The Northern Woman

September 1974

Issue XIII

EDITORIAL POLICY

The newsletter group, a separate yet supportive group of the Northern Women's Centre reflects the complexity of the make up of the Northern Women's Centre as a whole.

Being a smaller, unified group, the editorial board of The Northern Woman will attempt through collective creative and thought-provoking comments, to respond to, and express (through a consensus of opinion) their reactions to, various articles, letters and timely topics of interest.

Through such a policy it is hoped that The Northern Woman will become a tool for women to develop an increased understanding of their situation and forces affecting their lives.

E D I T O R I A L

This issue is dedicated to HEALTH — both mental and physical. For, as Simone de Beauvoir said, "Not to have confidence in one's own body is to lose confidence in oneself." For this reason it is necessary that all women have not only a knowledge but also an understanding of their bodies.

Up to this time the medical profession has been allowed to and willingly subscribes to a basic assumption that the patient, particularly a female, is quiet, passive, and ignorant of her body. As a result very few women have a positive attitude towards the medical profession. We are tired of being subjected to long waits, short and cursory examinations which do not alleviate any fears or provide answers to our questions.

A doctor is not omniscent; every patient has the right to question her/him and so receive clear informative explanations. Only when we cease to conceive of our bodies as objects of mystery and begin to voice our desires and to demand basic rights, will the attitude of the medical profession change.

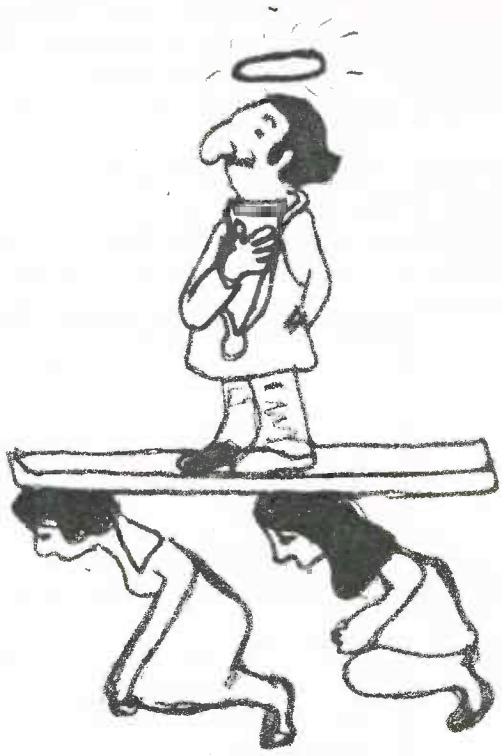
Until the demystification of the body and democratizatization of health services becomes a reality for all, we as women, must increase our awareness of the functioning of our bodies.

This Newsletter hopes to serve as a stepping stone in that direction. It is time we stopped deluding ourselves that our discomfort and dissatisfaction in the medical profession is a function of personal maladjustment on all our parts. The sooner we realize that our difficulties are common and widespread, the sooner we can humanize the sterile, impersonal world of medicine & health care.

YOUR RIGHTS AS A PATIENT

How often have you left your doctor's office with the feeling you were not treated as an individual, that your problems were not very important, that your questions were not answered to your satisfaction (if you could bring yourself to ask them at all), that you were rushed or treated in a paternal manner?

Some women have long complained to their friends about the doctor/patient relationship. Some women have developed a blind loyalty to their doctors, coming quickly to their defense should they be critized, although they may complain themselves about the treatment they received. But now more than ever before women are becoming more selective in their choice of who they see about their health needs. Because of the women's movement women are discussing openly and honestly their grievances toward many doctors.



YOU CAN CHANGE DOCTORS:

Staying with the same doctor means s/he has formed a medical picture of you in her or his mind, and s/he has recorded your health problems which can prove to be valuable when you come for medical advice. At the same time, the mere fact a doctor has your medical history shouldn't bind you to him/her if your not satisfied. Records can easily be transferred.

You don't have to settle for a single opinion:

You are well within your rights when you set out to corroborate the findings of any doctor. A second opinion can be particularly helpful when it comes to the advisability of surgery. There is a growing concern about the many hysterectomies and mastectomies that are performed. Explore all alternatives before agreeing to an operation.

The womens movement is the road to knowing and appreciating onesel

You are not obliged to participate in experiments:

New drugs and new surgical procedures must be tried out on someone before they gain acceptance, but if you happen to be that "someone" you have a right to know it, and be informed of the dangers involved.

CONTINUED

YOU ARE ENTITLED TO A REASONABLE AMOUNT OF TIME & ATTENTION

You have a right to expect that s/he has set aside the time to (1) give you a chance to talk about the problem. (2) Examine you. (3) Record the details (4) discuss it with you (5) Suggest what steps you can take to solve it, and (6) Answer any questions you may have. You have every right to expect PRIVACY -- you should be able to talk frankly without fear of being overheard. Your health records are privileged information and should not be made available to anyone who is not directly involved in your care unless you give your permission to make this information available.

Continuity of Care

A backup doctor should be standing by to answer your calls, or respond to any emergency, when your own doctor is away.

The Preservation of Personal Dignity: The manner in which you are cared for should be in no way affected by your sex, social standing, or race. Respectful and considerate care is every patients due.

Full Information Is Yours For The Asking: "What the patient doesn't know can't hurt her" is too often the attitude of many doctors. You have the right to ask questions expect truthful answers and explanations you can understand, also, the name & possible side effects of medications prescribed.

"Leave medicine to us doctors the experts!"

Men go to great pains to avoid talking about women in front of them ("Not in front of a lady") - it would give their game away. To overhear a bull session is traumatic to a woman: So, all this time she has been considered only, "ass", "meat", "twat", or "stuff", to be gotten a "piece of", "that bitch", or "this broad" to be tricked out of money or sex or love! To understand finally that she is no better than other women but completely indistinguishable comes not just as a blow but as total annihilation.

Shulamith Firestone
The Dialectic of Sex

BIRTH CONTROL METHODS

"The Foam"- Aerosol Vaginal Spermicide

Description; White cream with the consistency of shaving cream. It contains a sperm killing chemical. It comes in a can with a plunger-type plastic applicator.

Effectiveness
Foam is not as effective as a diaphragm used with cream or jelly, or as a condom. If it must be used alone, two full applicators should be inserted, as close to the time of intercourse as possible. If you absolutely don't want to get pregnant, don't count on foam alone.

Disadvantages
- Foam irritates some vaginas and some penises. Delfen, which is most effective, also tends to be most irritating.
-Not effective enough to depend on.
- Using it can be a (brief) interruption of sex if the couple do not treat it as part of the sex play.
-Responsibility is primarily the women's.

Advantages
--Easily available in drug stores.
- Is effective in helping to prevent VD.

JELLIES AND CREAMS

Spermicidal cream or jelly comes in a tube with a plastic applicator. It forms a film over the cervix which blocks and kills the sperm.

Effectiveness
It is not as effective as foam, so unless foam irritates, don't use creams or jellies alone.

Disadvantages Problems of leakage or allergy.
Advantage Can be bought at a drug store without a prescription.

CONDOM (Rubber, Safe, Prophylactic)

Description: A sheath, usually make of thin, strong latex rubber, designed to fit over an erect penis to keep the semen from getting into the women's vagina. Usually comes rolled up, unrolls to about 7½ inches. There are no "sizes", since all are considerably elastic. "Skin" condoms (made from animal membrane) are more expensive but tend to cut down less on sensation.

Effectiveness; Used alone, a good quality condom is 85-95 percent effective, with a spermicidal foam, 100 percent effective, depending on how carefully it is used.
(a) leave a half inch at the end of a plain-ended one for seman.
(b) Unroll carefully to avoid catching air in the end.
(c) Use a lubricant to prevent tearing, spermicidal foam, cream, jelly, K-Y Jelly, or saliva, but not vaseline. Appl the lubricant after the condom is on the penis.
(d) The man must hold the rim when he withdraws his no longer-erect-penis afte ejaculation; otherwise the condom might slip off, and sperm will get into the vagina. In case of accident, use cream or jelly or foam as quickly as possible.

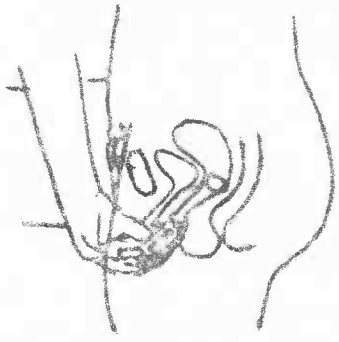
Disadvantages
- Can ruin the spontaneity of sex, unless the man and woman can share the unrolling of the condom, making it an enjoyable routine of sexual foreplay.
-Many men claim that the condom dulls sexual pleasure. Physiologically, this claim is highly questionable. These men are usually refusing to accept responsibility for birth control.

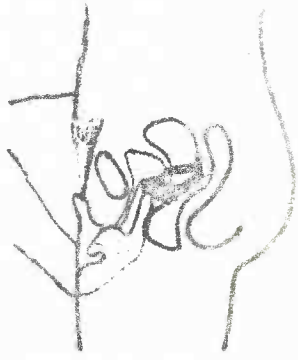
Continued ...

Advantages
- Cheap, easily avaible, easy to use
- A method of birth control that gives some protection against VD. It also protects partners from infection like trichomonas.
- Condoms have a shelf life of two years. A condom kept in a wallet or pocket will deteriorate, but a high quality condom can be used five or six times if cared for. Put it in a glass of water temporarily, thenwash it, dust with cornstarch, and reroll.

Inserting the Diaphragm

DIAPHRAGM AND SPERMACIDAL JELLY OR CREAM:

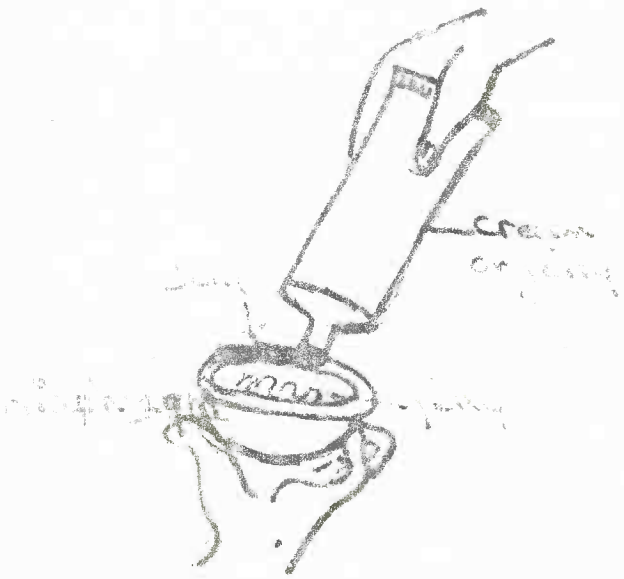




1880 - Diaphragm was a major breakthrough in the liberation of women from unwanted pregnancies.
Up until 1960 when the pill and IUD were invented, 1/3 of all American couples used the diaphragm.

DESCRIPTION

It is made of soft rubber material and is shaped like a shallow cup. It has a flexible metal spring rim. It should fit snugly over your cervix, locked in place behind the pubic bone and reaching back into the posterior fornix of your vagina. It comes in a variety of sizes, depending on the size of your upper vagina. The size you require is a difficult thing for you to determine, therefore a trip to the doctor is required.



HOW IT WORKS

Before a visit to your doctor, you should examine yourself internally to determine the positions of both the bubic bone and the cervix. This is essential when fitting into place the diaphragm. The doctor then fits several rings of different size into the vagina to determine the size you need. After fitting the first the doctor will or should ask you if you can feel it. If you say "no" he or she will take that ring out and insert the next larger size and this continues until you can only slightly feel the ring and that's your size. There is a possibility that after a woman has had a child, an abortion, an operation dealing with the pelvic area or has lost or gained ten pounds, it might be wise to be refitted.
After the visit to the doctor you should know how to insert the device yourself. About a teaspoon of spermicidal jelly or cream is smeared on the upper surface of the diaphragm (dome up or down, depending on your anatomy). Spermacide must not be

Continued ...

placed on the rim since this increases the possibility of displacing the diaphragm during coitus. With one hand you squeeze the diaphragm into a long, narrow shape. With the other hand, hold the vaginal lips apart, then insert the compressed device into the vagina until the far rim passes the cervix. You then push the front rim up behind the pubic bone and check that the cervix is completely covered. Plastic or metal inserters facilitate insertion especially for women with short fingers or dislike handling themselves.

use

The diaphragm is most easily inserted while crouching, squatting, lying down, or standing with one foot raised.
The diaphragm may be inserted no more than two hours and not less than 1/2 hour before sexual intercourse. If two hours pass, an inserter full of spermicide can be injected into the vagina or the entire procedure can be repeated.
You can walk around, bathe or urinate with a diaphragm in place, but you should recheck its position after a bowel movement.
After an act of sexual intercourse, an additional application of spermicide must be inserted into the vagina by means of an applicator before each additional coitus.
After intercourse, leave the diaphragm in for six hours or so to ensure that all sperm are destroyed.
Douching is unnecessary. Simply clean around vagina with a warm washcloth and towel.
Occasionally, hold the diaphragm up to the light and check it for cracks, or holes, especially around the rim.
After use, wash the diaphragm with mild soap and water, dry it gently and powder it with corn starch.
The diaphragm can be used during menstration although conception is unlikely at that time.
When positioned correctly the diaphragm cannot be felt by either sexual partner during coitus.

Diaphragms made of plastic are available in case of an allergic reaction to rubber. Also, the brand of spermicide should be changed if either partner is allergic to the kind being used.
The diaphragm is ineffective if left in a dresser drawer or purse. However, that is not the only reason for its potential failure. The device can slip out of position for a number of reasons: improper fit, cream on the rim, expansion of the vaginal walls during sexual stimulation, and frequent insertions of the penis. The diaphragm is much more easily displaced in coital positions where the woman is above the man.
The diaphragm and cream costs about $6.00. =

Word of Warning: It is best not to leave your diaphragm lying about as someone uninformed as to the form of a diaphragm may easily mistake it for an ashtray. Just a pun but it did actually happen. Tee Hee!

Much of my material I gathered from the Magill Handbook on "Birth Control" and the book entitled "Our Bodies, Ourselves". Also thanks Linda for the helpful article you gave me.

Val Packota

The secret is freedom and that means no bras or gridles. You got to do what you want to do and wear what you want to wear. Everybody is so hung up on the matching game-- the shoes have to match the bag which matches the coat and dress But the big question is, is it matching your soul.
Janis Joplin
Village Voice

THE PILL

The pill is, at the present time, the only birth control method that is 100% effective if taken as prescribed ie. every day for 21 days.. (depending on type of pill you take).

HOW IT WORKS

The pill is make up of synthetic chemicals that ordinarily enable women to conceive a baby.. The pill adds estrogen and progesterone in synthetic form to the body's own production of hormones.. Estrogen--chemical that acts on the brain centre that controls the pituitary gland resulting in the gland to decrease the production of egg--prevents development of other eggs--causes wall of womb to thicken and prepare it to receive fertilized egg. Also stimulates milk producing gland of of breasts. Progesterone--completes preparation of the wall of the womb with a further supply of blood and other fluids necessary for early stages of pregnancy--also seems to prevent release of any more eggs..

In effect, the pill, adding a considerable amount of estrogen and progesterone prevents pregnancy primarily by preventing the development of the egg in the ovary. If a low estrogen level is present on the last day of your cycle a hormonal message is sent by the pituitary gland which begins development of egg in the ovary. What the pill does is raise your estrogen level enough to prevent that message from being sent.. In effect your ovary remain inactive when taking the pill.

DISADVANTAGES OF BEING 100% SURE

There are varied opinions on the pill and problems linked with the pill ie. blood clots, cancer etc. However because the pill is 100% effective it is given publicity as giving women complete contrel over their bodies. However we must ask in this article what price do we have to pay for being 100% sure..

The pill must be prescribed by a doctor. Too often the pill has been doled out by doctors who have not done complete medical histories and examinations. Also the side-effect and dangers of the pill, to certain women have not been thoroughly explained. In a study done by the Vancouver Women's Health Booklet - 32% of the women surveyed said their doctors prescribed the pills without adequately checking their medical history..

The disadvantages and dangers of taking oral contraceptives as any other product medication cannot be overstated.

Neurosurgeon links pill to female infertility

Any synthetic chemical that "messes around" with body chemistry is dangerous to women susceptible to various physical problems.

Listed below are the reasons you should not take the pill or good arguments for thinking about other birth control alternatives.

WOMEN WHO SHOULD NOT TAKE THE PILL

-diseases or conditions associated with poor blood circulation
-bad varicose veins
-pulmonary embolism (blood clot in the lung)
-stroke
-retinal thrombosis
-heart disease
-heart defect
hepatitis or other liver diseases
-undiagnosed abnormal genital bleeding
-cancer of the breast or of the reproductive organs or a family history of breast cancer
-lactation (nursing mothers should not take birth-control pills
-cystic fibrosis

Doctor links migraines, estrogen use

G+M June 24/74

Pill may cause breast cancer, BMA warned

VOLUNTARY STERILIZATION---A PERSONAL EXPERIENCE

A significant change is occurring among many women today. Whereas in the past, most things affecting women were out of their hands (parents, husbands, "laws of nature"), today women are seeking control-- of their lives, of their bodies. The control they damand of their own bodies has had an obvious effect on our society ie.more money is being put into development of safer and more effective birth control methods, the abortion issue is being argued daily. Although these changes are seemingly insignificant in light of what should be happening, they still represent a change in attitude from even 15 years ago, when abortion was something that was never even mentioned by the average person. At one time women never questioned the fact that they would have children--it was inevitable--it was what women do. Women are questioning now, though, and the answers they're coming up with range from limiting the number of children they bear to one or two, to choosing not to have children at all. When the decision has been made not to have any (more) children the question then becomes which birth control method would provide the most effective, safest, long-term effects. Of ta two most effective methods--the pill (99%) and the IUD(95%), neither would appear to be too safe for any extended period of time. The most permanent, safest method, therefore, is obviously sterilization. It is one hundred persent effective and is usually final. It is the only reaaly permanent form of birth control.

Choosing sterilization is an important decision. Most people you talk to about it will probably react with shock especially if you have only one child or none at all. You may even have many internalized feelings yourself of infertility meaning "inferiority". However, after these have been examined and dealt eith, you will most likely run into the biggest struggle of all--finding a docto who will perform the operatinn.

I would like to relate my personal experience with voluntary sterilization, which, I believe could probably be generalized. I am a single parent with two children who,at the time I started investigating sterilization, were 3 and 4 years old. I have never beem married. I had been on the pill for 3 years, and given information that you should go off them every 3-4 years, I was getting worried about how ingesting this chemical into my body daily was affecting me. Examining other birth control methods, I discovered all of them to be unsatisfactory for me. The nexr safext, IUD, made me shudder; I didn't like the thought of a little bit of plastic and copper embedded somewhere in my body. Abstinence seemed to be the my only out(sterilization hadn't occurred to me yet). Being ayoung, sexually healthy woman, it didn't strike me as being any kind of a viable alternative.

Continued ...

It finally occurred to me that I was only looking into short-term methods. I knew I didn't want any more children. The thought of getting pregnant again filled me with terror; I paniced every time my period was a day late. So why not end my child bearing "career" permanently? For six months I battled with myself. After all, I was only 20 years old; isn't sterilization a rather drastic step? But, my children were getting out of babyhood dependancy and I loved the freedom it offered me. I spoke to everyone I knew about it. Many of my friends (mostly women) were incredibly supportive of my decision. The majority of people though, men and women, were shocked. Their shock, however only served to reinforce my decison. I made an appointment with my doctor. I wouldn't even have considered approaching my gynecologist about it (a man who reminded me faintly of Robert Young in a Marcus Welby-Father Knows Best combination).

I felt it would be fairly easy. After all, I was an "unwed mother", and many people were adverse to propagating the race of "illegitimate" children"(I wasn't too concerned about the resoning behind it--as long as I could get the operation done). My doctor, though, was just a little too liberal. He seemed to think I had just as much right to have children as a married woma.. did. He insisted I would meet a man some time ("After all, you're so attractive") and fall madly in love, want to get married and give him a-child-of-his-own. He also told me that if I were married my husbands signatureand consent would give me the right to be sterilized if he said I could.

After talking to him for a while, he fimally convinced me to think abot it even though I already had been for six months or more. I went off the pill and on his advice, had an IUD inserted.

His argument infuriated me after I had had time to think abat it. First of all, if I ever did meet a man I wanted to get into a long-term relationship with, he would have to accept my children as "his own".. I couldn't concieve of a relationship with a man who related to them as my responsibility, alone, an attitude which would be representative of an entire individualistic frame of reference which I can no longer relate to.

A short time later I approached another doctor, a partner of the first. His reaction was the same: I'm too young [illegible], I may change my mind, I may meet somenne etc.

A year later, when I was even more convinced that I should have the operation done due to extreme discomfort from the IUD, I approached another doctor. This time it was a woman, my reasoning being that she might be able to empathize with my situation to a small degree more than a man could. I was able to talk to her quite openly about my feelings and she finally agreed to speak to the gynecologist/surgeon about it. He agreed and they scheduled my admission into the hospital. I want into the hospital with no feelings of apprehension at all. I felt exhilerated; I finally had some control over my body.

The operation itself was a simple procedure, only in use for a year. The procedure was termed "laparoscopy" and was done by making two tiny incisinns in the abdomen and inserting a tube called a laparoscope which is used to cauterize the tubes. I was able to go home the following day. After I came home, I felt a real sense of freedom, as if, now that I no longer had to worry about getting pregnant, I could get on with the rest of my life.

continued . . .

My experience with the first two doctors made me realize just how much the medical profession views women as not having any right in determining their own lives. Abotion, bibth control, ahild birth, and sterilization are all things which, although they affect the woman directly are all somehoe removed from her hands. Major decisions are made not by her but for her, either by the man she is married to or by the man who is her doctor. The time is here, now, to start insisting that we be given the right of control over their own bodies which will mean another step in the direction of control overour lives.

THE MALE OPTION - VASECTOMY

To describe a vasectomy in the usual idiotic T.V. type advertisement one could say that "It takes away the worry of being close".

WHAT IS A VASECTOMY? How is it performed? How will it effect me? These are some of the questions that bother the average male, so, having had a vasectomy four years ago I shall attempt to answer these questions to alleviate any fears the male may have about the possible after effects of a very simple operation.

Generally a visit to your doctor to discuss the operation is mandatory and some doctors prefer the wife to be present, although this depends on the doctor involved, and in my own case all that was required was my wife's permission for the operation.

How is it done. Usually in the doctor's office under a very mild anesthetic. The whole experience takes about half an hour. The operative procedure is about ten minutes. All the operation entails is the making of two miniscule incisions in the "Bag" and locating the two Vas Deferens, cutting, tying and applying some type of plastic bandage over the small cuts. The whole procedure is less painful than a visit to the dentist. Although, it is usually suggested that one wait until the next day to resume work; the only discomfort is a slight pulling sensation of the testicles. Because, one support tube is removed they tend to drop until the muscles strengthen again. The advisability of wearing an athletic support for a few weeks is desireable. This slight inconvenience and a period of caution for about ten weeks is usually advised by your doctor to make sure that all live sperm have disappeared.

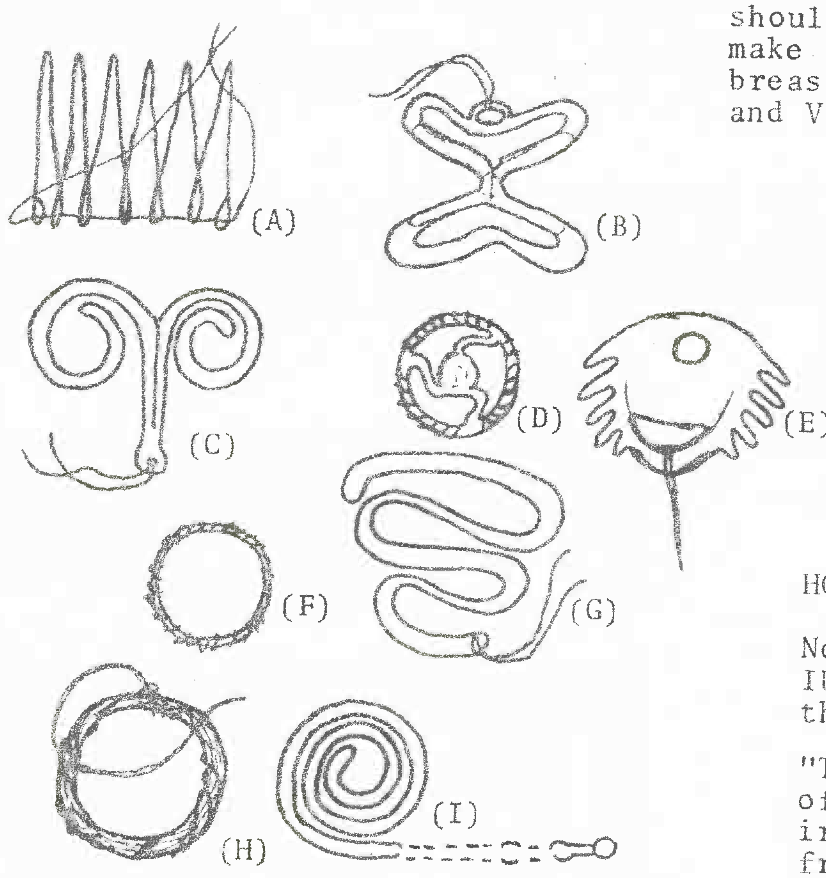
How will it effect me? After a month or so you will not even be aware that you had a vasectomy, and the location of any small scars are generally impossible. Will it effect my sex life? Rubbish! I would highly recommend it as a viable choice in the decision of birth control and it appears to me ludicrous to have a woman go through the major female operation of Tubal Ligation, or have her take the Pill when a vasectomy is such an easy answer.

Take this advice from a four year veteran!

Mike

IUD — INTRAUTERINE DEVICES

Several devices which are pictured here have been used by women. As can be seen the design of these devices has become less complicated over time as a result of much needed scientific work. However, much more research is needed in this area.



Over two thousand years ago Arab and Turk camel drivers discovered the principle of the IUD. They inserted tiny pebbles into the uterus of female camels by means of a hollow lead tube in order to prevent pregancy during long journeys through the desert.

During the nineteenth century IUD's were used extensively in the United States and Europe for a correction of uterine displacement, treatment of menstrual abnormalities and infertility and in the later part of the century, for contraception.

Today the IUD is usually a small plastic device, placed inside the Uterus by means of an inserter with one or two strings extending from the vagina so that one is able to see that the device is still in place.

AVAILABILITY

Most women should be able to make use of this method unless the uterus is exceedingly small or there is excessively heavy mentrual flow and/or cramping. Also people with V.D., severe vaginal and uterine infection should not use the IUD. To be safe make sure to have a full pelvic and breast examination as well as pap smear and V.D. tests if necessary.

- (A) Majzlin Spring
- (B) Birnberg Bow
- (C) Saf-T-Coil**
- (D) Ota Ring
- (E) Dalkon Shield
- (F) Hall-Stone Ring
- (G) Lippes Loop**
- (H) Zipper Ring
- (I) Marguiles Coil

** most recent devices

HOW IT WORKS

No one is absolutely sure how the IUD works to prevent pregnancy but there are several theories:

"The IUD, which touches the lining of the uterus at several points, irritates the lining and keeps it from developing properly, so a fertilized egg cannot find a good place to implant.

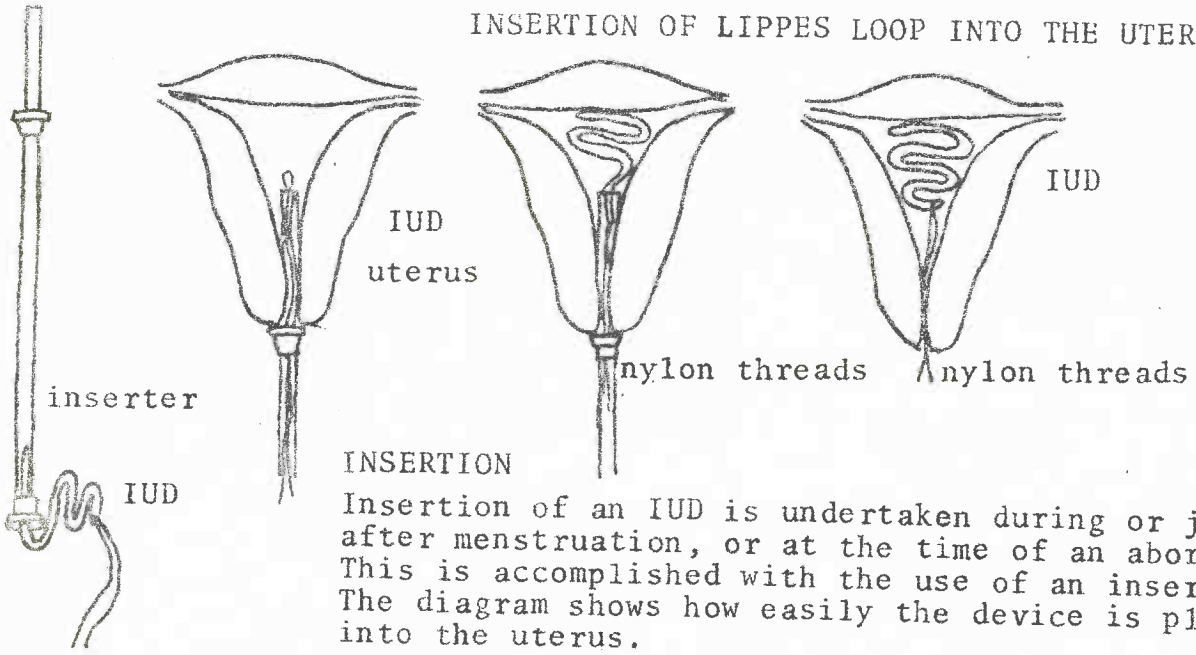
The IUD speeds up the peristaltic waves by which the fallopian tube moves the egg down toward the uterus. The egg's journey of 4-5 days gives the uterine lining time to become secretory under the influence of progesterone.

Studies are being done to determine if the presence of the IUD causes hormonal changes which cause the suppression of ovulation.

A fairly recent theory holds that the uterne wall responds to the foreign body by sending out macrophages - huge white blood cells - which try to get rid of the IUD, and failing that, devour egg or sperm or both. This is not an infection."1

1 - information taken from page 120 of Our Bodies Ourselves.

INSERTION OF LIPPES LOOP INTO THE UTERUS



INSERTION

Insertion of an IUD is undertaken during or just after menstruation, or at the time of an abortion. This is accomplished with the use of an inserter. The diagram shows how easily the device is placed into the uterus.

IUD's should always be inserted by a well-trained person because of the risk of infection. In Canada this usually means a doctor, although, in other countries these tasks are often handled by trained medical technicians. However, the demystification of the medical profession which results from the use of technicians seems to be a long way off at least in this country.

SIDE EFFECTS

Some women have more bleeding and cramping than usual for the first few days (One medical journal suggests that one or two months is not too long for bleeding to take place after insertion). One can only assume that these were "male" doctors who wrote the article.

ADVANTAGES

Eliminates worry about birth control at the time of intercourse. It is easier than remembering to take your pill or inserting your diaphram. It is probably safer than pumping your system full of chemicals.

In socialist countries where oral contraceptives are frowned upon, IUD's have been their alternative and have been used extensively by all women including those who have not had children. The reason for why the IUD is used less often in this country appears to be the profit motive. The pill costs only pennies to produce but costs the consumer up to $3.50 or more per month. The IUD, on the other hand, is a one-time expense. Obviously companies manufacturing these devices will push the more profitable of the two.

REVERSIBILITY

Chances of becoming pregnant after removal are the same as before using the IUD.

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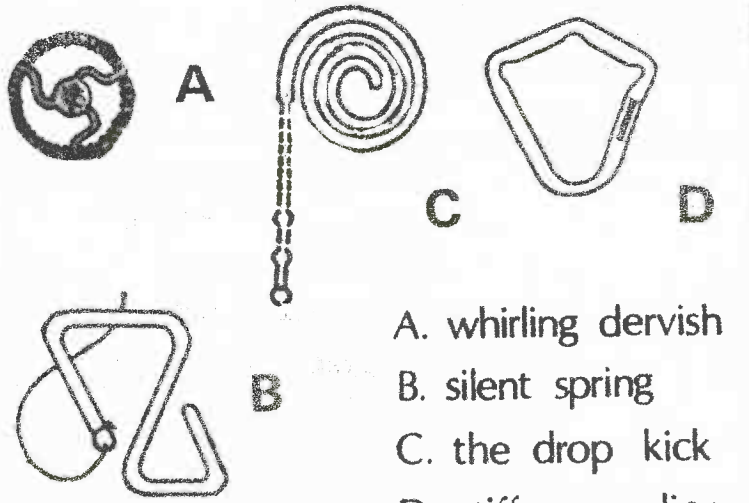
FOR MEN ONLY:

NEW BREAKTHROUGHS IN BIRTH CONTROL

CAN YOU NAME THESE I.P.D.'s ?



A. whirling dervish
B. silent spring
C. the drop kick
D. stiff upper lippy

NEW HEAT WAVE KILLS SPERM

ANDROGEN, FLORIDA July 10 - Scientists at Mammary Research Clinic announced today that they have developed an entirely new concept in birth control. Based on the finding of Dr. Sharon Suffrage, whose study on heat waves was published last year. the Clinic is testing the effects of heat on sperm production.

Dr. Suffrage discovered that when intense heat was applied to the scrotum, the male's sperm was immediately destroyed. Of course, so were the testicles, but Suffrage thinks that this minor problem can be overcome.

In announcing this new breakthrough in birth control, Suffrage explained that she is presently developing a portable hot iron which can be applied directly to the scrotum by the man himself. The hot iron will be marketed commercially by Suffrage Pharmaceutical Co. under the trade name "Hot Rod."

Several thousand male prisoners have been using the Hot Rod since April, and the results look promising. "We had only had 34 cases or third degree burns," she stated, and we are working closely with the local Burn Unit to see whether or not the patients will recover. Prison officials have noted that since the advent of the Hot Rod, there have been 43% fewer escape attempts. When asked about the correlation between the use of the Hot Rod and the incidence of prison breaks, the warden replied, "Well, the men seem reluctant to walk around anymore."

INJECTION DECAPITATES SPERM

RUTTING, N.M., July 10 - A simple method of birth control by injection of a liquid into the penis has been discovered at the Rutting Clinic by Dr. Eve Weltsmerz.

"Using an ordinary hypodermic needle such as used by junkies all over the world, the new chemical formula (pat.pending) will decapitate the sperm, thus rendering it incapable of entering the female egg," Dr. Wetsmerz declared.

Experiments on a thousand white whales from the continental shelf (whose sexual apparatus is said to be closest to man's) proved the new chemical to be 100% effective in preventing pregnancy and eminently satisfactory to the female whale since it does not interfere with her rutting pleasure.

THIS ARTICLE WAS TAKEN FROM "Her-self", 225 East Liberty Ann Arbor, Michigan 48108 (August, 1974)

FOR MEN ONLY: NEW BREAKTHROUGHS IN BIRTH CONTROL

IPD (Intrapenal device) IS TESTED

URP: The newest development in male contraception was recently tested on male prostitutes. Called the intrapenaldevice or the IPD, it is inserted through the head of the penis and pushed into the scrotum with a plunger-like instrument. Occasionally there is perforation of the scrotum which is disregarded since the male has no sensitivity to this area of his body. No one really knows how they work or what the long range effects will be, but then, who cares?

Common complaints have been severe cramping, massive hemorraghing and green discharges from the head of the penis which are merely signs that the man's body has not yet adjusted to the "new resident." Hopefully these symptoms will disappear within a year.

IPDs usually are implanted with a string to insure quick removal or for sado-masochistic "play." In cases where the sex partner has complained of the string, the string is removed and then the IPD must be taken out surgically.

PENIS COIL "STATISTICALLY SAFE"

INTERCOURSE, PA. July 10 - Dr. Sonia Softig of the Blue Balls Birth Control Clinic announced today the most effective method of birth control since castration.

The device, which Dr. Softig invented, is a microscopic oil which can safely be inserted into the penis with very little discomfort to the man. It will remain intact for as long as desired and can be removed as easily as it was inserted - that is, with a tiny steel rod which is gently rammed through the penis opening.

The main feature of the coil is its retentive power. Experiments on a hundred generations of pigs (whose sexual apparatus is said to be closest to man's) showed an expulsion rate of only 1.3%, with a complication rate of merely 18%.

Dr Softig announced that the new coil has also been tested on unsuspecting male grad students who visited their University Health Clinic during the week of July 1 - July 8. An experimental study at Macho University showed that of the 762 male grad students who were given the coil, only 112 reported any adverse effects. Of these, 84 requested that the coil be removed. However, they were informed that they would have to wait until the study was completed before they could have the coil taken out.

Dr. Softig has conceded that occasionally a man will not be able to tolerate the coil. But she emphasized that this is entirely the fault of that particular man. "When we get such a case," she stated, "we usually refer the man to a psychiatrist."

"UMBRELLY UNFURLED"

by Jane Field
Special Science Editor

PUDENDA, KANSAS, July 10 — An entirely new method of birth control has been discovered by Dr. Lura Merkin of the Merkin Clinic. A tiny folded umbrella is inserted in the penis and opens automatically when it has reached the apex of the shaft. The underside of the umbrella contains jelly (hence, the name "umbrelly") which causes the sperm to undergo a chemical change rendering it incapable of fertilizing the egg. Dr. Merkin said that the "umbrelly" can be inserted in the penis without an anasthetic, and with very little discomfort to the male. Thus, it can be done in a matter of minutes, in any soundproof doctor's office.

Experiments on a thousand goats (whose sexual apparatus is said to be closest to man's) proved the sperm umbrelly to be 100% effective in preventing pregnancy and eminently satisfactory to the female goat since it does not interfere with her rutting pleasure.

Dr. Merkin declared the "umbrelly" to be statistically safe for man. "Out of every hundred goats, only two died of intra-penis infection; only twenty experienced painful swelling in the unerected member; sixteen developed cancer of the testicles; and thirteen were too depressed to have an erection."

Dr. Merkin pointed out that early cancer detection is a feature of the Merkin Clinic. Removal of one or both testicles is now considered a simple operation and has very little effect on a goat's sexual prowess. Only one out of a thousand goats had to have a radical penisectomy — that is, removal of the penis as well as the testicles. "But it is too rare to be statistically important", Dr. Merkin said. Other distinguished members of the Women's College of Physicians and Surgeons agreed that the results far outweigh the risk to individual men.

FAMILY PLANNING

There have been obstacles to the practice of family planning. One of the main obstacles has been the fact that, until 1969 the Crimminal Code restricted sale and dissemination of information regarding contraceptives.

However, there still exists a barrier in family planning services and that is one of education and infromation. It is surmised that most people in Canada know about contraception, however, about a third of all pregnancies in Canada are unplanned.

The advantages of family planning cannot be overestimated:
"If every child is a wanted child, children are better cared for, both physically and emotionally. Mothers are subjected to lower health risks if births are spaced carefully. The assurance that another child won't come before it's wanted helps couples plan other material and non-material aspects of their lives with more confidence. And we know family planning in the wide sense in which it must be defined can assist some of the childless to bear normal healthy babies. Family planning is not simply the insertion of an I.U.D. It embodies a careful calculation of family needsbalanced a ainst family resources with the aim of happy, healthy, responsible family life."

*Economic Council of Canada

Dr. Marion Powell, Population Unit, School of Hygiene, University of Toronto, has been quoted in saying that having access to birth control information is not enough. It is a very complex problem to move people from attitude to practice. She felt that education is coming too little and too late, people's attitudes will have to shift to practice of family planning. She further states with all this knowledge society has been afraid to move beyond that.

A prevailing spirit seems to be that "we are our sisters keepers," and we are not doing our duty to others when remaining apathetic to affairs that are constantly calling for a change for the better. — Erma Stocking, Prov. Sec. of Sask. WGGA 1914

ABORTION

PART 3

The final criticism of section 251, (which states that it is illegal for abortions to be performed except by a qualified medical practitioner, who has the consent of a therapeutic abortion committee of three) is the obvious difficulties involved in enforcing this law.

That this law is not, and has not been enforced is beyond dispute. Innumerable abortions have been performed and continue to be performed in circumstances contrary to the law, and yet only a tiny fraction of these have ever been prosecuted. The main reason for this is that it is intrinsically difficult, almost impossible, to gather evidence of illegal abortions. Almost always, illegal abortions are carried out in a private manner with all parties involved consenting. Even those cases which come to the attention of hospital authorities and police cannot as a rule be prosecuted, for usually the women involved, who would seem to be the logical complainants, usually refuse to divulge the identity of those injuring them, or the precise cause of their injuries.

It would seem that the difficulty in obtaining evidence of illegal abortions, and thus the problem in enforcing the law, centres around the fact that most participants in the act — as well as witnesses, possible complainants and prosecutors — do not feel guilty about it, do not feel that what they are doing is wrong. Perhaps this suggests that the law is not fulfilling its intended functions.

When established, one of the purposes of the law was to protect society against the dangers of unscrupulous, untrained abortionists. However, as already pointed out, it has had little success. In addition, there are other laws prohibiting the practice of medicine without a licence which would logically already serve this purpose.

Another function of the law is to protect members of society against a dangerous operation. However, as an abortion is a relatively easy surgical proceedure, one wonders about the emphasis given to this particular operation.

Far from preventing harm to society, this law is instrumental in causing harm to many women who, desperate to rid themselves of an unwanted pregnancy, endanger and sometimes destroy their own lives and health. It is hard to imagine that even fear of prosecution would deter them.

To argue that any of the above are the real purposes of the section is merely, I believe, to cloud the issue. Clearly, the original purpose was to codify what the legislators held to be the prevailing religious and moral belief. As a result, this original purpose remains enshrined in section 251, although it is questionable whether it now actually represents the general views of society.

It is not the case that all Canadians believe abortion to be wrong. A great many believe that there is no moral or any other wrong in abortion per se. In fact, there are many who find it morally wrong to restrict abortions, because of the horrifying results. How can these people, if apprehended for their involvement in proscribed abortions, justifiably be found guilty of a breach of the law? They would have no wrongful or criminal intent — a requirement for conviction under the principles of the criminal law. And yet, so long as section 251 is contained in the Criminal Code, it is in fact considered a criminal offense.

In February of 1973, Stewart Leggatt, an N.D.P. member of Parliament from British Columbia, proposed to remove section 251 entirely from the Criminal Code. The vote in the House suggests approval for the motion, but a word of caution is needed: this was only a first reading, and so the vote may well mean only agreement that the matter be debated. We are likely to wait a very long time for the second, and crucial reading of this bill. Debate on a proposed change to the abortion law is never brief, and so we shall have to await a time when Parliament is prepared to allow all other business to be set aside. What the outcome will be is an open question. Hopefully, there will be discussion of the purpose of criminal law in general and of this section in particular, and on the effects that the restrictions on abortion are having.

It is in parliament, I believe, that the decision will finally be made — not by lawyers and judges using legal arguments but by politicians acting in response to public pressure or what they deem to be public pressure, as well as to their own individual and party stands. The issue is basically a matter of values and opinions, and for the law to be a good, responsible law, it must take into account the honestly held opinion of the citizens it is intended to protect.

— Val Packota ([illegible] National [illegible] Coalition for Abortion Law Repeal)

ABORTION LAW INTERPRETED: Abortion in Northern Ontario (Part I)

- the following is a summary of the research and articles done by Nan Rajnovich and Anita Dahlin, Staff Writers for the Sault Daily Star. Their articles appeared on January 25, 1973 - January 27, 1973 inclusive.

It is as difficult to get a therapeutic abortion in Northern Ontario as it is Quebec, a survey of hospitals, whose record of 8.6 abortions for every 100 live births come closest to the overall Ontario figure of 12, "Northern Ontario abortion committees are as strict as old-fashioned school marms."

The north part of the province is only one example of the uneven application of Section 237 of the Criminal Code since the federal amendment in 1969.

Ten of 34 hospitals in Northern Ontario have therapeutic abortion committees, ranging from Cochrane's Lady Minto Hospital with seventy beds to Sudbury Memorial with 242 beds.

Therapeutic abortions done at six hospitals, Thunder Bay McKellar and Fort Arthur General Hospital, Sault Ste. Marie Plummer Memorial, Sudbury Memorial, North Bay Civi and Cochrane Lady Minto totalled 276 in 1971.

Compared with the number of live births, the figure for this part of the province works out to 1.8.

Reporting hospitals comprise 75% of the hospital beds in those institutions with abortion committees. If those unreported did a comparable number of abortions the figure for the north might reasonably be placed at 2.4, or one sixth of the Ontario average.

Hospitals with such committees also include Kirkland Lake, Dryden, Kapuskasing and Kenora. Although there is only one hospital in Elliot Lake, Fort Frances, Hearst, and Timmins, all of which have more beds than Cochrane, none had an abortion committee. Sioux Lookout has two hospitals. The larger one, with 70 beds, is an Indian hospital run by the department of national health and welfare. It has no abortion committee.

In the 438 miles between Sault Ste. Marie and Thunder Bay, there are five smaller hospitals, none of which have abortion committees.

Toronto General Hospital did one ninth of the therapeutic abortions performed in Ontario in 1971 (1,816) and west Toronto East General's 1,004 did one sixth of all legal abortions in the province. London's Victoria Hospital did 1,380 and the Hamilton hospitals another 1,605 so that three cities carried nearly one half the load for the province.

(to be CONTINUED - PART II: The Role of the Newspapers Re: The Abortion Issue)

1975: International Women's Year

1. After completing massage on the back of the legs, glide hands over buttocks to central back.

2. Slide hands all the way back to feet and repeat #1 (all the way up legs) with some pressure.

3. Massage buttocks, knead the flesh as if kneading bread. At first work on both buttocks, then concentrate on one, then the other. (For this you can remain on one side of recipient. No need to change sides). Rhythmic strokes.

   Make small, 1/2" circles all over each buttock using the middle three fingers of your hand pressed tightly into a triangle with the middle finger on top.

   Make larger circles all over buttocks using heel of hand.

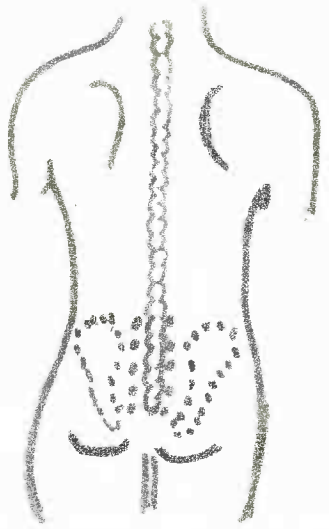
4. Spread fingers of hand wide apart. Place hand firmly against lower slope of one buttock. Now shake the buttock quickly first forward and back (30-40 shakes) then side to side. Repeat with other buttock.

5. According to the Tantric teachings, our psychological condition is more dependent on the state of the spine than any other part of the body.

   You will surely agree to this when you experience the deep sense of relief and release when your back is thoroughly massaged. Spend your time well on giving a back massage.

   Straddle your friend's thights. Give several strokes all the way up to the shoulders with some pressure. (Gets the circulation going)

   ALSO USE THIS STROKE BETWEEN OTHER STROKES. GIVES YOU A SHORT REST - TIME TO THINK WHAT COMES NEXT - AND DOESN'T BREAK CONTINUITY. FEELS BEAUTIFUL.



6. Use thumbs to press in (toward spine) and down (into back). Hold each press about 5 seconds. This is done at base of spine on points indicated.

7. Using thumbs make small circles into spine and up. Continue up to top of spine. Circles link together. At shoulders do some kneading out to upper edge of blade.

8. Slide hands back to buttocks. Locate muscle columns up of back (about half way between spine and side) and make 2-3 long, hard presses all the way up these to shoulders, kneading again at top.

9. Make circles into spine again using whole hand. Link circles as in #7.

10. Bend elbow. Place hand on small of back. (Hold hand in place with your foot.) Use your fingers of one hand as in #3 and thumb of other hand to knead muscles under shoulder blade. Repeat for other shoulder.

11. Hold one of his arms in both your hands. Lift and push elbow in circula motion watching shoulder muscle. When you see it rippling you know you have the right movement. Repeat for other shoulder (about 10 times).

12. Slide back to top of buttocks. Ask friend to take in a deep breath and hold it. After 4-5 seconds have him breathe out and MOVE WITH HIS BREATH pushing all the way up back, arriving at shoulders as his breath finishes. REPEAT TWICE. (MUCH pressure).

13. Knead Shoulder - neck area.

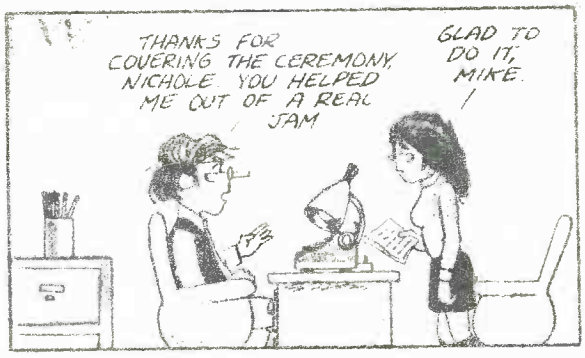
14. Stand, straddling recipient. Hold his shoulders firmly. Lift and drop them in rapid succession 40-100 times.

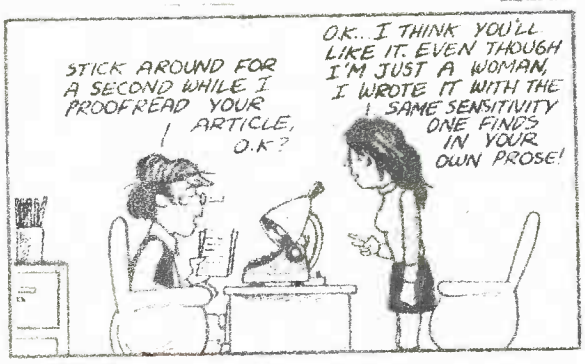
15. Experiment with strokes you think would be good. Do not hesitate between. Glide from one to the next. Try, lifting, rocking side-to-side presses, tapping, drumming. See if you can locate other tension-relieving pressure points like those in #6.

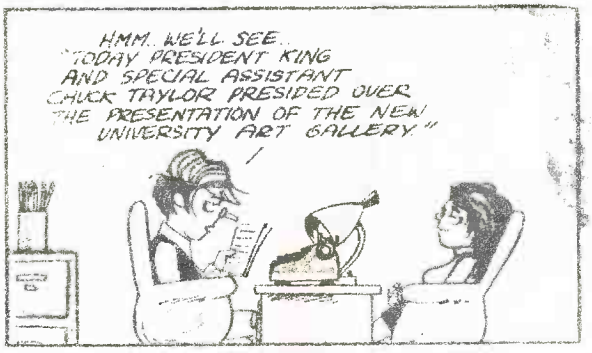
16. Draw lines along all limbs and up spine meeting at neck. Called "connecting".

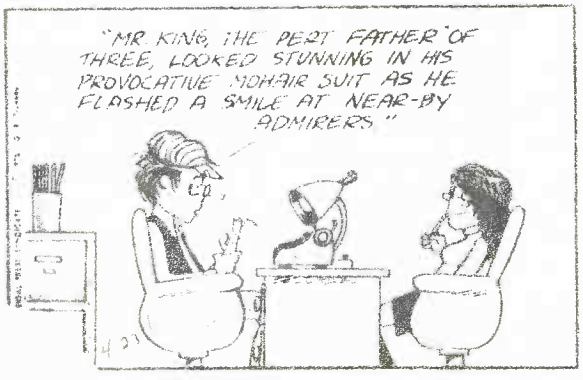
17. Scratch, tickle or slap his back as he wishes to stimulate skin.

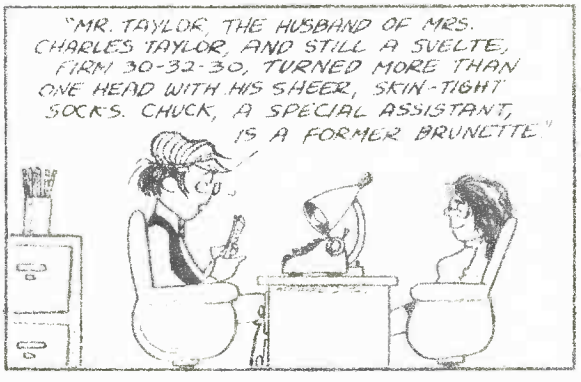
Comic Relief











Man is defined as a human being and woman is defined as female. Whenever she tries to behave as a human being she is accused of trying to emulate the male.

Simone de Beauvoir
The Second Sex

THE LAST (?) TABOO. . . . . .

We can talk about many controversial subjects today -- religion, sex, politics, rape, abortion, homosexuality -- some of which could be labelled as 'taboo.' A real 'biggy taboo' we tend to still avoid discussing is a dirty old 5-letter word: d e a t h.

Let's take that dirty old 5-letter word out of the closet and deal with it for what it really is -- a part of living.

Many people say it's 'depressing.' I say it's sad, but not depressing -- sad that a loved one is no longer among us; sad that someone in the prime of life has died of an incurable disease, or has been killed in an accident. There is, however, an off-shoot of death that can be depressing and that is when a bereaved, shock-stricken family spends money it doesn't have on an expensive funeral in order to please or influence rich relatives (who seldom offer to help out with the payments), or the neighbors, the boss, or whoever and, consequently goes into debt for months or even years. It's also depressing that when there is money available to pay for an elaborate casket (which means an expensive funeral) that the money couldn't have been spent, instead, on medical research, or an educational fund, or world relief -- if there's money to be spent, spend it on a living cause.

You might wonder "Why are you including this subject in The Northern Woman?" -- statistics indicate that there is a higher and earlier death rate among men which means that wives often outlive their husbands and are, therefore, faced with difficult decisions of great urgency at a time when mental and physical powers are at a low ebb. Women should be aware of ways to avoid spending life-time savings, or going into debt, prior to being faced with having to make what may well be the most expensive purchase in a life-time: that of a funeral.

In addition to feelings of grief and shock at the time of a death, there is also usually a feeling of guilt. Those three powerfully-combined feelings can persuade the most level-headed person to weaken, to even tell the funeral director "I just can't cope with all the details - you go ahead and do whatever you think is best..." then, when the statement arrives in the mail a week or two later, she suddenly realizes that the funeral she hazily authorized cost much more than she thought it would and will put her in debt.

There are people in Thunder Bay and in other Canadian and American cities who are ready to face death in a realistic and practical way; many of them are members of a memorial society - a voluntary group of people who have joined together to obtain dignity, simplicity and economy in funeral arrangements through advance planning. They not only encourage people to plan simple arrangements but also encourage them to direct funds to worthy, life-giving causes. They even encourage the bequeathal of eye corneas so that the blind may see, as well as lifesaving organs such as kidneys. You don't have to be associated with a memorial society in order to be realistic and practical about death, but it helps. (If you are interested in obtaining memorial society literature, either write to Box 501, Stn. F, Thunder Bay, or 'phone 683-3051).

Ernest Morgan, author of "A Manual of Death Education & Simple Burial" (Celo Press), writes: "About accepting death -- we commonly act as if we, and those we love, were going to live forever. But we are wrong, for all must die--nor can we know when this will happen..... The subject of death has long been taboo in our culture. This is unfortunate, for death is a normal and necessary part of life. Until we learn to face it honestly and accept it, we are not living at our best." and "....if we are to live with patience and gentleness and love, let us be about it today, for life is short."

Amen.

Lucy Tett

QUESTION

Darlene

When you come to love
someone
Does it mean you love
those less whom you
already love
Or do you come to love
more & more & more (?)

estelle freedlander

ELECTRO CONVULSIVE SHOCK

Electro-shock is a type of convulsive therapy used in our mental hospitals today. Convulsive therapy merely means giving a person an artificial convulsion. Electro-convulsive shock means exactly what it sounds like — a convulsion brought about by passing an electric shock through a person.

Shock was discovered as many other 'therapies' were discovered, as a treatment of the symptom and not the entire problem.

The groundwork for electro-convulsive shock was laid by a Budapest psychiatrist in 1935 by the name of Von Meduna. His research on 'schizophrenic' people (people who are out of touch with reality ... and a label which many psychiatrists apply at random) brought him to the following conclusion:

Convulsions temporarily eliminate 'socially unacceptable behaviour'. He chose the drug 'metrazol' as a means of inducing a convulsion. The convulsions were so extreme that the result was the death (murder) of many people. The term 'murder' is used here because the individuals who died as a result, where unknowing and helpless victims of 'scientific research'.

A few years later, in 1938, two Italian psychiatrists took up the cause. They developed a method of creating convulsions through the use of electro-shock. The complication this time was, again, extreme convulsions resulting in severe physical injuries and in some cases, death.

A paralytic drug called 'curare' was then introduced by A.E. Bennett as a means of preventing physical injuries by paralyzing the patients muscles. Curare further paralyzed the lungs and heart and, as a result, many people died. Later less traumatic muscle relaxants were introduced and, once the bumps were smoothed out, electro-convulsive shock became very popular. The reason for it's popularity was economy. It was quick, efficient and less staff were required. Further, it was much easier for the staff to 'control' quiet and obedient 'patients'.

Presently, shock is a popular form of 'treatment' in Thunder Bay Psychiatric wards. As Thunder Bay is the regional hospital, all of Northwestern Ontario's electro-convulsive shocks are administered here.

Very little is known about the long term effects of shock treatment, yet the medical profession continues to experiment with innocent people. One study on the effects of electro-convulsive shock reports:

1. As a result of shock one experiences confusion and memory gaps (loss of short term memory).
2. There is a decrease in one's learning ability after repeated shock.
3. There is a gradual lowering of one's level of recovery as the number of shocks increases, i.e. the memory takes longer to return.

The fact is that electro-convulsive shock is used because it works it temporarily eliminates the 'bad' behavior (symptom) and, when the 'bad' behavior returns...you are shocked again. The cause of the 'bad' behavior is most often ignored. It is ignored because a basic principle which underlies most 'therapy' is that of dealing with the individual and the individual's problems as they are manifested in a void, while ignoring or denying social/cultural and economic injustices which exist for the majority of the population.

Canadian psychiatric wards are usually filled with poor people, working people and women. Such individuals have been labelled 'mentally ill' by the medical and legal experts on madness — the psychiatrists and judges. The experts have spent many years compiling a list of labels describing different 'types' of mental illness. The most common are 'schizophrenic', 'psychotic', 'alcoholic', 'psychopath' and 'neurotic'. Once the individual has been catagorized she/he is locked up, 'treated' and then processed. The treatment too often is electro-convulsive shock.

There are therapists who strongly agree that electro-convulsive shock should be banned entirely as they view its use as inhumane and violent. The more conservative therapists agree in theory that shock should be used only in extreme cases where every other method of treatment has been tried and failed. However, in actual practice, shock is often used as the only form of 'treatment' without having attempted to explore other methods. Further, shock is used as a form of punishment. If the patient does not behave in a manner that is satisfactory to the staff, he/she is threatened with more treatment — shock. Finally, after a series of shock, the follow-up care is often minimal or non-existant.

Shock is given to an individual at the discretion of the doctor — not at the discretion of the person who is about to receive it, especially if that person has been involuntarily committed. There are two types of people in the Thunder Bay Psychiatric wards — voluntary 'incompetents' and involuntary 'incompetents'. Almost half (48%) of all mental patients admitted to Ontario's 17 mental hospitals were forcibly committed. The difference in the status of such individuals is the voluntary commits her/himself while the involuntary is committed by family or other institutions. The voluntary 'incompetents' still have the right to decide what happens to them, the involuntary have NO RIGHTS. In Ontario it only takes the signature of one doctor to have you committed. When a person refuses to accept the decisions of the doctors and staff as is her/his right, it is interpreted as a further sign of his/her 'illness'. Thus even the people who voluntarily commit themselves in fact have no rights. One Canadian Community Health worker states:

VULSIVE ...

If you're acting or feeling too depressed for your professional helpers they can shock the hell out of you with electric shock. For the next few weeks or month after this shock treatment, you'll be confused, 'disoriented' (sometimes not knowing where you are or what time it is) and forget a lot of things. If one or two shocks don't do the trick, they'll give you maybe 15, 20 or more shocks until you cheer up and snap out of whatever it is the staff imagine is bugging you and them about you. But don't worry; your memory will come back in about a month after they stop shocking you. Also a few blood vessels in your brain may have hemorrhaged or ruptured after 50-100 of these 'treatments', but you probably won't know it (until it's too late).

some

Procedures In Administering Shock

1. Food intake is either restricted or limited prior to shock
2. Hairpins and/or other metal objects are removed and long hair is braided
3. Dentures are removed
4. Tight clothing is removed
5. Person receiving shock is toileted and temperature, pulse and respiration are supposed to be checked
6. Drugs such as 'atropine' or 'dramamine' are given in order to prevent nausea and excessive salivation
7. Shock is usually given in a separate room so that other patients are not able to observe – especially those who are next in the line up
8. A special jelly called 'electrode jelly' is applied to the temples and then the person is placed in the desired position.
9. A mouth gag is inserted in the mouth so that the person does not bite or swallow her/his tongue.
10. The person assisting in the administration of the shock holds the mouth gag and then puts pressure on the patient's chin so that fracture or dislocation of the jaw will be averted.

SHOCK

After the shock is administered the following takes place:

1. Respiration is checked until normal breathing and color are reestablished (an ashen gray color indicates serious complications and should be reported immediately.)
2. Some people may become excited and/or combative if the nurse tries to control them...therefore assistance or restraints may be necessary
3. Since most people are confused and disoriented after shock... keep them in bed
4. An individual may also experience nausea, dizziness, blurring of vision and headache following shock, if so, give them some more drugs
5. An individual may be frightened at the loss of her/his memory but the staff stands ready to assure the person that it is only temporary.

(from a psychiatric nursing text, 1971)

call it

Why is electro-convulsive shock used?

There are many ways of looking at this final question. As has been pointed out, economically electro-convulsive shock is very useful. The majority of Canadian psychiatric hospitals are understaffed. Why? In Toronto in 1971, only 4% of the total Public Health Department budget was allocated to the mental Health Division. Since there are too few to handle the large number of patients, other methods of 'control' are necessary. It seems that the extreme use of drugs and shock have thus far provided a solution. Less staff are required to handle drugged or shocked patients, and in addition, less time is required in working with patients. Finally, symptoms are dealt with quickly with the use of shock, and as a result, hospital beds are emptied quickly. However, this solution must be questioned since, according to one article on Ontario psychiatric hospitals, 'In 1971, 67% was the rate of re-admission in the Toronto Queen St. hospital.'

Electro-convulsive shock is also very modern and follows the current school psychological thought, that of behavior modification. Behavior mod. (as it is called), appears to be a very simple philosophy. It says to reward good behavior and punish bad behavior. However, behavior mod. runs amuk because it must make gigantic decisions, like, what is 'good' and what is 'bad', and maybe worst of all, what is 'behavior'? The aspect of most concern is that people cannot be separated from the world they live in, much less their particular behavior.

For example, if a behavioral psychologist decides that a particualr behavior of mine, say drinking alcohol, is bad then he will try to punish my excessive drinking and reward me when I am not drinking. This of course, is dangerous because I may be drinking for significant reasons, like I am unable to find a decent job,

therapy

like my family is forced to live in a slum and my children are constantly hungry and in need of decent clothing etc. If the psychologist does not look beyond the symptom (drinking) he will identify me as ill and will try to eliminate my behavior most often ignoring the reasons for it.

Electro-convulsive shock is just one way of destroying people in our society. There are many others, yet we claim that people are important. Psychiatric 'hospitals', 'prisons', 'old folks homes', these are the reflecting mirrors of our culture. These are the mirrors we see ourselves in.

IN HIS MORNING PRAYER THE JEWISH MALE GIVES THE FOLLOWING THANKS; BLESSED ART THOU, O LORD OUR GOD, KING OF THE UNIVERSE, THAT I WAS NOT BORN A WOMAN.

OJIBWAY WARRIOR SOCIETY
OJIBWAY NATION, KENORA AREA

STATEMENT OF THE OJIBWAY WARRIOR SOCIETY

The following is a statement of the Ojibway Warrior Society giving a brief outline of the history, nature and role of the Warrior Society, as well as an outline of the present struggle of the Ojibway Warrior Society in Kenora, Ontario:

OJIBWAY WARRIOR SOCIETY

1. Since the origin of our communities, all Nations have had a Warrior Society.

2. The Warrior Society arises to protect and serve our communities in times of war and oppression. The Warriors come from amongst the hunters, trappers, workers, women and men, young and old.

The Warriors fought the invaders, the British troops and the French troops and the Spanish troops throughout North America. The Warriors have also fought the American and Canadian armies. The Warriors have fought against all attempts by foreign powers to destroy our communities and way of governing ourselves. The Warriors have also fought in the Second World War in the Canadian Army against the Nazis in Europe. The Warriors have fought in Wounded Knee (1973) and in Kenora and Cache Creek (1974). The Warrior Societies of all tribes and Nations have fought on all fronts for the liberation of mankind and for the basic right of every human being and every family and every nation against aggression and exploitation.

3. The Warrior Societies of all Nations and all Tribes honour our Governing bodies and Councils as well as the policies of the people.

4. If there is no war, our communities respond to the specific conditions and to the needs of the people. The Warrior Society participates in building the new society and works hard to build our Nations and our communities.

5. The Warrior Society is a tradition of all Nations, like that of the Medicine Society.

6. The Warrior Society learns from the Theory and Lessons of the Land and from the Great Law that everyone must be free and follow the revolutionary principles of the people.

7. The Warrior Society is part of the movement in the U.S.A. and in Canada to combat the policy that dictates and tries to destroy our government by the people and for the people. We seek the return of the right to govern ourselves. We seek the return of our land. We combat the wretched living conditions of our people. These wretched living conditions are the instrument of the oppressor to attempt to break the Sacred Circle which is the life of human being. The Warrior Society seeks justice and the return of the rights of our people.

The Ojibway Warrior Society is active in the Lake of the Woods Tribe of the Ojibway People. There has been prolonged oppression against our people that has degenerated critically throughout the centuries into an inhuman policy of bureaucratic and legal war that slowly but definitely is ending the lives of many Anishinabe People. The housing conditions are in a state of constant threat of fire. The shacks have to hold large families with no water or sewage and no electricity. And the twisted wicks are what light the experience of the young people at home.

Out of 85 people that yearly die violently in the Kenora area, approximately 15% die as a result of fire. 95% of Anishinabe People are unemployed. 4,000 are imprisoned each year in Kenora. The suicide rate is critical. The school drop-out rate is 75% of the enrollment in high school. This is the condition of our people.

Anishinabe Park was taken from the Anishinabe People by the Department of Indian Affairs and sold illegally to the City of Kenora in 1959. The Ojibway Warrior Society liberated the land which rightfully belongs to the Anishinabe People.

1975: International Women's Year

When the Northern Woman began, it dealt with basic emotion. Many of us began to discover, for the first time in our lives, that the frustrated feelings we had were not signs of insanity, but rather of having to deny ourselves the rights: to be us, to admit we had an ego, to try to be whatever we thought we had the ability and stamina to be, and to be accepted for our intelligence as well as our bodies.

The knowledge, understanding and acceptance that we really could be and do whatever we wanted was explosive. Sparks of new-found friendship and tremendous emotional support of one another flew in all directions, and ignited that almost-smothered desire for life in its fullest sense. That emotional support and acceptance that I found at first over-whelmed me, then fractured the direction my life had been going in. At last I was free to take control of my own life and to set my own priorities. The Northern Women's Conference in April, 1973 did that for many women, and out of that conference grew the Northern Women and The Northern Women's Centre, both of which supported and communicated with women as people.

For many of us it's been almost a year and a half since The Great Awakening has taken place. During that time, many women have found the direction they want their lives to go, and have made a lot of progress. Their consciousnesses have been raised, and they have graduated from lying on their backs to the walking and running stage of development. They're now taking on the broader social issues (rape, abortion, conditions in other lands, etc.) which must be dealt with. But what about the women who are not yet aware of why they are in the situations they're in?

The Northern Woman is beginning to reach above the heads of women who are not yet out of the babyhood stages of development.

I'm not advocation a regression of the part of the Northern Woman, or even a slower rate of growth. I do, however, suggest caution. I don't want The Northern Woman to become so intellectualized that only the aware woman can relate to it. We must not forget that we have many sisters who are still floundering in situations they don't quite understand. Women are still groping for someone, somewhere, who can look her in the eye and say honestly, without reproach or impatience, "I understand. I care. I'll Help."

I'd like to suggest that at least one page per issue of The Northern Woman be used as an "open" consciousness-raising forum. There are many women who are still too insecure (or have other reasons) to participate in a "closed" C-R session. I would not object to a writer remaining anonymous if she so desired. It is terrifying to speak and be identified at first. As she shares her experiences and feeling, she'll become more sure of herself and wouldn't remain anonymous forever (haven't we been anonymous long enough?).

Also, suggestions on how to act and react to male-chauvinist acts and statements would be helpful. Example: Are YOU a Women's Libber? When I'm up against a question like that, I usually ask the speaker to explain the term, and then I base my reply on his/her definition.

Sincerely,

EDITORS REPLY:

Your letter clearly expresses a concern many of us have been discussing lately. Are we relating to women who still cling to the obsolete social stereotype of helpless protected female. What can we do about it? Everyone agrees we need another conference, however as this is not possible, this year at least, we will start with your good suggestion of an "open" consciousness-raising page.

We do have a problem though. We are getting very little feedback, in writing, about the contents of the newsletter, so have nothing much with which to gauge whether we are in fact too "intellectual" for some readers. Are they even reading it? We really are in the toddler stage of development compared to some of the analytical writings of other women's papers. cont.

Editors Reply ... cont.

We do feel the newsletter is bringing issues to light in hopes of making more women aware of some of the problems women are having, because of their sex.

You are correct we cannot slow our rate of growth. We "can't slow the train" but we can reach out more effectively so that women can catch hold and get on board if they wish to.

We hope, Deanna, you will share with us more specifically how you dealt with the obstacles and put-downs you encountered in order to "take control of your own life".

NOTICES

--Bart and Bonnie are anxious to get the children's room in operation. All manner of equipment and supplies are desperately needed (a list is posted in the centre) If you have anything to donate please bring it to the centre or phone 623-3107 for pickup.

--Sita is moving to Macdiarmid (near Nipigon), this month. She has a new job there and a beautiful house to live in. She also has a three month old infant to be taken care of. She would like to find someone who would be willing to move with her in the role of helper -- to look after the infant and become part of the family. If you know of anyone who might be interested in assuming this position or are interested yourself, write to her at this address; Sita Wiesenthal, Macdiarmid, Ont. or phone Brian at 345-5767.

--If you would like to work part-time and are a school psychologist or behaviour consultant contact Karen Rhodes 622-7541.

--Next month's issue will be dedicated to WORKING WOMEN and any articles, letters or personal experiences would be appreciated. Please submit any material to Box 314 Thunder Bay "F" by Nov. 1st, or drop off at the centre.

-- Watch for the "Northern Women's Centre" grand opening, near the end of October.

--The funding we received for this newsletter is nearly all gone. We would like to continue (publishing?) with money received from subscriptions. Many of you have been receiving the newsletter free of charge. We think we are worthy of a $2.00 yearly subscription. Hope you do too. SUBSCRIBE NOW. Share your newsletter with your friends. Perhaps they too would like to SUBSCRIBE.

THUNDERBOLT

To the STEREO SHACK, Victoria Ave. who have refused to remove an obnoxious advertisement from their window... depicting a woman's breasts as stereo speakers. Breasts have one main function and being wired for sound is not one!!!!

THUNDERCLAP

To Helen Halet who was recently hired as Women's Director for the Thunder Bay YM/YWCA. Helen is also a very hard worker for The Northern Women's Centre.

A MOUSE IN WOMEN'S CENTRE ! ! ! Yes, it's true (a female one, of course). I don't know how many are in the nest but I'm aware of one so far and so shall tell you about her only.

She sat there, looking around at the women arranged in a circle. Sometimes she'd busy herself rustling papers, or scurrying out to the kitchen area, then back to the circle -- watching, listening, feeling uncomfortable about what she was seeing and hearing but too timid to do anything about it.

That mouse is ME -- and I have a very icky feeling about myself for not voicing my thoughts and feelings at last night's Women's Centre Meeting at which Ruth Cunningham, Director of Women's Programs, Confederation College, was unfairly (in my mousey opinion anyway) criticized for the way in which the recent 'Family Property Law' seminar was run. The criticism came from one who, to the best of my knowledge, hasn't attended one of our Centre's meetings before. Some of her criticisms were that the resource persons designated as group leaders were not adequately knowledgeable of our laws; that secretarial students from the College's Legal Secretary Division were more or less coerced into taking notes (one student per group) and, also, were allegedly told by some unknown person "It would be nice if you would wear a dress."

I appreciated having a non law-affiliated person as the resource leader in the group I was in -- though she couldn't answer <u>all</u> the questions put to her (many of which were off the subject we were supposed to be dealing with), she had done extensive reading and preparation which was more than the rest of us had done although we, too, were aware of the seminar months in advance. If a lawyer, for instance, had been our resource leader, I suspect most of us in the group would have felt inadequate and unwilling to participate. It emphasized to me the main overall concensus of the plenary session: that more education is vitally needed in the areas of matrimonial, family and property law, commencing in the elementary grades.

Regarding the note-taking roles of the College's secretarial students: these students were not totally obliged to be note-takers (nor, I am sure, were they obliged to enrol' in the secretarial course in the first place). Perhaps they saw this as an opportunity to practice their chosen field of work and, at the same time, as an opportunity to learn about family and property law. I think it was a beneficial and sensible arrangement for all concerned - the students, the invited participants, and the College.

Cont. ....