HEALTHMATTERS

A PUBLICATION OF THE VANCOUVER WOMEN'S HEALTH COLLECTIVE. Fall 1985 Vol. 1 No. 3

TOXIC SHOCK SYNDROME— Still with us

Do you remember toxic shock syndrome? It was highly publicized five years ago as a new disease which seemed to be attacking mostly young, menstruating women, sometimes killing them. The symptoms were: sudden high fever, vomiting, diarrhea, drop in blood pressure, and skin rash with subsequent peeling of the skin, especially on the palms and soles.

Toxic shock had been described in 1978 by a Colorado pediatrician, who was encountering it in children. The cause was unknown, but seemed to have something to do with Staphylococcus aureus, a common bacterium that many healthy people carry on their bodies, and which ordinarily causes an infection when introduced into a break in the skin. (eg. boils, abcesses, blood poisoning.)

In 1980 toxic shock syndrome was brought to the attention of the US Centre for Disease Control (CDC), which reported an association between it and menstruating women. A telephone survey of 52 women with toxic shock led to the discovery that all the women who contracted it while menstruating had been wearing tampons at the time. Another telephone survey showed that, of the women who used only one brand of tampon, more were using Rely when they got sick than any other single brand. Rely was a new, superabsorbant tampon which was being aggressively marketed at the time. Under pressure from the Food and Drug Administration, the manufacturer, Proctor and Gamble, withdrew Rely from the market, even though a group of independent scientists who reviewed the data advised that Rely was not linked more strongly than any other tampon to toxic shock. With Rely gone, the publicity died down, as did the number of new cases being reported to the CDC.

Has toxic shock syndrome disappeared? No, it has not, and the symptoms are still the same. After the removal of Rely from the market, cases continued to occur among users of other tampons. Also, up to 16 percent of reported cases occurred in children, men and women who were not menstruating. A three-year study in Vancouver area hospitals has concluded that it is much more widespread than is commonly believed. One third of the patients studied acquired toxic shock while they were in hospital. More than half of those studied were not tampon users. There is, however, no doubt that tampon use has still been contributing to toxic shock in menstruating women.

What causes toxic shock syndrome? After five years of research, that question has not yet been answered. A toxin has been isolated from some strains of Staphylococcus aureus, and may be the cause of the disease. Some researchers have suggested that a virus attacks the bacteria, causing them to produce the toxin. Another line of research is looking into special enzymes that staph bacteria produce during an infection. The strains of staph associated with toxic shock produce greater amounts of these enzymes than do related strains that do not cause the disease.

Although the exact cause has not yet been discovered, there seems to be a connection between the absorbancy of a tampon and the risk of contracting toxic shock. Most women have become ill when using higher absorbancy tampons.

A recent study claims to have found a new link. Researchers say that two kinds of fibre used in some tampons - polyester foam and polyacrylate rayon - remove magnesium from the vagina, producing an ideal environment for bacteria to make the toxin. The tampon manufacturers are reported to have removed these fibres from their products. It will be interesting to see whether tampon related toxic shock syndrome disappears as a result.

In the United States, women's health organizations have successfully lobbied the Food and Drug Administration to require tampon manufacturers to warn consumers of the toxic shock-tampon association. They are also trying to force tampon manufacturers to standardize the aborbancy ratings of their products, so that a woman wanting to minimize her risk but still use tampons will be able to determine which brand is the least absorbent.

The removal of the polyester foam and the polyacrylate rayon may have solved the problem, but it seems reasonable to use tampons with caution, if you do use them. If you develop a high fever with vomiting, diarrhea, and rash, contact a physician immediately.

References: The Rise and Fall of Toxic Shock Syndrome. Peter Radetsky
Science 85 Jan/Feb 1985 pg 73

Toxic shock syndrome:...
Anthony W. Chow
Canadian Medical Assoc. Journal
Feb. 15, 1984 Vol 130 pg 425

New Clue to Cause of Toxic Shock
Jean L. Marx
Science, Vol. 220 pg 290

The Vancouver Sun
June 25, 1985

INSIDE HEALTHMATTERS

Toxic Shock Syndrome

Health Collective Update

Dalkon Shield

Reproductive Technologies

Apartheid and Health

Health Shorts

HEALTH COLLECTIVE UPDATE— National Networking

This fall, the Health Collective will continue to present self-help workshops on Breast Health, Cervical/Vaginal Health, Menopause, PMS (pre-menstrual syndrome), and DES (diethylstilbestrol) thanks to a six month extension to our 1984 grant from the Health Promotion Directorate.

In the past, the grant allowed us to do research and develop information packets on these topics, and to travel around B. C., Alberta, and the Yukon, sharing what we had learned with women in various communities. Our hope was that women could use the information we had gathered and the self-help workshops we presented to facilitate information sharing and support groups in their own areas.

Now, through the grant extension, we are continuing to research and update our information packets. In addition, we are conducting more workshops in and around Vancouver. This allows us to train more women to facilitate self-help workshops so the information sharing can continue in the future.

One of the most exciting aspects of the grant extension is that it gives us the opportunity to do some national networking. For some time now, a group of women in Thunder Bay, Ontario (The Northwestern Ontario Women's Health Education Project) has been developing and presenting workshops on how to survive the stress of living in small single-industry towns. (Many of the communities in Northwestern Ontario rely on one industry, such as pulp and paper, as their main source of employment.) Their project has been tremendously successful and they are planning an area conference in October. Workers from the Health Collective's workshop project have been invited and plan to speak on their experience of doing workshops in B.C. We see this as an excellent opportunity for both groups to share experiences and skills. We expect to learn a lot from them.

Health Collective project workers also plan to visit Halifax in October. There, they will meet with women involved in the Women's Health Education Network (WHEN), a Halifax-based health education project what has been active in the Maritimes for years. Like the Health Collective, WHEN publishes a quarterly newsletter 'Vitality', and they recently received a grant similar to ours. Thus, it will be interesting for our project workers to meet these women, find out what they are doing, and tell them about our work. While there, we will also present our workshop series to women in various areas throughout the Maritime Provinces.

At present the Health Promotion grant extension is the Health Collective's only source of funding. Although it does make a significant contribution to the running of our Information Centre by paying two salaries and some of our expenses, it is substantially less than what we need. Moreover, it runs out in February 1986. The Health Collective is continuing to look into other sources of funding and, of course donations are always welcome.

Our Information Centre remains open and quite busy. Here, women call us to discuss their health concerns and to ask us questions. Women can also visit the Information Centre which offers an extensive health library and file collection. Both the library and files have been recently updated and made more accessible thanks to ongoing work projects. September also marked the start of another training session for women who want to work in the Information Centre or behind the scenes. Women who go through the trainig sessions become the volunteers that the Health Collective relies on to remain open, and for getting all the jobs done.

Times are hard but our spirits remain high.

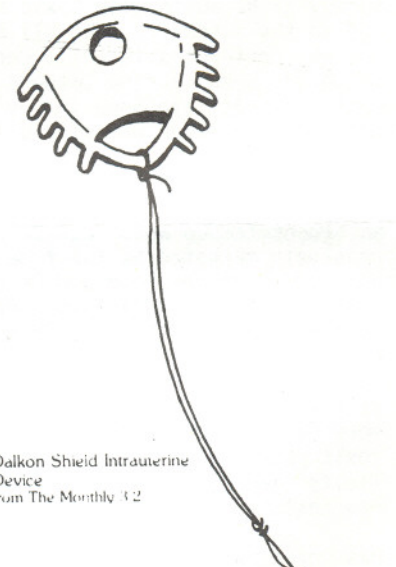
DALKON SHIELD— The plot thickens

On August 22 this year, A.H. Robins - manufacturer of the infamous Dalkon Shield - filed for protection under Chapter 11 of the U.S. Bankruptcy Act. If successful, Robins would be granted 120 days to reorganize its financial holdings. Chapter 11 is a rare piece of legislation that effectively allows companies to continue to operate their business and hold bankruptcy status at the same time. What this means is that claimants with suits pending against the company could be left out in the cold.

In June 1974 Robins halted domestic sales of the Dalkon Shield in Canada and the US at the request of the US Food and Drug Administration. However, women who already had the shield were not personally notified that it was a serious health hazard, and many women continued to wear them long after the halt in sales. In September 1984 Robins began a US ad campaign urging those women to have their Dalkon Shields removed at the company's expense. So far about 4,500 women have accepted the company's offer.

Earlier this year a Minnesota District Court judge report revealed that Robins has "engaged in an ongoing fraud by knowingly misrepresenting the nature, quality, safety, and efficacy of the Dalkon Shield. The ongoing fraud has also involved the destruction or withholding of relevant evidence."

Though the medical evidence shows that without a doubt the Dalkon Shield places the women who wear it at severe risk, Robins has not been prepared to settle suits easily. Throughout the trials Robins' lawyers have attempted to intimidate and devalue claimants by delving into private aspects of their lives that have no relevance to their injuries or to the legal issues involved. For example, an Iowa mother of two who suffered a severe pelvic infection as well as the loss of her



Dalkon Shield Intrauterine Device
from The Monthly 3 2

ovaries and uterus, was asked, 'prior to your marriage in 1963'(ten years before she was fitted with a shield) 'did you have sexual relations with anybody else other than your husband?' and ' Who were these sexual partners?' Clearly the tone and direction of the questioning was attempting to blame her for the problems the Dalkon Shield had caused.

continued on page 4

REPRODUCTIVE TECHNOLOGIES— Who's in Control

THE MOTHER MACHINE: Reproductive Technologies from Artificial Insemination to Artificial Wombs. By Gena Corea Harper & Row, New York, 1985

'We are in the midst of a dramatic biological revolution'.
Gena Corea's new book 'The Mother Machine' is essential reading for women and men everywhere. In it she examines the rise of reproductive technologies, looking at their current and historic uses all the while weaving in a strong feminist analysis. The images and situations she reveals are often shocking and at times left me shivering.

She opens the book with a riveting comparison. She describes the first artificial insemination which occurred in 1884 in the United States. The woman undergoing infertility treatment was artificially inseminated without her knowledge or consent. Corea described it as a rape.

Immediately after we are brought to a modern U.S. farm where farmers aggressively inseminate their cattle with 'sperm guns'. "They're basically a machine that have to produce a marketable product every year", explains a farmer. Corea's disturbing juxtaposition leaves no doubts that as far as she is concerned, in the field of reproductive technology, women are treated little better than cattle. Her analogy hits home when we learn that Fertility and Genetics Research Inc. an ambitious biogenic firm in the US. has been in the cattle industry for years and has adapted many of its techniques for women breeding!

Corea thoroughly smashes the myth that reproductive technologies are the answer to women's problems with infertility. She explains the procedures of embryo transfer, in vitro fertilization, surrogate motherhood, sex determination, artificial wombs and artificial insemination in great detail.

She emphasizes not only that these procedures fall far short of being the answers to women's infertility, but also that they are often falsely glorified in the media as modern miracles. The term test-tube babies for example, implies that the fetus actually grows and develops in a test tube, when in fact in vitro fertilization (the medical term) involves removing a ripe egg from the ovary, fertilizing it in a petri dish and returning it to the womb several days later. The procedure is often done not because the woman is infertile but because the man's sperm cannot fertilize the egg naturally.

Throughout the book Corea makes it crystal clear that the field of reproductive technology is very experimental. For example, by 1979, when two babies had already been born after IVF, the knowledge concerning potential genetic damage to offspring from IVF consisted of twelve studies on mice, rats and rabbits conducted by researchers who may not have been systematically looking for abnormalities. No research on primates had been conducted, a fact that defied international standards of medical practice.

Eileen Whalen·Sister Courage

Corea writes with clarity, insight and empathy for women. She understands why women volunteer for experimental programs and lays no blame with them. She acknowledges that some women have had successful experiences - they have given birth to healthy children - but points out that the majority of women are left with nothing but bills to pay. An Australian baby born in 1980 was reported as 'one of the most expensive babies in the world' costing her parents $1,500,000. Women who cannot afford the exorbitant fees for treatment are simply considered 'inappropriate' to participate in in vitro fertilization programs.

Even if a woman has enough money and is accepted into an in vitro fertilization program the probability of her giving birth to a live baby is very low. The most successful clinic in the US has only a 13% success rate. That is a 87% failure rate. Hardly the answer to infertility.

It is when Corea examines the motives behind the boom in reproductive technologies that my blood began to run cold. Women are often encouraged to participate in highly experimental programs by emotionally-loaded advertizing. One clinic in the US placed ads in newspapers reading "Help an infertile woman have a baby." Corea asserts that it is society's conditioning of women as nurturers that stimulates an altruistic response to such advertising. In addition, these women are not told of the hazards involved in such experiments.

The motivation of researchers and the medical profession is even more disturbing. Richard Seed, co-founder of Fertility and Genetic Research exclaims "I expect to get a Nobel prize (for my work)." He guesses that what he needs is a pregnancy by embryo transfer - an achievement which he notched up in 1983 - and a pregnancy in a post-menopausal woman. It seems that Seed is more interested in magic tricks than producing work of any real social value.

Another motive, says Corea, is to loosen women's claim to maternity while strengthening men's claim to paternity. This is done in two ways. First women are encouraged to mistrust their bodies with incredible statements like "Quite simply the womb is the most perilous environment in which humans have to live." Secondly, since it is almost exclusively men who conduct the research, control over who participates in programs and who makes decisions about treatment is entirely in their hands.

The ultimate goal of reproductive technology seems to be eugenics - an effort to 'improve' the human race by selective breeding. This final motive might explain why at the same time as wealthy white women are giving birth to $1,500,000 babies, black, Hispanic and Asian women are being forced into sterilization.

Since infertility is the reason why expensive fertility programs are in place, wouldn't it make sense to examine and work towards alleviating the causes of infertility Corea asks. Part of the reason why this doesn't happen is that a high proportion of infertility is iatrogenic - Doctor caused - infertility. IUD's being only one means by which women can become infertile.

The only criticism I have of the book is that at times Corea presents an anti-male perspective. Occasionally this caught me off guard, mostly because it didn't seem necessary. She states her terms of reference clearly in the introduction. Though they are too strong for me, they do not undermine the findings in her book. The facts stand for themselves.

Corea's book is extremely well researched and written. Her vivid and easy-to-read writing style combined with her thoroughness makes her arguments convincing and leaves no doubts about where she stands.

When you pick this one up you won't be able to put it down. MAGGIE THOMPSON

APARTHEID AND HEALTH—

In recent months we have had daily reports of the plight of black South Africans as the racist Botha government steps up its reign of intimidation and oppression. The system of apartheid - where blacks are routinely separated from whites and are forced into subordinate positions in society - is a well established one, and as such has had many long term effects on the black population.
What we don't hear in the media is the awful conditions of health among blacks in South Africa.

A report by the World Health Organization (WHO), titled Apartheid and Health, deals in detail with the severe detrimental effects of the South African government's policies on blacks.

The report contends that the administration of health in South Africa does not comply with the basic principles in the WHO constitution. For example, WHO states that health is 'a state of complete mental and social well-being and not merely the absence of disease or infirmity.' Using this definition the report concludes that the standard of health among black South Africans is appalling and as such falls far short of the WHO guidelines. Many preventable diseases such as cholera, diptheria, malaria and intestinal parasitic diseases are common among blacks while they are rarely found in whites.

The main causes of death in South Africa, 1976.

Order of importance	*African*	*White*
1	Pneumonia (excluding viral pneumonia)	Ischaemic heart diseases
2	Enteritis & other diarrhoeal diseases	Cerebrovascular diseases
3	Homicide & wilful injury by others	Pneumonia (excluding viral pneumonia)
4	Cerebrovascular diseases	Motor vehicle accidents
5	Tuberculosis of the respiratory system	Bronchitis, emphysema & asthma
6	Immaturity (not specified)	Malignant neoplasms of the trachea, bronchus & lung
7	Motor vehicle accidents	Senility (without psychosis)
8	Anoxic & hypoxic conditions	Venous thrombosis & embolism
9	Malignant neoplasm of the oesophagus	Diseases of the arterioles & capillaries
10	Measles	Suicide & self-inflicted injury

Source: H. C. J. van Rensburg & A. Mans. Profile of Disease and Health Care in South Africa

Another WHO principle asserts that 'Informed opinion and active co-operation on the part of the public are of utmost importance in the improvement of the health of people.' Though we could question whether this principle is upheld anywhere in the world, in South Africa clearly it is not. Blacks are completely excluded from any form of active co-operation in the political system. Though they represent over 75% of the population they are prevented from voting and are forced to live under the laws and policies developed by whites.

Black women and children in South Africa are especially susceptible to ill-health. Women have little power and are poorer than other groups. Also they shoulder the responsibility of caring for the young as well as the elderly.
- In 1976 the Infant Mortality rate among black children reached 378 per 1,000 compared to Canada's average of 13.6 per 1,000.
- Diarrheoral diseases cause 50% of deaths before age 10.
- Malnutrition causes 30% of deaths before age 10; and the list goes on.

The report concludes that the main causes of the problems are:
POVERTY; blacks supply over 80% of the economically active workforce. They are grossly underpaid and remain in abject poverty, living in overcrowded townships and squatters camps.
LACK OF HEALTH INFRASTRUCTURES; in rural areas health systems are very sparce.
TOO FEW HEALTH WORKERS; black communities have on average one doctor for every 44,000 people.

The South African socioeconomic system which is based on the premise that blacks are inferior, has profound effects on mental health.
Specific actions that contributed to mental illness were identified as: daily harassment, mass uprooting and separation from families, poor skill development in employment and overcrowding. Futhermore, the psychiatric services show a gross inequality in all areas - there are no rural programs and no services for the elderly. Incredibly, there are no black psychiatrists in the Republic of South Africa!

An examination of the government's budget clearly illustrates the priorities that the South African government has established
It devotes over 18% of its GNP to military expenditures, while allocating a mere 3% to health. By comparison Canada spends 1.8% of its GNP on military spending and 8.4% on health.

South Africa is a wealthy country and has the means to establish a comprehensive health care system. However the South African government has deliberately chosen not to do so.

International and internal opposition combined have already exposed the Botha government's atrocities; only continued pressure will create a non-racist society in South Africa.

Source: Radical Community Medicine Winter 1984-5

---

continued from page 2

DALKON SHIELD

In 1983 Robins offered $15,000 to Brenda Strempe in an out of court settlement; Strempe claimed that the Dalkon Shield had caused a severe pelvic infection. Later a jury awarded Strempe $1.75 million, all but $250,000 of which was for punitive charges because of Robins attempts to conceal information about the dangers of the shield.

Nearly 13,000 women have brought suits or claims against Robins for a variety of shield-related injuries, among them pelvic infections, perforated uteruses miscarriages, and congenital deformities. Suits settled up to Dec. 31 1984 have cost Robins and its insurers $315 million. There are about 3,800 suits pending.

If Robins is successful in its bankruptcy application the outstanding suits against it will be impeded and delayed, and yet again more women may have to forfeit getting fair compensation for the suffering they have endured.

Source: Washington Post April 11 1985
Globe and Mail September 28 1985

HEALTH SHORTS

Help for P.I.D.

The Canadian Pelvic Inflammatory Disease (PID) Society has been established in Vancouver.
The PID Society will give information and support to women with PID and their friends and families. Members say they also want to promote public awareness about PID.

Memberships are $5.00 for employed, $2.00 for unemployed and can be received from:

THE CANADIAN PID SOCIETY
PO Box 33804,
Station 'D'
Vancouver, B.C.
V6J 4L6

Also, the society is still looking for people to do work, especially telephone counsellors. Contact the above address if you are interested.

More on Smoking

In addition to the awful effects of smoking outlined in the last issue of Healthmatters, we recently discovered that tobacco in any form emits alpha radation from polonium 210. Polonium 210 is the end result of several radio-isotopes naturally present in air and soil which collect on sticky tobacco leaves and come through the plants' roots. The phosphate fertilizers used to grow tobacco contain especially high concentrations of these radio-isotopes.

Smokers are exposed to far more radiation from tobacco smoke than from any other source. A pack-and-a-half-a-day smoker absorbs a daily dose of radiation equal to the amount s/he would have received standing downwind of the Three Mile Island nuclear reactor for 21 hours after its infamous accident.

Radioactivity in cigarette smoke might explain why smokers of low tar and nicotine cigarettes have the same death rate from lung cancer as smokers of other cigarettes.
In fact there is enough radioactivity to cause at least 95% of all the lung cancer reported in smokers!!
Put that in your pipe and smoke it.

Source: Whole Life Times April/May 1985

Sponge Update

The contraceptive sponge, once heralded as another 'answer' in the search for a safe, accessible, and effective method of contraception for women, has instead generated more questions and concerns.

The sponge is a soft, disposable polyurethane foam body about two inches around. It is presoaked with non-oxynol 9(N-9), a common spermicide used with diaphragms and cervical caps.

In the first issue of Healthmatters, it was reported that N-9 had not been tested for long-term toxicity and carcinogenicity. Dioxane, a known cancer-causing agent, is a by-product of the manufacturing process of spermicide. And, as a result of a study presented to the FDA in 1983, this contaminant Dioxane has been linked to an increase of fetal malformations in pregnant women.

To make matters worse, 2,4 Toluendeiamine (2,4 TDA), a chemical sometimes released by polyurethane, is linked to liver, breast, and other cancers in rats and is listed as a "possible human carcinogen" by the U. S. Government. Since the sponge is made of polyurethane, one wonders how safe it can be.

Add to this the other problems sponge users have experienced-inflammation of the cervix, difficulty removing the sponge, sponge disintegration, toxic shock syndrome, and a lower rate of efficiency in preventing pregnancy than was initially expected-and you have a potentially unreliable and unsafe form of birth control. Presently, feminist health advocates in the U. S. are attempting to have the sponge recalled.

Source: Woman Wise Spring 1985

WORKERS FOR THIS ISSUE

Tina Crouse, Cathy Hluchy, Barb Mintzes, Colleen Penrowley, Barb Rines, Maggie Thompson and Lorna Zaback.

Hysterectomy

Since 1977 hysterectomy has been preformed more than any other single operation.

Seventy-six percent of all hysterectomies are preformed because of suspected cancer. It is shocking to note that the mortality rate from hysterectomy is greater than the mortality rate from uterine cancer.

Of the other 24% of hysterectomies, prolapsed uterus is the most common reason cited. A prolapsed uterus occurrs when the ligaments that support the uterus become relaxed and fail to provide the support, often causing the uterus to drop out of position. In many instances there are no noticable symptoms, a woman may not even realize she has a prolapsed uterus. In these cases it is discovered only during a routine pelvic exam.
Another common reason cited for hysterectomy has been bleeding between periods. Bleeding may be slight, and it may occur just once or twice and never again.

Women who have been advised to have a hysterectomy for any condition that is not life threatening should get a second medical opinion. It is preferable to get a second opinion from a fertility specialist who has been trained to preserve and reconstruct organs, rather than a gynecologist says Nora Coffey, editor of HERS NEWSLETTER (Hysterectomy Educational Resources and Services).
Statistics seem to back up Ms. Coffey's conclusion that gynecologists are eager to do unnecessary hysterectomies. Of the 76% of hysterectomies done for suspected cancer, only 5% actually had cancer!!

Source: Hers Newsletter Spring 1985

Keep It Coming

The Vancouver Women's Health Collective needs your support.
Subscribe to HEALTHMATTERS. Don't miss upcoming news about women's health.
HEALTHMATTERS subscription $15 a year for four issues.
SEND IN A DONATION. Tax deductible receipts issued for donations over $10.
HEALTHMATTERS subscription $15 ☐Donation of $__________.

NAME ______________________________

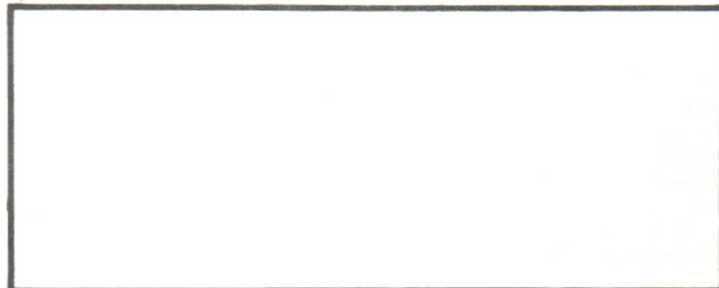
ADDRESS ______________________________

PROVINCE/STATE ______________________________

POSTAL CODE/ZIP CODE ______________________________

HEALTHMATTERS

Published Quarterly by
Vancouver Women's Health Collective
888 Burrard Street
Vancouver BC
V6Z 1X9



Printed by Press Gang, a feminist, worker-controlled collective.