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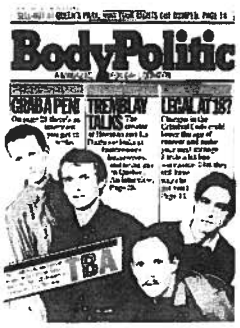

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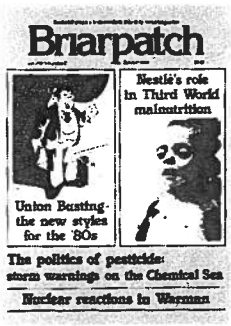

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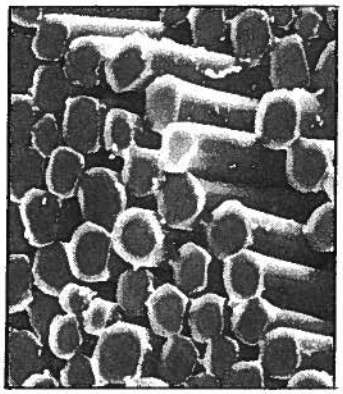
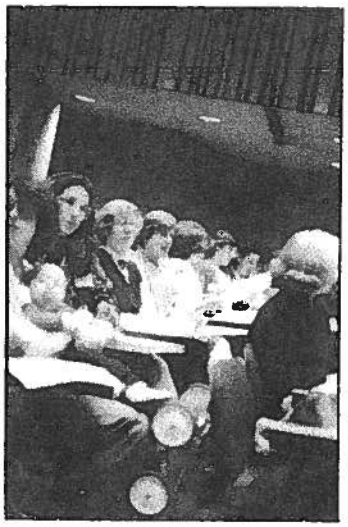


Features

Our Readers Write



News

Etcetera

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Collective Notes

Getting Rid of the Crab in this issue outlines dangers of the Dalkon Shield intrauterine device and discusses evidence being gathered for an international class action suit filed in Boston against its manufacturer, A.H. Robins Company.

On April 20th Women Healthsharing decided to join the class action suit. As we go to press, we are excited to announce that the Vancouver Women's Health Collective has decided to take action along side us.

The time is long overdue to extend definitions of corporate responsibilities and obligations to women. We are well aware that it would require an entire economic restructuring of industry for manufacturers of medical devices to *care* about women. Even so, this kind of court action can be one step towards a legal and economic framework which holds corporations accountable for the hidden, and often-times dangerous, costs of their profits.

We believe Canadian women should be represented in the case. Canada may have had the highest per capita Dalkon Shield usage of any country. Canadian women are still wearing Dalkon Shields — anywhere from 1,000 to 12,000 of us.

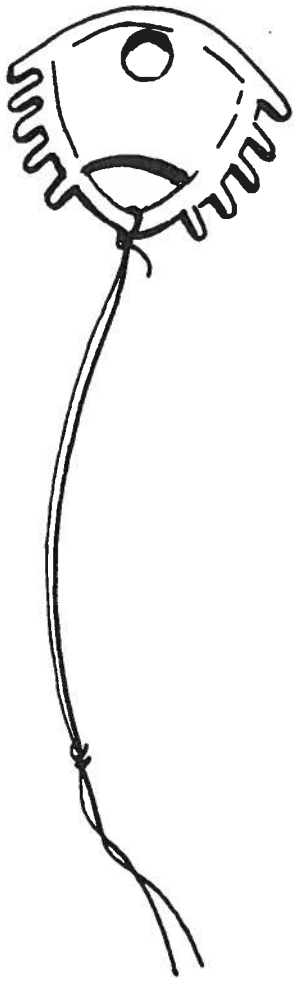
By joining the suit we can assist the U.S. courts to obtain data from health insurance plan records which will greatly strengthen the case. The Dalkon Shield tragedy is not a U.S. fight, not a Canadian fight, but an international fight that we can join.

But, why Women Healthsharing? Canadian organizations analogous to the U.S. National Women's Health Network or the Dalkon Shield Association of England (a membership organization of former Dalkon Shield users), both of whom are plaintiffs in the class action, would be ideal participants. Unfortunately no Canadian equivalents exist. We could hardly take on the mammoth task of grassroots organizing to form a users group (and still produce *Healthsharing*!) and a national women's health network is only in the incubation stages (See *Regional Reports*). So, we took the plunge.

At the same time, we challenge provincial and territorial governments to take legal action against Robins. Health insurance dollars spent because of Robins' errors and irresponsibility could be regained. It is time for our governments to become advocates for women. By putting the heavy guns of government on the side of individuals, these governments would do much to reverse an image short on credibility. It is up to us to force our governments to become watchdogs and then to keep them watching.

The U.S. courts have the power to hold Robins responsible for the product it produced and sold. Hopefully, the courts will, in a precedent setting verdict, force Robins to take recall action internationally. If so, other corporations will feel the waves of that action as pressure to appropriately test products, for safety *and* effectiveness, *prior* to selling them.

Women who today cannot feel safe about available contraceptives can take small satisfaction in the fact that at least one company is not getting away scot free. And we can take even greater satisfaction that some women, whose Dalkon Shields are removed, are saved from the trauma and death which has, at times, accompanied this device.



Dalkon Shield Intrauterine Device
from The Monthly 3:2

Madeline Boscoe
Betty Burcher
Connie Clement
Diana Majury
Lisa McCaskell
Jennifer Penney
Susan Wortman
Sharon Zigelstein

APPRECIATIONS

- **Our appreciation to Employment Development Branch for a grant enabling us to hire two wonderful staff people. We welcome Bev Rodrigue to Women Healthsharing and are glad to finally be paying Susan Wortman for all her work.**
- **An appreciation to ourselves for not having to apologize to Pat Foote Jones!**

Newsfronts

Safety Tests Faked on Pesticides

The federal government is allowing seventy-nine pesticides to be used across Canada despite evidence that the safety testing of some or all of the pesticides was faked.

The testing of the suspect chemicals was carried out by Industrial Biotest Laboratories (IBT), one of the foremost independent American chemical testing companies. In 1977 U.S. investigators discovered that IBT had faked some tests, run others improperly, and then reported that chemicals had passed their safety tests. One glaring example of falsification included more rats alive at the end of a test than at the beginning. After the scandal broke the company shredded some records.

Both the Canadian and American governments have accepted IBT recommendations and are leaving the suspect chemicals on the market until they are proven safe. Dr. Trevor Hancock, a Toronto public health official, says the Canadian government decision creates a "new Canadian principle of erring on the side of danger."

The chemicals in question are pesticides, herbicides and fungicides used by farmers, foresters, gardeners and public health officials for everything from killing weeds and insects to sterilizing drinking water and swimming pools. These chemicals have not yet been tested for their tendency to cause birth defects and cancer.

The federal government has withheld results of the tests from the public and provincial governments because legal advisors regard the information as the property of the corporations paying for the tests. IBT has indicated they would sue the government if the information is released.

Meanwhile we are in the dark while the federal government sifts through the unshredded evidence deciding which tests are valid and which ones need to be repeated.

Caffeinism — A New Psychiatric Diagnosis?

Does caffeine make the psychiatric wards go 'round? A pharmacist and psychiatrist with the Clarke Institute of Psychiatry think so.

In an editorial in the *Canadian Medical Association Journal*, Bezchlibnyk and Jeffries cite the effects of caffeine shown in a U.S. study of psychiatric patients who were switched to decaffeinated coffee without the knowledge of staff or themselves. During this three week period, psychologic testing showed a substantial decrease in suspiciousness, anxiety and irritability. One week after regular coffee was resubstituted, the patients had become more psychotic, slowed in their mental processes and reduced in social competence.

Depending on the caffeine content, as little as three to four cups of coffee a day produce observable side effects on the nervous system — nervousness, irritability, headache, rapid breathing, tremulousness and insomnia — signs of "caffeinism".

To psychiatrists, caffeinism or caffeine withdrawal may be indistinguishable from anxiety neurosis. Heavy drinkers of coffee score higher on tests for anxiety, are more likely to have a disorder diagnosed as psychotic and have higher depression scores.

Bezchlibnyk and Jeffries charge hospitals with the responsibility for reducing caffeine intake of patients. Hospitals presently offer tea and coffee at least six times a day (at meals, and during morning, afternoon and evening breaks) so that a patient can drink 12 cups a day, including refills, provided free of charge by the hospitals.

They also argue that hospitals should remove all drugs containing therapeutically useless amounts of caffeine. The caffeine antagonizes the other ingredients or, at best, adds nothing to the treatment. Also, hospital drug information groups should discuss caffeine intake as an issue in patient treatment.

"The widespread adoption of such changes will not come easily. In our experience it is the medical and professional staffs who oppose changes in caffeine consumption habits, not the patients." Bezchlibnyk and Jeffries call on physicians who understand that caffeinism is a significant medical problem to "put pressure on hospital administrators to reduce the availability of caffeine-containing drinks and drugs."

Radiation Update

A few of the depressing highlights from radiation stories of the last three months:

* Someone forgot to close a valve at Japan's Tsuruga nuclear power plant this March and released radioactive water into a nearby street. Over fifty people were directly exposed to the radioactive waste, including large numbers of temporary workers who were called in to clean up without being informed of the hazard or supplied with protective equipment.

The problems at the power plant were revealed when local authorities discovered large amounts of Cobalt-60 and other man-made radioactive substances in a bay near the plant leading into the Sea of Japan. It is not known how many people have eaten contaminated fish from the bay. Officials discovered that manholes through which non-radioactive waste water ordinarily drained were actually inside the radioactive waste disposal facility. The waste could have seeped from a storage tank into a manhole and then into the drainage system leading to the bay.

A researcher from the private Research for Energy Economics in Japan stated, "the safeguards built into these plants theoretically make accidents impossible."

* Doctors have been warned to check small lumps in the thyroid gland for cancer, particularly in people who had radiation treatments to the head or neck 20 or more years ago. About 50 years ago, doctors used radiation to treat infants believed to have an enlarged thymus gland (located high in the chest) or children with enlarged tonsils or adenoids. Until about 10 years ago, radiotherapy was considered good medical practice for acne.

* Old yellow and orange china dishes that Canadians have been using for years, may be radioactive. Over 30 Ottawa residents recently took their crockery into the Atomic Energy Control Board's downtown office and set Geiger counters there clicking. Until about twenty years ago, uranium oxide was used as a pigment in some yellow, orange, red and pink glazes. The mineral can leach into food and affect the kidneys.

* For over six months three levels of government have dithered about where to move radioactive soil found in a Scarborough, Ontario subdivision. Nobody wants to store the tons of soil involved. Meantime, the residents continue to be irradiated by particles in their backyards. The houses were built on the site of a 10-acre farm which had been used in the mid-1940's for waste radium disposal. Two journalism students located the waste and broke the story last November.

* The American Association for the Advancement of Science recently recommended that female flight attendants should not fly during pregnancy because

of their exposure to several different kinds of radiation. Fetuses are particularly radiation sensitive and are at risk of exposure to cosmic rays, solar flares, radioactive air freight and x-ray screening equipment in air terminals. Ozone and radionuclides released by nuclear weapons testing and nuclear power plants also add to the hazard. Supersonic transport jet crew members may be exposed to 10 times the level of natural background radiation normally encountered in a year. No long-term studies have been done on children carried by air hostesses employed during pregnancy.

* And here's to more research funded by our tax dollars! The Department of National Defence has embarked on research to stop nausea caused by exposure to lethal doses of radiation. Why? So soldiers who have been irradiated during a nuclear attack can control vomiting long enough to retaliate. The military will expose dogs to massive doses of radiation to simulate the sickness experienced in a nuclear war.

VDT News

The rash of new hazard concerns about video display terminals is resulting in union actions aimed at protecting (mostly women) employees who use the equipment.

The Ontario Public Service Employees' Union has supported Darlene Weiss in her claim for compensation for cataracts (clouding of the lens of the eye) that she believes resulted from VDT work. The Ontario Workmen's Compensation Board rejected the Thunder Bay woman's claim last month, but the union plans to appeal the decision. The claim has supporting evidence from Milton Zaret, a New York ophthamologist who reported that Weiss "has radiant energy cataracts caused by exposure to radiant energy from VDT's."

On another front, the Communication Workers of Canada have wrested an agreement out of Bell Canada to transfer pregnant long-distance operators from their VDT's to avoid any possible effects of radiation on unborn children from the television-style screens. The transfers will be made with no reduction in pay.

A Question of Spermicides and Birth Defects

A retrospective study reported in the April 3rd *Journal of the American Medical Association* indicates that birth defects may result from spermicide use. Using computer files from a large group health plan, the researchers found birth defects approximately twice as often among offspring of women prescribed spermicides than in babies of women using other contraception or no contraception. Pregnancies in women prescribed spermicides ended in spontaneous abortion requiring hospitalization 1.8 times more often than in women not using spermicides.

By using computerized records the study avoided personal recall bias and reduced selection bias. At the same time, the research has several faults. Women who used spermicide prior to contraception, at the time of conception and following conception could not be distinguished. In fact, researchers had no way to know if women even used spermicide because they used prescription records only.

Because spontaneous abortion records were retrievable for hospitalizations only, a bias might have developed by excluding early spontaneous abortions requiring only outpatient care. Further, women choosing elective abortions were excluded.

Although far from conclusive, the study does provide cause for worry about unknown effects of spermicides. The researchers speculate that the effects of the spermicide might result from damage to the sperm, ovum or zygote. If a sperm damaged by spermicide fertilizes an egg abnormalities could easily result. Alternatively, the spermicide could enter a woman's blood stream through the membrane of the vaginal wall. In this way the drug could directly damage an unfertilized egg or, if a woman continued using spermicides before realizing she was pregnant, the developing zygote.

The spermicide was correlated with several defects rather than one clear cut type of abnormality, leading the researchers to consider their results as tentative. Among women thought to have used spermicides there was an excess of infants with Down's syndrome, brain tumours, limb deformations and urethra deformities in male babies.

The spermicide most often prescribed in the study (80%) contained octoxynol as the active ingredient. The other 20 per cent contained nonoxynol 9. In Canada nearly all spermicides contain nonoxynol 9; none contain octoxynol. It is difficult to know, therefore, how applicable this study is to Canada.

Urea Formaldehyde — A Dangerous Way to Save Energy

Last month the federal government banned an insulating material that releases chemicals into the air which cause respiratory problems in humans and cancer in laboratory animals. Urea formaldehyde foam insulation has been installed in an estimated 80,000 Canadian homes in the last few years.

The insulation can break down, particularly in hot, wet weather, to release formaldehyde. The chemical is extremely irritating to the eyes, nose and throat, and can produce headache, cough and dizziness. In high enough concentrations it may instigate pneumonia. Formaldehyde can also react with hydrochloric acid, present in human perspiration and urine, to form the potent cancer-causing chemical bis (chloromethyl) ether.

The chemical breakdown of urea formaldehyde insulation is less likely to occur where the substance has been properly installed only between the studs of an outside wall of a wood-frame house and adequately dried. Other uses may release formaldehyde in concentrations high enough to be smelled by the occupants.

Local Boards of Health have been meeting about this problem throughout Canada. The Toronto health department has established a free formaldehyde testing program in foam insulated homes in that city.

Ironically, many of the urea formaldehyde installations were made with aid from the Canadian Home Insulation Program. The federal government has made no indication that it intends to pay for or supervise the removal of the dangerous material from Canadian homes.

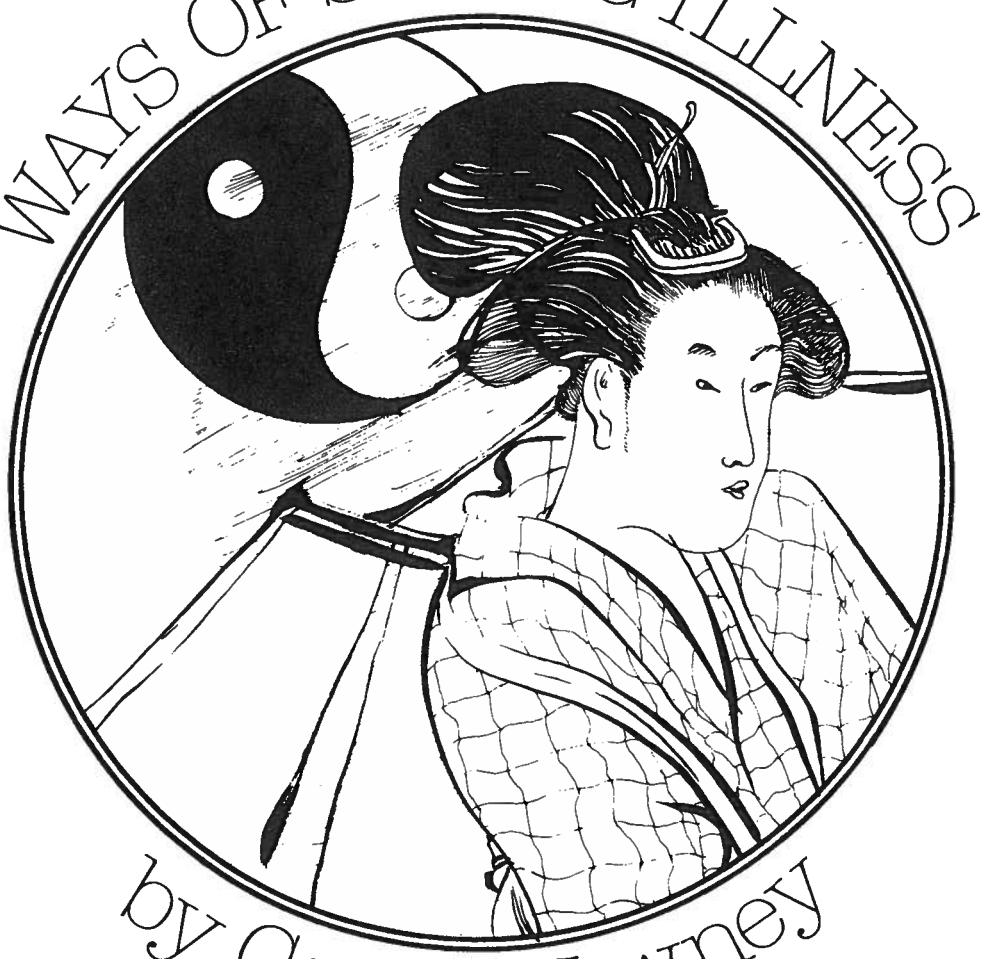
Abortion and Future Birth Risks

A team of investigators who evaluated 12 different studies of the effects of repeated abortions on subsequent pregnancies has concluded that problems appear to be small.

Dr. Christopher Tietze of the U.S. Center for Disease Control told the *Medical Post*, "my own view is it has not been established repeat induced abortions cause adverse effects in future childbearing. Some investigators have found them, some have not. In any event, they appear to be small. . . . This is important in the United States and Canada because a large proportion of abortions are obtained by young, unmarried women who have not yet given birth."

The studies which did report low birth weight as an adverse effect of previous abortions seem to be associated with the classical dilation and curettage (D & C) method of abortion. Vacuum aspiration or suction curettage, which is widely used in Canada and the U.S., is a faster procedure, easier to do and has a lower incidence of complications. It is hypothesized that the vacuum method does less injury to the cervix and lining of the uterus than the sharp curette used with a D & C.

WAYS OF SEEING ILLNESS



by Carole Yawney

This article is the second of a four-part series on Alternatives to Allopathy. The first article described the importance of Western medicine's tie to science and how it affects our thinking about alternatives. This piece discusses the influences of culture on how we define, and go about achieving health and healing. The following articles will examine the position of women as healers and patients in the allopathic framework, and the political economy of health in our present system.

What is health and well-being? What is illness and disease? How do we know when we are sick and what do we do about it? We learn the answers to these questions by growing up in a particular society. Our notions of health and illness are determined by the culture of which we are a part. Healing is embedded in culture.

While everyone experiences biological change as part of living, we learn the meaning of these changes from others in our culture. Most of this learning is informal. It includes exposure to sick people and how they are treated.

We learn what kinds of symptoms are regarded as minor, requiring perhaps no more than self-treatment with home remedies or recourse to a lay consultant. We come to recognize conditions that are considered more serious, for which we are encouraged to seek professional medical help. We catch on to what kind of behaviour is appropriate for the sick role and we are rewarded for it.

The extent to which a society possesses a medical culture varies, depending upon people's beliefs about the causes of illness and their anxiety about it.

The traditional Navaho, for example, had a very elaborate medical culture. E. Ackerknecht, in *Medicine and Ethnology* describes how they believed that illness was a punishment for wrong living and that health could best be achieved through social and religious harmony. The majority of their religious ceremonies, which occupied a central focus in their life, were devoted to the prevention and control of illness.

In contrast, the Cheyenne believed that illness could not be avoided since it was arbitrarily caused by invisible arrows shot by capricious spirits. Their medical culture was very simple and mostly informal.

In the first article in this series (R. Love, "The Power and Science of Medicine", Winter 1981) we saw how allopathy built upon scientific discoveries of the last two centuries and developed an approach to illness which has come to dominate the healing arts.

As we know it today, medical science is a specific response to the kinds of health problems which were literally plaguing society. The germ theory of disease, the discovery that gives much of allopathy its credibility, formed the basis of medical research in western cultures when widespread illnesses such as smallpox, cholera and tuberculosis constituted major health problems. However, once such illnesses could be successfully treated with vaccines or antibodies, little further attention was given to the social and environmental management of these conditions.

Societies change, disease profiles change, and so too should medical systems. The current orientation of allopathy is towards institutional or hospital-based medicine, relying as it does upon drugs, surgery and technology to intervene in acute-episode illnesses. But what happens when this kind of approach is adopted in cases which do not warrant such heroic measures?

drawings: Pat Foote-Jones

Many people experience numerous chronic conditions which allopathy only succeeds in managing or masking — if indeed it does not complicate the picture with iatrogenic side-effects. (Iatrogenesis refers to health problems a patient develops as a result of the method of treatment.) And finally, what about the problems which fall entirely outside of allopathy's treatment capacity?

The change of the disease profile in western society from contagious to chronic requires us to consider and search for different causes of illness. Our belief about the causes of illness determine what we do about an illness. If we think spirit possession is the problem, we hire an exorcist. In our own society, recognition of stress and environmental factors as causes of illness, requires that we take more preventive measures. As we redefine what constitutes illness, we change our approach to therapy.

We take for granted that medical science, or allopathy, has developed universal or absolute categories for illness. It can only do this within the limitations of its own medical model and by frequently violating local cultural understandings. Medical science can *describe* illness clinically without recourse to cultural factors, but it cannot *explain* or *treat* all illnesses successfully without taking into consideration non-biological aspects.

A case in point is the incidence of *kuru,* a culture-specific illness found among the Fore people in New Guinea. Kuru is characterized by progressive deterioration of the nervous system over a period of several months, accompanied by trembling, loss of control of movement and extensive brain damage. All kinds of explanations were offered — malnutrition, poisoning, heredity — but each lead proved unprofitable. The answer was contingent upon understanding cultural variables.

Among the Fore it was the custom for close relatives of a dead person to show their respect by consuming the corpse. Women and children were the main participants, and the brain of the deceased was especially prized. This became important as statistics began to indicate that children and women were the greatest victims. Dr. Carleton Gajdusek experimentally tested and proved a theory that kuru was caused by a virus which lodges in the brain of its victim and was transmitted through cannibalism. Without developing a biocultural understanding of this health problem, its cause may have gone undetected.

All definitions of health and illness imply some notion of deviation from a culturally accepted norm. Sometimes we feel much better than we usually do, and identify this as a super-healthy state. At other times we feel less healthy than we normally do. In our society though, we tend to place more emphasis on avoiding the negatively defined state, as opposed to analyzing and pursuing the circumstances that help make us feel really good. Like the Cheyenne belief in the cause of illness, we seem to think that feeling super-healthy is a result of arbitrary energies. But in actual fact, if our society were more health-oriented than illness-oriented, we would be able to have more control over the factors that contribute to our sense of well-being, and actively seek to cultivate them.

While it may be possible to measure in a scientifically objective way an abnormal or pathological condition, what really counts is whether the people involved experience the biological change in question as illness, and seek therapy accordingly. For this reason a distinction is often made between disease and illness. Disease refers to a pathological state of the human organism which can be described scientifically. Illness refers to the recognition by the individual in question that s/he is sick. While there is often no doubt in most societies when someone is seriously ill, there exists a wide range of conditions which are defined differently cross-culturally.

One factor which is important in this regard is the prevalence of the condition in the population. Within certain cultural contexts, many diseases are not regarded as illnesses because their incidence is so widespread that they are regarded as part of the collective fate. In some parts of the world malaria and yaws which are endemic to certain regions are not considered illnesses. Symptoms associated with lung disease among miners are often tolerated in a matter of fact manner and ignored.

For many of us the common cold is regarded at best as a nuisance. The very language we use to describe it — *common* — implies that the appropriate cultural response is to accept it stoically. But why should we accept it? What is the relationship between the air we breathe and our almost continuous experience of upper respiratory irritation? René Dubos argues in *Man Adapting* that if we thought the air were as polluted as untreated sewer water, we would no sooner breathe the one as drink the other. Dubos suggests by analogy that this is almost the situation in which we find ourselves. According to the above definitions, our plight is one of disease, but not illness.

Another approach to the so-called common cold is to regard it as a flushing out of toxins and accumulated wastes. But we need to ask what it is about our society that makes it such a frequent episode. Are we really exposed to that many sources of contamination that our normal systems of elimination are incapable of handling these problems?

If we re-defined our approach to the common cold, and treated it less as the result of "catching a bug" and more due to environmental and personal factors, then our health-seeking behaviour would be different. Demanding more control over environmental problems and finding new ways (through diet and nutrition) to assist our body in handling toxins, are two possible routes.

In *Man Adapting* René Dubos makes the point that the approach which treats disease as an external agent (i.e. a germ) capable of getting into the body and damaging it is not much different from the beliefs of prescientific medicine. Prior to the development of the germ theory, "such explanations took the form of demonological concepts, disease being regarded as resulting from the malevolent influence of taboo violation, sorcery, revengeful ghosts, etc."

In addition to the prevalence of a condition, the cultural values of a society affect its definition as either an illness or a disease. The cultural symbolism of the body itself often tells us whether to ignore or treat symptoms. What parts of the body are considered vital to the individual's functioning within her culture? The French for example are obsessively concerned about their livers, something quite appropriate for a wine-drinking culture. In the summer in France after the 14th of July, people take to the countryside to give their livers a rest.

In North America our concern is with heart and brain malfunctioning to the extent that we often ignore or tolerate for long periods of time other symptoms, such as liver or gall bladder disturbances. The prevalence of low fat, low cholesterol cookbooks, however, attests to our fear of heart disease.

Cultural beliefs about the nature of the body affect the kind of therapy sought after a health problem has been identified. Evidence exists that many non-western peoples gained extensive knowledge of human anatomy due to their involvement in hunting, cannibalism, and sacrifices. Some even practised autopsy. However, frequently beliefs about mutilation, about cutting the skin, stood in the way of applying this knowledge practically in the form of surgery.

Pain is generally considered symptomatic of a health problem in all societies. However, several studies show that culture plays a role in controlling the expression of pain and influences the degree to which pain is subjectively experienced. In her comparative study, *Birth in Four Cultures,* Bridgette Jordan argues that while pain in childbirth is universally expected, the degree to which a society is socially supportive of the labour and birthing process itself and the extent to which mothers-to-be exercise control over their pregnancy and delivery affect both the objective and subjective experience of pain.

Jordan reports that birthing in the Yucatan takes place at home amidst familiar surroundings with the assistance of a midwife. It is a cultural tradition that both the women's mother and her husband be present for the event. While some pain is anticipated and experienced, it is far less than is reported in North American accounts, resulting in totally unmedicated births. The fact that birth is not induced artificially permits the mother-to-be to experience the process as natural and non-traumatic. In North America, medical practices surrounding birth often precipitate women into a crisis state involving unmanageable pain. The more we define childbirth as illness, the more likely we are to be sickened by it.

Other examples could have been used to illustrate the relationship between culture and definitions of health and illness. In Hong Kong there is a condition that we would recognize as measles treated within the cultural framework of traditional beliefs about the unity of opposites. The universe is considered to be composed of *yin* and *yang* elements. Yin is represented by dark, female, cold or receptive energies. Yang refers to light, male, hot and active energies. This concept permeates the culture. Thus it is no surprise that it is used to help explain health and illness.

In an article in *Asian Medical Systems* Marjorie Topley explains that biological changes are perceived as attempts of the yin and yang energies within the individual to balance themselves. From this point of view measles is regarded as a necessary experience for children to undergo in order to re-equilibrate their yin and yang forces at that stage of life. Traditionally the Chinese have regarded measles as a kind of *rite de passage,* a socially significant occasion in the life of the individual. This situation is reminiscent of attitudes to eczema in children in 18th century Europe, where it was regarded as releasing "bad humours".

The history of syphilis in Europe dramatically sheds light on the connection between culture and healing. This is described by Owsei Temkin in *The Double Face of Janus.* Following the major syphilis epidemic between 1490 and 1520 the relationship between its symptoms and sexual intercourse became clearer. But a double standard emerged with respect to both its moral implications and its treatment.

The aristocratic ideal during this period was represented by the *cavalier,* the legacy of the Mediaeval knight. With amorous adventures or sexual exploitation comprising a good part of this lifestyle, venereal disease was interpreted in a positive light. In fact, it seems that noblemen who had not contracted the condition were considered "ignoble and rustic".

"The common folk, on the other hand," Temkin writes, "fared quite differently! In sixteenth century Paris, syphilitics were scourged and treated by barbarous methods. An aristocrat, however, was scarcely ever hospitalized and did not have to submit to the scourging of syphilitics, which did not scandalize

the world of the period; indeed, the very idea of such submission would have been absurd."

It was not until the rise of bourgeois morality in the 18th century that venereal disease among members of the upper classes began to acquire a moral stigma. The association of V.D. with extramarital sex then had to be condemned in light of the new morality which extolled the virtue of family life. This attitude has developed to the point where in today's society V.D. is regarded as a collective concern and its widespread nature considered a threat to the "moral health" of the state. Temkin concludes that having passed beyond the bounds of illness, V.D. "now appears in the final analysis as a crime."

These are some examples of how particular cultures might treat conditions which we call diseases. When a health problem is peculiar to only one society it is referred to by anthropologists as a culture-bound reactive syndrome. This simply means that the complex of behaviours and symptoms involved are culture-specific, that the same pattern has not been manifested identically in any other culture.

Because it is often difficult for observers to get at the physical manifestation of illnesses in other cultures (due to the intimacy and privacy of health problems), many of our examples of culture-specific disorders are behavioural in nature. *Windigo* or *witiko* in traditional Ojibway culture refers to a morbid depressive state in which the individual is obsessed with cannibalistic fantasies which can culminate in homicide. The windigo is a monster-giant which possesses people. It is represented by a skeleton with a heart of ice. This may reflect anxiety in the culture about cold winters and fear of famine.

In his book, *Patients and Healers in the Context of Culture,* Arthur Kleinman describes a Chinese case of frigophobia, characterized by an intense fear of cold. The patient wore several layers of clothing, wrapped in several blankets, and would not open the windows, even in summer. This was interpreted as due to his intense anxiety about his yin or cold energies overwhelming his yang or hot energies.

There are other culture-specific conditions which were first observed in a particular society, but became generalized to include similar behavioural disorders in other cultures. Here we could include voodoo death (extreme stress and fear causing death), arctic hysteria (erratic behaviour resulting in spasms, convulsions, and amnesia of the event upon waking), and running *amok.*

Our own society also has ways of conceiving of illnesses which are experienced as real even though allopathy may have no explanation for them. Most of us are familiar with the phenomenon of what we call crib death in infants. Only in a society where a baby sleeps in isolation in a crib or carriage is this phenomenon recognized by being labelled as such. Many of us have experienced dysmenorrhea for which allopathy has neither cause nor cure. In fact, allopathy sometimes suggests that it is all in our mind.

This raises another point. Even the contents of one's mind are culturally framed. What we would consider symptomatic of mental illness might be regarded as evidence of divine providence in another society. There is a very thin line between what constitutes a vision and an hallucination. Illnesses accompanied by visions may be prerequisites for the attainment of healing or religious status in some societies. Handsome Lake, a famous Seneca prophet and social reformer, began his career in New York State with a vision in the early 1800's. In some societies, it is not the hallucination per se that is regarded as problematic, but its content. If it makes cultural sense, it is acceptable. In some cultures vision quests were socially institutionalized forms of behaviour. In our own society, the Roman Catholic Church canonizes individuals who have culturally acceptable visions.

Throughout this article the terms illness and health have been used as if they are static conditions, with very clear distinctions between them. But they really are very ambiguous terms. In our own society one form of non-allopathic healing — naturopathic medicine — regards health and illness, not as relative states but rather, as dynamic processes and expressions of the life force of the individual organism. Because of this, such physicians often say that they do not treat disease, but that they treat *people* with diseases.

This excursion into how other cultures or subcultures within our own society approach illness help us broaden our perspective and handle our own illnesses in a more comprehensive and less narrow-minded way. It is clear that what we believe to be making us sick — or whether we even know when we are sick at all — profoundly affects what we do about it. We might also remember René Dubos's words in *Mirage of Health* that perfect health is an elusive utopian goal:

". . . all the Arcadias past and future could be sites of lasting health and happiness only if mankind were to remain static in a stable environment. But in the world of reality, places change, and man also changes. Furthermore his self-imposed striving for ever-distant goals makes his fate even more unpredictable than that of other living things. For this reason health and happiness cannot be absolute and permanent values, however careful the social and medical planning. Biological success in all its manifestations is a measure of fitness, and fitness requires never-ending efforts of adaptation to the total environment, which is ever changing".

I would like to thank Women Healthsharing for all the feedback and assistance they gave me during the collective editing process for this article. It was a good experience in finding better ways to express particular thoughts as well as in collaborating in a philosophical sense.

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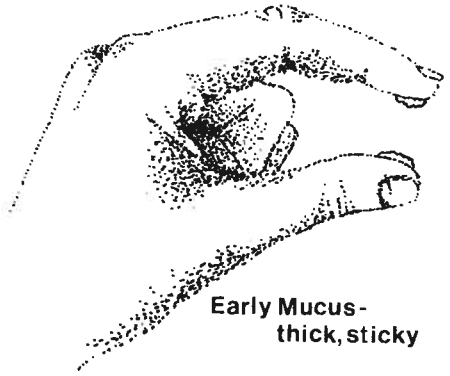
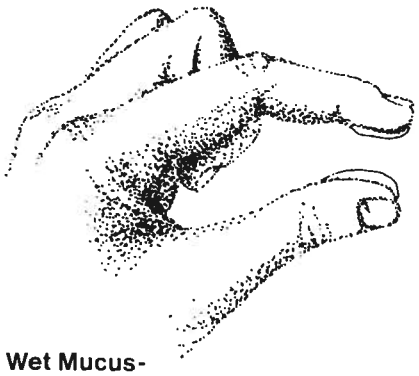
Controlling Conception — Naturally

by Vicki Van Wagner
illustrated by Julie Burge



Early Mucus-
thick, sticky



Wet Mucus-
milky, no dense matter

Lubricative Mucus-
(Spinnbarkeit)
stretchy

As disillusionment about the Pill and intrauterine devices becomes more widespread, a growing number of women have begun to search for alternatives. Several methods of birth control, based on a detailed knowledge of the female reproductive cycle, are becoming increasingly popular. The most common are usually referred to as Natural Family Planning (NFP). The more exotic include Lunaception and Cosmic Birth Control. Because they are alternatives to chemical and artificial barrier activist, has coined the phrase Organic Birth Control and, indeed, they all emphasize working with nature. They have in common using knowledge to prevent or achieve conception.

The origin of natural family planning is the much maligned rhythm method. The rhythm method developed from the findings of two independent doctors, Dr. Kyusaku Ogino of Japan and an Australian, Dr. Hermann Knaus, who realized that ovulation occurred two weeks prior to menstruation. Unfortunately, their knowledge was less than complete. They assumed that women's cycles were of fixed length. Ovulation does occur between twelve and sixteen days, most often fourteen days, before menstrual bleeding begins as Dr. Ogino claimed. The problem with the accuracy of rhythm lies in calculating the preovulatory days. These doctors recorded a woman's cycle for a period of six months to a year to determine the length of the cycle. They realized that the early days of the menstrual cycle were the cause of variation in cycle length from woman to woman, but assumed that a regular pattern would be maintained by the individual.

Unfortunately, for the majority of women, somewhat irregular menstrual cycles are the norm. Many external factors can influence the menstrual cycle, for example, illness, emotional stress, lactation and menopause. This makes the mathematical calculations of the rhythm method irrelevant to all but a woman who has very regular cycles.

Natural family planning has arisen to improve upon the rhythm method and to determine the exact time of ovulation. The two most widely used methods are the basal body temperature (BBT), the ovulation method (sometimes called the Billings method) and a combination of these methods called the symptothermal method. The principles underlying these methods have been known for at least one hundred years in medical literature, although refinement is constantly taking place. There is also evidence suggesting that in the past knowledge of the signs and symptoms of ovulation may have been part of a tradition of female knowledge handed down from mother to daughter and from midwives to women in their care. This knowledge was probably lost both as midwives were discredited — male doctors becoming the experts advising women — and as urbanization and modernization weakened other rituals for passing on this information. Mary Swanandron in her book, *Natural Sex*, claims that evidence of these rituals has been documented for both African and American Indian societies.

Meanwhile in Western culture, in the late 1800's, Mary Putman Jacobi recorded the temperature of six women

students, discovering that their temperatures were consistently lower in the first half of their menstrual cycle, followed by a higher temperature maintained until menstruation. In the 1840's, Ponchet described "mittelschmerz" (the low back pain experienced around the time of ovulation) and mucus excretion changes from "thick and whitish" to "liquid and profuse."

Yet this information was not applied to birth control until much later. In 1934 German Catholic priests began teaching basal body temperature to determine the fertile period. Once the temperature had risen, couples could safely have intercourse until menstruation. Yet this demanded abstinence at least half the time, so BBT was combined with calendar rhythm to determine the safe days pre-ovulation. Calendar calculations, however, do not accurately indicate when ovulation is about to occur.

Another Catholic, an Australian gynecologist, John Billings, was concerned by his patients' distress over the failure of the rhythm method. In 1953 he began a search of the scientific literature for a consistent indication of ovulation. Again and again it appeared: The cervix excretes a specific type of mucus at the time of ovulation. It was known that this mucus helped to direct sperm cells into the uterine cavity and filter out abnormal spermatozoa. Sperm can survive several days in this clear, slippery ovulatory mucus. Billings decided to learn from his female patients if this mucus could be recognized to pinpoint ovulation. By 1962, after a systematic study, Billings was able to work out the rules of cervical mucus testing as a method of family planning. Hormonal studies were undertaken to demonstrate it scientifically. It was found that the slippery, clear mucus was correlated with the high estrogen levels which occur just before ovulation. The last day on which this mucus appears signals ovulation, after which rising progesterone levels change the mucus and make it hostile to sperm. Billings was so impressed with the reliability of this mucus method he dropped the use of the BBT and taught women to rely on interpretation of mucus alone, calling it the ovulation method.

A combination method was developed by the French Canadian couple, Gilles and Rita Breault, founders of Serena (the Service de Regulation de Naissance) in 1955. When they began their work, any public discussion of birth control was punishable by up to two years in jail as an offence under the criminal code of Canada. Having practised rhythm (resulting in four children) and then the BBT method, they were very excited after reading information about symptoms to indicate ovulation. They began using cervical mucus, intermenstrual pain, breast sensitivity and intermenstrual bleeding as signs of ovulation and BBT as a back-up to establish exactly when ovulation occurred. A visiting French Jesuit priest spread their method to France, and named this hybrid the sympto-thermal method, as it relies on both the ovulatory symptoms (primarily mucus) and the basal body temperature rise.

Another sign of the fertile period was investigated by Edward Keefe, a gynecologist who, like John Billings, learned of the sign by encouraging his patients to examine their cervix for the changing mucus pattern. Many women reported a change in the texture of the cervix and in the size of the os. Keefe taught women to view the cervical os with a speculum and to palpate the cervix with their index finger. He found most patients were able to detect the changes in cervical mucus; about one half could detect the softening of the cervix itself, and a majority could feel the opening of the os with ovulation and its closing in the post-ovulatory phase. For the small number of women who have scanty mucus, these signs can be especially important to detect ovulation.

The physiological mechanisms involved in using these techniques are not always perfectly understood. Much of the endocrinology and its connection to the reproductive cycle is still a mystery. Many of the facts that are known inspire a respect for the interrelation of the body's systems which chemical and barrier methods lack.

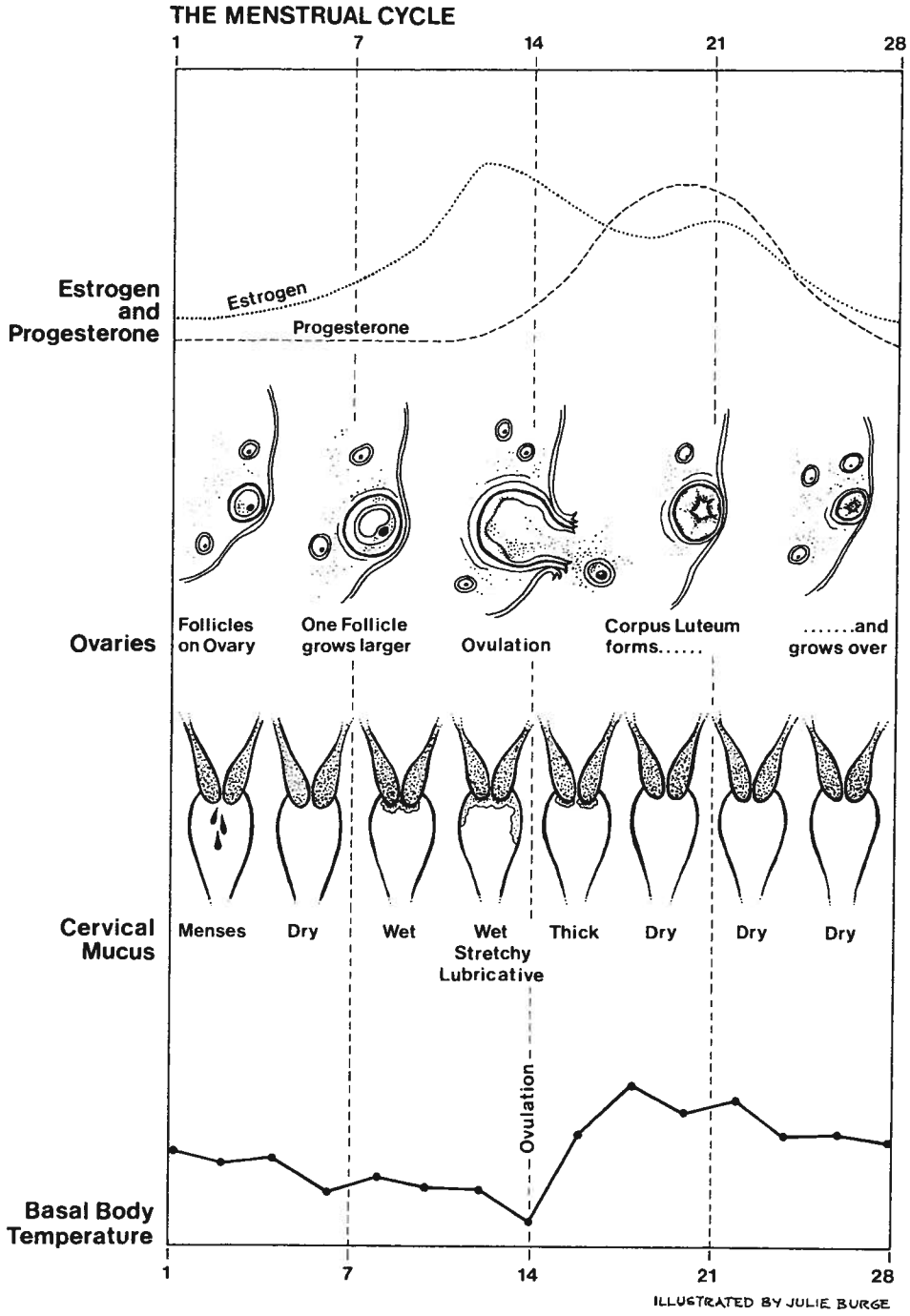
During most of the menstrual cycle sperm rarely penetrate beyond the cervix. When levels of estrogen are low the os is closed and blocked by thick, white cervical mucus composed of a complex network of fibers. This mucus is tacky to the touch and hostile to sperm and bacteria. Stimulated by a hormone called follicle stimulating hormone (FSH), several immature egg cells or ovum begin to develop. FSH continues to rise, reaching a peak about seven days before ovulation, when the ovary begins to secrete estrogens. FSH begins to decline. Estrogen must rise to a certain level and be maintained in order to stimulate a surge of lutenizing hormone (LH), which triggers ovulation.

This high estrogen level is thought to be responsible for the change in the mucus produced in the gland-like cervical crypts prior to ovulation. The mucus, called fertile-type mucus, is clear, slippery and lubricative, much like the white of an egg. It provides an optimal environment for sperm survival and transport. Sperm can feed on this rich alkaline mucus or harbour in the cervical crypts before swimming up into the uterus. The LH surge lasts about forty-eight hours and, as well as stimulating the ripened ovum to burst from the follicle, it triggers the production of progesterone by the corpus luteum, the yellow body left behind in the ovary after the egg is released.

Among other effects, the progesterone changes the cervical mucus back to its thick, impenetrable pre-ovulatory state and maintains a temperature rise of .2 - .4° centigrade until the end of the cycle. Both FSH and LH decline and reach their low point seven to ten days post-ovulation. The corpus luteum continues producing progesterone and estrogen, preparing the uterine lining for a fertilized egg.

Without conception, these hormones will decline and through feedback to the pituitary, will signal production of FSH to start the cycle again. At this point the uterine lining is shed. If conception does occur, the corpus luteum maintains the levels of estrogen and progesterone until the placenta develops enough to take over hormone production. These hormones keep the uterine lining intact and inhibit ovulation since, at their high level, FSH is never stimulated.

Irregular cycles are the trouble spot of the NFP methods. Variations usually occur in the length of the pre-ovulatory phase when estrogen levels do not reach a high enough elevation to trigger the LH surge. Observing the cervical mucus is the surest way,



besides a blood or urine test, of finding out the phase of a woman's cycle. If fertile type mucus appears, estrogen is at a high level and ovulation will probably follow. Some irregular women have a kind of continuous mucus, resulting from low estrogen levels. It can usually be easily distinguished from the fertile type mucus, as it is crumbly, flaky or clotty rather than stretchy and lubricative.

Irregular cycles always involve a delay in ovulation; upsets to the cycle never cause ovulation to occur sooner. Once ovulation has occurred, menstruation will follow about twelve to sixteen days later, although some causes of irregularity such as nursing or quitting the Pill may involve one or two cycles with a shorter post-ovulatory phase.

To keep careful track of where a woman is in her cycle, most advocates of NFP recommend careful recording of mucus patterns and often BBT as well. Although BBT gives a clear indication that ovulation has occurred, it must be taken at the same time each day under the same conditions in order to be accurate. Some women may find it difficult to achieve this consistency, and rely on mucus and other signs to indicate ovulation. BBT does ensure greater accuracy in pinpointing the beginning of the post-ovulatory infertile phase, so many NFP clinics advise women to take a daily temperature before rising and try to interpret variations due to illness, a late night or overtiredness, any of which may alter the temperature reading. Breast feeding and pre-menopausal women, as well as those with other types of irregular cycles, must rely on their observations of mucus patterns as their temperature charts may be erratic.

There are a few interesting variations on this basic methodology. One is called the Ovutimer, developed by Dr. Harold Kosasky to help women identify the time of ovulation. It is a small device which measures the viscosity of cervical mucus, indicating when sperm can pass through the cervical os and ovulation is imminent. According to Kosasky, the accuracy of this device is such that a woman would have to abstain for only about 60 hours, an improvement on simple mucus observation techniques. In *Women and the Crisis of Sex Hormones*, Barbara Seaman claims a home model ($10.50) should be available "if all goes well at the FDA" in the late 1970's. Where is it? There are rumours of keeping it a prescription item, although it could not possibly cause any physical harm. In Seaman's words, "this seems like a mere political effort to keep good birth control in the hands of the physicians."

Cosmic Birth Control, developed by a Catholic gynecologist and psychiatrist in Czechoslovakia, claims that the angles of the moon and sun play a part in a woman's fertility. This method requires two periods of abstinence, ten days during ovulation and four days during the cosmic fertility time. These often coincide, but may vary. Predictably, these ideas were first treated with the same scepticism with which the scientific community views astrology. However in 1970, a highly respected professor of gynecology, Kurt Rechnitz, published a study of 1,252 women for whom the method had proven 97.7% effective.

Officially sanctioned by the Catholic Church in Czechoslovakia, it is also popular in Germany and Eastern Europe.

Another unorthodox technique was developed by a Californian woman, Louise Lacey. In her book, *Lunaception*, Lacey tells the story of her search for a method of birth control that would not interfere with her body. She stopped using oral contraceptives after developing fibroid masses in her breasts while taking the Pill, only to suffer from menopausal-like symptoms. Starting with the common knowledge that farmers use light to influence the reproductive cycle in egg production, Lacey speculated that the diurnal light/dark rhythm might be important in reproduction. Lacey found that the moon's light has been proven to influence the reproductive cycle in many sea creatures, acting as a trigger which stimulates internal mechanisms. After reading about light experiments of E.M. Dewan, Lacey began to block out the artificial light entering her bedroom on all but several days mid-cycle, when she slept with a 75 watt bulb turned on in a cupboard across the room with the door half shut. Not only did her cycle regularize, it came into step with the lunar cycle — new and full moons corresponding to periods and ovulations. She kept a careful record of her basal body temperature to validate this. Within a day or two after the first night with the light on, her temperature rose.

It has often been called an old wives' tale that breast feeding will prevent pregnancy. However, it has recently come to light that there may be more truth to this idea than was apparent during the period when early introduction of solid foods was the fashion in baby care. With the recent popularity of breast feeding, more women are delaying any supplementary feeding until the baby is six to nine months of age. Studies cited by anthropologist Dana Raphael in *The Tender Gift*, a cross cultural look at breast feeding, indicate that total breast feeding can inhibit ovulation. The hormonal mechanisms are as yet unknown, but there is agreement among researchers that it is the sucking stimulus provided by the infant at the breast which is responsible for lactation amenorrhea. However, breast feeding is not recommended as a form of birth control since ovulation will occur before periods are re-established.

Many of these alternatives have not yet been fully researched to document how effectively they can be used. Several factors have been noted about their use by those involved in popularizing them. Obviously, to use them correctly demands discipline, cooperation between the woman and man involved and being easy about touching and paying close attention to one's body. It takes time, usually about six months, to really learn the skills of observing mucus and interpreting the pattern of the individual woman's cycle. It requires personal counselling and follow-up with an experienced teacher to fully understand mucus and temperature graph variations.

Several groups have formed in North America to perform this function. In the Couple to Couple League, Sheila and John Kippley teach couples wishing to learn NFP as a team, emphasizing the man's participation in this form of contraception. Couples trained by Serena Canada teach through public lectures and couple to couple counselling in many towns across the country. Family Life Clinics found in several Catholic hospitals have counsellors who teach NFP from pictures, diagrams and personal experience. Women's groups teach women to observe not only the cervical mucus but also changes in the cervix itself, through regular use of a speculum and mirror in a self-examination.

Despite the bad reputation of the rhythm method and the scepticism of the medical profession, these NFP methods are becoming increasingly popular. Women (and men) choose natural family planning for many reasons. Many women value the sense of being in touch with one's body and are not comfortable tampering with it by using chemicals. The appeal to Catholics is obvious. It seems in many ways ironic that much of the inspiration and funding for research into NFP came from the Catholic church, since more and more women are beginning to see NFP as a feminist form of birth control.

Some feminists value the sense of control and the knowledge natural family planning give a woman about her own body, and the sense of freedom from a male-dominated profession. The spread of NFP among more than Catholic groups coincides with feminists' stress on self-help, which encourages women to examine and be familiar with their own genitals and body processes.

For those looking even deeper into the politics behind birth control, these methods are almost revolutionary since no profits can be made from natural family planning. In Barbara Seaman's words, "There would be little profit for drug companies and physicians in [these] methods — which work simply by identifying the fertile period. There is no research money . . . for who would finance such efforts. Nonetheless, astonishing breakthroughs . . . have been occurring, and right now, almost in secret, millions of modern women are successfully practicing natural fertility control, which is totally free of side effects."

Some women claim that NFP is limiting to spontaneous sexual expression. Others claim that the freedom from the fears of the dangers of the Pill and IUD, the inconvenience of barrier methods and the fear of pregnancy (during infertile times) is a relief which improves their sex life. Many enjoy the imaginative ways of both love-making and simple expression which the so-called abstinence period encourages.

Whether or not these methods appeal to women as forms of contraception, valuable information is being passed on about the rhythms of the female reproductive cycle. Every woman has a right to know and understand her reproductive cycle and fertility. It is through knowing ourselves and communicating with each other that we can free ourselves from the dominance of male experts and their theories and sales pitches. NFP can help us begin to understand our biology without the bias of male prejudices and vested interests. Unlike the Pill which many women reported left them always available and feeling free only to say "yes", NFP can help develop our power to say "yes" or "no".

Vicki Van Wagner teaches human sexuality and women's health at a Toronto alternate high school.

Getting Rid of the Crab

by Madeline Boscoe and Connie Clement

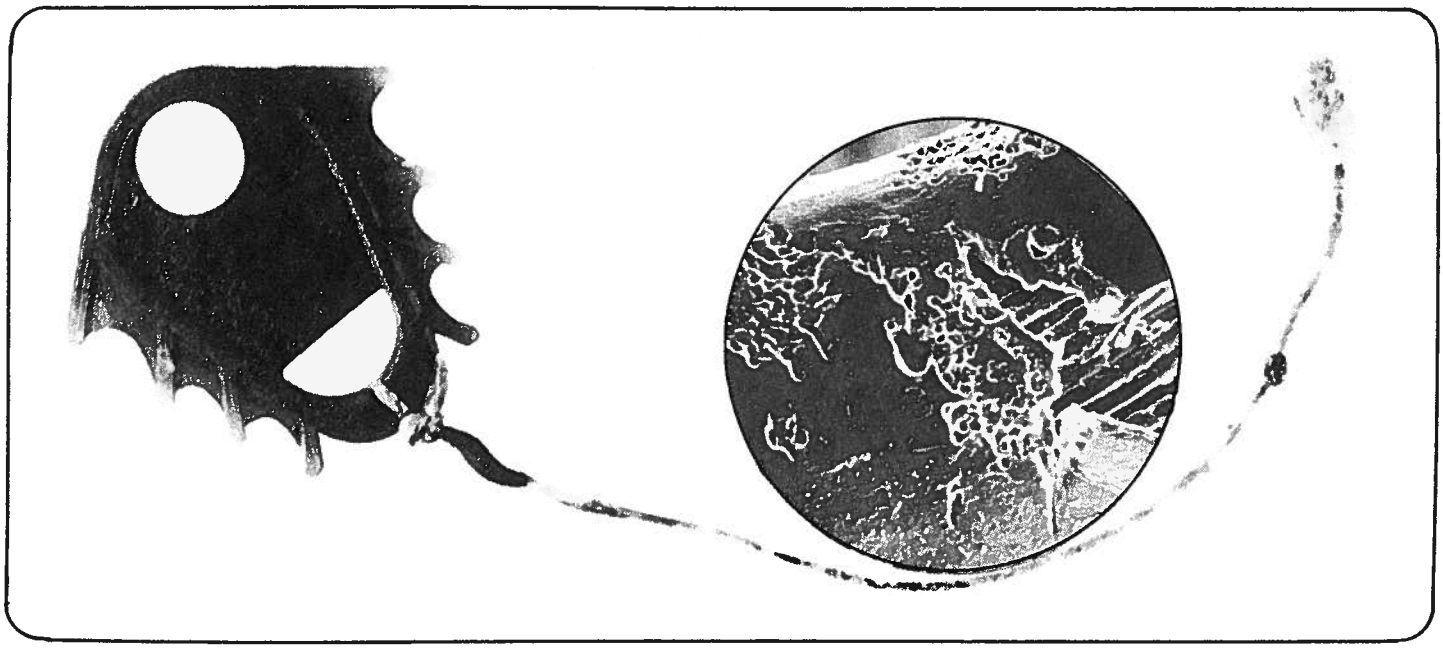


Photo: Robert Rose

Dalkon Shield and enlarged section of corroded string (electron microscope photo).

If you are one of an estimated 500,000 women still wearing a Dalkon Shield intrauterine device device (IUD) — have it taken out! Have it taken out *today!*

The latest research indicates that wearing a Dalkon Shield does not pose a *potential* risk to your health, as does wearing any other IUD. It poses a *certain* peril. It has been implicated in seventeen U.S. deaths and in uncountable cases of severe infections.

When the Dalkon Shield was taken off the market in 1975, many of us sat back, thinking the battle had been won. The danger was past, the problem solved. But, as with our battles for abortion access, we are learning that our relief was sadly premature.

A.H. Robins, the manufacturer of the Dalkon Shield, has been charged in a class action suit. The suit alleges that Robins wantonly continued to sell one million Dalkon Shields to unsuspecting doctors who inserted them into equally unsuspecting women, after Robins knew the Shield was unusually dangerous.

The suit also alleges that: 1) Robins was negligent in researching the safety and effectiveness of the Dalkon Shield before marketing it; 2) Robins knew about particular dangers at least two years before it finally stopped selling the Dalkon Shield; and 3) Robins purposely withheld information about the Shield from the countries where it was sold.

The class action suit was filed in January in Boston on behalf of all Dalkon Shield users. The National Women's Health Network (U.S.), the Dalkon Shield Association of England, and four individuals were the original plaintiffs. According to a Network press release, they are asking the courts to require Robins to undertake a comprehensive recall program to reach all users, physicians, hospitals and distributors in all countries where Robins marketed the Shield and to pay for or reimburse medical costs incurred by women who have the Dalkon Shield removed.

The core of the case is that it is not enough for a company to simply remove a dangerous product from the market. Corporations must be held accountable if they produce and market a dangerous product.

Why the Dalkon Shield is so Dangerous

IUDs used in the West have two parts: a body, or matrix, and a tail string. The body of the IUD should sit totally within the uterine cavity, which is sterile. The tail, attached at one end to the matrix, extends through the cervical opening into the vagina, which normally is not sterile but houses bacteria.

Commonly used IUDs are variously shaped as a T (Gyne T), a double S (Lippes Loop), a 7 (Cu-7), a ram's horns (Safety Coil) or a flattened crab (Dalkon Shield). All strings — except for the Dalkon's — are made of a solid, single strand. The Dalkon Shield's tail is a multifilament tail composed of 200 to 450 filaments twisted together and coated with a sheath.

Since 1938, when Howard Clark published "Foreign Bodies in the Uterus" in the *American Journal of Surgery*, we have been aware that bacteria in the vagina can travel up *all* IUD tail strings and into the uterus. This transport mechanism has been linked to the increased frequency of pelvic inflammatory disease (PID), a general term for infections of the uterus. PID shows itself in flu-like symptoms, lethargy and severe cramping. It can lead to lowered fertility, possibly hysterectomy and, in severe cases, death.

It must be noted that *all* IUDs are linked with these complications. Although monofilament tailed IUDs may some day be found to be more dangerous than we now know, the Dalkon Shield has, thus far, a higher rate of related infections than do other IUDs. It was directly responsible for a number of fatal septic abortions (miscarriages caused by uterine infection). The multifilament Nylon 6 string of the Dalkon Shield is thought to be the culprit.

The Dalkon Shield's multifilament string offers a much greater surface area for bacteria movement. As well, capillary action (the upward motion of fluids) draws bacteria into the uterus through the free spaces between the filaments. In effect, the Dalkon Shield tail acts as a wick, pulling bacteria up from the vagina and into the uterus.

The tail sheath and the filaments housed within it were made from Nylon 6. As early as 1960, it was known that Nylon 6 is not chemically stable and not safe material to use inside human bodies. Nylon 6 absorbs water which makes it eventually brittle and crumbly. Worse, this process is enhanced in the presence of fatty acids and acidic environments such as in the vagina and uterus.

As the nylon erodes and deteriorates the sheath develops surface cracks and pock marks. As breakdown continues, the sheath ruptures and either buckles or breaks off. In either case, the filaments are exposed. Each break in the sheath surface allows bacteria to escape directly into the uterus.

As the strength and flexibility of the tail diminish, the chances increase of the string breaking during removal. One purpose of the tail is to make removal easy. If it is gone, a woman must usually go into a hospital for a "D and C" to have the IUD removed.

Dr. Robert Rose, a Professor at MIT,

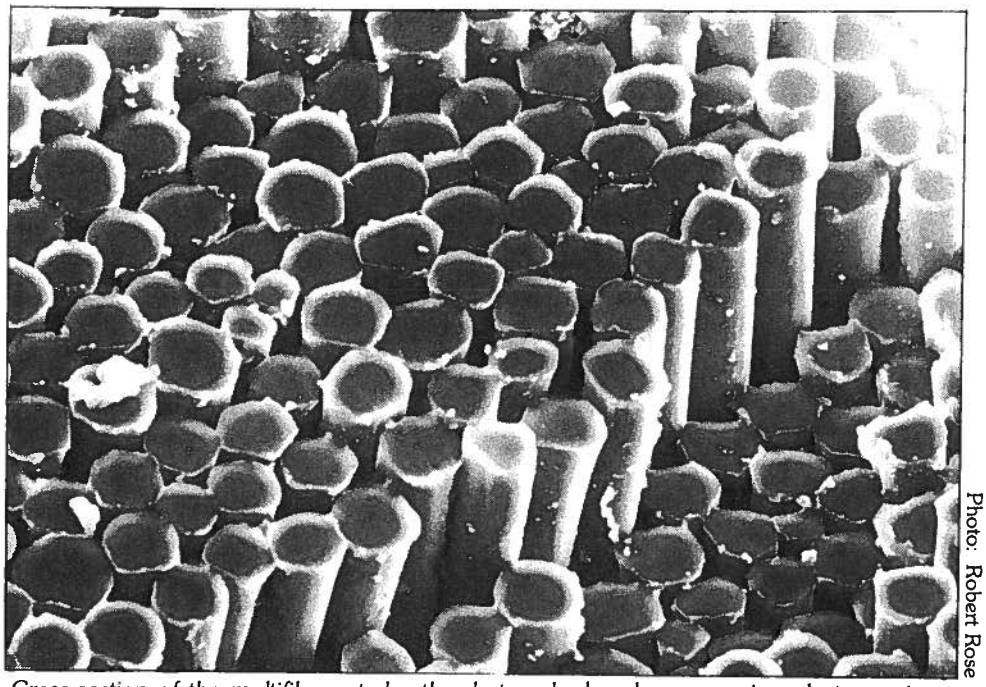


Photo: Robert Rose

Cross-section of the multifilament sheath, photgraphed under a scanning electron microscope.

examined the physical properties of Dalkon Shields using scanning electron microscopes. According to an advance submission to the Court, he believes that "within twelve months of insertion, the deterioration pattern of Dalkon Shield strings can reasonably be expected to produce sheath rupture in *all* women wearers." (our emphasis.)

The Whole Sad Story

The story of the Shield so far is enough to make one blanch. And there is more.

Robins began marketing the Dalkon Shield in January, 1971 with a high-powered promotional campaign. They purchased the rights for the device in 1970 and made modifications in size, shape and chemical composition. This new "improved" model, with the Nylon 6 tail, went on the market with *no reputable clinical trials*.

Robins was either aware or should have known from a search of the medical literature that the Dalkon Shield would pose a significant health risk.

A major component of the promotional campaign was that the device had a failure rate of only 1.1 per cent, approximately half that of other IUDs. This rate was based on a study carried out by Dr. Hugh Davis, co-developer of the original Dalkon Shield. He studied 640 women who wore the Shield for an average of five months. Although not reported in the promotional literature or in Davis' published research (*Obstetrics and Gynecology* 36, 1970), it was later reported in *Family Planning Perspectives* (Fall 74) that *participants had been instructed to use a contraceptive foam* on days ten to seventeen of the menstrual cycle.

The initially reported 1.1 per cent failure rate was supposedly based on the use of the IUD alone. It was a lie. The company's literature never mentioned the contraceptive foam.

The low number of users studied and the short time the Shield was in place raise other questions about the study. Robins obviously did not know the long-term safety or effectiveness rates. Remember — this was an IUD that was meant to be worn *indefinitely*. The company began to learn about the Dalkon's safety as doctors and users wrote to complain. At least three million women wearing the Shield were used by Robins as human guinea pigs to test a new product, without their knowledge or consent.

Robins also described the Shield as being the IUD of choice for childless women. This was new. Until this time, IUDs were favoured only for women who had children because their uteri were bigger and more able to accommodate a foreign object.

The class action suit plaintiffs also charge that Robins used faulty methods to assemble the strings, failed to provide adequate insertion directions and failed to give complete warnings and information about potential defects.

As early as March, 1972 Robins knew of insertion difficulties and string hazards and had designed modifications. We know this because the class-action lawyers have copies of Robins' own internal memos. Despite their awareness of the dangers, Robins did not make any changes and intentionally continued to market a product the company itself recognized as defective.

Of the at least three million Dalkon Shields inserted worldwide (out of a total of five million produced), *one million* were inserted *after* Robins knew the dangers.

Also in 1972, Robins expanded its exports. According to an article in *Mother Jones* (November, 1979), Robins approached the U.S. Agency for International Development (AID) offering them the Shield in bulk packages, *unsterilized*, at 48% off for use in population control programs in the Third World. In Canada, IUDs come double-wrapped with their own sterile disposable instruments and individual instructions. Not so, overseas.

Dear Doctor Letters

By the Spring of 1974 the Dalkon Shield had been linked to the deaths of 16 women who developed complications following miscarriages caused by uterine infections. In response, Robins issued a "Dear Doctor" letter, recommending that Shields be removed during pregnancy. This letter, sent to all physicians in the U.S. and Canada, did not mention non-pregnancy related infections.

A few weeks later, on June 6, the U.S. Food and Drug Administration ordered Dalkon Shields off the market. The action took effect in Canada on the same date.

Although Robins did buy back an unknown number of Shields, no recall was undertaken. Most Dalkon Shields stayed in women or on doctors' shelves. No recommendation to have Shields removed from non-pregnant women was made, either by the government or by the company. Instead, the policy was that if no problems were experienced, Dalkon Shields could be left in place *indefinitely*. Today 500,000 Dalkon Shields world-wide are still unaccounted for.

It wasn't until September, 1980, after 4,460 lawsuits related to the Shield, that Robins changed its tune. Six years and three months after Dalkon Shield sales were banned, Robins sent another "Dear Doctor" letter, this time urging U.S. and Canadian physicians to remove the IUDs from women still using them.

Amazingly, their letter did not even allude to the specific hazards of Dalkon Shields outlined in this article. Instead, the recommendation for removal was based on recent findings by Dr. Waldemar Schmidt and colleagues at the University of Texas. They have linked calcium build-up on a variety of IUDs

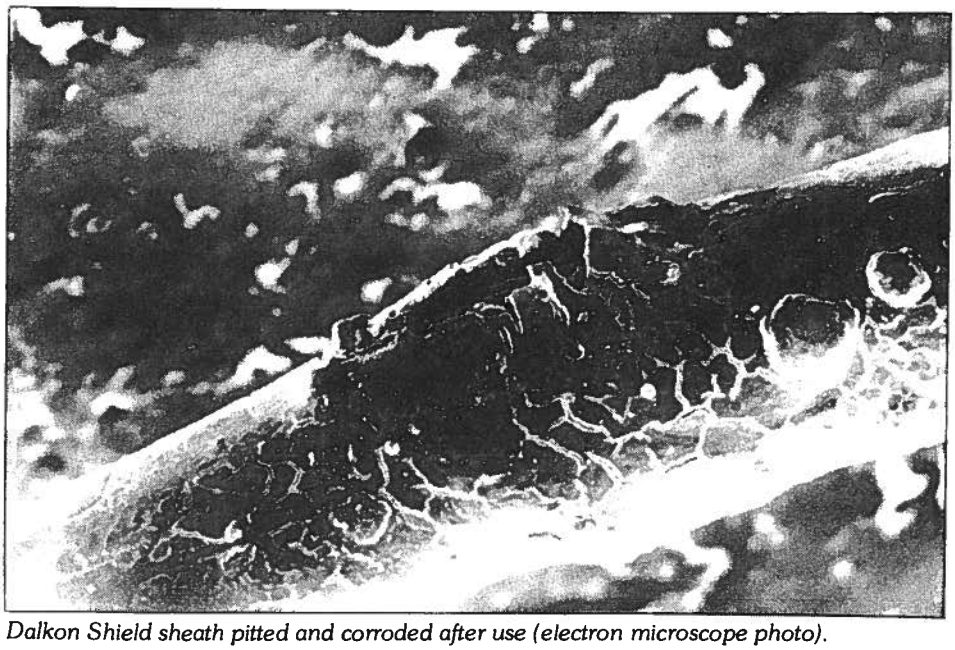


Photo: Robert Rose

Dalkon Shield sheath pitted and corroded after use (electron microscope photo).

DALKON SHIELD USERS

WARNING: If you have a Dalkon Shield in place it should be removed immediately by an experienced physician. If you've been wearing an IUD for six years or more, but don't know what kind it is, there's a good chance it's a Dalkon Shield. Recent research indicates that no IUD, regardless of make, should be worn much more than 2 or 3 years. So even if it turns out your IUD isn't a Shield, you've still made a good move.

IF YOU WANT TO HELP: Dalkon Shields are being collected for study. If you have one removed (or you have an old one still around), you can donate it. The IUD should *not* be washed or cultured; just place it in a vial of formalin. Send any IUDs to *Healthsharing*, the Vancouver Women's Health Collective (1501 West Broadway, Vancouver, B.C. V6J 1W6).

We will forward any Dalkon Shields received to researchers in the States. Please enclose your name, address and the length of time the device was worn. If you experienced any complications please include a brief history. If anonymity is important, we will keep personal details on file and forward your IUD identified by a number only.

All three of our organizations are willing to act as clearing houses for Dalkon Shield users who want to communicate with other users. We will collect names and addresses and pass them on to others. We cannot, however, put out a lot of energy to help you organize.

worn for three or more years with the development of actinomycosis (an uncommon and highly injurious bacterial pelvic infection).

Such information, which does not specifically address the deterioration of Dalkon Shields, will not encourage physicians to recognize the urgency involved in removing the Shields. Women wearing Dalkon Shields who may have read the Associated Press story about the so-called "recall" of Dalkon Shields would have been unable to know why or whether their IUD was any more dangerous than others.

"Dear Doctor" letters may reach all practising physicians but they aren't sent to all the counselling clinics which many women use for birth control information. Nor are they sent to women themselves, unless, of course, they happen to be women doctors. "Dear Doctor" letters leave at bay all women who may not be receiving direct care from physicians, who have moved and can't be traced, or who may have forgotten or never been told what kind of IUD they are wearing.

Equally problematic is our Federal Government's stand. In January, Dr. R.W. Campbell of Health and Welfare Canada downplayed the number of Canadian women who might still be wearing Dalkon Shields without emphasizing its dangers. The Canadian government has thus far taken no action.

To date, Robins has not been held liable for the safety of Dalkon Shield users. Nor has Robins been forced to take on financial responsibility for the damages experienced by users or for the cost of removal.

The present class action case is calling for a worldwide recall, a precedent-setting action. This will be a long battle. It will need our anger and indignation. Robins isn't going to be fighting just for itself. It will be fighting for the entire drug industry, and will have all their resources to draw upon. The prospect of requiring *worldwide* recall of defective drugs and devices, we are sure, is giving many pharmaceutical executives headaches.

Madeline Boscoe is a member of Women Healthsharing.

Connie Clement is a member of Women Healthsharing. She works as a family planning community worker for the City of Toronto.

Reviews

Shared Intimacies
Reviewed by Lisa McCaskell

Shared Intimacies is a practical and upbeat book. It seems to be aimed at women who are comfortable in their sexuality and who may be trying to make small improvements in their sex lives. The two authors, Lonnie Barbach and Linda Levine, see their book as serving two main purposes. Their first goal is to try to answer the question: how do you keep a long-term monogamous relationship from becoming boring sexually? Their second stated aim is to document information and solutions from women who have overcome particular sexual problems so that these suggestions may be used by readers who have encountered similar problems.

To achieve these two goals, the authors interviewed 120 women across the United States. The majority of those interviewed were white professional women, slightly more than half of whom were married or living with someone. It is a small and narrowly based survey, particularly in comparison to the research done for the *Hite Report*, an earlier book dealing with women's sexuality. Three thousand women supplied the data for the *Hite Report*, which covered all areas of women's sexuality, focussing on the women themselves — how they felt, what pleased them and what didn't, the importance of intercourse, masturbation and much more. *Shared Intimacies*, by way of contrast, tends to define or portray a woman's sexuality within a couple.

Barbach and Levine adopt a cookbook approach to sexuality. Particularly in the first half of the book, a variety of recipes for good sex are offered. Seen in this light, *Shared Intimacies* may be a useful book. But for those who are trying to develop a better understanding of women's sexuality, the book does not fill many gaps. Little new ground is charted as we are led from one exciting sexual experience to the next, with only limited explanations and analysis from the authors. Only positive experiences are documented and only happily solved problems are mentioned, giving the book a hopeful feeling. We learn that it *is* possible for women to deal with the, at times, overwhelming problems of day to day living while maintaining an exciting and fulfilling sex life.

In an attempt to convey this positive message, however, it is possible that the book may backfire for some readers. Faced with 300 pages of successful and rewarding sex, some of us may feel threatened, unimaginative, conservative and boring. *Shared Intimacies* creates an unreal storybook atmosphere. This factor, combined with the homogeneity of the group of women interviewed, narrows the book's usefulness.

The second half of the book is probably the most practical and the most useful. The chapter, "What to Do When You Run into Trouble", offers practical suggestions and ideas about a variety of common and not so common health problems. Topics range from well known dilemmas, such as lack of time, to problems and inhibitions, lack of orgasms and male problems with erection and ejaculation. Common health problems such as V.D., contraception and bladder infections are dealt with briefly. Perhaps most interesting is the section on long-term health problems such as spinal cord injuries and degenerative diseases. It is often forgotten that women with such large-scale health problems are also sexual beings who have the right and the ability to enjoy sexual satisfaction.

The second half of the book also deals with the thoughts and feelings of pregnant women who have found ways to maintain their sexual identity and keep an active sex life throughout their pregnancy. The reality of parents as sexual people is also discussed. The final section deals admirably with a subject that is rarely discussed or considered — the idea of older women as sexually active. Frank interviews may give some readers a first glimpse of older women as sexual beings.

Shared Intimacies is not a definitive new statement on women's sexuality. It does, however, contain some new, and at times, thought-provoking information. As a manual and resource of helpful hints and suggestions for a more exciting sex life it succeeds admirably.

Shared Intimacies by Lonnie Barbach and Linda Levine, is published by Doubleday, Garden City, New York, 1980.

Lisa McCaskell is a Registered Nurse working in Toronto, and a member of Women Healthsharing.

The Political Palate
Reviewed by Connie Clement

The Political Palate . . . the very name is enough to cause my tongue to tingle in anticipation and my mind to pause with pleasure at the concept. A political sense of taste. Even better, a feminist sense of taste. That's what *The Political Palate* is all about. It's a feminist cookbook.

A feminist cookbook?! Hmm humm, that's right. *The Political Palate* is a cookbook written and self-published by the Bloodroot Collective, four women who own and operate a feminist restaurant in Connecticut called Bloodroot.

I admit to bias. I'm a feminist who believes my feminism affects all aspects of my life. I'm a sucker for a fine meal. A part of my heart still harbours the New England I left ten years ago. One of my personal harbingers of spring is finding bloodroot in bloom in shady woods after the snow has melted away. And if all that isn't enough, the book was a birthday gift from the first friend I took to lunch at Bloodroot — my mother.

Truly, truly, I am guilty of bias. I admit it, but I still mean it when I say I think you'll like the book.

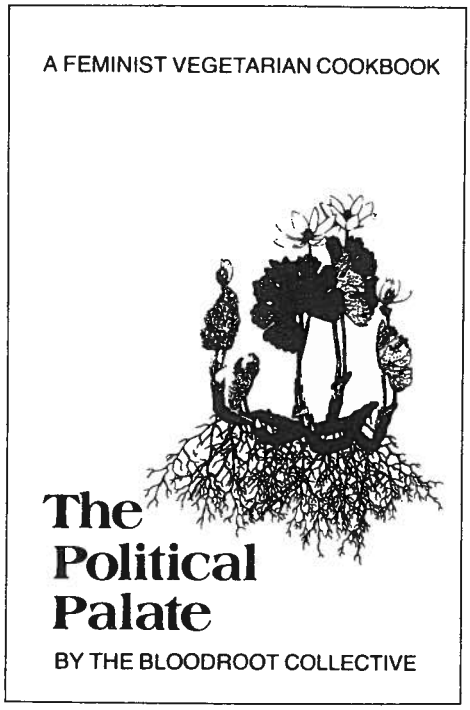
The recipes in *The Political Palate*, nearly all vegetarian, are arranged seasonally, reflecting the collective's inseparability of personal and political. The food is vegetarian because of opposition to killing and torture of animals when alternative food is readily available, and because of concern for the wastage of land resources needed to produce meat for market. The authors tell us that the food is organized by season to be in tune with the land and the passage of time. Equally important, eating seasonally-available, locally-grown food is a first step toward freeing up land in the third world from producing luxury export crops.

My major criticism of *The Political Palate* is that the introduction which outlines these concerns is spiritual. It includes no critique and no analysis. Only people who have already read about the politics of food and agribusiness will comprehend the issues alluded to by the collective.

The recipes include foods you'll recognize (blueberry pie and split pea soup) and foods you may never have tasted (avocado stuffed with shredded parsnips and curried mayonnaise). The book includes recipes for dishes made with foods you can buy at the store (apple cobbler), plants you can grow in your garden (leek and sorrel soup) and a few plants you'll have to pick along the roadsides (hot and sour soup with wild daylily buds). Drawn from many cultures are recipes with names which roll off your tongue as you say them — aioli, gnocchi, hupi pollivka and baba ghanouj.

The foods in *The Political Palate* are not just seasonal, but well-seasoned, as are the meticulously strewn quotes from a wide assortment of feminist writings, which complement the recipes. As with the recipes, you'll find books you'll recognize and some you've never read.

In the recipes the four members of the Bloodroot Collective share their art; in the chosen quotations they share their beliefs and visions. What better place could there be for this quote than the page with a recipe for curried apple and potato soup?:



In her bottled up is a woman peppery as curry,
a yam of a woman of butter and brass,
compounded of acid and sweet like a pineapple,
like a handgrenade set to explode,
*like a goldenrod ready to bloom.**

The Political Palate includes two bibliographies — a list of cookbooks and a much longer list of feminist books ("Food for Thought" as the authors call it).

A book such as this could only have grown from a collective of feminists who tend a restaurant, which houses a bookstore, at the end of a street overlooking a salt water inlet.

The Political Palate by the Bloodroot Collective (Betsey Beaven, Noel Giordano, Selma Miriam and Pat Shea) is published by Sanguinaria Publishing (85 Ferris Street, Bridgeport, Connecticut, U.S.A. 06605), 1980. $8.95 (U.S. dollars) in paperback.

* "The woman in the ordinary", from *To Be of Use*, Marge Piercy, Doubleday, 1969

Connie Clement is a member of Women Healthsharing. She is a family planning community worker for the City of Toronto.

Regional Reports

Your response to Regional Reports *has been overwhelming. Already we have expanded the column by a page. The column demands even more space but our understanding correspondents allowed us to edit extensively. Welcome to our new correspondents and thank you all for your hard work. If you are interested in becoming a regional correspondent for* Healthsharing, *please write Diana Majury, c/o Women Healthsharing.*

NOVA SCOTIA — Deborah Kaetz

Extra Billing: Extra billing is a focus of activity for the Women's Health Network (WHEN) and the newly-organized Nova Scotia Health Coalition, comprised of health-oriented professional and consumer groups.

All doctors in Nova Scotia belong to the province's Medical Services Insurance (MSI) program, paid for by taxes. Approximately 52% of the doctors in the province charge extra fees. According to recent statistics, these additional charges to patients constitute an amount equal to 3.07% of total MSI spending.

Uranium Exploration: On March 12 The Burlington Women's Institute in Hants County presented a brief on uranium mining to the West Hants Municipal Council. As a result, the Council moved to petition the Nova Scotia government for a moratorium on uranium exploration until a public inquiry into the risks and benefits of mining can be held.

Uranium exploration is being carried on by private industry in many areas of the province. Health and environmental groups are concerned about the danger of inadequate storage of radioactive mining wastes and the threat of ground water and air contamination caused by the disturbance of otherwise stable radioactive ore deposits.

WHEN Conference: In conjunction with its annual general meeting, WHEN sponsored a conference on May 1 and 2. This year's theme was *Food: Awareness and Action*, with the focus upon our whole food system — safe growing, handling, processing and storage of raw and processed materials — strategies for remedying unhealthful social, political, economic and nutritional aspects of that system. Mary Goodwin, author of *Food: Where Nutrition, Politics and Culture Meet*, was the keynote speaker.

NEWFOUNDLAND/LABRADOR — Frances Ennis

WHEP: The Women's Health Education Project (WHEP), funded by a three year grant from Health and Welfare Canada, has just begun operation in Newfoundland and Labrador. The Project's goal is to help women maintain and promote health for themselves, their families and their communities.

The rationale for this project cannot be understood without addressing the geographic, demographic and social context of the province, as this calls into question the urban-conceived social service delivery systems introduced here. Medical treatments, especially surgery, are being increasingly centralized in hospitals in major centres. At the same time, doctors in the many small provincial clinics are reluctant to make bold diagnoses and act on them, when more sophisticated instrumentation (and possibly more accurate diagnoses) are available at the major hospitals.

The health care delivery system in Newfoundland and Labrador is not prevention-oriented. Few resources are spent on public education programmes. A recent study indicated that only 16% of mothers attended prenatal classes and that 66% of all new mothers received no information on breast feeding.

Carefully prepared information and skill development introduced to women in communities throughout the province could diminish the isolation of women in these communities. Our mandate is to conduct a survey within communities across the province to find out women's health needs. While the results of the survey are being compiled, plans will be undertaken for a "Consultation", designed to promote a two-way flow of information where women express community concerns and resource people respond to those concerns. Based on information derived from both the Consultation and the survey, workshops will be designed to meet the specific needs of communities.

QUEBEC — Clara Valverde

The National Coalition for Abortion on Demand: At their last general meeting, the National Coalition endorsed the following:

1. As an immediate priority, to support abortion clinics controlled by women. The Coalition is asking the provincial government to reallocate funds presently going to the Lazure clinics to existing, and future, women-run abortion clinics.
2. To put efforts into setting up a pan-Canadian common front to repeal the abortion laws. Concerned women's groups should contact: Coordination Nationale pour l'Avortement Libra et Gratuit, 310 Notre Dame, Hull, Quebec J8X 3V2.
3. To hold a day of activities across Quebec on May 16, the Second International Day on Abortion. The theme of the day will be "women decide".

Women's Abortion Centre in Montreal: The Centre de Sante des Femmes of Montreal, in collaboration with other groups and individuals, has opened the third women-controlled abortion centre in the province.

Birthing Issues: Many women's groups in Quebec are fighting for the right to give birth in a warm environment of their choice and to have birth seen as a natural process, not as an illness. These groups have formed an umbrella organization called Naissance Renaissance. On April 12 women involved in the Montreal group, Alternative Naissance (a member of Naissance Renaissance), sponsored a day of activities on home births at the University of Quebec.

Regional Reports

The only alternative birthing centre in Montreal, the Carolyn Birthing Center, was recently closed down on a technicality by the Professional Corporation of Physicians of Quebec. Some of the 52 women who gave birth there during its year of operation, and other women interested in birthing centres, are trying to get the Center reopened. For more information call: Mynam 272-8459 or Ulla 935-7732.

The provincial government has set up a series of small conferences on birthing in the Montreal and Laval regions which culminated with a city wide meeting on April 26. The government, like the Professional Corporation of Physicians of Quebec, are pushing women to put their energies into reforming hospital conditions, instead of concerning themselves with home births and birthing centres.

ONTARIO

North West Ontario Women and Health Conference: Sue Heffernan of Ignace reported on a Conference held on May 1 - 3 in Dryden. The 165 participants came from Kenora, Dryden, Ignace, Red Lake and many other small north west communities. The main conference themes were stress, alcohol and prescription drugs, childbirth and conception control, and unnecessary surgery. Fifteen of the 18 speakers were from the conference region. The conference organizers, a group of approximately 20 women from the north west, had such a positive experience in working together and such an overwhelming response to the health conference, that they have offered to organize this year's Northern Women's Conference.

Simultaneous Ontario Conferences: Two Ontario women and health conferences, funded by Health Promotion Branch — Ontario Region, were held simultaneously in Toronto on March 27 - 29.

Jan Curry reported that approximately 200 women registered for the Woman: The Centre of the Wheel of Life conference, organized by the Native Women's Council of Sudbury, in conjunction with an advisory committee of native women from all over Ontario. The central theme, reflected in the conference title, was discussed in terms of mothering, bonding and the family, and provided the focus for each of the sessions. The Saturday workshops dealt with addiction and herbal medicine, nutrition, mental health, midwifery and mothering. Sunday skills sessions followed up on these areas. The two elders present directed and focused the tone of the conference and helped to create the spiritual base and ceremonial quality which made this more a "gathering" than a conference.

Between 200 and 250 women took part in the Strategies for Well Being Conference organized by representatives from seven health and women's organizations. Theme sessions explored technology, taking responsibility, professionalism and the commonality of women's health problems. Occupational health, violence, poverty, chemical dependence, community organizing, fund raising, burn-out, media and reproductive issues were among many strategy and skill sessions held. Networking was emphasized throughout the conference, with Francophone, Toronto and national networks getting a boost. The ad hoc funding committee for a national network is meeting with government contacts and the Toronto network has had one meeting.

MANITOBA — Lissa Donner

Women's Health Clinic to Open: Pregnancy information Service (PIS) of Winnipeg has received funding under the Canada Community Services Program to establish a Women's Health Clinic. The Clinic opened May 4, 1981. PIS has been operating two evenings per week out of the facilities of Klinic, a community health centre.

The new Women's Health Clinic will provide complete health care to women and their children, with an emphasis on prevention and self-help. The staff will include, two medical assistants/receptionists, a director, one full-time physician and volunteer workers. The Clinic is soliciting additional funds to augment the low level of government funding. Send tax-deductible donations to: Women's Health Clinic, 555 Broadway Ave., Winnipeg.

Ste. Adolphe Nursing Home Lockout Settled: On March 11, 1981 the nurses' aides at the Ste. Adolphe Nursing Home, about ten miles south of Winnipeg, staged an 8 hour rotating strike. Management responded by firing all 46 aides. Of these, only three crossed the picket lines and re-applied for their old jobs. Strikebreakers were bused in daily from a similar facility in nearby St. Norbert, owned by the same family which owns the Ste. Adolphe institution.

The lockout was unique and exciting because of the strong community support for the women. Husbands and children joined the picket line; the parish priest offered the parish hall basement as a union headquarters; casual workers at the nursing home walked out in sympathy; the village held a dinner and dance for the workers.

The support of the nurses working in the nursing home was also critical. As the result of their complaints, the Manitoba Organization of Nurses' Associations made a public statement that care in the institution was not satisfactory, in direct contradiction to the statements of the Minister of Health that the lockout was in no way affecting patient care.

The lockout ended on March 27 when the owners agreed to take all the original workers back and to submit all other items to binding arbitration. The strike-turned-lockout will remain an enduring and heartening example of a community united in support of its women workers.

Regional Reports

ALBERTA — Ellen Seaman

Social services scandal: A major scandal has broken around foster care and child protection. The report of the Alberta Ombudsman severely criticized the screening and supervision of foster families and described the Alberta Child Abuse Registry as totally inadequate. Several top-level child care officials have been transferred and recruitment of social workers is taking place, but cynics remain skeptical about fundamental changes in the department.

Home Births: In a classic Catch-22 situation, the Alberta Medical Association has decided that no doctor may perform home births unless s/he has hospital privileges. It was just over a year ago that the one remaining Alberta doctor brave enough to do home births *lost* his hospital privileges.

Heritage Trust Fund: Albertans can look forward to an explosion in medical technology as the government tries to buy prestige through a $300 million medical research endowment fund. Areas of research include biomedical engineering, research into synthetic antigens, a children's research facility and purchase of equipment such as a heavy ion nuclear accelerator.

Another local scandal: Smiths Ambulance, which has a contract within Edmonton to deliver all ambulance service, and its owner pleaded guilty to defrauding Blue Cross and the Alberta Social Services Department of $60,000. The scheme involved substituting the name of welfare recipients for cancelled calls and for "customers unable to pay". The company's owner was fined $60,000. Smiths is still providing ambulance service in the city while the city attempts to buy the company out. Smiths has also been accused by former employees of substandard maintenance of vehicles and equipment and of skimping on purchase of expensive supplies.

BRITISH COLUMBIA

VICTORIA — Susan Moger

Abortion: Victoria has for the last 6 months been the site of a vociferous battle between pro-choice and pro-life forces. In September 1980 approximately 1500 people attended the Annual General Meeting of Victoria General Hospital to elect the hospital's Board of Directors. A pro-life slate was swept to victory, with an almost two to one majority. After the election, a surprise motion to dissolve the hospital's therapeutic abortion committee passed easily.

October found the annual general meeting of Victoria's other major hospital, the Royal Jubilee, to be almost a repeat performance. However, since only 4 of the 13 trustees on the Jubilee board are elected, the pro-life people (who did fill all 4 elected seats) could not get a majority.

By November many of us were wondering if any women could get an abortion in Victoria. However, in December both hospitals re-established larger abortion committees with membership that will change every month. Thus abortions are presently available, but the situation is precarious. Publicity around the issue has made women hesitant to seek abortions in Victoria. A Family Practice Clinic in Bellingham, Washington has reported an increased number of requests by Canadian women for pregnancy termination. A local psychiatrist wrote a letter-to-the-editor stating, in part, that "A malicious rumor has developed, because of recent publicity, that it is impossible to get an abortion in Victoria. Girls become fearful and leave it too late. We are now back in the era of septic self-induced abortions presented at emergency wards."

VANCOUVER

Brief News: Beth Hutchinson provided us with information on the current fee dispute between doctors and the provincial government. The doctors in British Columbia, already the highest paid in Canada, are asking for a fee increase totalling 41%. Since the end of March, doctors have been entitled to bill patients the difference between the proposed fee schedule and the 1981 Medicare fee schedule.

A B.C. Supreme Court judgehas recently ruled that workers appealing against decisions by the Workers' Compensation Board have a right to access to their files and that failure to provide such access is a denial of natural justice.

Letters

We reserve the option to print letters to Healthsharing with minor editing for length, unless they are marked "not for publication."

Non-ionizing Radiation

I would like to comment on Jennifer Penney's excellent article on Radiation in your Spring 1981 issue. She says in relation to ionizing radiation, "When people worry about . . . birth defects from radiation, this is the type they are worried about." Jennifer is probably right, people do worry about ionizing radiation but the non-ioning forms should not be ignored.

Both birth defects and damage to chromosomes have been produced in experimental animals exposed to radio frequency and microwave radiation. In addition, a significant number of young women working at the American Embassy in Moscow who were exposed to microwaves were found to have chromosomal abnormalities. There have also been reports of an association between microwave radiation and increased birth defects in the offspring of pilots.

The evidence is by no means conclusive. The question of potential genetic effects of radio frequency and microwave radiation is open and needs to be investigated.

Gary Cwitco
National Representative, Communications Workers of Canada

Sponges or Tampons?

With regards to *Troubles With Tampons* by J.F. Houldon (Winter, 1980): Are there any plans to do a comprehensive article on sponges? I have been using a sponge for almost a year now with no problems. It seems much better than tampons — more comfortable and ecological. My family doctor, however, advised against its use, because of problems keeping it sterile or at least bacteria-free. Given the alternatives, though, I am reluctant to switch (napkins give me dermatitis).

LouAnne Meloche
Windsor, Ontario

Microwave Ovens

Your Spring issue, my first, is very interesting. I suggest you also consider other electromagnetic exposures — microwaves from ovens etc. Microwave ovens are being successfully promoted for working women, the handicapped, etc. *Consumer's Report* this month has a big spread *but* waffles on safety. *Science News*, March 14, tells of a "Landmark Award for microwave sickness" from low-level exposure. Leakage is the criterion with no mention of what is happening to food.

Once again women are being taken to the cleaners.

Alice Steele
Peterborough, New Hampshire

Concerns about Alternatives

I have some reservations about the article on endometriosis in the Spring 1981 issue. Conventional medicine may be ineffective and potentially harmful but "alternatives" should be examined critically. Clara Valverde describes treatments with little rational explanation of how or why they work. Her methods may do no harm but just because a drug is "natural" is no guarantee it is good for you (e.g., deadly nightshade). Even vitamins and minerals in quantities many times what could be consumed in food resemble pharmaceutical products more than they resemble natural substances.

I do not wish to criticize self healing. But, we must take care to work rationally and not throw out the "scientific method". The companies marketing herbs and vitamins are big business and we should treat them with some scepticism.

Ellen Seaman
Edmonton, Alberta

Autonomy as Power

I think there may be another perspective on Ellen's perception of Alberta's Bill 84 (*Regional Reports*, Spring, 1981). Certainly some groups may fear losing their autonomy, but if you translate autonomy to *power*, this effect may not be totally bad.

Homeopaths and other alternative care givers here in B.C. were very optimistic about the Alberta Bill. The Bill might neutralize the strangle-hold of allopathic medicine and dilute the ability of conventional medicine to control competitive approaches. Having all health occupations controlled directly or indirectly by the medical profession has certainly limited options available to consumers.

After reading my latest issue, I'm once again amazed at the quality of research and insight. *Problem:* I'd love to be able to contact contributors. Is there any way to develop the network idea further? Routing mail through you people?

Louise Morgan
Vancouver, B.C.

Health Wanted

If you are having a specific health problem and aren't coming up with a solution or if you are researching a topic, write to Health Wanted c/o Women Healthsharing. We will print your request in Health Wanted so that readers can respond directly to you. Be sure to include a complete mailing address.

Turn of the Century Health

I am researching women's health problems in Toronto 1880 - 1930. I would welcome autobiographical material and personal reminiscences describing childbirth experiences or gynaecological disorders and their medical treatment. Please write to Felicity Nowell-Smith, P.O. Box 63, King City, Ontario L0G 1K0

Acne Sufferers

Do you or have you suffered social or emotional trauma due to acne? I am conducting a survey to write an article on the emotional turmoil of women with acne experience. Your name will be kept confidential. Please write to Paul Weinberg, 485 Broadview Ave., Toronto, Ontario M4K 2N4.

Women Healthsharing
Box 230, Station M
Toronto, Ontario M6S 4T3

Resources & Events

The International Women and Health Resource Guide

by the Boston Women's Health Book Collective and ISIS

This is a joint project representing four years of gathering information from around the world. Annotations for both literature and groups appear in English and, where applicable, one other language (French, Spanish, Italian, German). Single copies of the Guide are available for $5.00 (surface mail) or $8.00 (air mail) from the Boston Women's Health Book Collective, Box 192, W. Somerville, Massachusetts, USA 02144

Midwifery Associations — B.C. and Ontario

Midwifery associations have recently formed in B.C. and Ontario.

The British Columbia Association of Midwives (BCAM) was formed following the conference, "Midwifery is . . . a labour of love." The purposes of the Association are to improve the quality of care available to the childbearing family, and to enhance the safety and flexibility of childbirth by promoting the legalization of midwives. Membership is open to midwives, obstetrical nurses and childbirth educators. Associate membership is also available. Cost is $10 per year. For further information write to BCAM, 1053 Douglas Cres., Vancouver, British Columbia V6H 1V4.

The Midwifery Task Force is an interdisciplinary planning group working towards a creation of a model midwifery service to serve the people of British Columbia. For further information write to MTF, 926 School Green, Vancouver, British Columbia V6H 3N7.

Meanwhile in Ontario, the Ontario Association of Midwives has been created. The Association is open to midwives, parents, friends and other associates concerned with homebirth and midwifery. Cost is $10 annually, which includes a subscription to the quarterly newsletter, *Issue*. For further information write the Ontario Association of Midwives, 20 London Rd. W., Guelph, Ontario N1H 2B5.

Midwifery Conference — Loving Hands

The Ontario Association of Midwives is hosting a conference and retreat in Elora Gorge Park (near Guelph, Ontario) from August 16 to 20.

Featured speakers include Rahima Baldwin, author of *Special Delivery* and president of Informed Homebirth, Murray Enkin, professor of Obstetrics at McMaster University, Irene Gordon, a certified lay midwife from New Mexico and Lee Saxwell of the British Columbia Association of Midwives. Camping and day-care are available. For further information please write to the Ontario Association of Midwives, 20 London Rd., Guelph, Ontario N1H 2B5.

Education for Survival

These are four ninety-minute tapes of the highlights of the 1980 Black Hills Survival Gathering in South Dakota. The topics are Nuclear Power and the Endangered Human Species, Multinational Corporations and You, Environmental Pollution and the Point of No Return — American Indian Perspectives on Human Extinction. Cost is $9.50 each or $35 for four. Include $1 for postage outside the U.S. Available from White Buffalo Multi-Media, P.O. Box 73, Woodstock, New York 12498.

The Childbirth Picture Book — A Picture Story of Reproduction from a Woman's View

by Fran Hosken, drawings by Marcia Williams

This book is designed as a basic resource book for women and men, especially the young, to inform themselves about reproduction and birth. It includes female and male anatomy, pregnancy, nutrition and birth control.

Published by WIN News, 187 Grant St., Lexington, Massachusetts, USA 02173. Cost is $7; bulk rates are available.