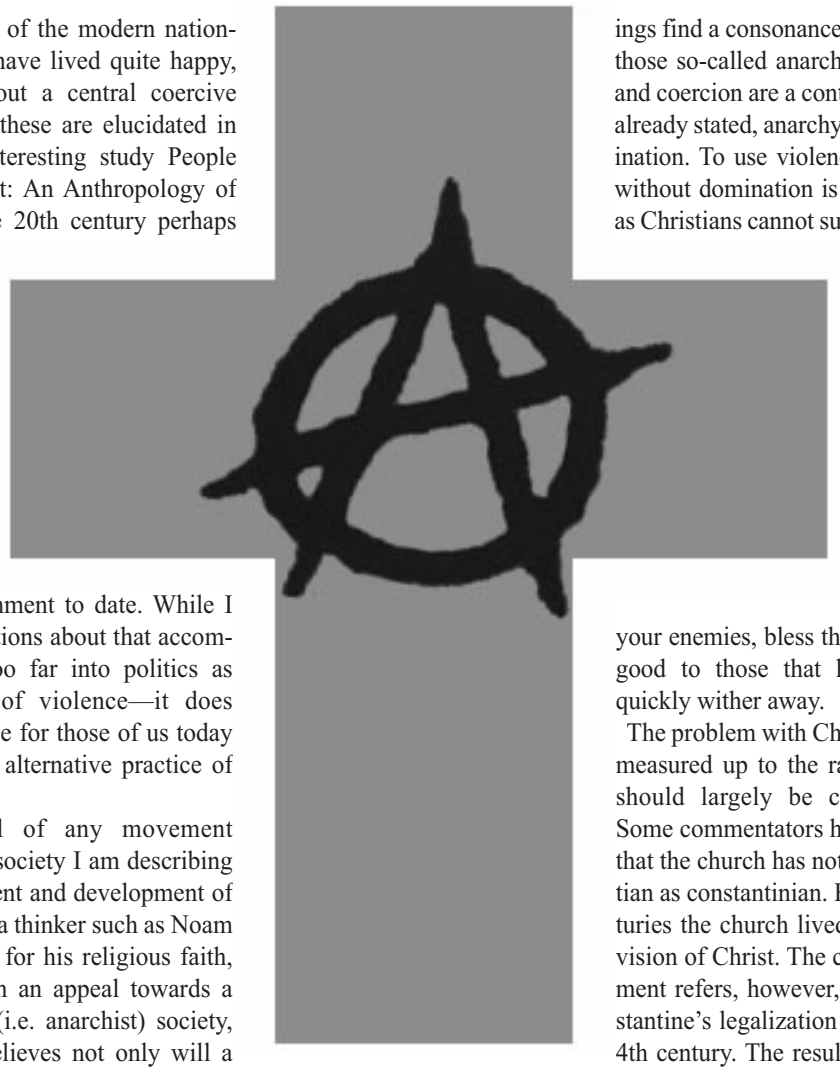
Anarchism is a term notoriously hard to pin down, as, by definition, it resists a concrete definition. In its most basic sense it means no rulers or no domination. Anarchists tend to be suspicious of any clear blueprint for exactly what anarchy would look like. There is certainly some value in pointing to actions that look like a desirable way to live, but anarchism is not static—it is dynamic, an orientation, acknowledging certain principles, freedom being foremost, that must be maintained at all times.

Currently, the most interesting group moving along this line is the Zapatista movement in Chiapas, Mexico. Although they have not identified themselves with anarchism explicitly, I don't think it would be unfair to describe them as at least anarchistic. They are anti-political, in that they are not seeking to run for office. Unlike their Latin American revolutionary counterparts, they are not attempting to take over state power. Instead, they are engaging in a social revolution, desiring to simply live autonomously as they see fit, outside of the pernicious confines of the "new world order" of free market globalization. Marcos, who the media tend to identify as their leader, neglecting his title Subcomandante, describes the Zapatista worldview in his typically lyrical way: "I am as I am and you are as you are; we are building a world where I can be, without having to cease being me, where you can be, without having to stop being you, and where neither I nor you force another to be like me or you,' when Zapatistas say, 'a world where many worlds fit', we are saying, more or less, 'everyone does his own thing.'" (October 26, 1999)

Inevitably the question arises: if everyone does their own thing, won't everyone just kill each other? This is a serious issue, and human nature appears to be such that it's pivotally relevant to the topic at hand. While I don't think the legitimacy of anarchism lives or dies on this issue alone, it would be foolish to deny the human impulse towards both good and evil. But it is anarchists, surprisingly I think, who have the most realistic take on this, as they understand that the more power is decentralized, the less likely the temptation towards evil. As Lord Acton famously remarked, "Power tends to corrupt; absolute power corrupts absolutely."

When asked about her anarchism, Dorothy Day would often intone the work of Peter Kropotkin, the 19th century Russian biologist, whose book Mutual Aid provided a scientific basis for anarchism. Contra Darwin, he found through empirical study a decided trend not towards competition, but towards cooperation amongst animal and human species when faced with survival. Implicit here is the true nature of anarchy—personal responsibility—over and against anarchy pejoratively understood to be what each individual is going to do without regard to anyone else. In other words, when Marcos says "everyone does his own thing," he is not describing an atomized existence free of others, but a society where people live in solidarity with one another, responsible to everyone, without looking to that most violent and impersonal institution, the state.

Of course, any serious proponent of anarchism wouldn't argue that once the state was eliminated that everything would become perfect and utopian. But there have been, before the invention of the modern nation-state, societies that have lived quite happy, peaceful lives without a central coercive apparatus. Some of these are elucidated in Harold Barclay's interesting study People Without Government: An Anthropology of Anarchy. Within the 20th century perhaps the most notable experiment in anarchism was in Spain during the thirties. Although the movement was ultimately quashed by Franco and the fascists, it remains in many ways the largest anarchist accomplishment to date. While I have serious reservations about that accomplishment—going too far into politics as well as their use of violence—it does remain a sign of hope for those of us today working towards an alternative practice of social life.



Part and parcel of any movement towards the kind of society I am describing is the acknowledgment and development of a spiritual life. Even a thinker such as Noam Chomsky, not noted for his religious faith, has discussed this in an appeal towards a libertarian socialist (i.e. anarchist) society, in saying that he believes not only will a spiritual change help bring about this new order, but that this new order would actually contribute to such a revolution. We live in such an alienated, narcissistic culture that this is no easy task. But I do think the central urgency of the day is, as Dorothy Day put it, how to bring about a revolution of the heart.

Enter Christianity. Anarchists have not only resisted the nation-state; they have, more broadly, stood in opposition to anything that dominates: patriarchy, capitalism, consumering, technology and, of course, Christianity. The Spanish anarchists, noted above, for example, were steadfastly anti-Christian. How then, can I, as a Christian, legitimately call myself an anarchist? This will take some unpacking, though unfortunately space limits a full articulation.

Jesus was a subversive in first century Palestine who stood against power and domination in both its Roman and Jewish guises. Again and again throughout the four Gospels, Jesus challenges institutionalized authority. Even before adulthood, echoing the story of Moses, he was saved by his parents' disobedience to the ruler Herod's decree that all children under the age of two be slaughtered. Herod's political move reflected his fear of a competitor. There was no such split then between religion and politics. They were both intertwined. Jesus' followers, both during his life and after, called him "Lord" and "Son of God," thereby expressing directly political sentiments—for, after all, these titles were given exclusively to Caesar.

Jesus' attitude towards power is especially clear in the story of his 40-day retreat where satan tempts him. He makes Jesus an offer: in exchange for worshipping satan, he can have all the power over the world. Much, I'm sure, could be done with that power—universal equality, justice, etc…—but Jesus rejects it. The option to lord over others, even if it's seemingly benevolent, is to enter the realm of evil.

In contrast to the Romans, Jesus offers his own example as the path to true servanthood: "You know that among the Gentiles [i.e. the Romans] those whom they recognize as their rulers lord it over them. But it is not so among you; but whoever wishes to become great among you must be your servant, and whoever wishes to be first among you must be slave of all." Throughout the Gospels, Jesus subverts top-down authority and shows another way: the bottom-up and non-coercive way of the cross.

Perhaps the most important feature of Jesus' ministry was that he rejected violence. The pacifism of Jesus' life and teachings find a consonance with anarchy. In fact, those so-called anarchists that use violence and coercion are a contradiction in terms. As already stated, anarchy is a rejection of domination. To use violence to create a society without domination is a non sequitur. If we as Christians cannot support war, this at least implicitly subverts the work of the state, which is war. As Randolph Bourne noted almost one hundred years ago, "war is the health of the state." If the state were actually to live out Jesus' teachings—"love your enemies, bless them that curse you, do good to those that hate you"—it would quickly wither away.

The problem with Christianity is that when measured up to the radical life of Jesus it should largely be considered a failure. Some commentators have observed though, that the church has not been so much Christian as constantinian. For the first three centuries the church lived out a rather faithful vision of Christ. The constantinian arrangement refers, however, to the emperor Constantine's legalization of Christianity in the 4th century. The result was an amalgam of power and the Christian faith. To be a citizen of the empire and a Christian became one and the same. Out went radical, counter-cultural Christianity and in came an imperial, violent Christianity.

Within this rather sad history of the constantinian church of the past 1700 years there has remained a current of faithful revolutionary Christians. And it is in these groups that there is to be found hope for a renewed, anarchical Christianity. Examples include: the Beguines, Waldensians, Desert Fathers and Mothers, Quakers, Diggers, Anabaptists and within the 20th century, the anarchist, pacifist movement, the Catholic Worker.

As noted above, most anarchists are as equally opposed to the state as they are of the church. As a Christian myself, I can sympathize—the dominant path of Christianity has been in collusion with oppression. The groups cited above do point out a path that is important to highlight, however. They too resist Bakunin's notion of God as tyrant in the sky. Instead, they view God as, above all, Love. Being inherently non-coercive, love is willing to suffer, to persevere until we turn towards God. The cross is that sign par excellence for Christians. If God then won't trespass on our gift of freedom, how could we possibly justify doing what God refuses to do to one another?

It has been my goal in this essay to show that Christians should take seriously what anarchists have complained about in our religion, and that the both of us, perhaps rather surprisingly, share a similar orientation. Given the political options of our era, the Christian should choose anarchism, for it's the only one that rejects the state and its coercion altogether, unlike the socialists, greens, democrats, etc. If we realize this, there's a chance that we can truly "build a new society within the shell of the old."

I would invite anyone intrigued by this line of thinking to come to the 4th annual Anarchism and Christianity conference that will be taking place at the Illinois Disciples Foundation on August 4-5th. We will have a chance to explore more in depth what it means to bring Christianity and anarchism together to not only engage a critique of the state, but more practically—How do we live in community? What is our relationship to the police? Technology? Education? For more information, go to www.jesusradicals.com

I would also invite folks interested in a practical outlet to consider coming over to the Catholic Worker House where many of us are intentionally asking these questions and trying to live out the answers.