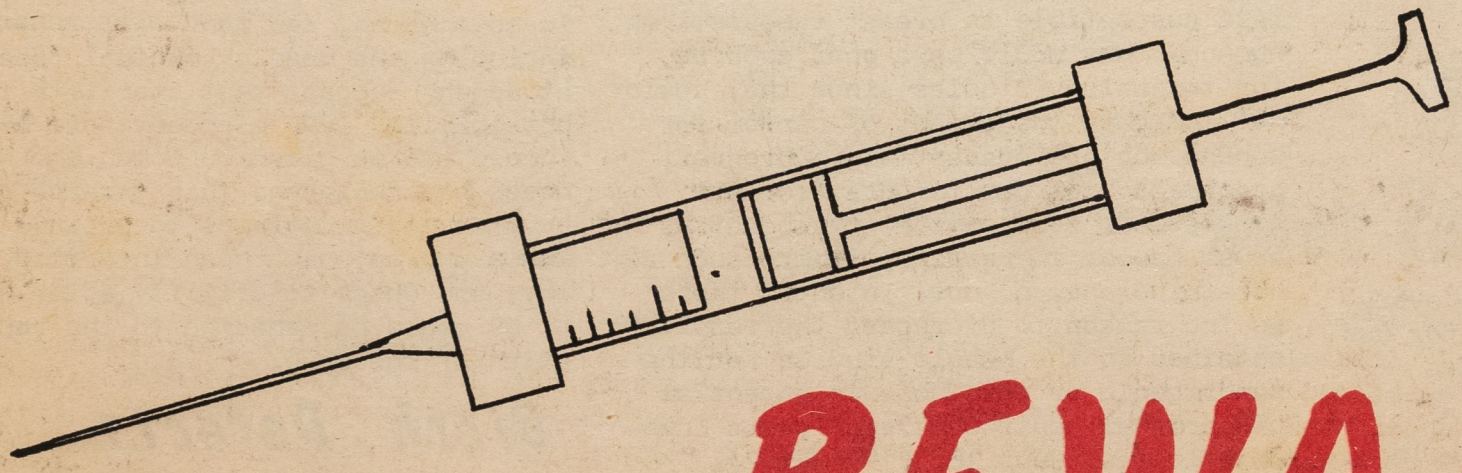
Abortion is a woman's

Right to Choose

Registered for posting as a publication Category B.

ISSUE No 20 MARCH 1980 20 CENTS

DEPO PROVERA



BEWARE.

WHOSE RIGHT TO CHOOSE?

One of the central demands of the women's movement has always been the Right to Choose. We demand the right to decide whether and when to have children. We demand access to free and safe methods of contraception. Our ability to acheive these aims however, is extremely limited, for we do not control the laboratories and clinics throughout the world where contraceptive research and trials are carried out. The control lies in the hands of multinational drug companies and government funded population control agencies. The priorities of these organisations are to provide the most economical ways of preventing population growth - the safety and convenience of women using contraception is not a high priority.

The western powers want an effective way to limit population growth in third world countries where poverty, unemployment and civil unrest are rife. Population control is seen as necessary to ensure the security of multinational investments. Development aid to third world governments is often now dependent on acceptance of population control programs through organisations such as IPPF - International Planned Parenthood Federation and UNFPA - the U.N. Fund for Population Activities.

Similarly, in developed countries, the birth control movement grew out of racist and classist attempts to limit the growth of the lower and immigrant classes. For example, the Family Planning Association of NSW was formerly called the Racial Hygiene Association. So while we can be thankful that we have gained some reproductive freedom we must also question the value of contraceptive technology when control of that technology is not in our hands. We may be exercising our Right to Choose as we take our pill every day, but we should be aware that the primary motive of the drug comapnies manufacturing contraceptives is profit, not the health and free choice of women.

The major breakthroughs this century for the population controllers have been the Pill, the IUD, and now Depo Provera. Only now, thirty years after its world wide introduction, are the so called 'side effects' of the Pill being publicised. Doctors still don't tell us of the women who have died from thrombosis, heart failure and other pill risks. Nor do we hear of the women who have become infertile or died from infections from IUDs. The medical experts will tell us that these risks must be weighed against the advantage of convenient reliable contraception, but how often is a woman given all the information to make an informed decision.

Even if we were given the full facts, how many of us could interpret them? One important example of the ways contraceptive experts confuse us is in the use of the term 'woman years'. One woman on a certain drug for one year constitutes one 'woman year', ten women on the drug for one year is ten 'woman years'. When considering the long term risks of a drug eg. the risk of a cancer that may take twenty to thirty years to develop, we need to know how long each particular woman was on the drug, how long each woman was monitored after using the drug, not just how many 'women years' are involved in the study. What does the claim of 77,000 woman years of research into Depo Provera really mean?

The need to rigorously evaluate medical and statistical information is one of the most important and neglected areas of feminist thinking. When we look at contraceptive drugs and devices we are healthy women looking for something that we can use safely for many years, we are not ill and looking for a cure, - this means that we should not accept products with a high risk level.

As western feminists we must accept also that the contraceptives we have, risky as they may be, are the 'best' of the larger number of drugs and devices tried out, in guinea pig fashion, on third world women. The need for this awareness and vigilance is amply illustrated in the story of Depo Provera.

DEPO PROVERA WHAT IS IT?

Depo Provera (Medroxyprogesterone Acetate) is the population controllers dream. It is given as an injection, usually at a dose of 150mg every three months, and during that time the hormone in the drug is slowly released into the system. It has three effects. Mainly it inhibits ovulation but it also makes the lining of the uterus less able to accept any fertilised egg and it makes the cervical mucus 'plug' more sticky and more of a barrier to sperm.

"ADVANTAGES"

It is manufactured by the Upjohn Company, an American drug company and it is promoted as having the following advantages.

1. Depo Provera (DP) is extremely efficient as a contraceptive having a lower failure rate than the Pill.

2. DP requires no motivation on the womans part. She does not have to remember to take a pill every day.

3. As DP only needs to be given every three months, it is convenient for use in remote rural areas. Trials are being done on a six month dose.

4. It is culturally acceptable - In many parts of the world people trust injected drugs more than oral or other treatments and associate them with improved health.

5. DPs long acting effect separates contraception from sex, reducing the need for repeated motivation as with barrier methods (Diaphragms, condoms etc.)

6. No estrogen. Many of the 'side effects' of the Pill, both the deadly and the less serious are associated with estrogen. DP does not contain estrogen.

7. Loss of periods. Most women using DP stop having periods. (This also is promoted as an advantage of the drug.)

8. Use during breastfeeding. DP usually does not suppress the milk supply of nursing mothers as the Pill does.

HOW SAFE IS DEPO PROVERA?

Ever since Depo Provera was first used as a contraceptive in the early sixties there has been a continuing debate about its safety. As stated above - we don't control the research. The great majority of studies of DP have been done by population control agencies with a vested interest in the drug or by the manufacturer and there is now evidence to suggest that the Upjohn Co. did not reveal the full results of its safety tests on DP. Many of the studies acknowledge Upjohn for providing supplies which could be taken to mean the drugs were supplied free of charge.

CANCER?

The centre of the controversy is the studies on beagle dogs conducted by the manufacturer Upjohn. DP induced breast tumours in the dogs studied. These tumours were clearly malignant and metasticized (spreading) and occured very early in the life span. These results have been duplicated in repeat studies. Advocates of DP argue that these studies should be ignored because dogs are uniquely sensitive to progestins generally and are more susceptible to breast tumours naturally than humans are. There is no evidence that beagles are more susceptible to progestins than humans and in fact they excrete progestins at a rate remarkably similar to humans. Control dogs not given the drug did not have a high incidence of breast tumours and in fact as pointed out by two industry scientists, had a 'remarkably low' incidence.

Obviously, if beagles did not get breast tumours at all, or if they were less susceptible to breast tumours than humans, they would be a poor species for toxicology studies since they could not indicate the extent of danger for humans who are susceptible. Moreover, beagles do not get tumours from all progestins. Some synthetic progestins cause cancer in beagles, others such as norethindrone, do not. In short there is 'no reason to disregard the results obtained in the beagle studies for the tumorigenic or carcinogenic potential of hormonal contraceptives' (Acta Endocrinologica, Supp 185 (1974) 252).

The evidence from the beagle studies was sufficient to cause the withdrawal of oral contraceptives containing medroxyprogesterone acetate and other similar progesterones. However the 'need' for an injectable contraceptive was seen to be so great that DP itself was not withdrawn.

Other studies on animals suggest that DP may speed up the growth of pre-existing cancers. This quality may be related to its ability to suppress immunological defenses.

Studies on monkeys showed that DP may be associated with cancer of the endometrium, the lining of the uterus. It should be noted that the first group of beagle dogs studied died from uterine disease. The second test group were given hysterectomies, so the effect on the breast could be studied.

Despite the wide use of DP, there have been very few, properly controlled studies on the rate of cervical cancer in women using the drug. The limited evidence suggests that among DP users there is approximately three time the rate of cervical cancer than among non DP users.

Bleeding Problems

The main publicised 'disadvantage' of DP is its effect on bleeding patterns. In most women DP causes amenorrhoea - no periods. What effect prolonged absence of periods has on women is unknown. In up to 30% of women DP produces unpredictable and prolonged bleeding or spotting. Apart from the inconvenience or total exhaustion and despair induced by such problems, anaemia can result or be exacerbated especially in undernourished women. A number of women in the UK have ended up needing D&Cs to attempt to diagnose the cause of continual bleeding. Many doctors 'solve' the problem by giving women estrogen with DP to control the bleeding. This practice discounts the 'no estrogen' advantage of the drug and in many cases the estrogen is given in daily tablet form again detracting from the 'convenience' of DP. Bleeding problems are the major cause of women stopping use of DP.

Delay in Return of Fertility

The standard three monthly dose of DP in fact lasts longer - on average eight to ten months according to an Upjohn newsletter. Other studies show a delay of one year and some say that normal fertility will return for most women within TWO YEARS after stopping the drug. Properly conducted studies have not yet been done to test whether DP could induce permanent infertility in some women, and many researchers, including the head of medical research at Upjohn suggest that sterility is a possibility. IPPF also say that DP should not be given to women who have never had children. This warning however is an attempt to exclude women who may have been infertile anyway, and whose infertility after use of DP could be damaging to the reputation of the drug.

Birth Defects

As it is impossible to predict when fertility will return many women will get pregnant when the level of DP in their blood is low enough for ovulation to occur but while they still have DP in their bloodstream. For these women, and for those given DP before knowing that they were already pregnant, the effect of DP on the development of the fetus is of vital concern. In this regard, DP is markedly different from non-injectable hormonal contraceptives because if a woman is exposed to DP during pregnancy, the drug will continue to act for some months or longer.

Again the evidence is contradictory. While some studies show no birth defects, other studies show masculinisation of female fetuses, including enlarged clitorises. Progestins in general have been associated with a syndrome of defects labelled VACTERYL- vertabral, anal, cardiac, tracheo and osophagal, renal and limb in humans. S. Shapiro, Director of Drug Epidemiology at Boston University concludes that 'there are reasonable grounds for suspecting that exogenous female hormones, medroxyprogesterone (DP) included, may be harmful to the fetus.

Effects on Infants through Breast Milk

No long term studies have been done on the effect on the development of a child who is breast fed by a women using DP. It is known that DP passes into the breast milk at an equal concentration to the level in the mothers blood. Despite this DP is being given to thousands of breastfeeding women.

Effects Similar to the Pill -

As DP is a progesterone - one of the two synthetic hormones in most brands of the Pill, it is not surprising to find that it produces many of the same 'side effects' of the pill. Reported effects include weight gain, nausea, loss of interest in sex, headaches, dizziness, raised blood pressure, fluid retention, and possibly diabetes. On the question of weight gain, researchers in Mexico say that this is no problem really as 'women in low socio-economic groups accept this well, especially those who are undernourished'!! If a woman experiences side effects on the pill she can just stop taking it but with DP she must live with the effects until the injection wears off. So much for 'control of our boddies'.

WORLD WIDE USE

Despite the lack of conclusinve research, DP is currently used by about 5 MILLION WOMEN in over 70 COUNTRIES, and its use is increasing. Mainly it is used in third world countries, as part of international population control programs through organisations such as UNFPA and IPPF. These organisations receive 35% and 40% of their funding respectively from AID - the U.S. Agency for International Development!

One example of the use of DP in the third world will illustrate how it can be abused. In THAILAND, Dr Edwin McDaniel has been running a DP program at the McCormick Christian Clinic in Chiang Mai since 1965. His program now injects an average of 1,300 women every day. He says that if there are no complaints, a repeat injection, including the paperwork, can be processed in 60 to 90 SECONDS!

While agreeing in theory with the recommendation from Upjohn, that women should be given a complete examination including a pap smear and breast check, McDaniel says;

> 'However, in certain communities and ethnic groups and in many under developed countries ... insistance on physical examination will discourage many women who should receive contraceptive assistance, and will give the family planning program a bad name at village level.. Many of our women have little or no idea of modern medecine and have never been to a hospital or clinic or seen a doctor or nurse before.. Family planning personnel (should not) cling too rigidly to more academic and professional standards'. !!!

Obviously, if examinations etc were carried out routinely, this would greatly reduce the present conveyer belt speed of McDaniel's clinic and decrease the 'cost effectiveness' of DP.

Apart from McDaniel's clinic, which is not a government project, it is worth noting that in 1978, the Thai government ordered THREE MILLION DOSES of DP from IPPF.

Depo Provera is also used on a smaller scale in developed countries, eg. Britain, Australia, USA, - mainly on mentally retarded women, women from minority racial groups and poor women. It is widely used in New Zealand. In these countries, the easy administration of DP, and the fact that its use takes all control from women themselves, could lead to doctors preferring DP to other methods which require more time consuming explanations and fittings.

Informed Consent

Many abuses relating to DP centre around the question of choice and informed consent. Indeed few women are offered anything but a travesty of choice. Many women in England have been coerced into accepting DP in exchange for abortion. Sometimes consent is not sought at all and women are given DP in the guise of other medication. Obviously women in mental hospitals are particularly vulnerable to this kind of abuse.

NOT APPROVED AS CONTRACEPTIVE

Because of the medical controversy surrounding DP, many developed countries have not approved it.

The AUSTRALIAN Drug Evaluation Board has not approved it for contraceptive use, only for use in the treatment of cancer of the endometrium (lining of the uterus). THIS DOES NOT STOP DOCTORS FROM LEGALLY PRESCRIBING IT. In fact the Health Dept. has sent a letter to family planning clinics saying they may use it with the 'informed consent' of the woman. Currently, the Board of the Family Planning Association of NSW has put a moratorium on its use pending further information on the safety of the drug. This could prove to be a very contraversial move as FPA/NSW is a member of the Australian Federation of Family Planning Associations, which in turn is a member of IPPF. The Upjohn Co has announced that it intends to reapply to the Australian Drug Evaluation Board for approval of DP.

In BRITAIN, the Committee on the Safety of Medecines has approved its use as a contraceptive in only two circumstances; (1) for women whose male partners are undergoing vasectomy and who are waiting for it to be effective, and(2) for women who have been immunised against rubella for the active period of the immunising virus.

In the U.S.A. the Food and Drug Administration (FDA) first looked at DP in 1967 and in 1973 was going to approve it as a contraceptive but postponed its final decision. Again in 1975, approval appeared imminent but was withheld. Finally in March 1978, the FDA rejected the application from Upjohn. The reasons given were;
- the safety questions raised by the beagle dog studies,
- the fact that satisfactory alternatives are available in the USA,
- the need to use estrogen for bleeding problems increasing the risks,
- the possibility of birth defects and
- doubt about Upjohn's ability to yield meaningful data in post marketing studies about breast and cervical carcinoma in women.

The FDA rejection of DP has caused a furore as AID cannot export a drug which is not licensed for distribution in the US. Attempts are being made to to introduce new legislation in the US to get around this restriction and allow the export of drugs not approved in the USA. In the meantime, international organisations such as IPPF and UNFPA will continue to distribute DP from Upjohn's other manufacturing plant in Belgium.

Women in Thailand's Chiang Mai Province line up for a Depo shot.

In attempting to get the US government to approve the export of DP to the third world, the population experts have stressed the higher maternal mortality rate in these countries, saying that the risk/benefit ratio is different from the USA. One doctor even said that the long term risk of cancer is not so important in third world countries where life expectancy is shorter anyway!!!

What should WE do?

On first hearing about Depo Provera, our initial reaction may be to say we must publicise the dangers of this drug and have it banned. This is a short-sighted view however, as focusing on the risks of DP could lull women into a false sense of security about the safety of other major contraceptives. Although the quantity of research into DP is small by comparison to the Pill or the IUD, there have been no reported deaths from DP, while deaths related to the Pill or the IUD are well documented. As the table shows the safest form of contraception is a barrier method with back up abortion. (table over page →)

The question of access to abortion is very relevant to how we should view Depo Provera. Unless abortion is freely available, women will always feel fearful enough of unwanted pregnancy to choose the more effective as opposed to the more safe method of contraception. Doctors will also bias the information they give in this direction. NEW ZEALAND, with its restrictive abortion laws is one of the few western countries where DP has been approved as a contraceptive and is widely used.

The case for banning Depo Provera lies more with its potential for abuse and the fact that it is the method least in the control of the woman herself, rather than on medico- scientific grounds.

The real problem is not Depo Provera - it is the question of who controls research, promotion and information about drugs. We need to put more energy into evaluation of existing contraceptive research and into doing our own research and then spreading the information to our third world sisters.

IF YOU HAVE ANY INFORMATION ABOUT THE USE OF DEPO PROVERA IN AUSTRALIA
OR
IF YOU WANT A BIBLIOGRAPHY OF THE RESEARCH ARTICLES ON DEPO PROVERA

PLEASE WRITE TO W.A.A.C.
62 REGENT ST.,
SYDNEY , 2008

Table . Annual number of total deaths associated with control of fertility per 100 000 nonsterile women, by egimen of control and age of women.

Regimen of Control	Age Group (years)					
	15–19	20–24	25–29	30–34	35–39	40–44
No control	5.6	6.1	7.4	13.9	20.8	22.6
Abortion only	1.2	1.6	1.8	1.7	1.9	1.2
Pill only/nonsmokers	1.3	1.4	1.4	2.2	4.5	7.1
Pill only/smokers	1.5	1.6	1.6	10.8	13.4	58.9
IUD only	0.9	1.0	1.2	1.4	2.0	1.9
Sterilization only	10.0	10.0	10.0	10.0	15.0	20.0
Traditional methods only	1.1	1.6	2.0	3.6	5.0	4.2
Traditional methods + abortion	0.2	0.2	0.3	0.3	0.3	0.2

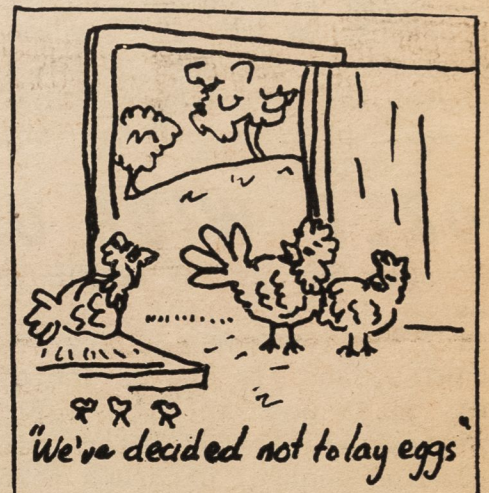
Potts M, Speidel JJ, Kessel E: Relative risks of various means of fertility control when used in less developed countries. *In* Risks, Benefits and Controversies in Fertility Control (ed JJ Sciarra, GI Zatuchni, JJ Speidel), p 28. Harper & Row, Hagerstown, MD, 1978.

Tietze C: New estimates of mortality associated with fertility control. Fam Plann Perspect 9:74, 1977.

W.A.A.C meets

Womens Abortion Action Campaign meets every second Wed. at Women's House - 62 Regent St, Chippendale - for inq for inquires-660 6029

Right To Choose printed and published by Vicki Brown for WAAC



IUD DANGER!

Professor Briggs, at the Deakin University Summer School, released findings of a study he made of twelve women having Copper-7 IUDs removed after three years.He compared them with a control group of twelve women having Lippes Loops (a different kind of IUD) removed.

He found that fiveof the twelve women with Copper IUDs had a substance called menalaldhyde in their cervical mucous. Menalaldhyde is formed when fats go rancid, and it is carcinogenic(cancer-causing) and mutagenic.

Professor Briggs postulated that the copper in the Copper-7 IUD produces a change in the fatty tissue in the uterus. He said, however,that he did not know how significant the presence of menalaldhyde was, and he thought that any residual copper should be shed during the woman's period.

The Family Planning Association which inserts the largest number of IUDs into N.S.W. women, is not recommending removal of Copper-7 IUDs, but will remove them if the woman so desires.

Hopefully these findings will prompt drug companies and governments to really research the possible side effects of contraceptives BEFORE their release.

ABORTION RESTRICTIONS in QUEENSLAND - - More fights to come

The Queensland government has drafted legislation which is designed, at least, to restrict abortionsto public hospitals. It has also been suggested that it would make abortion illegal in all circumstances unless the women's life is in danger or could involve psychiatricapproval, various limitations based on age and marital status, and approval procedures so lengthy that abortion would become a much more arduous procedure--all of which would require running the gauntlet of disapproval of the medical establishment.

At present the Queensland abortion laws are very vague. The Greenslopes clinic in Brisbane does perform abortions but this is the only clinic that does so and is far from adequate in that it costs women around $200 for the termination of their pregnancy. Other women are forced to pay high prices for travel and come to NSW.

Ifthe new bill is passed and abortions are only available in public hospitals, even without the other expected limits, it is very unlikely that many women would be able to obtain hospital abortions. Public hospitals all over Australia at present have limits on the number of abortions they will perform - unless you are in dire circumstances you are likely to be refused.

Hospital abortions are a very clinical experience in which the counselling, support and detailed contraceptive advice available at feminist is not provided Women are often subjected to punative treatment being placed in beds in labour wards or with women having miscarriages.

Women are demanding free safe abortion and health care and the right to be able to make informed decisions on their own behalf. The proposed law denys all of this - abortion would become highly restricted for all women and particularly for working class women on low incomes. More than anything this law makes it impossible for women to make their own decisions as the legal power is given to the medical establishment.

Subscribe !

___ I SUBSCRIBE TO RIGHT TO CHOOSE. ENCLOSED IS $2.00 FOR 4 ISSUES.

___ I ENCLOSE $ ____ FOR THE CAMPAIGN.

___ SEND MORE INFORMATION ABOUT WAAC.

NAME .....

ADDRESS .....

POST TO: WAAC, 62 REGENT STREET, CHIPPENDALE, NSW, 2008.