

FALL 1982

\$1.75

Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

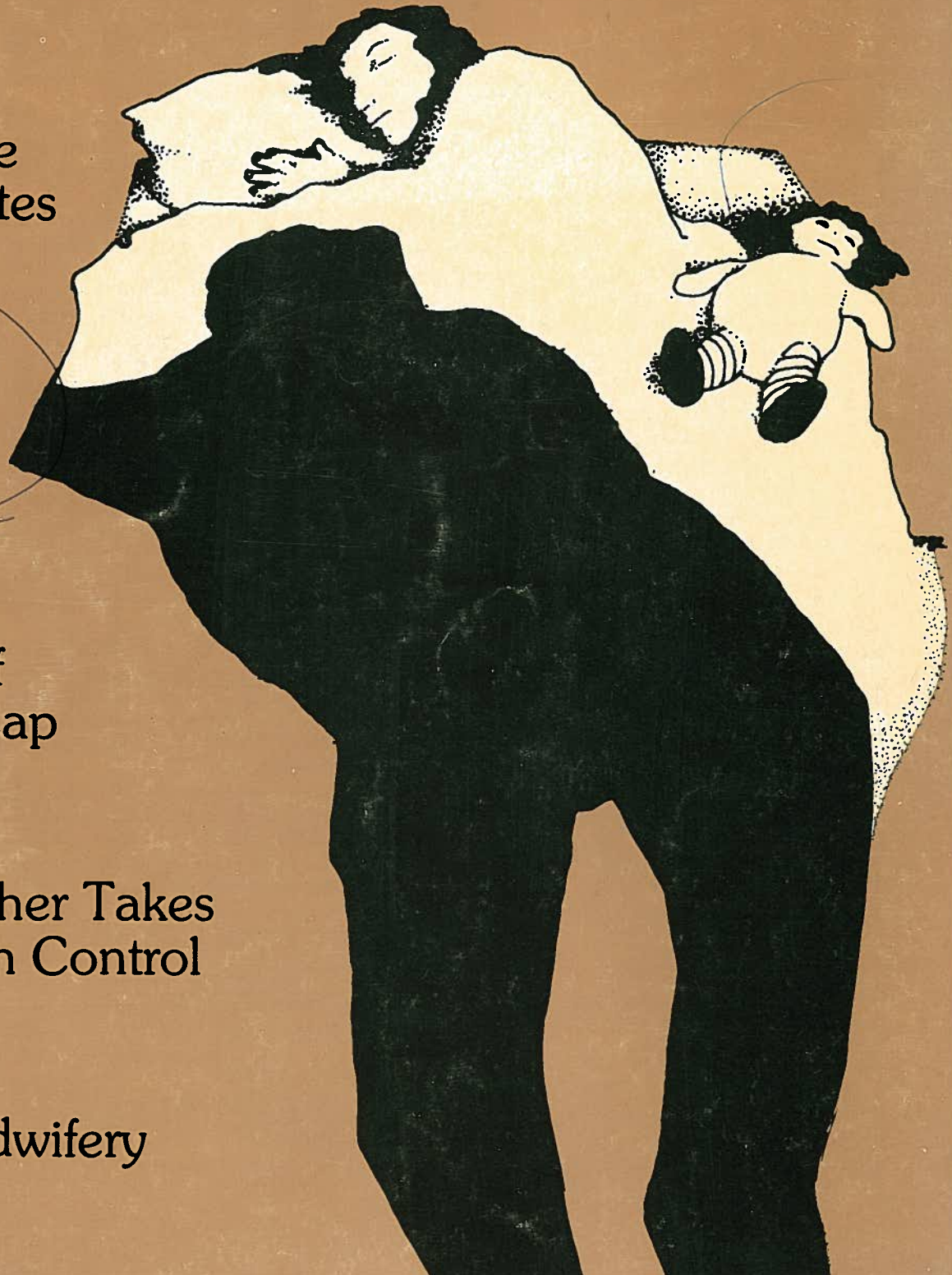
Unmasking the
Incest Advocates

The Case 
Against
Depo Provera

The Revival of
the Cervical Cap

Dawna Gallagher Takes
a Look at Birth Control

Update on Midwifery



READ HYSTERIA!

for a blend of information, analysis, and discussion of our experiences as women. Each issue focuses on a theme important to women.

\$8 for four issues; \$15 for organizations/institutions; \$20 for Sustaining Subscriptions; \$2.50 for a sample issue. (Please add \$2 for postage outside Canada.)

Make Cheques
Payable to:
HYSTERIA
Dept. C,
P.O. Box 2481,
Station B,
Kitchener, Ontario
N2H 6M3



†NEW FICTION†

Quilt

by DONNA E. SMYTH

This powerful new Nova Scotia novel explores a day in the lives of three women — a widow, a housewife and a woman who has been violently abused. \$7.95

Also from *The Women's Press*:

DRAGONHUNT

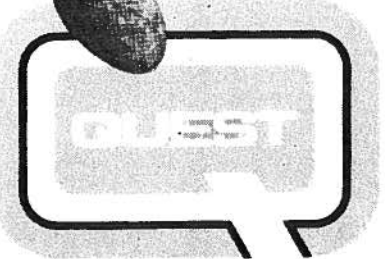
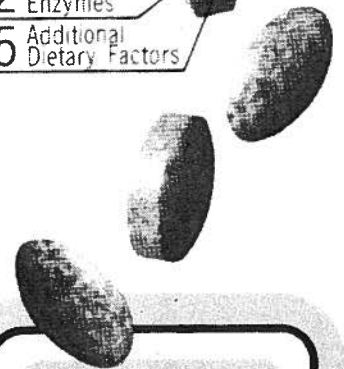
by FRANCES DUNCAN \$5.95

THE TRUE STORY OF IDA JOHNSON

by SHARON RIIS \$3.25



15 Vitamins
11 Minerals
3 Amino Acids
2 Enzymes
5 Additional Dietary Factors



SUPER
'ONCE-A-DAY'

Quest Vitamin Supplies
Vancouver, B.C. V5X 3E8
Markham, Ont. L3R 4B5

TORONTO WOMEN'S BOOKSTORE

85 Harbord Street
west of Spadina
922-8744



SOLVING PROBLEMS TOGETHER WORKSHOPS WITH HOGIE WYCKOFF

SEPT. 11: SHARING POWER
1982 IN GROUPS

SEPT. 12: MEDIATING
1982 CONFLICTS IN
LOVING
RELATIONSHIPS

COOPERATIVE
PROBLEM SOLVING
SKILLS FOR EVERYONE!

FOR INFORMATION:
WENDY WILDFONG
977-0119

Collective Notes

Depo Provera and cervical caps . . . more birth control methods to choose from and still no choice at all.

Janis Sarra's Depo article shows how this injectable hormone is in danger of being pushed on us the way it has been in the Third World. Rosemary Knes tells us how the cervical cap is being held back from our eager hands.

Pushing for Depo to be approved in Canada as a method of birth control are the medical and drug industries. They tout the convenience of the once every three months injection as a "carefree" solution to our birth control needs. We have to ask — carefree for whom?

We can see that Depo will certainly be "carefree" for our doctors who won't have to worry about patient compliance and who, we note, will get a guaranteed office visit every three months, paid for by our health insurance plans (and, in many cases, out of our own pockets).

Depo will certainly be marketed to women as a "carefree" solution. We are told that we don't want to worry about birth control interfering with our spontaneity at the Big Moment. But again we ask — spontaneity at what price?

As with other systemic methods of birth control, the "shot" has a reputation for bad "side effects". Depo has been associated with infertility and cancer and has been implicated in population control scandals.

On the other hand, the medical industry generally has a less than enthusiastic attitude to barrier methods like the diaphragm. Resistance to the cervical cap comes as no surprise to us.

Doctors talk about the hassle, inconvenience, and even the discomfort one goes through before one can use the cervical cap comfortably. Hassle for whom? Somehow we are expected to persevere with the discomfort and hassle of contact lenses and make-up. No one is trying to talk us out of these.

We freely admit that to be properly used, cervical caps require a deep understanding of ourselves physically, sexually and socially — but this is a positive aspect of this method of birth control. Acquiring this knowledge is itself a freeing and liberating experience. We gain power over our reproduction, sexuality and availability.

However, it is true that barrier methods are not as effective as pills and shots. Unplanned pregnancy is a real fear. We are told, either implicitly or explicitly, that getting pregnant is the worst thing that could happen to us, much worse than the possibility of infertility, loss of libido or cancer. It is implied that we are not serious about contraception if we choose non-invasive methods such as the cervical cap or condom.

How is it that abortion is never mentioned as a back-up? The safety of the first trimester abortion is well-known. Choosing to have an abortion is a difficult decision. The decision itself and all that follows from it have been greatly complicated by the lack of availability and the way abortion has become the central plank in the political platform of the New Right (as it is now called, although it looks to us as if the New Right is just the Old Right given a fresh coat of paint).

Depo and cervical caps are on opposite ends of the birth control spectrum. Analyzing the situation makes us reaffirm demands that have been made for over a century — the need for more research into safe and effective birth control for men and women and easy access to abortion. We've heard them all before. The struggle goes on . . . but still no research; no safe, effective birth control; only limited access to abortion . . . the struggle must go on.

Madeline Boscoe
Betty Burcher
Connie Clement

Anne Rochon Ford
Diana Majury
Lisa McCaskell

Jennifer Penney
Susan Wortman
Sharon Zigelstein

Inside Healthsharing

FEATURES

- 8 Update on Midwifery**
by Betty Burcher
- 10 Breach of Trust: Unmasking the Incest Advocates**
An analysis of the pro-incest lobby
by Anne Rochon Ford
- 14 A Comic Look At Birth Control**
by Dawna Gallagher
- 16 In Great Demand: The Revival of the Cervical Cap**
A discussion of the history, use and availability of cervical caps
by Rosemary Knes
- 20 The Case Against Depo Provera**
The rights of women have been violated by the use of this drug as a contraceptive
by Janis Sarra

NEWS

- 4 Newsfronts**
25 Regional Reports

OUR READERS WRITE

- 7 My Story, Our Story**
For My Mother
by Amy Gottlieb
- 27 Letters**

ETCETERA

- 3 Collective Notes**
6 Healthwise
24 Review
A New View of a Woman's Body
How to Stay Out of the Gynecologist's Office
reviewed by Melanie Conn
- 28 Resources and Events**



Reaching a collective agreement to contribute yourself from quicksand

**published by
Women Healthsharing**

Collective members

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

Associates

Rona Achilles, Adelyn Bowland

Office Manager

Elizabeth Allemang

Regional Reporters

Winnifred McCarthy
Susan Hower, Ellen Seaman
Susan Moger, Clara Valverde
Regina Healthsharing
Lorna Zaback

Thanks This Issue To

Elizabeth Allemang
Gilbert Bélisle
John Ford
Linda Lounsberry
Linda Bumett

Cover Illustration

Christina Farmilo

Typesetters

Dumont Press Graphix

Printer

Muskox Press

Healthsharing (ISSN: 0226-1510), Volume III, Number 3, June, 1982. Published quarterly by Women Healthsharing, Inc., A Resource and Writing Collective, Box 230, Station M, Toronto, Ontario M6S 4T3. Phone: 416-598-2658. Women Healthsharing endeavours to print material with which we agree; however not every article or column reflects the opinion of all collective members. Authors and artists retain copyright, 1982. No part of this magazine may be reprinted without prior permission. Unsolicited manuscripts or artwork should include a stamped, self-addressed envelope. Subscription rates are \$6.75/year, individuals; \$13.50/year, institutions and groups; \$25.00/year, sustaining. Foreign subs, including USA, are \$8.00/year, individuals; \$15.00/year, institutions.

Newsfronts

Nurses Better Than Doctors

A University of Manitoba study shows that nurse practitioners can be more effective in treating patients with high blood pressure than doctors. The report is one of several recent investigations which have demonstrated that nurses can provide an equal or superior quality of medical care.

The study, published in the *American Journal of Public Health*, compared groups of patients attending a traditional hypertension clinic with care provided by physicians, with a new blood pressure clinic staffed by nurses.

Patients attending the nurses' clinic were much more successful in losing a significant

amount of weight and lowering their blood pressure than those treated by doctors. Nurses' patients lost as much as 11 kilograms while the most a doctor's patient lost was just over two. Patients in the doctors' program were more likely to gain weight.

Janice Ramsay, principal investigator for the study, pointed out that doctors were more likely to prescribe drugs for hypertension while the nurses opted for weight and diet control. However, even where doctors referred their patients to hospital dieticians, weight control was poor.

"Nurses showed a preference for managing their own

patients" Ramsay told *Healthsharing*. "They took the time to sit down and give practical advice. People don't see him (the physician) for advice around food purchasing and preparation, what to avoid, chemical composition of food and so on."

The study also confirmed past research which has shown that "nurses follow their patients more closely by scheduling more appointments and spending more time with them than physicians."

Ironically, the release of this information coincides with the death of most Canadian nurse practitioner programs. Only one of seven original training programs for nurse practitioners remains in place today, at the University of Alberta, says Ramsay. It appears that the opposition of doctors to the independent work of nurse practitioners has been most effective. "Nurse practitioners have nothing to do after training," Ramsay declares. "They can't utilize it because jobs just aren't available."

Watch for Herpes — In the Can

New information about the survival of the herpes virus on toilet seats, has raised anew the spectre of venereal disease spread in public washrooms.

Dr. Trudy Larson of the University of California found that the herpes simplex virus (HSV) can survive on a toilet seat for at least four hours. Both the oral and genital types of the virus also survive for at least 72 hours on dry gauze, 18 hours on a speculum, and one hour on gloves. As Larson pointed out in an address to the American Pediatric Society, this "gives rise to speculation of possible non-venereal transmission of HSV to susceptible patients in the setting of the clinic exam room, hospital or during routine daily activities."

Transmission of the virus is unlikely to occur through intact skin, but is possible if it comes into contact with the mucous membranes of the vaginal wall

or mouth, or open cuts in the skin. Larson recommends using paper covers to provide added protection on toilet seats, as well as careful hand-washing. She pointed out that laundry bleach kills the virus.

Larson suggests that her study's findings help explain cases of genital herpes in children and adults who have no history of direct sexual contact with affected persons.

Better Use of the Bathroom Wall

Tired of staring at bare walls or reading about other people's sex lives in public washrooms? A recent issue of *The Lancet* reports on a study that suggest a more productive use of this time.

American researchers at Upstate Medical Centre in Syracuse found that both undergraduates and practising nurses benefitted from exposure to posters on lavatory walls describing CPR (Cardiopulmo-

nary Resuscitation) skills. Lay undergraduates improved 24% in theoretical knowledge and practising nurses improved significantly in both theoretical knowledge and performance.

'Passive exposure' is a useful health education technique because it is self-instructional and reduces teacher and student time to a minimum. Its major disadvantage is that the posters have to be replaced frequently because of graffiti.

Contraceptive Shot to the Nose

If Scottish scientists have their way, women who currently begin their day by swallowing a birth control pill may switch to a shot of nasal spray... contraceptive, not decongestant.

The spray consists of a synthetic version of a substance called luteinizing hormone-releasing hormone (LHRH) which is naturally found in the body. Daily intake of the substance inhibits ovulation.

Dr. Hamish Fraser, who wrote a report on the new contraceptive for *Nature*, explained that it is given as a nasal spray because "it can be easily absorbed into the bloodstream through the mucous membranes in the nose. It cannot be turned into a pill because the stomach would break it down chemically and render it ineffective."

Fraser believes the nasal contraceptive would be more acceptable to millions of women than the pill which, he complains, has led to "an excessive fear of side effects, a suspicion of new developments and an environment in which pharmaceutical companies find it financially impossible to develop new contraceptives."

The spray produces none of the "side effects" associated with the pill (headaches, nausea, weight gain, etc.). However, it is not without its problems. Taken daily, it can produce "variable and unpredictable" changes in estrogen levels in women: Too little estrogen and women develop menopausal symptoms. Too much and there develops a proliferation in the endometrial cells lining the uterus. The long-term effects of this "side effect" are unknown.

The spray could also result in amenorrhea (absence of menstruation) in many women.

LHRH contraception has also been tested on men by means of daily injection for 6-10 weeks. While the sub-

stance was successful in creating a substantial decline in sperm counts, it also caused a decline in sex drive, impotence and even hot flashes in test subjects. Fraser argues that LHRH "in principle permits partners to share fertility control". Unfortunately, men are unlikely to increase their historically small role in birth control if these effects are known. Back to the drawing board.

We've Come a Short Way, Baby

A recently published survey of a thousand male and female medical students, faculty and administrators, found that men have a long way to go before accepting women as equals in the medical profession.

According to the report, published in a recent issue of the *Journal of the American Medical Association*, almost half the men surveyed believed that "women physicians who spend long hours at work neglect home and family." Women sharply disagreed with this viewpoint.

Almost half the men rejected the idea that more women leaders are needed to train medical students. Over a third of the men described themselves as "more productive" in medical academia than women.

In one area, male and female students agreed substantially. They described male faculty as tending to be more egotistical, and women as more sensitive and altruistic.

The authors of the study also had some interesting comments on the differences between female students and faculty members in their level of support for more women in teaching positions. "In general, female students are more fervent than female faculty members, a finding that probably reflects prevalent attitudes among older women physicians, many of whom succeeded without 'affirmative action', leaving them less receptive to external interference or 'special treatment'. (In feminist literature, this is known as the "Queen Bee Syndrome".)

The authors also comment on male resistance to increasing numbers of women as students and faculty in medical schools: "As a group, male students are directly threatened by competition with burgeoning numbers of women medical students for postgraduate training programs and, ultimately, private practice and academic positions. It is well known that persons in the throes of the process of socialization in a profession are more resistant to changing the 'rules of the game' than those already established."

Ginger Beats Out Graval

Try powdered ginger instead of Graval the next time you anticipate a bout of motion sickness. It works better.

Two Ohio psychologists recently compared the effects of powdered whole ginger root, dimenhydrinate (Graval, Dramamine) and a placebo in 36 women and men with a high susceptibility to motion sickness. Capsules were given to

the test subjects, who were then blindfolded and placed in a tilted, slowly revolving chair. Every 15 seconds, the subject reported on the degree of motion sickness she experienced.

People receiving the ginger capsules were able to stay in the rotating chair much longer, and felt less nausea and other symptoms.

Tanning Agents Unsafe in the Sun

Suntanning agents, widely promoted as protecting the skin against harmful effects of the ultraviolet rays found in sunlight, may cause some of the problems they are supposed to solve.

The *Medical Post* recently reported that two types of chemicals widely used in suntan and sunscreen lotions are carcinogenic (can cause cancer). One group, called psoralens, promote the mutation of cells when applied to the skin. Ironically, this process is enhanced in the presence of ultraviolet light.

Mice treated with psoralens and exposed to ultraviolet light, developed multiple tumours, some of which developed into malignant cancers. The rate of skin aging was also much faster in rats treated with psoralens.

Psoralens are extracted from the small citrus plant bergamot, and are also used in some teas

and cosmetics.

People should avoid using sunscreens with psoralens or bergamot derivatives, or at least stay in the shade!

Dihydroacetone (DHA) is the other chemical to be on the lookout for. DHA is used in artificial tanning lotions such as QT. Like the psoralens, it appears to be most potent in combination with ultraviolet light.

The Harvard researchers who delivered the bad news about DHA also tested other agents such as para-aminobenzoic acid (PABA) and PABA-esters. They reported that most of these substances appear to be inert, although some impurities have been found which have cell-altering properties.

Maybe the Victorian ladies who went to great efforts to protect their skins from the sun had the right idea.



JEWELLERY INDUCED DERMATITIS

If gold jewellery is giving you a rash on fingers, ear lobes or wrists, you can attribute it to the high price of gold on the market today. Gold of 14 Karats or less is likely to contain nickel alloy, the agent which is really causing the dermatitis to erupt. Sensitive skin and emotional disturbance appear to be the major factors contributing to dermatitis in areas exposed to jewellery.

SCOLIOSIS

Teodolinda Busico is trying to obtain information on Scoliosis groups or societies in Ontario, Canada or other countries. Please write to her with any information you may have at 346 W. Pike Creek Rd., Tecumseh, Ont. N8N 2L9.

HORMONAL IMBALANCE

Geraldine Soloway of Toronto is interested in hearing from anyone who has been operated on for a craniopharyngioma brain tumour and is on medication because of a hormonal imbalance resulting from the operation. Write her at 68 Dunn Ave., Toronto, M6K 2R6 or phone 416-536-2315.

DES DAUGHTERS

Harriet Simard of Montréal is trying to organize a DES publicity/action campaign in Canada. If you are a DES daughter, Harriet would like to hear from you. Write c/o S. Simard, Box 233, Snowdon Post Office, Montréal, Québec, H3X 3T4.

Healthwise

Lactose Intolerance: No More Milk?

by Yvonne Tremblay

Your doctor, chiropractor, naturopath or nutritionist has just diagnosed you as having Lactose Intolerance, and you've heard of it but aren't too sure what it's all about. Does it mean no more milk products?

Lactose Intolerance is a condition in which individuals have very low levels of the intestinal enzyme lactase. Lactase breaks down the milk sugar lactose into glucose and galactose so that they can be absorbed by the body.

Symptoms include abdominal distention, frothy diarrhea, flatulence, rumbling noises in the bowel, and spasmodic abdominal pain. These symptoms, following consumption of milk products, are a good indication of low lactase levels. Removal of foods containing lactose from the diet (i.e. all products made from animal milks including cheese, yogurt, ice cream, powdered milk, and processed foods containing these products) should eliminate these symptoms.

Lactose Intolerance is equally common in both sexes. Its incidence is lowest in white adults of Scandinavian and West European ancestry (2% to 8%) and highest in those of Mediterranean, African and Asiatic origin (60% to over 90%). It is common as well among Eskimos and North American Indians.

Lactose Intolerance can be inherited. Theories suggest that in early times where dairying and drinking milk became the pattern, adult humans eventually developed a tolerance for lactose and it was incorporated into their genetic make-up.

All babies are born with the ability to break down lactose. In those predisposed to lactose intolerance, lactase levels diminish considerably after three or four years of age. Decreased lactase activity, as a result of surgery or disease (i.e. celiac disease, cystic fibrosis, protein malnutrition), is also common. Restriction of milk products is usually temporary.

Treatment should be individualized. People vary in their ability to consume different levels of milk products. Some can tolerate one or two glasses of milk per day. Many can consume fermented dairy products such as yogurt, cottage cheese, buttermilk, sour cream and cheese with no problems.

The most significant breakthrough for those who are lactose intolerant came in the early sixties with the discovery that certain microbes can make lactase. A product called Lact-Aid was then developed. (It is available from most health food stores or drugstores in powder or liquid form.) It is stirred directly into a litre of any milk, refrigerated 24 hours and is ready to drink. The milk will have a slightly sweeter taste. If your sensitivity to milk is a result of lactose intolerance, using Lact-Aid should eliminate symptoms within three to five days. If you are still bothered, a milk allergy, ulcer or other problem might be the cause.

Dairy products are important to the diet because they are a good source of high quality protein and are rich in B vitamins and minerals. The help of a good therapist trained in nutrition is important in determining to what extent milk products can be kept in the diet of someone whose lactase levels are low. Lactose Intolerance need not necessarily mean the elimination of all milk products from the diet.

Yvonne Tremblay holds a Bachelor of Applied Science in Human Nutrition from the University of Guelph. She is currently a freelance food and nutrition consultant in Toronto.

My Story, Our Story

My story, our story is every woman's experience — our collective experience — with health.

For My Mother

by Amy Gottlieb

She is gone now, existing only in my memory. I carry her around daily, remembering. Her smell, her warm voice, her sensual Jewish nose, her vibrant energy, her anger, her self-denial. I recall her strength, caring and knowledge of the world. I recall her broken confidence, unrealized dreams, frustrated energy. I vividly remember the Sunday phone calls, the numerous letters and before that, the seventeen years I lived with her.

And then the image that I can't push out of my mind comes back. She is lying in bed, in the back room of the apartment in the middle of Manhattan that she made her own for 28 years. In the back room, where I used to sleep when I came to visit. In the back room, where the sound of fire engines never lets you forget the city. In this room, in this bed, my mother felt her last pain, her last caress.

The knot won't untie. My shoulders and neck are like steel, protecting me from losing control, losing any semblance of my life which continues. I am sad and bitter at my loss. I lay awake at night fearing for my life and all of us, thinking about those tiny deformed cells making a home in her body, eating away at her for 21 years. Just deformed cells.

I take courage from her long struggle to survive, to go on even when the pain of recognition was enough to rip her apart. I take courage that I have survived what I have dreaded for most of my life. I have depended on her strength to survive, on the strength and

tenderness of my loving friends. And it is with my mother, my friends and all daughters that I want to share my pain and my hope.

It's been six months since she died, yet I can remember each second of every day I spent watching her die. The sense of powerlessness watching her slip away, wondering what else she was feeling besides fear. Watching her sleep, giving her pain killers, making her comfortable, all the time wondering ... is this my mother? How could she be dying? The last night, sleeping in the same room with her, aware of her every breath, she cried out for me and my father in her stubborn and raspy voice. I was suddenly shaken into full recognition that, yes, this was my mother.

Sirens ring in my ears, terrorizing me. The ambulance is rushing to the hospital along the all-too-familiar streets, past gutted tenements, sleek apartments, the constant street life. My mother cannot see this at all, strapped into the stretcher, hooked up to oxygen, unconscious. I feel caught between the continuing life on the streets and my mother's life that is about to go out. And the siren pierces my consciousness bringing tears of fear, the tears of a small child frightened of saying goodbye to one of her most precious lifelines.

The red tape, the questions, the madhouse hospital environment and then the deafening voice of the doctor, "she won't make it through the day." Being asked whether we want her to be put on life support systems gives us only the faint illusion of having control. Better to see her die in grace rather than to live on as a mere vegetable.

I'm holding her hand, caressing her face, kissing her forehead, taking her all in. Not wanting to let go. The pacing, waiting for the doctor, waiting for death. While Wiesia and I talk with her doctor, she takes her last gasp. But I can't go, I can't leave her, she can't leave me.

I plant kisses on her face, hold her hand, stare at her scarred chest, never wanting to forget.

Out on the street, I want everything to stop. Don't they know, don't they care that for me the most precious woman in the world has died!

The stabbing pain and the sirens give way to numbness as the four of us get drunk. A Jewish wake.

How do you say goodbye to a mother, a companion, a friend? By remembering, celebrating, passing on the power of this woman. How hard that is to do in a society that fears death while creating it. How hard that is for me to do while feeling abandoned, like my anchor has been stolen.

I have woven my way through grief and pain, back to the arsenal of memories warm and strong. I envy others whose mothers are still alive, who can pick up the phone to talk with them, or who can visit them on a Sunday afternoon. I cry when I see or smell women who remind me of my mother.

Sometimes I have felt emptied of all my life, for the first time being able to acknowledge that I wanted to die with my mother. But alongside my feelings of loss, have grown my feelings of strength, my sense of carrying around inside of me all the beautiful and not so beautiful, radiant and not so radiant things my mother and I shared. I am aware of my loss and my gain. My fear and my courage.

Amy Gottlieb is a socialist feminist active in the Toronto International Women's Day Committee and Lesbians Against the Right. She is a typesetter and a paste-up artist.

MIDWIFERY UPDATE

by Betty Burcher

Eighty percent of babies around the world are born at the hands of a midwife. In Canada, midwives are illegal. Canada is the only industrialized nation in the world that does not recognize midwives. The re-emergence of the midwife in the last decade is part of the movement of women to gain control over our bodies, particularly reproductive control. Presently, midwives operate outside of the traditional healthcare system, primarily attending births at home.

We have received information from women in B.C., Ontario and Quebec where midwifery and homebirth are most public. We know that there is probably lots happening elsewhere and would love to hear from you. Please contact us or any of the organizations listed at the end of the article. It is important that information is shared so that we can discuss issues and take action, rather than watch as decisions are made for us.

Ontario

Midwives practice primarily in southern Ontario, but there are a few working in other areas. Metro Toronto midwives practice in a unique situation, working with several doctors who attend homebirths so there is always a doctor present at the birth. In the past year some midwives have been attending hospital births with sympathetic doctors, including obstetricians. This relationship allows midwives to bring women with complications into the hospital without meeting the hostility and ridicule that greeted them in the past. However, this a fragile bond and could easily be jeopardized if physicians are forced to stop attending homebirths.

In January 1982, a notice appeared in the College of Physicians

and Surgeons *Bulletin*. (See Health-sharing Volume III, No. 3 *Newsfronts* for more information). This carefully worded statement discouraged physicians from attending homebirths because the College considered homebirth not to be safe or in the patient's best interest. The College also considered it professional misconduct for a physician to permit, counsel or assist any person not licensed as a physician to engage in the practice of medicine. This statement is the clearest indication that the College (the governing body of the medical profession) has taken on homebirth and midwifery in Ontario.

A coroner's inquest in Kitchener, Ontario was held in June to investigate the stillbirth of an infant. The mother was attended at home by two midwives but was transferred to hospital when complications arose. The child died in hospital. The coroner concluded that the child died of anoxia (lack of oxygen) as a result of infection.

The recommendations of the coroner are surprising. Initially it was feared that the inquest would lead to charges against the midwives, either criminal charges or charges of practicing medicine without a license. Instead, recognizing that midwifery and homebirth are going on, the coroner recommended that literature on homebirth be made available and that the College of Physicians and Surgeons and the College of Nurses set standards for and establish a program of study in midwifery in the province of Ontario.

A second inquest was held in Toronto in July to investigate the death of a child born at home with both midwives and a doctor attending. An autopsy revealed that he died of accidental asphyxia caused by undetermined complications during the last 15 minutes of birth.

The coroner, Dr. Paul Tepperman said that he could see no problems with the level of care given to the infant and his mother by the doctor, but that he wanted the inquest to serve as a forum

to discuss setting guidelines for doctors performing home deliveries. He estimated that as many as 3% of Ontario's live births (3600 births take place at home every year. The major recommendations of the jury were that the province institute a certified training program for midwives and that a study be established to determine the feasibility of "flying squads" to deal with emergencies that arise in homebirths. It also called for guidelines for doctors who deliver babies at home, that records be kept of the monitored fetal heartbeat throughout the birth and that the placenta should be retained when a stillbirth occurs.

A year and a half ago, the Ontario Association of Midwives was formed initially as a support and information sharing network. It is composed solely of lay midwives and has no connection with nurse midwives. Following the two inquests, the Association has taken on a more formal structure.

Because of the recent inquests, a defence fund has been established to raise funds for legal costs. As well there are initial discussions about forming either a branch or an organization similar to the National Association of Parents for Safe Alternatives in Childbirth (NAPSAC).

Quebec

There are a number of midwives practicing in Quebec, mostly in urban areas. Montreal area midwives are turning people away because they cannot meet the demands for their services.

Homebirth is not illegal; however, the Quebec College of Physicians does not approve and doctors who attend homebirths do so at their own risk. As a result, there are not many who do.

From 1962 to 1972 there was a course offered for nurse-midwifery, primarily for nurses working in missions in the Third World. A group of

nurse-midwives trained in this course are pushing for the licensing of midwifery.

One very active provincial organization is called Naissance Renaissance and is working to humanize childbirth and for the legalization of midwifery.

In the last year the Parti Québécois government has held workshops all over the province asking women what they want. All of the workshops asked for birthing centres and midwifery. As a result the government has established committees at different levels looking at midwifery.

In an attempt to save money, the government has decided to close six small obstetrical wards in Montreal, centralizing maternity care in the bigger teaching hospitals. One of the closed wards was more progressive as well as having a good relationship with midwives. It is at this hospital that the Montreal childbirth movement is pushing to establish a birthing centre. The equipment and more importantly, "the spirit" is there.

The midwives are presently loosely organized in a network but plan to formalize their organization and hope to establish standards of practice.

British Columbia

In British Columbia, the situation differs from that of Ontario and Quebec. Doctors do not attend homebirths and hence midwives work as independent practitioners attending births at home.

Several years ago, there was an inquest into the death of an infant at home. The mother was attended by a woman who was previously trained as a doctor but was no longer licensed. The publicity and momentum around this inquest sparked a group to push for a birthing centre. It was to be run independent of physicians and to be staffed by nurse-midwives. Despite their intensive lobbying and excellent model, the centre was shelved because of lack of funding from the provincial government.

The focus on legalizing midwifery has become much more political in the last few years. There are two organizations. One is the B.C. Association of Midwives to which lay-midwives, nurse-midwives and obstetrical nurses all belong. The other organization is the Midwifery Task Force which has



drafted proposed standards, curriculum and legislation with the aim of legalizing midwifery in the province. Their model is adopted from Holland where midwives are a separate group, not encompassed under nursing. The standards they have created are taken from the World Health Organization guidelines for prenatal care and midwifery around the world. The Midwifery Task Force has met with the Ministry of Health several times and is now trying to get support for their proposal. Opposition comes from the B.C. Medical Association who are publicly opposed — "B.C. doesn't need midwives; we have a good health-care system."

Where Do We Go?

Obviously the issues of homebirth and midwifery are complex. There are many questions that those of us active in the childbirth movement — parents, potential parents, nurses, midwives and women — must address. We must decide whether the battle should be fought quietly by individuals working for changes here and there or by becoming organized and politically active, demanding the changes we want. Where do we stand on the question of licensing and standards? Who should establish the standards? Who should license midwives? Do we adopt a model like the College of Nurses or

College of Physicians? Should midwifery be a separate practice and not encompassed within nursing? Should nurses be working as midwives or are they too traditional, too steeped in the medical model? Where and when should medical technology be used?

It is still a small group of women who choose to give birth at home or who choose to have a midwife attend the birth. We are fighting for the right of all women to have all of the options available. However, despite the promising recommendations of the Ontario inquests, and the progress made to legalize midwifery in B.C., we still have a long way to go. But we are moving!

Betty Burcher is a member of Women Healthsharing and a nurse working in Toronto.

Childbirth Organizations

B.C. Association of Midwives,
1053 Douglas Cres.,
Vancouver, B.C. V6H 1V4

Ont. Association of Midwives
20 London Rd. W.,
Guelph, Ont. N1H 2B5

Naissance Renaissance
C.P. 249,
Montreal, Quebec H2T 3A7



Breach of Trust: Unmasking the Incest Advocates

by Anne Rochon Ford

illustrated by
Christina Farmilo

as a green light for sex between adults and children.

The incest advocates are not confined to men making a living from pornography, however. They include a wide range of people, from pedophiles who publish tacky little newsletters that circulate from hand to hand, to well-known and widely-publicized academics such as W.D. Pomeroy, co-author of the Kinsey Report. What we might call the "pro-incest lobby" is not a coordinated force, although small organizations of incest advocates do exist. It is not likely that Pomeroy would want to be lumped with the groups which push such lyrical slogans as:

*Sex before eight
Or else it's too late*

Nonetheless, these individuals do share a common interest in getting incest recognized as a legitimate sexual activity.

Because of the strength of the incest taboo, and because incest is illegal, not all of its advocates are willing to stand up and be counted. As a result, it is difficult to paint an accurate picture of the extent of pro-incest sentiment. Nevertheless, there are indications that the numbers of people advocating this activity are increasing. In addition to the growth of pro-incest academic literature on the one extreme, and hardcore pedophile materials on the other, magazines such as *Penthouse* and *Forum* are replete with pro-incest sentiment both in feature articles and letters. We can only guess at the potential impact of these sentiments. However, the readership of these magazines together with *Playboy* surpasses that of *Time* and *Newsweek* combined.

In this article, I have focussed on the phenomenon of father-daughter incest. This kind of incest, a frightfully dangerous expression of the patriarchal family, is by far the most common type. Although the film industry might have us believe otherwise, mother-son incest accounts for only about 5% of cases of reported incest, according to North American statistics available to date. Sibling incest, where there is not an imbalance of power between those involved, is usually much more benign.

Sexual values have changed dramatically in the last ten years. With these changes, we have seen an erosion of age-old sexual taboos. Many people now consider masturbation to be a normal activity for adults and a healthy and vital component of a child's sexual development. Sexual relations without the benefit of marriage vows no longer make social pariahs out of women.

Many of us judge the breakdown of these sexual taboos as positive and liberating. However, the attack on taboos has recently taken a new and frightening direction by those who interpret the current sexual revolution

Few of the public advocates of incest admit any self-interest in their advocacy of father-daughter sex. This is reserved for the more extreme pedophile literature. Instead, their central argument is based on the *child's* right to sexual freedom.

The pro-incest lobby also argues that the daughter of an incestuous father usually *wants* the relationship, and often seduces or lures her father into it. We are told that she can and does enjoy it, just as she would any other pleasurable, sensual experience. In addition, we learn that even if the daughter does not initiate the sexual contact, she usually consents to it and goes into it willingly. Finally, we are led to believe that the girl usually only suffers from the experience when it ceases to become secret and she learns of societal disapproval of the act. Implicit in all these arguments is an unstated assumption that the father in the patriarchal family has a right to sex with his children.

A closer look at some of the arguments of the pro-incest lobby will show glaring flaws in their logic.

“The child has a right to sexual freedom and therefore, to sex with adults.”

Those advocating adult-child sex as a positive experience for the child tend to give a great deal of emotional weight to the argument that anything different would be denying the child her right to sexual freedom. Sounding terribly altruistic, they claim that they are speaking on behalf of those who are still too young to speak on their own behalf. It is not surprising that many people take this argument seriously, given the seemingly selfless manner in which it is often presented.

Whether for or against adult-child sex, most people seem to be in agreement that there is a sexual side to a child's nature. Unfortunately, our understanding of child sexuality is still quite limited, and what we do know of it has been, for the most part, adult-defined, and more specifically, male-adult defined.

The distinction must be made as to whether or not adult-defined sex, quite different from the sexual exploration *between* children, is what is appropriate for children. Judith Golden, a Toronto therapist who has worked extensively with victims of incestuous

assault, sees those who have been introduced to adult sexuality at a very young age as having been “robbed of the right to grow up as a child.”

In sexual exploration between children, there is more likely to be a relationship of peers, where one is not objectified. In adult-child sex, however, the child is far more likely to be sexually objectified and to carry the sexual image of herself as a victim into adolescence and adulthood. It is not surprising, therefore, to learn that female prostitutes often have had childhood encounters with adults.

A number of studies conducted to date in the United States indicate that there is a strong correlation between incestuous assault in childhood and delinquent behaviour in adolescence and sexual maladjustment in adult life. Reports from the Prison for Women in Kingston, Ontario, show that as many as 80% of the women who are serving time there were victims of some sort of sexual assault in childhood or adolescence.

We must ask seriously whether the claim of adult-child sex being in the child's best interest isn't just a cover for the self-serving interests of those adults advocating it. Noting how frequently such an attitude is conveyed in pornographic magazines like *Penthouse* and *Hustler*, Judith Lewis Herman comments: “Such statements of concern for the well-being of children seem a bit out of place, appearing as they do in publications whose main purpose is to supply masturbatory fantasy material to men, and which generally display an attitude toward children ranging from utter indifference to the most violent hostility. . . . [T]he panderer's interest in the sexual rights of children must be considered on a par with the mill owner's interest in the ‘right’ of children to work in factories.”

“The girl child is capable of being seductive and luring her father into sexual relations.”

The child as seducer, or more specifically, seductress, is one of the most common themes in the literature advocating “positive incest”. In an article in the November 1976 issue of *Penthouse Forum*, Dr. W.D. Pomeroy claims that, “Incest between adults and younger children can also prove to be a satisfying and enriching experience”. In one account, he refers to a child pressing up against an adult as a

“seducer”. In a recent case of sexual assault in Wisconsin, the judge presiding over the case referred to the five year old girl who had been molested as “an unusually promiscuous young lady”.

What is perhaps most alarming about the girl child as seductress theory is that it has come to be seen as something quite innate to young girls, rather than as something which is learned. This assumption is part of the legend of child sexuality which Freud has passed on to us. In his extensive work with female patients, Freud encountered an alarmingly high number who had had sexual relations with their fathers. Perhaps because many of these fathers were known to him, Freud had difficulty in accepting the daughters' stories that the fathers had initiated the behaviour. Instead, he chose to conclude that because of the pervasiveness of this phenomenon, the daughters must have been fantasizing that this had happened, based on deeply buried erotic feelings for their father. This theory has received considerable attention in the psychiatric community and its spillover into popular culture has been the Lolita syndrome and the seductive young nymphette of book and screen. The medium of advertising promotes the image of the young girl as seductress, thereby encouraging the notion that young girls lure men into sexual relations.

The realm of sexual excitation is individual and diverse. It is not particularly unusual for an adult male to be sexually aroused by the tenderness of his young daughter, but what is important about that arousal is what that father chooses to do with it. It is he who makes the decision, it is he who is in control.

The claim that he was seduced into the sexual relations is an attempt to avoid the issue that the father, because of his position of authority as parent, has the final say in any such situations.

“Children need sex and are capable of enjoying sex with an adult.”

Since the early 1970's, when a renewed interest in the study of incest began to develop, individuals advocating the practice have encouraged women to come forward and state that they were not damaged, emotionally or physically, by an incestuous experience with their father in childhood.

Some have come forward and stated publicly that they enjoyed the experience. Television talk shows and men's magazines have played up these kind of stories. However, as Herman documents, most incest studies show greater numbers were damaged by incest than enjoyed it. Nonetheless, the pro-incest lobby continues to point to those rare women who have said they found it pleasurable, or tell you how often they read letters by such women in magazines. (Whether these letters are describing real experiences, or are fabricated for the purposes of sexual titillation is a big question.)

Whether a girl enjoyed sexual relations with her father or not does not change the fact that she did not enter into the relationship with free and informed consent. As American psychologist David Finkelhor notes, "The wrong here is not contingent on proof of a harmful outcome."

"A child is capable of consent in an adult sexual relationship."

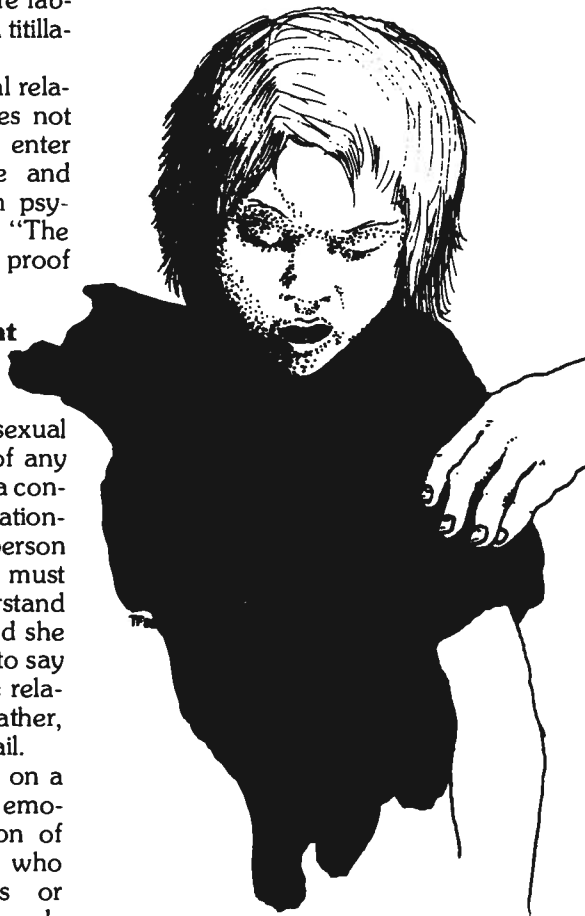
The pivotal component of any sexual relations between two persons of any age or sex is consent. Consent is a concept which applies only in the relationship of equals. In order for any person to consent to sex, two conditions must prevail: she must know and understand what it is she is consenting to and she must be in a position to feel free to say yes or no, as she chooses. In the relationship of a young girl to her father, these two conditions do not prevail.

Because a child is dependent on a parent for both her physical and emotional needs, she is in a position of extreme vulnerability. A child who refuses her father's overtures or demands, risks having her vital needs — for love and support, or material needs such as clothing, food and shelter — withheld. She is also vulnerable to emotional blackmail, that she will "hurt" her father by refusing.

In most father-daughter relations, that vulnerability is not abused, at least not sexually, but in the case of incest it is exploited to suit the needs of the perpetrating father. Not only is a young girl not aware of all the consequences of entering into a sexual relationship, she is clearly not free to say no if she does not want it. The defense of many an incestuous father has been "But she wanted it. She went into it willingly". Willingness implies consent. As Her-

man says, "Because the child does not have the power to withhold consent, she does not have the power to grant it".

More than women, more than the elderly, more than any ethnic minority, children are without power in our society. Dependent on adults for money, food, shelter, and even their own freedom, children may be able to manipulate, but this is not *real* power. Pedophiles will often make the argu-



ment that a child is in control of the situation because they can threaten to blackmail an adult with information about their sexual liaisons. But the one who has real power is the one who can ultimately resort to physical violence to get his way. Rarely, if ever, does the child have this recourse. In relations of incest, the parent is in control and has the final say on any and all matters.

"The child usually suffers from the experience only when it ceases to be secret and the child learns about societal disapproval."

People using this kind of logic ignore

the real pain that is felt by victims while the incest is taking place. We need only to read personal accounts like those of Charlotte Vale Allen, Kathleen Brady and Louise Armstrong (See Resources), to know that it was a painful experience for them long before they learned that others disapproved of it.

Judith Golden paints this portrait of the women she sees in her practice: "I have worked with women whose sexual experience is severely limited by their inability to respond, who flash back to incest positions, touches, etc. Women who have been so manipulated by their fathers that they are constantly on their guard, women who react to men in childlike voices and seductive behaviour that goes halfway and then pulls back, women who hate men, who hate women, whose self-esteem scrapes the bottom of the barrel, where depression and guilt have dominated their functioning".

This is not to deny that societal reaction to an incestuous relationship might exacerbate a situation over which the child was at most unhappy and confused. In the vast majority of cases, police officers, social workers, doctors and teachers have not been trained to deal sensitively with the victim of incest. Like a woman who is reporting a rape, the young girl experiences the situation as doubly traumatic as she recounts it to often disbelieving or horrified adults. This only points to the need in our society for more individuals who are trained to deal with victims of incest and not to alienate them further. But to say that it is only because society disapproves that the girl becomes traumatized is to not hear her entire story. This is all too clearly another case of justification for the benefit of the adult who initiates the sexual activity.

"It is erroneous to equate incest with rape and violence."

American psychiatrist James Ramey takes what some would view as a "liberal" perspective on the incest question. In a 1979 issue of the *SIECUS Report* (Sexual Information and Education Council of the U.S.) he downplays the potentially harmful effects of incest. Not only does he warn readers away from the personal accounts of women like Louise Armstrong, he states that "The problem arises when incest is automatically equated with rape and violence, although we know

that this is generally not a proper analogy”.

To state that incestuous assault is not on a par with rape and violence is to deny the assaultive nature of the act — the father is in control, not the daughter — and to deny the real emotional and physical pain of many of its victims. Charlotte Vale Allen, in her account of her incestuous relationship with her father explained that: “After incest, you don’t trust anyone. It’s the same kind of physical and mental invasion as rape, except that the rapist isn’t a stranger with a knife. It’s your father who’s supposed to be protecting you”.

Insofar as father-daughter incest involves an element of coercion — be it promises of material gifts or favours or threats of physical violence — it is a form of rape. Incestuous assault, like pornography, is a violation against women, and until that fact is acknowledged, society will continue to turn a blind eye to the pleas of its victims.

In the arguments made by those

advocating positive father-daughter incest, what is missing is an acknowledgement that, in the vast majority of cases, the motivation for incest is the self-serving interest of the adult who perpetrates it. To avoid facing this reality, we are told that the child initiates it, the child consent to it, the child enjoys it, and the child needs it. Articles and letters in magazines like *Penthouse* try to downplay the assaultive nature of the act by referring to it as “home sex” or “family sex”. In one British pedophile magazine, an anonymous author speaks in glowing terms of the man who has “the nerve and character to make tender love to his own daughter”.

The issues surrounding the question of incest are not black and white although it is frightfully tempting to try and paint them that way. In the family setting, the distinction between intimacy and sexuality can be very fine yet it is a distinction which has to be made if that form of child abuse known as

incest is to be prevented. Let us not think that we have made great strides in combatting this form of abuse in the family. Wife battering, another form of abuse of male power in the family, drew a round of laughs in the House of Commons last spring when a report detailing its prevalence in Canada was presented.

With the alarming increase of the portrayal of the young girl as sex object not just in pornographic magazines but in films, on television and in advertising, the words of the pro-incest lobby are being digested by a non-discerning public. As long as these words are not contested, questioned and debated via equally popular forms of media, they will only continue to proliferate.

Anne Rochon Ford is a member of the Healthsharing collective and a student at the University of Toronto. The initial research for this article was done for a course in the Women’s Studies program at the University.

THE WOEFULLY INADEQUATE INCEST LAW

by Diana Majury

Yes, incest is illegal. It’s an offence under our *Criminal Code* for any person to commit incest.

But the narrow legal definition, and the restrictions attached to it render the incest provision almost useless. By definition, incest only takes place between blood relations: children, parents, grandparents and siblings. A step-father, an uncle, a “live-in boyfriend” cannot be convicted of incest. Only sexual intercourse (penetration of the vagina by the penis) constitutes incest. Anal intercourse, masturbation, fondling — our law does not recognize these as incest.

Even when the obstacle presented by the definition is overcome, it is very difficult to obtain a conviction for incest. There is an express requirement that a person accused of incest cannot be convicted upon the evidence of a single witness unless that evidence is corroborated. This means that there must be independent evidence which confirms the witness’s story: statements made by the accused of the victim’s blood found on the accused.

Corroboration used to be required in rape cases but was eliminated in 1975. There was discussion at that time of also repealing the incest corroboration requirement. However, one member of parliament, an ex-defence lawyer, persuaded his colleagues that the requirement is essential to protect against wives who use an incest charge to get back at their husbands.

Corroboration is also required for the

unsworn testimony of a child. This refers to a child under 14 whom the court determines does not understand the nature of an oath, and is interpreted by the courts to mean that an oath is a promise to God to tell the truth. The myth here is that children lie or fantasize incest stories. Incredible, in light of the fact that the real problem is children’s concealment of incest and fear in coming forward, not concocted stories.

To make things worse, under the wording of the incest provision the victim can herself be charged and convicted of incest. She can avoid punishment if she can prove that she acted under restraint, duress or fear and this is not always easy. It is an outrage, in our criminal law that the victim of an offence can be charged along with the perpetrator.

The crime of incest is directed at potential genetic problems of “inbreeding”. Hence the restriction to sexual intercourse between blood relations. Our law does not address the coercion, the abuse of authority, the breach of trust inherent in most incestuous situations. Bill C-53, the proposed new sexual offences legislation, has been heralded as providing improved protection and a more sensitive process to victims of sexual offences. It does little for victims of incest. The Bill offers some improvements, but retains the narrow definition and the focus on genetics rather than power. As women, we are concerned not with genetics but with coercion, the manipulation of a power relationship.

There are other criminal charges which can be laid in an incest situation — rape, indecent assault, assault. There is a great debate whether a specific offence of incest is needed or it would be more appropriately dealt with under other sexual offence provisions. The question is whether there is something about incest which makes it different from other sexual offences and thus necessitates separate delineation.

In addition to the Criminal Code, provincial child welfare legislation can be invoked in an incest situation. A victim of incest is considered a “child in need of protection” and thereby subject to intervention by the Children’s Aid Society. Incest offenders were frequently charged with contributing to juvenile delinquency under the *Juvenile Delinquents Act* (this is no longer an offence under the new *Young Offenders Act*). The problem with using child welfare or juvenile legislation is that they focus on the conduct of the victim, rather than placing full responsibility on the perpetrator. There is an element of “blame the victim” in these approaches.

The law is only a band-aid; it offers no solutions. But as a band-aid, it does provide some recourse to victims of crimes and a statement against conduct which we, as a society, find intolerable. At least, such is the theory. But all too frequently the law provides little or no recourse for women and the statement it makes does not reflect our reality.

Dawna Gallagher Takes a Look at



THE PILL - FULL CYCLE

... by dawna gall

The Hazards of FOAM

1 First there was the weight gain.....

2 Well if I go...

3 When I noticed that I was only experiencing 2 moods hysteria and suicidal depression...

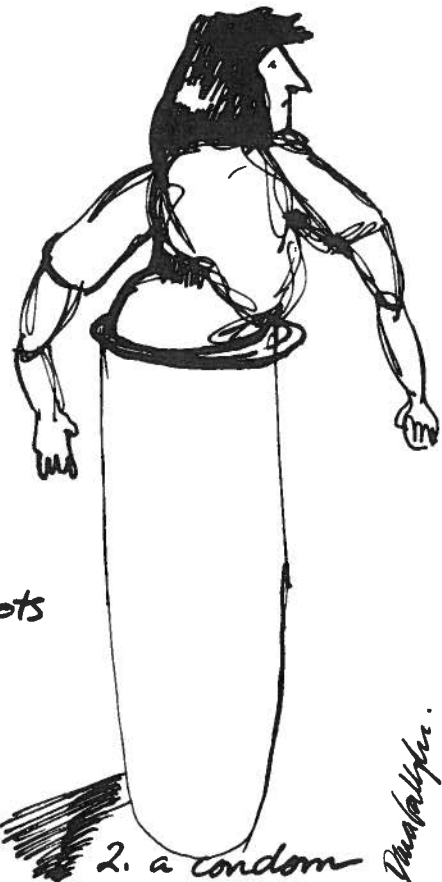
4 while for 1 discob...

5 AN WE PART I go free.

the spontaneity of the diaphragm

Dawna Gallagher

Birth Control



A QUICK COMPARISON:

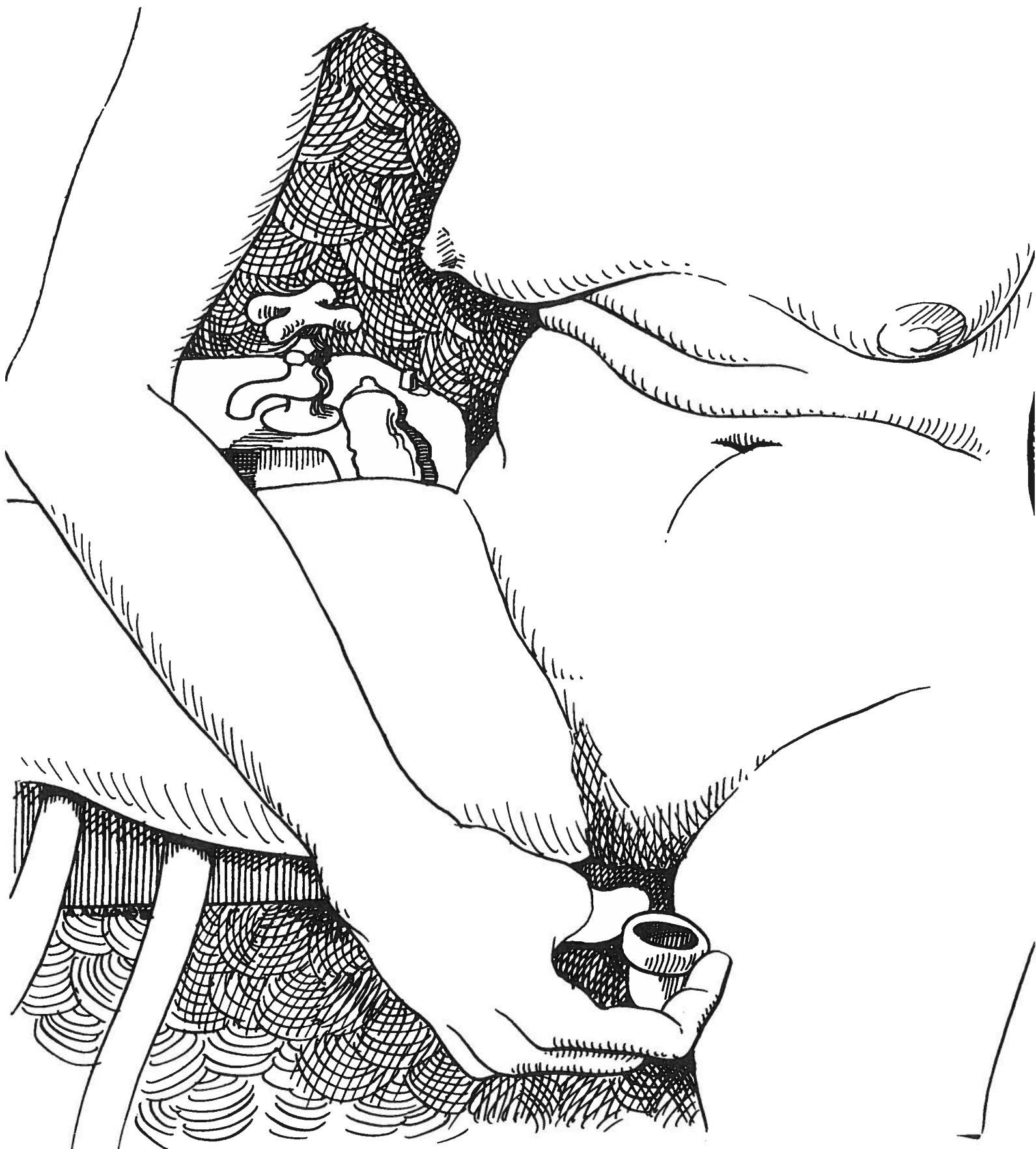
1. a pair of rubber boots



2. a condom

eed to
a new
Danalalpa.

IN GREAT DEMAND: the revival of the cervical cap



The phone rings at Toronto's Bay Centre for Birth Control. At 11 a.m. this is the fourth caller of the day requesting an appointment for a cervical cap fitting. "I'm sorry," says the receptionist, "I'll have to add your name to our list. We're booked up for the next five months."

The Bay Centre is one of the few Canadian clinics where women can be fitted with cervical caps. Women from Ontario, Quebec, the Maritimes, as well as neighbouring U.S. states call the centre for information.

Health clinics and Planned Parenthood centres are noting a definite increase in the number of requests for information on this form of birth control which had almost become extinct. Stories and articles appearing in newspapers, medical journals, women's magazines, and feminist publications indicate that a cervical cap revival is underway.

A small, rubber object, shaped much like an oversized thimble, the cervical cap falls into the category of barrier methods of birth control. It blocks the cervix, preventing sperm from entering the uterus and fertilizing the egg.

Compared to its sister barrier method, the diaphragm, the cervical cap is smaller in size but has a deeper cup. It is made of a thicker rubber, with a more rigid rim than the diaphragm. Placed high in the vagina, it fits snugly over the cervix where it is held in place by suction.

The diaphragm, on the other hand, fits in the vagina longitudinally, one end under the pubic bone and the other end under the posterior fornix. Because the diaphragm is held in place by its wire rim and the muscles of the vaginal wall, there is a chance of displacing it during sexual intercourse; the cervical cap is more likely to remain in place with its suction hold.

The two methods also differ in use of spermicide. Some women find spermicide to be "messy" and for these women it is an added attraction that the cervical cap uses less spermicide than

the diaphragm. Because the main contraceptive function of the diaphragm is to hold spermicide in place, the importance of adding it for repeated acts of intercourse is stressed by medical professionals and birth control counselors. However, additional spermicide is unnecessary with the cervical cap since it is held in place by suction which prevents sperm from getting past the cap. It, in effect, is a true barrier.

For many women the cervical cap's most attractive feature is versatility. It can be used in a similar fashion to the diaphragm — inserting it prior to intercourse and then removing it six hours later — or it can be used as a removable intra-vaginal device that can be left in place for several days at a time.

A 1953 U.S. study by Drs. Tietze, Lehfeldt and Liebmann, published in *The American Journal of Obstetrics and Gynecology*, found a preference for the cervical cap over the diaphragm because the cap can be left in for longer periods of time

Being able to keep the cap in place for up to five days makes it the first barrier method to overcome the common complaint of interruption of sexual spontaneity. This complaint has been a reason why many women have turned to the Pill and the IUD. Statistics, however, show that Pill use is dropping. In the U.S., the proportion of women using the Pill fell by as much as 25 per cent between 1975 and 1978, and it's likely to have fallen further since.

In Canada, clinics and doctors are noting a similar trend. Joanne Chuchryk, registered nurse working with the Bay Centre cervical cap study says more and more patients are changing their birth control methods from the Pill and the IUD to barrier and natural contraceptive methods. Reasons range from health problems which include depression, nausea, headaches, migraines, and blood clots to simply personal preference, wanting more control over one's body and health.

The cervical cap is not a new method of birth control. Women have known for centuries that

covering the cervix with various materials would prevent conception. In ancient Sumatra, women molded opium over the cervix. In the Orient, oiled silk paper was used, while in parts of Europe beeswax was put to use. According to popular history, Casanova recommended that a half lemon be placed over the cervix in order to prevent conception. (There is no proof that this was actually Casanova's idea. It was more likely the innovative method of one of his many mistresses.) This, interestingly, had the added effect of a natural spermicide — the acidic nature of the lemon juice. Later, these devices were made of such exotic materials as ivory, silver and platinum. These cup-like objects were early forms of the cervical cap.

With the vulcanization of rubber in the early 1840's, the cervical cap became more widely available to women. The earliest known reference to the rubber cervical cap was in 1838 by a German gynecologist, F.A. Wilde. He recommended a cervical cap specially molded by taking a wax impression of the cervix. At the same time, a New York physician, E.B. Foote, developed his version of the cervical cap but failed, for some reason, to popularize it in the U.S. as well as Wilde did in Europe.

About 1884, Dr. H.A. Allbutt, a Leeds physician, published a booklet with the lengthy title, *The Wife's Handbook: How a woman should order herself during pregnancy, in the lying-in room and after delivery, with hints on the management of baby and on other matters of importance, necessary to be known by married women*. Allbutt made mention of the rubber cervical cap in his section entitled, *How to prevent conception when advised by the doctor*. "It is but right to say," wrote Allbutt, "that these pessaries [cervical caps] are at present only on trial. Time will show whether they can be relied upon to prevent conception. My opinion is that they will do all their inventor claims for them."

Nearly one hundred years later the cervical cap is still "on trial". Limited research makes its effectiveness rate hard to determine. The few studies that

by Rosemary Knes
illustrated by Adrienne Alison

have been done, however, show it to be a reliable method of birth control.

The U.S. study done by Tietze, Lehfeldt and Leibmann in 1953, is the study which is referred to most often by researchers and medical professionals. This study put the effectiveness rate, under ideal conditions of use, at 98 per cent — not significantly different than the diaphragm. In 1978 the Emma Goldman Clinic for Women in the U.S. conducted a study on the cervical cap. While statistical information was minimal due to limited funding, the results indicated it to be a safe, effective method of birth control that should be available to women as a contraceptive choice.

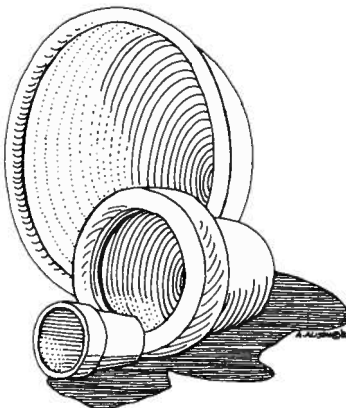
The preference given to the diaphragm may be a reason why the cervical cap has not been widely available to North American women. Early U.S. birth control activist, Margaret Sanger, was impressed with the diaphragm which was developed shortly after the cap. By 1916 her clinics were fitting, albeit illegally, hundreds of women with diaphragms.

Why Sanger favored the diaphragm over the cervical cap is hard to say. Common belief held that the cap caused an "evil odor". Actually, odor has been a problem for some women using the cap. The odor, sometimes described as "rubbery", may be caused by leaving the cap in too long. Frequent removals and cleaning may help eliminate odor problems. The Bay Centre recommends a water-vinegar soak (one-quarter cup vinegar to one cup warm water) for 15 to 20 minutes or a soaking in rubbing alcohol. Liquid chlorophyll has also been suggested, but the Bay Centre does not recommend this because of possible staining either to the cervix or the cap.

Aside from odor, other reasons for limited use of the cap in North America include difficulty in securing well-made caps, confusion of the cap with harmful intracervical or intrauterine devices, and lack of statistics on effectiveness. It was also thought that the cap had to be inserted and removed by a doctor. In the earlier part of the twentieth century it was thought that only prostitutes could find and reach the cervix.

Even today, some physicians are doubtful that women are able to insert and remove the cap properly. According to Ottawa gynecologist, Dr. W. Sim, "It's too small, which makes it difficult to handle. Women will find it difficult to insert and remove."

Yet, the New Hampshire Feminist Health Clinic, which has been fitting women with cervical caps since 1978, hasn't had any problems instructing women to use the cap. Susan Keady, registered nurse and cervical cap study monitor for NHFHC, says women like the cap because it is small, making it more comfortable to insert.



Relative size: diaphragm, cervical cap and thimble.

"A lot of it has to do with the way women are taught to use it," she says. "We take the time to show them how to use a speculum, to look at the cervix with a mirror. They have a better understanding of where, exactly, the cervical cap is supposed to go." To Marieke, a cervical cap user of one month, the blanket suggestion that women would find it difficult to use a cervical cap is "horrendous". "It's like learning to put earrings in pierced ears. You just learn how to do it." However, some women do have difficulty with the cap. Short fingers and a highly positioned cervix can cause problems for a cervical cap user.

General inaccessibility remains a primary reason why the cap is not widely used in North America. In North America, Ortho Pharmaceutical marketed the cap in the mid-50's. However, when the Pill was introduced on the market in the late 50's, Ortho became one of its manufacturers and ceased to manufacture the cap.

Barbara Seaman, of the U.S. Women's Health Network, suggests that drug companies have taken the cervical cap off the market for profit reasons. In the U.S. annual Pill sales bring in \$320 million. In Canada, it's a \$50 million a year business.

In her testimony before the U.S. Senate Subcommittee on Health and Scientific Research in August, 1979,

Seaman noted, "... Ortho has acknowledged this device might cut into spermicide sales. Outside of rhythm, the cap is probably the best contraceptive bargain we have."

Seaman also suggested that the Food and Drug Administration in the U.S. was deliberately suppressing the cervical cap. In 1978, a shipment of cervical caps from England, ordered by and addressed to a New Jersey doctor, was seized by U.S. officials acting on the orders of the U.S. FDA. "Violative within the meaning of the Federal Rules and Regulations," claimed the FDA. "Labelling fails to bear adequate direction for use. Needs prescription." In April of 1979, the FDA proposed to ban the cervical cap as a contraceptive method. Their reasons: lack of modern studies and a potential for the device to be injurious.

The U.S. Women's Health Network claimed this "ludicrous". The organization pointed out that the FDA in the past had approved drugs and birth control methods which were far more hazardous than the cervical cap. Modern studies, the health groups stated, require money and facilities. Funding usually comes from drug companies or government, and neither had appeared to be interested in cervical caps.

As a result of the hearing before the U.S. Senate Subcommittee, two million dollars were allocated for studying the effectiveness and safety of the cervical cap. At least fifty clinics in the U.S. are now conducting such studies.

The FDA requires all sites of studies to conform to a specific format. Women must agree to participate in the study although written consent is not required. They must stay in contact with the study until 1985, if they continue to use the cervical cap until then. An examination every six months is required, as well as filling out a mailed questionnaire on the third and ninth month of every year of use.

The New Hampshire Feminist Health Clinic reports that, as of January 1980, they have fit 387 women with cervical caps since June 1978. Six pregnancies have resulted. In California, at the Berkeley Women's Health Collective, 150 women have been fitted since mid-1979, with two pregnancies as of January 1980.

In Canada, studies in Vancouver, Winnipeg, Toronto, and Ottawa are either underway or will be launched in the near future. The Women's Health Clinic in Winnipeg has been offering cervical caps to their patients since May 1981, although they have not been keeping any statistics on its use until recently. Clinic director, Pat Stainton estimates that over the past year approximately 140 women have been using cervical caps. She is aware of one pregnancy which occurred. A formal study has started this summer at the Clinic. The Planned Parenthood Centre in Vancouver was scheduled to have a study underway by the summer of 1982 as well.

Alison Rice, a registered nurse-practitioner, will be helping design the study in Vancouver. She is enthusiastic about the effectiveness of the cervical cap, noting that in actual use (as opposed to theoretical use), the cap and the diaphragm are as effective as the Pill.

The study at the Bay Centre in Toronto has been going on since May 1981. As of March 1982, 280 women have been fitted with cervical caps. Nine pregnancies have occurred. "We're finding this a bit alarming," admits Dr. Marion Powell, director of the study. Most pregnancies ended in abortion. Interestingly, many of the women went back to the cervical cap.

One of the biggest problems for the Bay Centre's study and for Dr. Norman Barwin, director of the Family Planning Unit at the Ottawa General Hospital, is getting enough cervical caps. Lamberts Ltd. of England is the only supplier. To order and pick them up at customs, and to make sure all the right papers have been signed, is often a heavy load on a busy physician.

The medical profession has, however, shown some interest in these studies. Dr. Powell notes that many doctors come to the Bay Centre to learn about the cap. "But we can't handle all doctors' requests or even attempt to teach all of them," she says.

In Canada, cervical caps fall under the classification of medical devices within the jurisdiction of the Health Protection Branch of Health and Welfare Canada. Medical devices do not require government approval for production, sale, or distribution. These devices are subject only to standards set by the Food and Drug Act of the

Canadian Criminal Code. The cervical cap, like the diaphragm, was given this classification because, according to Dr. A.K. Dasgupta, Chief of the Health Protection Branch of Health and Welfare Canada, it has not exhibited problems or dangers to public health (unlike the IUD, which must be approved by the Health Protection Branch).

Dr. Dasgupta feels the drug companies would manufacture cervical caps if there were sufficient demand for them. "We can't ask them to sell something they don't want to," he says. Major drug companies like Ortho, Wyeth, Searle, and Julius Schmid, have all indicated that they have no plans to market the cervical cap, despite interest shown by large numbers of women.

The Pill is the only contraceptive which Wyeth Pharmaceuticals manufactures. According to marketing development manager Michael Lecours, it is one of the company's major products. Mr. Lecours maintains that Wyeth is



Cervical cap in place

concerned that women have a wide range of birth control methods available to them. He notes that Wyeth publishes a pamphlet which explains the various methods of birth control available. It does not list the cervical cap.

Drug companies could play a large role in investigation and studies says Joanne Chuchryk at the Bay Centre. "But they centre their energies on the Pill, both in terms of research and sales. Pill sales give them their biggest income. I can see why they would hesitate to bring in the cervical cap." While the Bay Centre has been funded by drug companies to do studies on the Pill, none have offered to fund research on the cervical cap.

It's a common trend. Out of a total of \$155 million spent worldwide on all aspects of reproductive and contraceptive research in 1979, less than \$1 million (two per cent) went toward research on barrier methods. The majority of funds were spent on research and development of female hormonal contraceptives: improved pills, subdermal implants, intranasal sprays and anti-pregnancy vaccines.

One enterprising company in Chicago, Contracap, Inc., sees a market for the contraceptive. Their cervical cap is an exclusive design, custom fit to a woman's cervix. Impressions of the cervix are taken much like a dentist would take impressions of the jaw. In fact, the cap was developed by the unusual team of a dentist and a gynecologist. It is about 1.0 mm thick, made of a thin, transparent material similar to rubber. Designed to be worn for long periods of time, its feature is a one-way valve which allows uterine discharge to pass through but prevents sperm from entering. So far, two women have worn the cap continuously for 28 months with no problems. Paul Moriarty, president of Contracap Inc., hints that clinical studies for this new cervical cap will be established in Canada soon.

Reaction to Contracap is cautious. Susan Keady, of the New Hampshire Feminist Health Clinic wonders whether it would appeal to women who come to the clinic. "There isn't the control over this cap [Contracap] that there is with the one which we supply [Lamberts]. Many women want to get away from having to rely on medical professionals. The Lamberts cap can be inserted and removed by the woman herself but this other cap has to be inserted and removed by a medical professional."

The cervical cap does represent control over body and health. Yet, many Canadian women will not have access to this alternative contraceptive.

Rosemary Knes is a librarian researcher with Southam News in Ottawa. She has worked extensively with the women's movement in Ottawa. The original research for this article was done for an honours research paper at the Carleton School of Journalism.



Rachel Burger/cpf

Racism and the Depo Program

In South Africa, where white demographers are increasingly concerned about the accelerating black birth rate, Depo is being forcibly administered to black women by government-funded family planning agencies.

Dr Nthato Motlana, one of South Africa's leading black physicians, charges that "there is no such thing as 'informed consent' here. The agencies are administering Depo Provera shots to young black girls without even asking their consent."

Until very recently, a similar practice existed in Zimbabwe. Under white rule, Depo was the most widely-used contraceptive among black women. Today, some 100,000 women continue to be injected. Prime Minister Mugabe's government, however, has decided to phase out Depo use within two years, as it considers the drug unsafe.

THE CASE AGAINST by Janis

Depo Provera may soon be approved for widespread contraceptive use. A report recommending government approval for the drug has been before Monique Begin, federal minister of Health and Welfare, since January 1982. This report has yet to be released for public scrutiny despite, or because of widespread concern about Depo Provera among feminists and scientists.

Depo Provera, or Depo as it is frequently called, is the trade name for the injectable form of medroxyprogesterone acetate, a synthetic progesterone-like hormone. Depo prevents both ovulation and menstrual bleeding by disrupting a woman's normal hormone pattern. Depending upon the dosage, a single shot will stop periods for three to eight months.

Although Depo is currently used in over 80 countries and has been given to approximately 10 million women for birth control, the drug is the subject of worldwide controversy. Short-term side effects include weight gain or loss, depression, dizziness, loss of hair, limb pain, abdominal discomfort, vaginal discharge and darkening spots of facial skin. These health effects are very similar to those experienced by women taking the birth control pill.

Problems which have been linked to long-term use include cancer of the uterus, breast cancer, drastically increased incidence of diabetes, shorter life expectancy, severe mental depression, substantially lowered resistance to infection, and, after stopping the injections, irregular or excessive menstrual bleeding and temporary or permanent infertility.

In Canada, Upjohn Company Inc., the only manufacturer world wide of medroxyprogesterone acetate, has marketed Depo Provera for 20 years. It was originally approved for marketing by the federal government in the early 1960's. According to some medical sources it was used largely for contraception when it was first marketed and more recently

has been used to stop menstrual bleeding in mentally retarded and physically disabled women. Depo has two federally approved uses — treatment of endometriosis, a disorder whereby the lining of the uterus (endometrium) grows outside the uterus and treatment for cancer of the endometrium.

Since the drug is used for more than its "approved" uses, the precise meaning of drug approval in Canada bears comment. The Canadian Food and Drug Act and regulations were formulated to control only labelling, processing, sale and advertising of drugs. Actual use of nearly all prescription drugs is unmonitored. Physicians are free to prescribe Depo for contraception, amenorrhea or whatever the individual doctor decides is appropriate. There is no onus on a prescribing physician to record reasons for use, or to be accountable in any way for prescribing Depo for a non-recognized use.

What the law does do is prevent Upjohn from promoting Depo Provera for anything other than its two approved uses. The result, states Dr. Doug Squires (Manager, Scientific and Regulatory Affairs, Upjohn Canada), is that Depo manufactured in Canada is assumed to be used only as approved by the federal government. In fact, no one really knows the precise extent to which Depo is used or what it is used for.

The precise health effects of Depo are extremely controversial. The medical establishment recognizes the short-term health effects mentioned above. However, as with oral contraceptives, these unintended health effects are considered to be minor. Debate has revolved around potential carcinogenic characteristics of Depo. In 1971 human trials testing Depo as a contraceptive were stopped in Canada and the U.S. when both governments expressed concern about early results of some company tests. Their concern focused on the potential of the drug to

DEPO PROVERA

Sarra

cause mammary cancer in beagle dogs. These same concerns played a dominant role in the U.S. decision to refuse approval for contraceptive use in 1968.

The beagle studies indicated that dogs among the high dose treated group developed an average of 3.56 nodules in the breast, compared to only 1.25 average among the control group. Not only the incidence, but also the size and severity of breast lumps were greater among treated beagles. When Upjohn later carried out another study to compare their product with natural progesterone, Depo was found to induce breast cancer at lower dosages, although the natural and synthetic products both resulted in comparable incidence of cancer.

The beagle studies, in spite of their seemingly frightening results, have been easy to dismiss. The World Health Organization in 1978 questioned the relevance of the test findings because beagles are known to be especially susceptible to developing breast cancer. Repeatedly medical and company spokespeople have admitted the accuracy of the findings, while denying the relevance.

Especially remarkable is the extent to which the significance of the breast cancer incidence among Upjohn's test beagles has become a red herring. In spite of the attention of government, medical and media representatives being solely focused on the breast cancer findings, breast cancer was not an isolated negative health effect of Depo. Stephen Minkin, advisor to the U.S. National Women's Health Network, has been one of few researchers to undertake a re-examination of Upjohn and government records. In a 1980 paper, he challenged medical complacency about Depo Provera. Minkin found that the beagles did more than develop breast nodules. He reported that "within three and a half years, all of the high dose treated dogs and half of the low dose dogs died from

the action of the drug on the uterus." Further, he found that all treated dogs and treated rhesus monkeys developed enlarged clitorises, and a significant proportion of treated animals developed endometrium abnormalities. As well, treated animals in both species had lower resistance to infection and higher mortality than control animals.

Perhaps the most striking evidence of questionable research practices occurred during a second round of beagle tests. In order to focus on breast cancer, the only health problem which had attracted U.S. government attention, Upjohn persuaded FDA officials of the need to perform hysterectomies on all dogs prior to the study! Upjohn explained that "the hysterectomies were done to prevent infection, and to allow dogs a longer lifespan in order for scientists to check for possible adverse effects of Depo Provera." In other words, it was assumed that Depo might damage the reproductive organs, thereby killing the beagles before they would have a chance to develop breast cancer. The apparent hypocrisy of this is almost beyond belief.

Just as with breast cancer findings, researchers have argued that endometrial abnormalities found in animals cannot be applied to humans. An epidemiological study was carried out by Dr. Edwin McDaniel in Chiang Mai, Thailand, where more than 100,000 women have received Depo. The study, which purports to have evaluated all proven endometrial cancer cases treated in Chiang Mai hospitals, found no Depo usage among the women documented. Minkin, who re-examined documents connected with the McDaniel study, discovered that of 60 hospital admissions for endometrial cancer between 1973 and 1978, only nine were ultimately included in the study results. In an article in the November, 1981 issue of *Mother Jones*, Minkin documents the basis upon which the other 51 cases were

Ways Around the Restrictions

Today, the International Planned Parenthood Federation (IPPF) and the UN Fund for Population Activities (UNFPA) are the two largest buyers of the drug.

Despite the fact that Depo is forbidden for use as a contraceptive within the United States, US AID supports the IPPF in London, which in turn buys the drug from Upjohn's subsidiary in Belgium. In 1979, US AID, through the IPPF, supplied Depo Provera to 378,000 women in Mexico, Sri Lanka and Bangladesh. AID also directed the UNFPA to purchase 600,000 doses for Bangladesh and 1 million for Thailand.



Waiting for Cancer Results

Dr. Malcolm Potts, medical director of the IPPF (1969-78) and now director of the International Fertility Research Program, spearheads the "Depo Provera for the masses" campaign. He insists that the drug must be given to millions of women over the course of decades before its carcinogenic effects can be judged. "We are not going to know whether Depo Provera is safe," he explains, "until a large number of women use it for a very long time."

The Pushers of Depo Provera

According to Upjohn, the manufacturer of Depo Provera, the drug has been given to 10 million women and accounts for one percent of the company's annual sales. From 1971-1976, Upjohn admitted spending \$4 million US to secure contracts for the sale of its drugs in 29 Third World countries. The sale of Depo Provera increased dramatically.



Rachel Burger/CPF

Informed Consent — Take a Minute

In an IPPF sponsored clinic in Thailand, 60,000 women received Depo injections. Each woman was given the time to make her "free choice" and have her injection — 60 to 90 seconds. At the Khao I Dang refugee camp in Thailand, women who agreed to be injected were promised a chicken — a powerful inducement in a camp where refugees are fed about 4 ounces of meat a week. The International Red Cross reported that at the Kamput refugee camp, the injections were simply compulsory.

In many Thai camps, Cambodian women are required by the authorities to have an injection before they marry. A member of the Red Cross claims that 59 percent of the women who received Depo had no idea what the shot was for, and only 15 percent were asked beforehand if they were pregnant. In one camp, a volunteer reports, individuals were given bounties for each woman they brought in for injections. Some women were processed more than once.

excluded from the study. While it cannot be proven now how many of these women, if any, took Depo Provera, nearly all of the 60 women were younger than the statistical norm for this type of cancer.

Another concern about Depo Provera results from its effect on offspring of women unknowingly pregnant while the drug is still in effect. The FDA has been hesitant to approve Depo for contraception because of fetal impact, which may include congenital heart defects or abnormal genital development. Depo may also cause health problems for nursing infants if their mothers are receiving shots. Depo is even promoted for use among nursing mothers in some developing countries because some studies have shown that the drug promotes human milk production. At the same time, Upjohn admits "it is not known at this time whether children who receive some of the drug through breast feeding will have a health problem later in life." Even if no long term problems result, the ability of Depo to reduce infection resistance will undoubtedly be felt by young infants absorbing the drug through breast milk.

Opposition to Depo Provera in Ontario has focused on the use of Depo to suppress menstruation of mentally retarded women in institutions. The issue of Depo use in Ontario-run retardation facilities was originally raised by Mike Breaugh (NDP Oshawa) in the provincial legislature in June, 1980. Although the government has ignored NDP calls to ban the drug until health effects are more precisely known, public and media pressure sparked the Ministry of Community and Social Services to commission a study. The report, "The Utilization of Depo Provera in Ontario Government Facilities for the Mentally Retarded" by Dr. D.E. Zarfes, was released in October, 1981.

Zarfes found 533 women in nine mental retardation centres, aged 11 to past menopause, received Depo during the past two decades. Peak use was between 1974 and 1978. Of these women, 208 received Depo for more than five years. In 96.6% of the total cases, cessation of menstrual periods

was stated as the reason for use.

Of these 533 women, 21 have died. Three have died of breast cancer. This is 25 times the rate expected to occur based on general incidence rates among women aged 30 to 40 years. In 13 women, epileptic seizures increased in frequency or severity. Partial loss of vision occurred in 59 women and total loss in 31 women. Zarfes was able to cite spotting and other "minor" health effects even though staff had not documented such health effects.

The Ontario study was a limited sample. It lacked a control group and an adequate statistical data base. Zarfes concluded that his study raised more questions than it answered about the relation of Depo to the incidence of breast cancer. His report, which included a cursory examination of current literature, concluded that the drug's use should *not* necessarily be banned in institutions. Instead the report takes a position which is unlikely to rile government officials or the medical community — it recommends that risk/benefits be explained to physicians on staff in institutions and that a ministerial committee be established to study the need for menstrual suppression among the mentally retarded.

Although largely ignored in the conclusions of the study, the report pointed to a number of critical issues in the mental health care system. For instance, why were many women not given regular pap smears? Why aren't annual physical examinations carried out on women in provincial facilities? Why are staff physicians allowed to use drugs for non-approved use? Why are side effects of drugs, especially drugs being used for experimental purposes, not recorded and given medical attention? The most distressing of all the unanswered questions is why, upon discovery of sloppy record keeping and an apparent lack of base line health assessments, the government has not yet acted to improve these conditions?

One recommendation of the Ontario study which has been carried out is to refer the report to Health and Welfare Canada for its consideration. In January, 1982 a Special Advisory Committee on Reproductive Physiology, headed by Dr. Robert Kinch of

the Royal Victoria Hospital in Montreal, spent two days evaluating the Ontario study, internal reports from Upjohn and current world literature about Depo Provera. According to both Kinch and Ian Henderson, director of Health and Welfare Canada's Bureau of Drugs, the advisory committee's report indicates that there is every reason to consider using Depo Provera as a mass contraceptive in Canada.

According to Kinch, the health concerns raised by the Zarfes study are not legitimate because of the lack of study controls and inadequate records of other drugs given simultaneously to women in the institutions studied.

The federal report has not been released although it was sent to Monique Begin shortly after the two day evaluation. The evaluation meeting, which solicited research findings from Upjohn, was not publicized and solicited no submissions from women who have used Depo or from health groups concerned about the drug. One can only speculate that the evaluation was designed to ensure a rubber stamping of Depo's continued use.

Upjohn has not yet applied to sell Depo for contraceptive use. Instead, Upjohn's principal lobbying effort has been before the Food and Drug Administration in the U.S., where Depo use is approved only for treatment of endometrial cancer. Should contraceptive usage for Depo Provera be approved in the States, where a hearing is expected in the near future, it might only be a matter of weeks before the Canadian government would follow suit. The British government's recent refusal to approve Depo, in spite of the recommendation of their scientific advisory committee offers some hope that the Canadian government might think twice about Kinch's recommendations.

There has been increasing opposition worldwide and within Canada to the continued use of Depo Provera for contraceptive and hygiene purposes. Third world women in several countries have challenged the indiscriminate use of the drug. The National Council of Women of Kenya has written "we need urgently and sincerely to ask ourselves whether we would jeopardize the health of our nation in our effort to control the population explosion... [there is] responsibility on the experts and authorities to give

to the women full information and protect her from unnecessary risk."

The U.S. National Women's Health Network has issued a health alert about the hazards of the drug and has waged effective political opposition to FDA approval of Depo Provera for contraceptive usage. In England, a "Ban the Jab" campaign has attempted to alert women to health hazards related to Depo, and the campaign is being taken up throughout Europe.

The Vancouver Women's Health Collective is attempting to survey women who have taken Depo, but have few financial resources available to use in their effort to contact women. In Ontario, the NDP health critic, Ross McClellan, has called for a ban of Depo in all uses except those currently approved by the federal Bureau of Drugs. More recently, the Toronto Department of Public Health has called on the Ontario College of Physicians and Surgeons to set guidelines for approved uses of Depo. The Quebec Public Interest Research Group has just carried out a survey of research findings about Depo and released a short report entitled "Depo Provera: A Shot in the Dark".

The Canadian Association for the Mentally Retarded at its 1981 annual meeting passed a resolution supporting "the Ontario Association for the Mentally Retarded demand that a moratorium on the use of Depo Provera for control of menses and/or contraception be instituted immediately." The resolution called upon Health and Welfare Canada to apply the moratorium to all Canadian jurisdictions.

Should Upjohn make application to the federal government for use of Depo as a contraceptive, and at this time I have every reason to believe it would be approved, the Canadian medical profession will be subject to an expensive advertising campaign. The result will be more extensive use of Depo. Who is going to warn women of potential health effects? Who will take responsibility for the potentially disastrous health effects of widespread Depo use?

Janis Sarra works as a researcher for the NDP Caucus, Ontario Legislature specializing in health, social services, occupational health and women.

Promoted for Nursing Mothers

Depo Provera belongs to the class of drugs which can cause birth defects as well as serious medical problems for women. However, the drug is sometimes given to pregnant women, and Upjohn promotes it in Third World countries for nursing mothers.

In Thailand, researchers found that nearly 15 percent of nursing mothers receiving injections had a reduced milk supply. If we consider that Depo is often given to the poorest groups in most countries, those already nutritionally at risk, the implications are grave.

But the social effects don't stop there. In Bangladesh, after 1 year of use, 60 percent of Depo users experienced side effects described in *The Lancet* as "menstrual chaos". Abnormal bleeding is a potential health problem. It is also significant in cultures where women are excluded from areas of social life as long as they show signs of menstrual bleeding.



Thanks to the Cultural Survival Newsletter for their article on "Medicinal Drugs in the Third World" (Fall, 1981) which provided the informational briefs on these pages. For the whole article please write them at 11 Divinity Ave., Cambridge, Mass. 02138 USA.

Reviews

Illustrated Self-Help

Reviewed by Melanie Conn

A New View of A Woman's Body, *The Federation of Feminist Women's Health Centers, Simon & Schuster, N.Y. 1981, 174 pages.*

How To Stay Out Of The Gynecologist's Office, *The Federation of Feminist Women's Health Centers, Peace Press, California, 1981, 136 pages.*

Originally, I was to review only *A New View* and then for reasons I'll describe later, decided to include information on a second book, *How To Stay Out Of The Gynecologist's Office*. As a woman who has been actively working in the area of women's health since 1970, I am very familiar with the work of Feminist Women's Health Centers, a group who have provided information and inspiration for years. For that reason I was delighted when they produced two substantial books last fall, after years of smaller pamphlets and articles.

A New View is outstanding for its illustrations. Suzann Gage, who has provided anatomical drawings for F.W.H.C. for years has produced more than 150 large, beautifully drawn and clearly labelled illustrations for this book. The text is composed of captions (often fairly lengthy) for the drawings which give the book a kind of encyclopedia format. Some of the drawings break new ground: there are several of clitoral anatomy, including cross-sections during sexual arousal and orgasm that with the accompanying text provide a unique practical guide for learning about female sexuality.

The straightforward tone of the section, *The Clitoris: A Feminist Perspective*, is echoed in other sections which include *Self-Examination, Well-Woman Examination, Birth Control and Feminist Abortion Care*. Information is presented in simple language with the emphasis on women learning about their own bodies and about accessible home remedies when required. The authors don't entirely ignore standard medical approaches; they refer to common practices such as ERT (Estrogen Replacement Therapy) for menopause or diuretics for menstrual cramps. They point out the risks and go on to suggest positive and reassuring alternatives.



Another highlight of the book is a fully-illustrated section, *Menstrual Extraction*. It presents information about this home method for evacuating uterine contents and deals with some of the questions that have been raised about the safety of this technique. The authors are particularly careful to advocate the use of menstrual extraction only in a group of experienced women.

There are also 8 pages of full-colour photographs by Sylvia Morales of healthy women's genitals showing common vaginal conditions and the dynamic changes that occur during the menstrual cycle. These remarkable

photographs provide yet another aid to the woman breaking through cultural inhibitions to begin to learn about her own body.

Unfortunately the text moves rather quickly from one topic to another. I am concerned that this brevity may sometimes prevent a woman from knowing that she needs more information than the book provides. For example, while the section on Pap smears is well-illustrated, it gives scant direction for treatment, standard-medical or otherwise. Similarly, the section on tubal ligation by laparoscopy makes no mention of the potential problems following the surgery (chronic pain and bleeding in some women), information which is important for a woman to have in making a decision about sterilization. Another serious example of omission is around *Pelvic Inflammatory Disease (P.I.D.)* which is mentioned very briefly as being "not responsive to home remedies". As P.I.D. approaches epidemic proportions in North America, it is critical for a book such as this to present more information around available treatments.

Because of this concern, I turned to *How To Stay Out of the Gynecologist's Office*. While it is less extensively illustrated than *A New View*, it includes more complete information about specific conditions. It also provides more of a context for self-help, detailing problems with the health care system, offering fuller directions for self-care and more information for making choices about treatment. Also included is *A Women's Guide To Medical Terminology*, a valuable glossary.

I don't think any one (or two) books are sufficient for a woman to consult in dealing with her own health. But, these two complement each other well and I found it interesting and informative to refer from one to the other. The politics in both are consistent: "Self protective tactics are only short-range means to improve health care" (*A New View*). Lasting improvements require widespread changes. These books, in teaching self-help provide us with some of the power we need to continue that longer fight.

Melanie Conn is a member of the Vancouver Women's Health Collective. She is currently working as a carpenter in a women's construction collective.

Regional Reports

Three of our original regional reporters — Beth Hutchinson, Deborah Kaetz and Barbara Luby — have taken on other commitments and will no longer be sending in reports to Healthsharing. Many thanks to all three of you for your support, energy and commitment. And we welcome our new reporters . . .

BRITISH COLUMBIA VICTORIA

Susan Moger

Women Against Pornography: Victoria has a new group that has gained a high profile in a very short time. Women Against Pornography (WAP) began in the fall of 1981 as a collective of 8 women. They now have 6 members and 30-40 supporters. As their first project, they developed a display about pornography and began public education work.

Then WAP met Red Hot Video, a store that sells adult video tapes. After having viewed two of Red Hot Video's choice of offerings — *Never a Tender Moment* and *Young and Abused* — WAP went to the police and laid charges. No word yet as to the outcome. However, WAP has been very active leafletting and picketing Red Hot Video and conducting an opinion poll on the streets of downtown Victoria. Of the 188 people interviewed, a rousing 78% agreed that pornography (both magazines and video tapes) is harmful and should not be readily available.

Pam Blackstone, a long-time feminist activist, says she finds her work on this issue exciting, being on the attack, on the offensive rather than the defensive. As a result of this new stance, the group is creating new strategies to bring the issue to the public. While they have run into just about every argument known to "man" used to defend porn, WAP is skilled at combating them. The group needs access to research which connects porn with violence and would also like to have contact with groups across the country involved in the same fight. Pam may be reached at: 9026 West Saanich Rd., RR#2, Sidney, B.C. V8L 3S1.

VANCOUVER

Lorna Zaback

Abortion Rights Activities: A Provincial Day of Action on Abortion and Reproductive Rights took place May 8, 1982. The day, organized initially in response to Joe Borowski's challenge to existing abortion legislation, was marked by events in various areas throughout the province. A march and rally was held in Victoria; women in Terrace organized an information day, as well as a discussion on local radio about abortion issues and the implications of the Borowski challenge; in the Okanagan Valley, women in several centres leafletted shopping malls with

literature concerning reproductive rights; in Vancouver, 600-700 people attended a spirited march and indoor rally.

The coalition in Vancouver that co-ordinated the day's activities is continuing to meet and gather information and statistics and intends to do further public education on reproductive rights issues.

ALBERTA

Ellen Seaman

Sad News: The Women's Health Action Network which sponsored the successful Health Action conference in October/80 has folded. The group was unable to develop a specific focus after the conference and, after a year long struggle, made the decision to disband. They distributed the funds remaining in the kitty to a number of health-oriented groups, including a donation to Women Healthsharing.

Decentralization: On the provincial front, we are all anxiously waiting to see what effect the decentralization of social services will have on health care. The government has apparently decided to maintain the family Planning unit; which it was considering disbanding. However, there is a great deal of anxiety about mental health services under the new system. These services are already in a dismal state and fear has been expressed that decentralization will lead to increased access to confidential records, less qualified staff, and a lower priority for these services.

SASKATCHEWAN SASKATOON

A Swing to the Right: The Conservative victory in the recent provincial election threatens the rights of women in Saskatchewan. Health Minister Graham Taylor said there is a "good chance" any groups counselling pregnant women about abortion will be deemed ineligible for future government funding. His department will try to determine how many abortions are being performed in Saskatchewan and what might be done to discourage them. Refusal to fund abortion through the Medical Insurance Commission and tightening up of hospital boards that review abortion requests may be the result.

Taylor has the support of his party behind him. At last year's PC convention, resolutions were passed to urge the provincial government to do whatever is possible to protect the unborn and terminate funding to organizations

Regional Reports

"engaging in activities that tend to undermine the moral fabric of society." Now in power, undermining the rights of women does not appear to bother this new government.

REGINA

Regina Healthsharing

More Government Pro-Life: Gay White Caswell, the Saskatoon-Westmount MLA, is assisting Health Minister Taylor to develop a provincial government stance that clearly denies a woman's right to free choice on abortion. On the same issue, Caswell finds herself in the middle of a libel suit filed by Dr. Sal Gordon because of a letter she wrote to the Saskatoon City Council in which she implied that Gordon is a pornographer who promotes moral confusion, pregnancy and sexual experimentation resulting in suicide. Gordon, a professor of Family Studies at Syracuse University in New York, was lecturing throughout Saskatchewan.

Lobbying From Scratch: Regina Healthsharing Inc. is putting the finishing touches on their Women's Health Centre Proposal and planning strategy for presentation to the Government. As the result of the election changes, the process of lobbying has to begin all over again. The Women's Health Conference Fall Proceedings are "HOT" off the press and include summaries of the wide variety of workshops provided. Available for \$5.00 each from: Regina Healthsharing, Box 734, Regina Saskatchewan S4P 3A8.

QUEBEC

Clara Valverde

An Ailing Friend: The Montreal Health Press, the women who brought us those well known booklets on birth control, VD, and recently on sexual assault, face the possibility of closing down.

Over the last 15 years the Press has sent out 15 million books and posters. They now face a serious financial crisis. In the past they sold their booklets in bulk to organizations who then distributed them for free. But due to cutbacks in social and health services, organizations can no longer afford to buy them. Accordingly, the Press is changing their policy of free distribution to one of "non-profit". But it will be a while before the change brings about any tangible results. In addition to changing their distribution system and coping with the decline in sales, the Press needs funds to revise their VD handbook and to write one on menopause. They are asking friends and organizations to send donations: Association A Votre Santé, P.O. Box 1000, Station "G", Montreal, Quebec N2W 2N1.

I remember when I was in grade 10 and someone brought copies of the Health Press Birth Control Handbook to our health class. At that time it was illegal to talk about such topics in schools. The handbooks gave us our first exposure to clear, straight-forward material on this topic. It was badly needed. The Montreal Health Press has probably been the most effective organization in providing health information to large numbers of people in Canada and Quebec, maybe even North America. It would be a shame to see it die.

NOVA SCOTIA

Winnifred McCarthy Susan Hower

Women in Practice Studied: How do you choose a family doctor? Do you prefer a woman to a man? Why? Until recently you may not have had a choice. Statistics show that in Canada during the last twenty years the number of women medical students increased from 10% to 40%. Questions relating to this visible and dramatic change in medical personnel, from both the consumer's and practitioner's point of view, are of interest to Dr. Martha K. Laurence, Department of Family Medicine, Dalhousie University. Along with two family practice residents, she is finishing a preliminary study on issues facing Maritime women practitioners in primary care. Among the themes that emerged from talking to the women physicians about the study was the high incidence of women patients reporting their previous inability to discuss gynecological concerns with male doctors.

Nutrition: *Go with Good Food* is the title of a slide-tape series which discusses the categorization of snack foods and reinforces the importance of selling nutritious snacks in school canteens so that students do not get a mixed message. The slide series is being used by each health care unit in the province and has also been purchased by the Department of Health in Newfoundland. Although the presentation, developed by Barb Anderson, a community nutritionist and Brenda Ziemer, a dental hygienist, was designed for Nova Scotia, it should apply to most schools across Canada.

When Resolutions: The Women's Health Education Network has been acting on resolutions passed at the WHEN '82 Conference. In particular, WHEN President, Muriel Maybee is co-ordinating a province-wide strategy for Operation Dismantle, the concept of a global nuclear disarmament referendum, to be held at the municipal level in the Fall of 1982. And recently, WHEN Co-ordinator, Valerie Edey, presented a brief to the Uranium Inquiry-Nova Scotia calling for a total ban on all uranium activity.

Letters

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

Healthsharing Collective members would like to thank our readers for their letters of support in response to our editorial on Burnout in the last issue. Unfortunately, we didn't have enough space to print all the letters but we wanted to say thanks — we appreciate your caring enough to let us know that you understand and support us.

A Linguistic Bone

I think your magazine is great! as evidenced by the enclosed gift subscription orders. However . . . I have a linguistic bone to pick with you.

In the item on Dioxins in the Newsfront section of the June issue, the term "emasculatation" is used. Since it is supposed to mean, in the context, "to render powerless," I do not consider it an appropriate choice of words. As so many of us are discovering, balls do not necessarily equal power!

Thanks.
Maggi Redmonds
Toronto, Ontario

Scare Tactics

We are concerned about the inaccuracies and oversimplifications stated in the article *Cervical Cancer: The Facts* by Cheryl Adams in your June issue. We have been researching abnormal Pap test results and are writing to present some additional information and to express a different perspective.

What does the article's opening sentence mean? ("This year over 10,000 women in Canada will be diagnosed as

having cervical cancer.") Does this mean 10,000 of us will have inflammation of cervical cells, dysplasia, carcinoma in situ, microinvasive or invasive cancer? Not many women actually have cervical cancer; many women have evidence of abnormal cervical cells. From the article it would seem that all these women should follow the same treatments and it is assumed that if they do not they will all go on to get cancer.

We do not consider that all these conditions are necessarily cancerous or pre-cancerous. Even Cheryl states that "a small number are the pre-cursors of cancer." She does note that many dysplasias will disappear if left untreated but nowhere in her article does she suggest any solutions other than current North American surgical practices. There are growing numbers of reports in the medical literature, from some doctors' practices and from women's own experiences, that less drastic measures than cryosurgery, cone biopsy and hysterectomy can reverse these conditions. Also women can prevent future cervical problems with what we have learned from healing ourselves.

Lumping all these conditions together as cervical cancer rather than understanding their differences can promote more fear. The major emotion mentioned in the article is fear. We think that having "The Facts" about cervical cancer helps women understand what is happening to us better and helps us take control over our own bodies. Cheryl's confidence in the medical profession, the oversimplification of (what should be) useful information for women, and what she describes as her "terrifying

experience" may help to increase a reader's anxiety.

The medical profession has historically considered the uterus an extraneous organ. The nature of cervical cancer is not very well understood and, in the face of this, the medical profession has developed the most extreme solutions, namely cut it out. A British study published in 1981 showed 136 out of 139 women with abnormal cervical cell changes reversed to normal through use of condoms during intercourse and no other treatment. Many cervixes can be saved through cautious observation, repeated tests, changing bad health habits, lowering stress, and natural remedies. For example, chronic inflammation from infection can cause cervical cell changes resulting in abnormal Pap results. Clearing the infection and then repeating the Pap test may produce a normal result making surgery unnecessary.

The article places much confidence not only in common surgical practices but also in preventive Pap tests. Getting a yearly Pap test may help to detect cervical abnormalities but by itself will not prevent them. Some women unfortunately develop rapidly growing abnormal cells that Pap tests do not help predict. There is also great controversy among physicians, public health officials and cancer agencies over how often Pap tests need occur (every year, every three years, etc.) but included in the group of women who should get them done more regularly (every 6 months) are women on the pill and who use IUD's. Women who do not have intercourse are not necessarily protected against abnormal Pap results. Women who have had hysterectomies may still have their cervix and need Pap tests. Even if the cervix has been removed, a scraping of the cells from the vaginal walls is recommended regularly. Older women are more at risk to get invasive cervical cancer. So, even when your Pap results have been normal for your whole life, being post-menopausal is no reason

to cease having Pap tests done. Figuring out for yourself how often you think you need a Pap test should be a regular and positive part of our caring for our bodies.

Conflicting data about the causes of cervical cancer is frequently presented. We liked Cheryl's cautioning women against associating cervical cancer with "promiscuity," but then she goes on to say that that connection may be "premature." We think that there may be a number of factors influencing the health of the cervix, but we disagree with any moralistic overtones. Our society is always blaming women for our situation. Nor do we think that "race" is an accurate term when it is really economic class and ethnic culture that have been shown to be distinctive. Some researchers believe that changing sexual and cultural habits among Jewish women are influencing changes in the rising number of Jewish women with abnormal Pap results. It is also predominantly women of lower economic status who risk getting cervical cancer. Age at first intercourse is the only consistent factor appearing in epidemiological studies. The man's role, the role of infectious agents (chlamydia, herpes, etc.), the role of carcinogens in our environment and workplaces, the role of birth control methods, adequate nutrition, health care and stress are not yet definitively associated with cervical cancer, but are obviously important in various women's experiences with abnormal Pap results.

Robin Barnett
and Rebecca Fox
members, Vancouver Women's
Health Collective

APOLOGIES

• to M.S.L. Occupational Health Centre for neglecting to print their advertisement for a clinic doctor in our last issue. The Clinic still requires the services of an occupational health physician. Anyone interested write to Occupational Health Centre, 104-570 Portage Ave., Winnipeg, Manitoba.

Resources & Events

More Than Toxic Shock

Toronto's Public Health Department has prepared a Women's Health Products Study. Arising from the concern created by Toxic Shock Syndrome, it investigates discrimination against women in health matters and examines the health implications of feminine hygiene products and birth control methods.

In full 82 page (\$4.50) or summary (\$1.50) form, it is available through the Department of Public Health, Administrative Services Division, 7th floor, East Tower City Hall, Toronto, Ont., M5H 2N2.

Wife Battering — Report on Violence in the Family

A readable and clear examination of society's response to wife battering. This report, prepared by the Standing Committee on Health, Welfare and Social Affairs, documents the needs of the battered woman with respect to the police, the courts, emergency shelters and second stage housing, welfare and professional help.

It makes recommendations concerning police training, funding for shelters, treatment for batterers, publicizing the issue and for a federal-provincial conference to deal with jurisdictional problems.

The bilingual report is available free of charge from the Canadian Government Publishing Centre, Supply and Services Canada, Hull, Que., K1A 0S9.

Depo Provera: A Shot in the Dark

The Quebec Public Interest Research Group has recently released this 16 page investigative briefing report. They

have compiled information on the history and medical implications of Depo Provera and examine the current situation in Canada, in particular, the Zaffas report and response to it. Complete references and a bibliography are included.

This report is available either in French or English for \$1.00 from Q-PIRG, 2070 Mackay Street, Room 399, Montreal, Que. Phone number: (514) 879-4510/4500.

Rising Up Strong — Women in the 80's

This set of two video tapes documents the collective actions of women today on issues such as day care, equal pay for work of equal value, reproductive rights and violence against women.

The first tape, entitled *At Work and At Home*, examines the problems of low wages, job ghettos, responsibility for housework and inadequate childcare facilities. The second tape, *Control of Our Bodies*, deals with the right to control and define our sexuality, to live our lives without fear of assault and to determine if and when to become mothers.

Interviews with activists from these struggles fill the two 30 minute video tapes (colour, 3/4). They were produced by Linda Briskin and Lorna Weir and are available from DEC Films for rental or purchase. Write 427 Bloor Street West, Toronto, Ont., M5S 1X7 or call (416) 964-6901.

R.E.A.C.H.

R.E.A.C.H. (Research, Education and Assistance for Canadians with Herpes) has recently produced a comprehensive resource manual detailing medical and

psycho-social aspects of herpes entitled — *The Herpes Handbook*, as well as pamphlets of a more general nature. Both are available at a cost upon request. Other resources include telephone information and counselling and self-help groups. For more information write P.O. Box 70, Station G, Toronto, Ont., M4M 3E8, or call (416) 698-6225.

The Second Canadian Conference on Day Care

Sponsored by the Canadian Council on Social Development and Health and Welfare Canada, this conference will be held September 23-25, in Winnipeg, Manitoba.

For further information, contact Lyse Teasdale, Canadian Council on Social Development, P.O. Box 3505, Station C, Ottawa, Ont. K1Y 4G1, or call (613) 728-1865.

Selected Bibliography on Incest

Judith Lewis Herman, *Father-Daughter Incest*, Harvard University Press, Cambridge, Mass., 1981.

Florence Rush, *The Best Kept Secret, the Sexual Abuse of Children*, Prentice-Hall, Inc., New Jersey, 1980.

Charlotte Vale Allen, *Daddy's Girl, A Very Personal Memoir*, McLelland and Stewart, Toronto, 1980.

Katherine Brady, *Father's Day: A True Story of Incest*, Seaview Books, New York, 1979.

Toronto Rape Crisis Centre, *Resource Manual on Incestuous Assault*, Toronto, August 1980.

Louise Armstrong, *Kiss Daddy Goodnight*, Pocket Books, New York, 1979.