

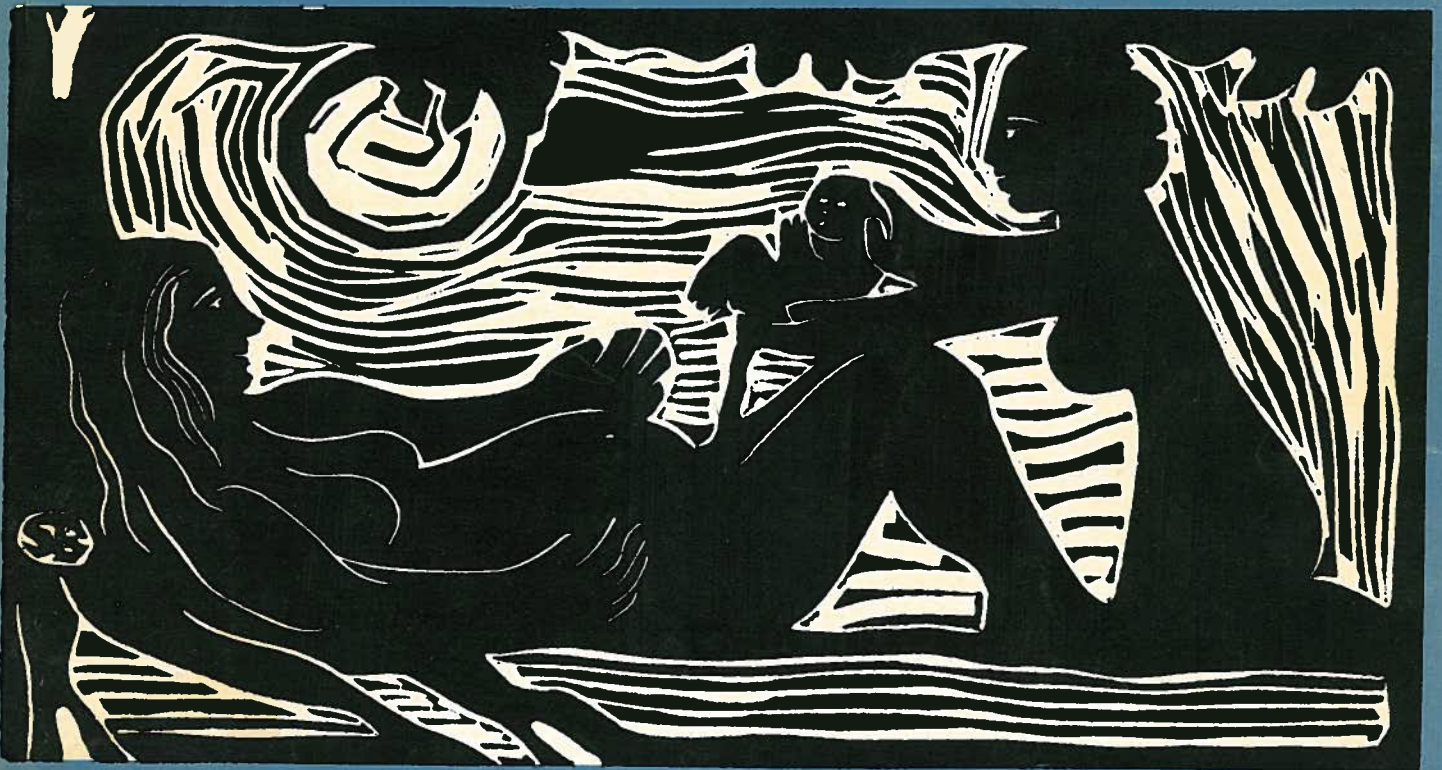
Summer 1983

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Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

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of reproduction**



PLUS: Mercury Poisoning in a Dental Office
African Genital Mutilation

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à vos risques et périls

Nancy Miller Chenier



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Men, Women and the
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Nancy Miller Chenier

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Women's Health Handbook

Mary Breen of Kingston Interval House is developing a handbook of easily readable materials for women with limited reading skills. She invites comments and ideas to assist in the production and distribution of this handbook. The materials will focus on topics such as pregnancy, birth control, preventive health measures and nutrition.

Please Contact:
Women's Health Project
286 Montreal Street,
Kingston, Ontario
K7K 3H1
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A:

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COLLECTIVE NOTES

It's Four Minutes to Midnight... and the Doomsday Clock is ticking. We all think about nuclear doom: "I want to be in the centre; I want to die instantly, not a lingering death from radiation burns." "I want to survive; I've seriously thought of moving to New Zealand."

Sometimes in our hectic days of editing, writing, scrambling to meet deadlines, we wonder if our struggles are for naught. In the grand scheme of things, when the very survival of the planet is at stake, how important is publishing a women's health magazine?

We are sometimes overwhelmed in the face of this ultimate threat to health, the 'final epidemic'. But we surely must face and work through this despair — the process Joanna Macy wrote about a year ago in *Healthsharing* (Summer, 1982). And we must create a vision of what a new world could be.

It doesn't make any sense, the rhetoric of the world leaders: "limited nuclear war", "winnable nuclear war", "ultimate deterrent systems", "zero options" and now Reagan's talk of Star Wars technology to fight nuclear war in space. It's the patriarchy gone mad!... or as Mary O'Brien, in this issue, would have it: "the tyranny of the penis rampant!" It's the antithesis of feminism's basic values of peace, respect, caring and bread.

The rhetoric obscures basic facts we should know:

- Hunger and illiteracy around the world could be eradicated with the \$600 billion (U.S.) spent on arms worldwide last year.
- The Canadian government, which claims to be a world force for peace, is complicit in the arms race. As a member of NORAD and NATO, Canada serves as a lackey to the United States. Nuclear weapons are deployed on Canadian territory, ready for use.
- Canadian branch plants of U.S. multinationals manufacture nuclear weapons components with the help of government subsidies, our tax dollars. Litton Systems Canada, located in a Toronto suburb, manufactures the LN-35, the "black box" navigational core of the Cruise guidance system.
- The Cruise is a sophisticated missile. It is slated to carry a "small" (200 kiloton) nuclear warhead — more than 15 times the strength of the atomic bomb dropped on Hiroshima. Its small size — less than 20 feet — is a serious threat to verifiable, bilateral arms control. Once deployed, the location of the Cruise cannot be determined by satellite surveillance. Once launched, it cannot easily be detected by radar as it travels just at tree top level.

Reagan's double speak claims that this very accurate, aggressive first strike weapon will act as a deterrent to the USSR, reducing the likelihood of nuclear war. In reality, deployment of the Cruise will make both super powers more edgy, more ready to respond if there is a suspicion, however vague, of an approaching Cruise. This becomes even more dangerous as we approach the era of computerized launch-on-warning.

- On February 10th our government signed a General Weapons Testing Agreement which paves the way for a specific agreement to test the guidance system of the unarmed, air-launched Cruise probably over Alberta.

Since the late 1970's we have witnessed a tremendous and growing outrage in response to the buildup of nuclear arms. Hundreds of thousands of people have demonstrated in Europe and North America. Members of the Green Party were just elected in West Germany. We have glimpses of a growing anti-nuclear movement in Soviet bloc countries. Last November in over 100 Canadian municipal elections, 70-80% of those who voted on the question said "yes" to disarmament.

No one wants a nuclear war. We must all vote with our feet and join the thousands of people across the country who marched on April 23 to demonstrate against the Cruise. We must continue to do everything possible. Tell your M.P. what you think; 2 out of 3 M.P.'s are still undecided on the Cruise missile testing. Write the newspapers. Speak out in your community.

We must stop the clock; we must turn it back.

The image of the Doomsday Clock, created by the Bulletin of Atomic Scientists, was first set in 1947 at seven minutes before midnight. It has been moved forward and backward nine times since then. In January, 1981, it was set at four minutes to midnight.

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No More Study, No More Statistics, We Want Action

The majority of the poor in Canada are women. Statistics released in February by the Canadian Council on Social Development disclose that 66% of elderly women in Canada in 1980 were poor; 46% of single women were poor; and two out of three poor families in Canada had a woman as the principal income earner.

M.P. Margaret Mitchell, in an open letter to women's groups across Canada, describes these facts as "shocking." They are shocking, but they come as no surprise. They are not new. We have known, and the government has known, for a long time that women, and particularly older women, are vastly

over-represented among the poor in this country. Yet pension and other reforms are still under study; the government continues to take no action to address the needs of women and the poor in Canada. Instead, they host a reception on Parliament Hill for the Board of the National Anti-Poverty Organization. Thanks for the cocktails, Pierre!

Margaret Mitchell's proposal for a standing committee on the status of women "to review government action, or lack of it" may have some merit. But what we don't need is further protracted study and discussion; we need action.

Problems with Artificial Insemination

A professor of clinical genetics in the Department of Community Medicine at Memorial University in St. John's, New-

foundland has found that children conceived by artificial insemination by donor may have certain chromosomal

abnormalities four to seven times as often as do normally conceived children. In a study of all artificial inseminations carried out until mid-1980 in six eastern Canadian fertility centres, Dr. Clark Fraser found slightly higher rates of Down's syndrome, Edward's syndrome and Patau's syndrome in the offspring.

The information was gathered from 817 questionnaires sent to patients who had been artificially inseminated through centres in Québec City, Montréal, Ottawa and Toronto. Fraser noted that the results of chromosomal disorders may, in fact, be even higher than was reported, since the question of confidentiality may have affected individuals' willingness to respond.

These preliminary findings have led to a call for a large-scale prospective study in Canada. In addition, the use of prenatal diagnosis with artificial insemination conceptions warrants exploration.

Cancer, birth defects, lowered resistance to disease, miscarriage, heart disease, depression and impotency have all been linked to exposure to these chemicals or to TCCD, the dioxin contaminant in 2,4,5-T. Widespread concern about human health problems has caused 2,4,5-T to be suspended, severely restricted or banned in the U.S.A., Ontario, British Columbia, Saskatchewan, Denmark, Italy, the Netherlands and West Germany.

In undertaking this action, the plaintiffs risk the loss of their homes, farms, businesses. To date, legal costs have amounted to over \$50,000. The trial is expected to last 40 days which represents a minimum of another \$100,000. A victory in this case would set an important precedent which could lead to further restrictions on 2,4-D and 2,4,5-T, in Canada and beyond. The plaintiffs need moral and financial support. Direct inquiries and donations to Herbiicide Fund Society, c/o P. Cumming, Gabarus, Cape Breton, Nova Scotia.

Homebirth Under Attack In Ontario

The Ontario College of Physicians and Surgeons issued new guidelines in March 1983 that make homebirths in Ontario legally high-risk. Until this time, homebirths in the Toronto area were attended by both doctors and midwives. Now, the new guidelines have eliminated most physicians attending homebirths, putting homebirth parents and attending midwives in a more precarious legal position. This has happened in most major North American cities in the last decade.

The College statement warns all doctors in the province to discourage homebirths and lays out guidelines to be followed if a woman wants a homebirth.

The guidelines include a list of conditions that would indicate that homebirth should not be allowed and a requirement that any physician who attends a homebirth must have full

obstetrical privileges and an active staff appointment hospital to which she can refer patients if any difficulty should arise. It is the requirement that doctors must have obstetrical privileges that eliminates some of the Toronto-area homebirth doctors and threatens others since hospital privileges can easily be removed.

The College states that "recent events of a tragic nature" prompted them to establish these guidelines. They are inferring about two deaths in 1982 of planned homebirths (one in hospital and one at home) that prompted inquests in Kitchener and Toronto. In both of these inquests, no one was found negligent. However the Ontario Association of Midwives believes that the College is using these incidents to sway public opinion against home-

birth and midwives. As well, the Association believes that the guidelines are misleading in the information presented as "factual". In one British study quoted, showing that homebirths have an increased mortality over hospital births, no distinction is made between planned and unplanned homebirths (miscarriages, births in taxis and so on).

The Ontario Association of Midwives has issued a statement in response to the College which has been sent to the College, and the press. On Mother's Day in Toronto homebirth and midwifery supporters held a successful rally. Because they believe that official recognition of midwifery is the way to improve maternity care in Ontario, a group of professionals and consumers have formed the Midwifery Task Force. This group will be working to increase public awareness of midwifery and to work on legislation. For further information call 1-416-960-1204.

Herbicides on Trial

A Nova Scotia court case with international ramifications is scheduled to commence on May 2 in Sydney, Cape Breton. On trial are the phenoxy herbicides 2,4-D and 2,4,5-T; at issue are the environmental/human health hazards associated with these toxic chemicals used by Nova Scotia pulp and paper companies in forest spray programmes in order to eliminate competing hardwoods from monoculture softwood stands.

Sixteen Nova Scotia residents are suing Nova Scotia Forest Industries, a Swedish-owned pulp and paper company. The plaintiffs are trying to prevent the spraying that would directly affect their property and water supplies. (Ironically, both chemicals have been banned in Sweden since January, 1983.)

Hormone Pump to Induce Ovulation

It is estimated that approximately 30 to 40% of all women who have fertility problems are not ovulating regularly, because of either a congenital or an acquired deficiency of the gonadotropin releasing hormone (GnRH). Until recently, the only medical treatment for problems of ovulation was the synthetic hormone, Pergonal, which involved expensive daily injections.

Dr. Robert Reid, assistant professor of obstetrics and gynecology at Kingston General Hospital in Kingston, Ontario, claims to have developed a method to stimulate ovulation which is safer and less expensive than Pergonal. The treatment involves a computerized pump which automatically injects synthetic GnRH into the woman every one to two hours. The pump is similar to that used for the administration of insulin.

Last summer, Reid engineered the first pregnancy in Canada using the new method. He is currently conducting clinical trials with four other patients at Kingston General Hospital. Reid claims that synthetic GnRH, unlike Pergonal, has no known side effects.

Women's Detox

A proposal to fund a detoxification centre for women in Ottawa has been submitted to the provincial Ministry of Health.

Although the Ottawa region has a 20-bed detox unit for men, there are no beds designated for women, according to Ellen Adelberg, chairperson of the Women's Detox Committee. The Committee, which was formed in 1979, hopes to establish a six bed centre serving women in both languages.

"Currently, a woman who is either drunk or stoned has only

The Contraceptive Sponge Has Arrived

The 24 hour, over the counter, spermicide-permeated sponge will be available in western U.S. states next month. The U.S. Food and Drug Administration approved this new barrier contraceptive in April and claims its effectiveness rate is 85%.

No fitting or prescription is necessary. Just moisten with water to activate the spermicide and insert by hand. The polyurethane sponge is said to be effective, even with multiple acts of intercourse, for up to 24

hours. Remove it by pulling on the attached loop.

The \$1.00 sponge named "Today" is produced by V.L.I. Corporation of Costa Mesa, California. They have plans for marketing in Canada and Western Europe as well as across the States.

As reported in the *Hamilton Spectator*, the sponge has no 'significant' side effects and, although more tests are needed, it appears to have no relation to toxic shock syndrome.

two options," Adelberg said. "She may go to the emergency department of the hospital where she may be admitted or the police can keep her overnight in a cell and release her in the morning."

The centre would provide detoxification for a period of up

to five days, ongoing daily support groups and referrals to existing services within the community.

**Maureen McEvoy,
Ottawa, Ont.**

Keeping Diarrhea in Check

Now I want to explain that I've never considered diarrhea to be a priority problem faced by the women's health movement in Canada. Certainly, being a mother to a toddler has moved it up the list several notches for me. And a recent visit to Latin America mad that the impetus behind th for a parent-child resource

Disclaimers aside, diarr us and our children. Some

The most important si bowel movements. There food in stool, explosive or times the diarrhea is accor.

In Canada, most case gastro-intestinal tract. The intestines, which make abs

Diarrhea may also be more serious illness and fe antibiotics is inappropriate

Parasites may also cau analysis of stool samples. as a "side effect".

The most important as fluids to replace those los don't drink acidic types su and herbal teas, flat ginger

Avoid solids, milk and digest them and they will variety of fluids on hand a way.

If you are vomiting, try you're sure it will stay dow

An important exceptio if your baby has diarrhea her illness.

Don't take over-the-c diarrhea. They don't help feces may breed more bac

In a day or two, as the reintroduce solid foods. I begin. For children banan: mended. The adult diet sh to a normal diet, leaving n

Usually, these precaut washroom within a day of thing more serious than a doctor if you have any of

- blood in the stool
- a fever of 40° C (104° F)
- vomiting that makes it ir
- if the diarrhea last more

Small children can becom: is vomiting. See your doct

- an inability to urinate fo
- a dry mouth, and no te
- unusual sleepiness.

Jennifer Penney is a mer educator for a community



APOLOGY

Women Healthsharing apologizes to Carole Yawney and the Canadian Naturopathic Association for any confusion which may have arisen from placement of information in our Spring, 1983 issue. A box containing several addresses was intended to accompany the article by Carole, *Naturopathic Medicine: A Radical Orthodoxy*.

The box should have read:

Learning About Naturopathy

1. Canadian Naturopathic Association
Suite 306, 259 Midpark Way,
Calgary, Alta. T2X 1M2
2. Ontario College of Naturopathic Medicine
43 Benton St.,
Kitchener, Ont. N2G 3H1
3. National College of Naturopathic Medicine
11231 S.E. Market St.,
Portland, Oregon 97216
4. John Bastyr College of Naturopathic Medicine
1408 N.E. 45th St.,
Seattle, Wash. 98105

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MERCURY POISONING

by Lissa Donner • drawings by Michelle Clusiau

I met Diane Gibson eight months ago, when she called looking for help. She had mercury poisoning, she said, from working in a dental office. She had never received workers' compensation. She was too sick to work. Her request prompted me to read the literature and I was surprised to learn that mercury poisoning in dental offices is well-documented. Furthermore, Diane had all of the symptoms which are commonly associated with inorganic mercury poisoning.

What seemed initially to me to be a simple, straightforward case has become very complex, a knotted pathway full of false starts and wrong turns. The interview which follows is the story of her struggles with illness, with the dental and medical professions, with the compensation system, with family and friends, and with herself. It is a story of pain and struggle, but also one of immense strength and tenacity.

I worked as a dental assistant from 1969 until 1978. I did just about everything from cleaning the office to bookkeeping and assisting with patients.

I was exposed to mercury when I mixed the amalgam (made of mercury and silver) used for dental fillings. It's mixed in a machine called an amalgamator. During this process the two metals are bound together. After the mixing was completed, I would squeeze out the excess mercury by hand. On average, I made about 100 batches per day, although the amount varied greatly. Nobody ever told me it

was dangerous. I also used to clean up and store the scrap amalgam and so I was unknowingly breathing in mercury dust.

Q *When did you first experience mercury-related symptoms?*

A In 1969. Although, of course, I didn't know then what was wrong with me. At first my symptoms seemed vague. The dentist I worked with said that my personality had changed. I often had headaches and my moods swung quickly up and down. I developed chronic lower back pain and bowel dysfunction.

Q *How did the symptoms change over time?*

A They got worse. This is still difficult for me to talk about.

I have chronic headaches. From 1973 - 1978 they were at their worst. It was blinding pain, without any let up. Nothing helped, not even Demerol. I tried heat and cold and complete darkness. Sometimes the pain got so bad that I would hit my head against a wall. Even my hair falling onto my forehead was enough to make me scream. I was so consumed with the pain that it was impossible to think. I still have headaches, but they are less intense and less frequent.

My face used to twitch very noticeably, mostly on the left side. My mouth and face felt numb, so that when I ate, food would sometimes fall

out of my mouth. I would drool a lot, especially in my sleep.

My memory and concentration are impaired. When I was working, I would often not remember where I had put an instrument. I was sure that I knew where it was, but my memory was often wrong. Although this has improved over time, even now I sometimes can't remember where things are around the house. Several times a week, when I'm out shopping or whatever, I blank out and can't remember what I'm doing. Then I get angry at myself and usually just stomp home.

My perception was, and still is at times, impaired. I first noticed this when I was still working as a dental assistant and I would reach for the wrong instrument. I also used to walk into door frames a lot.

When I was a dental assistant, my eyes became very sensitive to light. My vision was blurred. Optometrists couldn't find anything wrong, but I felt a lot of pressure, like my eyeballs were going to pop out. My perception was also disturbed. For example, if something was priced at \$27.95, I might see \$2.79. My vision has improved since I left work, but my eyes are still very sensitive to light, and they ache a lot.

I felt pins and needles and numbness in my limbs; at other times my skin was so sensitive that I couldn't stand to be touched. This has really improved; I don't feel the pins and needles nearly as much, but my hands and feet still feel cold a lot of the time. As well, my hands tremble. This was at its worst just after I left the dental office.

This was also a time when my legs would just give out on me and I would fall down on my way home. I would wake up at night shaking uncontrollably. It felt like a thousand electric shocks were shooting through me.

Shortly after I began to work as a dental assistant, my feet began to swell. Later the joints in my hands started to swell. Often, I couldn't get into any of my shoes, so I couldn't go anywhere. This started to subside a few years after I left work. I still have a lot of joint pain, especially in my hips, legs, feet and wrists. I've been tested for arthritis, but the test results are negative.

I had to have all of my upper teeth removed. My gums would swell and my teeth became very mobile and very sore. This was not ordinary gingivitis. I know how to floss my teeth. By this time, I'd figured out that my problems were mercury-related and I did not want any more mercury fillings. The dentist I was seeing didn't believe me. It became a real trauma just to walk into his office. He wouldn't put in non-mercury fillings, and did not believe that my teeth hurt me the way they did. In the end he did agree to build me a complete upper denture.

My speech and writing are impaired. Sometimes I stammer and reverse the order of words. My handwriting is sometimes scribbled and shaky, and I often reverse letters and numbers when I write and read.



The Hazards of Working with Mercury

Mercury has been an occupational hazard for hundreds of years. As early as 1600, mercury nitrate was used in the felting of hats. Hence the "Mad Hatter" of *Alice in Wonderland*. "Mad" hatters were exhibiting the signs of chronic mercury poisoning. Mercury was the first substance to be occupationally regulated — in 1665 in Idrija, Yugoslavia. In recognition of the hazard, the working hours in the mercury mines were reduced from 14 hours to 6 hours per day.

Mercury is a particularly insidious poison. It is the only metal which vapourizes at room temperature. Since mercury vapour has no odour, accidental inhalation is a real risk. Mercury poisoning can also occur through ingestion or absorption through the skin.

ACUTE mercury poisoning, caused by high levels of exposure, is rarely seen. Its symptoms include respiratory irritation, digestive disturbances, kidney damage. In severe cases central nervous system damage also occurs.

CHRONIC mercury poisoning usually results from long-term, low levels of exposure. It causes a great variety of symptoms. The central nervous system is the primary target. Damage to the CNS from chronic mercurialism results in psychological disturbances — shyness, irritability, insomnia, indecision, depression — tremors, sensations of tingling and numbness and lack of coordination. Other symptoms include gingivitis, excessive salivation or dryness of the mouth, disturbances of taste and smell and loss of appetite.

There are three types of mercury —

metallic, organic and inorganic. ALL ARE TOXIC. Epidemics of organic mercury poisoning such as those among native people in Northern Ontario and the residents of Minamata, Japan, have been the result of industrial pollution. A 1972 epidemic in Iraq, which killed 459 people and poisoned 6530, was the result of the ingestion of methyl mercury fungicide used to treat the wheat seed used in bread making.

Occupational exposures to mercury may occur among the makers of:

- acetone
- paper
- fulminates
- batteries
- scientific instruments
- mercury vapour lamps
- disinfectant
- dyes and colours

I have had insomnia quite often since 1976. Partly, my mind just wouldn't shut down, and other times, if I was woken by physical symptoms, I couldn't get back to sleep. Sometimes I used to go for days without sleep. Now, I just can't sleep a lot of the time. Several times a week it's 3 or 4 a.m. before I fall asleep, and then I'm awake early in the morning.

I often laugh and cry inappropriately. This really interferes in my relationships with other people, and is still upsetting to me. I used to be an outgoing person, but I have become very fearful of people and situations, even those I know well. I often feel confused as well as anxious, and I have difficulty making even simple decisions.

I feel depressed most of the time. It's hard to know how much of that is the mercury and how much is that I'm just so tired of feeling sick all of the time.

I become uncontrollably angry at unpredictable times. Part of me would really like to hurt other people, and sometimes I really don't know why I want to lash out at them. I grabbed a doctor by the necktie once, but that was after he'd told me that all of my symptoms were in my head.

I find telling you all of this for publication very threatening. I'm worried what others reading this will think of me, but I know that if I don't let others know, then they may go through the

same thing alone. It's a horrible thing to live with, especially when you want to harm those you love.

Q *I think that you have a lot to be angry about.*

A I know that you think so, and that helps somewhat. But at times the anger is overwhelming, and I'm not even sure who or what I'm angry about.

Q *How did doctors and dentists react to you when you described your problems?*

A Well, first of all, nobody even checked me for mercury poisoning. This makes it hard for me now, because after all these years my blood mercury levels are normal, even though I am still quite sick. I think if I'd had a blood mercury level taken earlier — when the results would have been elevated — then perhaps doctors would believe me now.

Basically, up until a few months ago, all the doctors I saw dismissed me as "crazy." I was a "hypochondriac." They gave me tranquilizers, relaxants, and anti-epileptics. In the dental offices, my lack of co-ordination was a subject for joking. The dentists, as well, wanted me to take drugs. One even gave me Valium. There were lots of drugs in the dental office — pain killers

and tranquilizers — and I could have had whatever I wanted. That was easier for my employer than giving me time off work to go to a doctor.

Q *How did you feel when everyone decided that you were a "crazy woman"?*

A Very, very alone, and desperate. Listening to all those doctors tell me it was all in my head would have made the sanest person crazy. I began to believe them. The hurt, shame and guilt were tremendous.

Q *How did you find out about mercury poisoning?*

A Someone gave me an article by Ben Berck on mercury in dental offices, entitled "Mercury Vapour as an Atmospheric Contaminant in Dental Offices" (*Archives of Environmental Toxicology*, 3:2). I started doing some more reading and it was like a jigsaw puzzle being put together. I was terrified. I wanted to know, yet I didn't know who to trust. I called Jay Cowan, who was the N.D.P. critic on workplace health and safety in the Manitoba legislature. He put me in touch with Bob Sass, then the director of Saskatchewan's Occupational Safety and Health Branch. Sass had written about another worker, George Smith, who

The following workers are also exposed:

dentists and other dental workers
induction furnace workers
mercury boiler workers
photographic workers
mercury pump workers
farmers and farm workers
tannery workers
electroplaters
gilders
metal refiners
bronzers
fur handlers



Resources on Mercury Poisoning

• *Mercury Exposure in the Environment* by L. Friberg and J. Vostal (Cleveland: CRC Press, 1972)

• *Criteria for a Recommended Standard...Occupational Exposure to Inorganic Mercury* by the National Institute for Occupational Safety & Health (U.S. Dept. of Health, Education and Welfare, 1973)

• *Chemical Hazards of the Workplace* by N. Proctor and J. Hughes (Toronto: Lippincott, 1978)

• *Occupational Medicine* by Carl Zenz (Chicago: Year Book Medical Publishers, 1975)

• "Mercury Vapour as an Atmospheric Contaminant in Dental Offices" in

Archives of Environmental Contamination and Toxicology by Berck, et al (Vol. 3 No. 2, 1975 pp. 229—236)

• "Exposure of Dental Workers to Mercury" in *American Industrial Hygiene Association Journal* by H. Buchwald (Vol. 33 1972 No. 7 pp. 492—502)

• "Mercury Vapour Exposures in Dental Offices" *Journal of the American Dental Association*, P.A. Gronka (Vol. 81, 1970 pp. 923—925)

• "Mercury Toxicity in the Dental Office: Neglected Problem" *Journal of the American Dental Association*, by D. Mantyla and O. Wright (Vol. 92, 1976 pp. 1189—1192)

also had mercury poisoning, and he arranged for me to talk to him. Talking to them all pulled me through some tough times.

Q *What did you do then?*

A I began the long task, which now seems impossible, of trying to "prove" that I have mercury poisoning. Now that the acute phase is over, analysis for mercury content in blood is meaningless. A sympathetic dental researcher here recently did an analysis of my hair for mercury content, and found it abnormally high. How much this "proves" is debatable. I believe that there are still mercury deposits in my bones and other tissue, but this is impossible to prove. They just don't have the medical technology.

But I did keep trying for a long time. The general medical consensus about me was that I was schizophrenic and manic-depressive. If I spoke about my mercury poisoning, they all viewed this as a further symptom of my mental illness. In their minds the problem wasn't that mercury was making me crazy, but rather that I was crazy to think that my symptoms had anything to do with mercury. Then I really started to feel crazy. I felt so alone, and I became very, very depressed. I thought about suicide.

I became afraid of what would happen if people knew how depressed and angry I sometimes felt. Because of this fear, I tried to hide a lot, and not let anyone know how bad it really was. Of course, this just made me feel more lonely and isolated. My handicap now is an invisible one, and so people find it hard to empathize with me.

Q *Are you eligible for workers' compensation?*

A No. Dental offices in Manitoba and Alberta, the two provinces in which I worked, are not covered by workers' compensation. Dentists can voluntarily opt for coverage. Unfortunately for me, none of the dentists I worked for did so. If I'd gotten mercury poisoning in a factory, or as a hydro worker like George Smith, I'd be a lot better off financially, and probably emotionally too.

Q *How do you manage now?*

A It's a struggle 24 hours a day. Support from understanding people helps, but I still feel alone with it at times. My symptoms are not as bad now, and they can be expected to lessen over time, but there is no cure. That's the most difficult thing for me

still, knowing that there is no cure. I still forget simple things and often have trouble saying what I mean to say. I'm trying to be less hard on myself when these things happen.

Q *What do you think others working in dentistry should do?*

A If they're still hand squeezing amalgam, stop! Read about mercury poisoning and get tested for it. I think that they should talk to others, in the same office and in their associations, and take group action. There is a new regulation on the handling of mercury in Ontario, but at the request of the Canadian Dental Association, dental offices have been excluded. They say they can look after their own offices and don't need government interference! This is completely unacceptable.

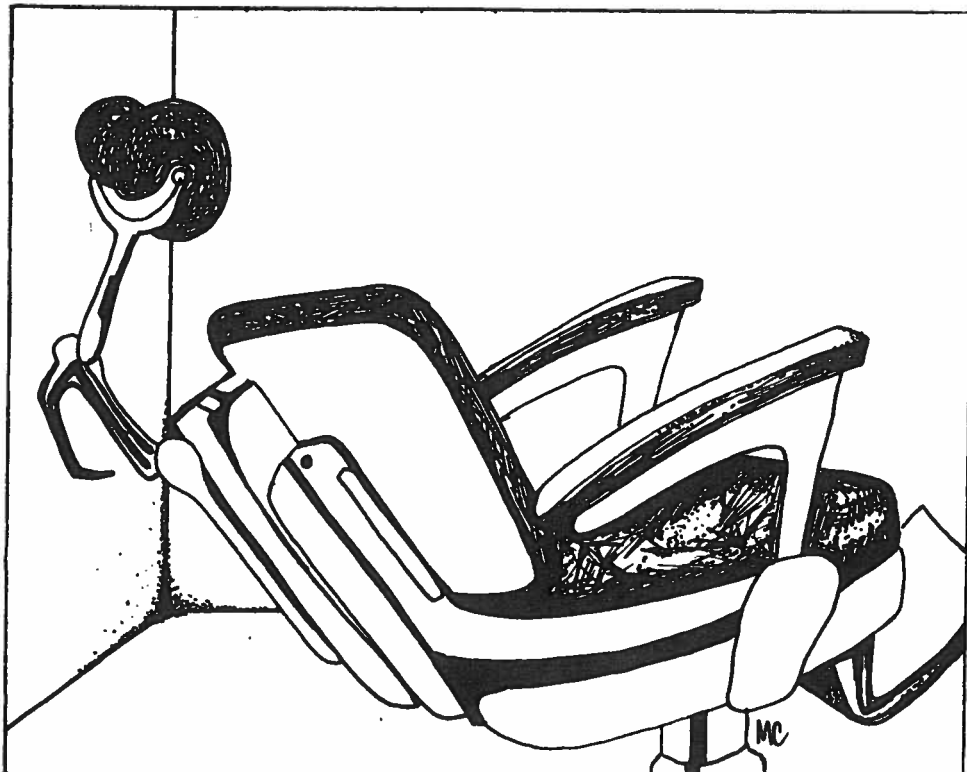
There are a whole list of hygiene precautions recommended for dental workers in most of the literature on the subject, including: not eating or drinking in work areas; working with mercury only on smooth, lipped surfaces; ensuring the proper ventilation of amalgam-mixing areas; not salvaging scrap amalgam for recycling; using only impervious and seam-free floor coverings; not wearing work shoes or clothes out of the office and not allowing smoking in dental offices.

But I think that there are some other important things that don't often get mentioned. I think that dental workers should also: make sure that they aren't exposed further to mercury in their hobbies and crafts; wear a mercury vapour monitor and an x-ray dosimeter at all times; leave the office for breaks; keep informed about new research and procedures in mercury handling and substitution; question any potential employer about their attitude towards mercury.

Speaking from personal experience, ignorance is not bliss.

Diane Gibson would like to correspond with others who have experienced problems as a result of mercury exposure. Please write her c/o MFL Occupational Health Centre, 98 Sherbrook St., Winnipeg, Manitoba.

Lissa Donner is a social worker who is Executive Director of the M.F.L. Occupational Health Centre in Winnipeg.



NAMING OUR EXPERIENCE

MARY O'BRIEN ON THE POLITICS OF REPRODUCTION

excerpted by Kathleen McDonnell

linocuts by Susan Barsel

Mary O'Brien is a feminist theorist and one of the most provocative thinkers in the Canadian women's movement. Trained in Britain as a nurse and midwife, she now teaches women's studies and political theory at the Ontario Institute for Studies in Education in Toronto. She is a founder of the Feminist Party of Canada. -

The following are excerpts from an address delivered in Toronto on March 13, 1983 entitled "The Politics of Reproduction," which is also the title of her book, published in 1981. In these excerpts she weaves together a number of themes and concerns in an effort to identify how women's experience of ourselves, of our bodies, of reality itself, has been appropriated and redefined by men, and what women must do to reclaim our experience.



MEN UNDERSTAND THEIR experience as profoundly dualist, as a series of separations. The "universal" that they create to try and heal these separations is a product of mind, yet is separate from mind. It refers to a reality which is separate from its idea. It seems to me to be extremely important to understand not only this odd universal man, but also why he has found it necessary to, as it were, usurp the definition of women, and why it is absolutely essential that we take that definition back unto ourselves and our own experience.



IT'S VERY OBVIOUS when you read man's literature that he's preoccupied with death. What is less obvious is that his way of presenting human experience also denies birth.

It's a funny thing, but there is, in our history of the West, all this intellectual ferment of the centuries, a philosophy of almost everything. Nowadays we have philosophies of advertising, philosophies of credit policy, philosophies of job descriptions — We have all these kinds of philosophies. And yet, we have no philosophy of birth.

Why is that?

Is the absence of a philosophy of birth related to the fact that universal man does not need to get born because he is not a product of nature, but a product of mind?

And even if that were the case, is it not a funny way to put it? And what's the matter with getting born? What is the matter with *giving* birth? If you're so keen to have continuity over time, and indeed I think it is a condition of social stability that we should have some kind of continuity over time, what's the matter with the continuity of the species over the generations? Why can not we organize our sense of the world and its continuity around that very concrete, practical, everyday continuity of the species?

I wanted to know the answer to that question, and I didn't know quite where to look for it. Universal man

doesn't look for it. Universal man doesn't think it's important. What he does, this abstract creature, is talk about the "essence of man," a sort of metaphysical ketchup, which you pour on things to obscure what they look like and what they taste like and what they really are.

Universal man takes upon himself the capacity of forcing the dualism of the world into unity. The natural world and the historical world stand in contradiction to one another for universal man. And he tries so hard to conjoin them. He tries so hard to mediate that contradiction, but he can do so only in thought.

And therefore thought comes, to many men, to seem more real than reality. The concept of man, universal man, is more real than actual men, than the life of the individual.

Now, there are some interesting developments that come from this particular way of looking at the world. The way to deny the humanity of any particular biological species is to deny it the power to think, which universal man believes to be that which separates him from the other world. Man seems to see his relationship with the natural world not only as a separation, but as a struggle. And that's a very serious way of looking at the natural world because old Mother Nature seems to have moved from man's endeavour to control her into an out-of-control phase, in which she's being systematically destroyed.

And I think it's because of that result of the understanding of the natural world and the historical world as separate from each other, as alienated from each other, that we have to poke into the obscure recesses of patriarchy's understanding of the world and itself. Not so that we can reform them. But so that we can destroy them before they destroy us.

Knowledge can be thought of, like universal man himself, as floating free in history, waiting for the fine tuned mind to pluck it out of the ether and reproduce it on the earth for our edification. Or it can be thought of as, in fact, in some way related to reality. And it is of course the latter notion of knowledge, knowledge grounded in human experience, that I favour. And I think most feminists do. We have suffered quite a lot from ungrounded knowledge, unsupported assertions, ideologies of universal man, and his right to dictate the conditions of our being to us.



BIOLOGICAL DETERMINISM is evidently a very awful thing. What it means, of course, is that there is no such thing as transcendence. Transcendence is what universal man does to biology. He gets away from it. He gets into the life of the mind, and leaves the life of the body in the care of women in the private realm.

Now, why is it so objectionable to say that biology determines anything? That's a dangerous thing to say in a liberal society because you immediately destroy the perception of free will, and we all know that whatever universal man has or doesn't have, he has a free will. Biology is a trap for unwary patriarchs who find themselves in the uncomfortable position of not being able to transcend the natural world and make history.

We must never attempt to derive knowledge of the human world from the biological world, evidently, without a large number of reservations; not the least of which is that the biological world, since it does not think, is not only static but is inferior to the historical world. It is, of course, the condition of the historical world. But as a condition, it's just there. There is no vitality.

No thought. No liveliness. Nothing. It's just brute, mute and ahistorical. Which is a pity, because that's where women live.

Women, evidently, don't manage to transcend biology.

What is it about me, as a woman, which seems to be incapable of transcendence? The obvious answer is that patriarchy has defined me that way. And, therefore, I have to ask how is it that we've gone all through history and let these buggers get away with it?

Of course the immediate answer to that is we have not. All that metaphysical ketchup has been poured over our efforts at resistance, and therefore we have lost our history. But far more than that, patriarchy has had the power to use our incapacity for transcendence to see that we don't live in the real world. What's the real world? The world that man invents. We live in the unreal world of biology. These worlds have come to be known historically as the public and private realms. And I



have become convinced that the separation of public and private — which is the essential part of the structure of patriarchal control — will become the central locus of struggle *against* the suppression and oppression of women and the power of men to define us.

The feminist revolution, it seems to me, is developing its strength and its strategies in the private realm. This revolution is in fact changing the world, has already changed the world. These changes are the product of women beginning to identify themselves.

The private realm is being transformed. And it's not at all clear yet what kind of transformation that will be, or what kind of historical effects it will have. It has certainly transformed our perception as women of our own sexuality. It has released us from the tyranny of the penis rampant. It has brought about the notion of personal relationships which are not necessarily rooted in reproduction. It has taught us to know one another better as women as we begin to live together, in a much broader sense than has been possible for us historically.

When women lived together historically, the social organization of women's houses, whether they were brothels or whatever, was such that the structure guaranteed friction between women. Friction because their only purpose in being there was in some sense to have a man. And I am of the generation which was brought up to believe that not to have a man was a fate worse than death. Not to have a man, to fight over the men, to fight over the available men. These were not women's communities. Women did not make them, nor say what their social conditions would be.

We are doing that now. We are learning through a revolution, it seems to me, which cannot be defined as a revolution because it defies the definitions of revolution, which men made. And that's a pretty exciting thing.



WHAT I HAD BEEN searching for was a method of understanding birth as real. Now, it wasn't very hard for me personally to understand that. Not because I have children, because in

fact I don't. But because I have been in the past a midwife and have been present at these tremendous celebrations of femininity. And I do not from that experience find it possible to give credence to the notion of birth as alienation, birth as biological, uninteresting and ahistorical. I have this common sense view that unless people get born, there wouldn't be any history. You don't find that view in the annals of male-stream thought.

I think that what I was struggling with was the notion that birth is not, in fact, simple. That birth is an extraordinary complex process. Not in the physiological sense, but in the sense of human consciousness. Of what it means to be a parent. And, of course, it means something quite different to be a mother, than it does to be a father.

What I tried to analyze was that difference. And I didn't want to analyze it simply as a poem, or as another abstract universal. I wanted to relate it to real experience. And, therefore, what I had to do was look at the process of biological reproduction, which I had learned as a student midwife many years ago. You know, impregnation, conception, pregnancy, all of these things; biological series of events, running on totally apart from that whole business of making history that men are getting on with in the meantime.

Birth is experienced differently by men and women. Now why would men go to all the trouble to make their definition stick? Man's experience of paternity is the experience of alienation. The transformation of the relation to the species to a mere abstraction. It's very hard for us living in an oppressive, patriarchal society to remember and understand that paternity is an idea. What kind of idea is it? It is an idea which depends on knowledge. The knowledge of cause and effect. The knowledge of the relationship between sexual intercourse between men and women, and the birth of a child.

Paternity is in fact a historical discovery. At some moment in history, of which alas we do not have records, but we do have resonances, man discovered that he was at the same time included and excluded from biological reproduction. It's an odd thing, really, paternity, when you come to look at it.

There he is, knowing that his seed has been cast, and not having a clue as to its subsequent fate. Between the conception and the creation falls the shadow, as T.S. Eliot put it. The shadow is lapsed time, alienation.

But I don't want to suggest that patriarchy is a neurosis. Although historically it may become one.

I believe that the question of the uncertainty of paternity relates to the notion of knowledge as process. Knowledge as continuous. I think that's the condition of knowledge, and I think that may well be the way consciousness works. But whether that's true or not, what is true is that the consciousness of the father is an alienated consciousness. And the history of the species shows tremendous efforts on the part of men to resolve, to unify, that gap between their experience as an individual, and their relationship to the species.



Cast adrift. Rejected. No wonder existential man is saddened. Then, at the end of all that happens, he dies and sinks out of sight. With no sense of reality, no sense of continuity.

Women are quite different. Women, in giving birth, engage in a unity of experience and thought. It is, of course, popular to suggest that because a woman in labour cannot help what she is doing, she doesn't know what she is doing. What nonsense! Of course she knows what she is doing. She knows quite well that she is giving birth to a child. Her child, who is like herself, but separate from herself. Who will, in turn, be involved with the reproduction of the species. Who guarantees. And the birth of a child is always a celebration for women and even occasionally for men. Not because this child is born. That's what men do, pick out certain children: "This child is born today and the angels are singing!" Ordinary children are born every day. Sometimes they survive. Sometimes they don't. Sometimes their mothers survive. Sometimes they don't.

But enough survive and enough women labour that the process ensures the continuity of the species. What we

are asked to believe by patriarchy is, in a sense, that history is not grounded, or else that it is determined by all kinds of things — like the way we get our food (Marx), or our sex (Freud), or how we deal with death (Existentialism). *Birth*

is the condition of history, the material condition of history. It is the condition of continuity. It is the condition of species' survival.

And that doesn't necessarily mean simply that it's important. You know,

so what? Well, the *so what* is this: that it is experienced differently by men and by women. One, an experience of labour and integration; the other, an experience of alienation which is at the same time, in a curious way, freedom.

Man values paternity not because it unites him with the species, but because it frees him in two ways. It frees him from the reproductive labour of producing children. And it frees him to identify what it means to be a father. And he's been very busy in that area over history. And very innovative. There is in most cultures only one definition of mother: she who bears the child. There are thousands of definitions of fatherhood.

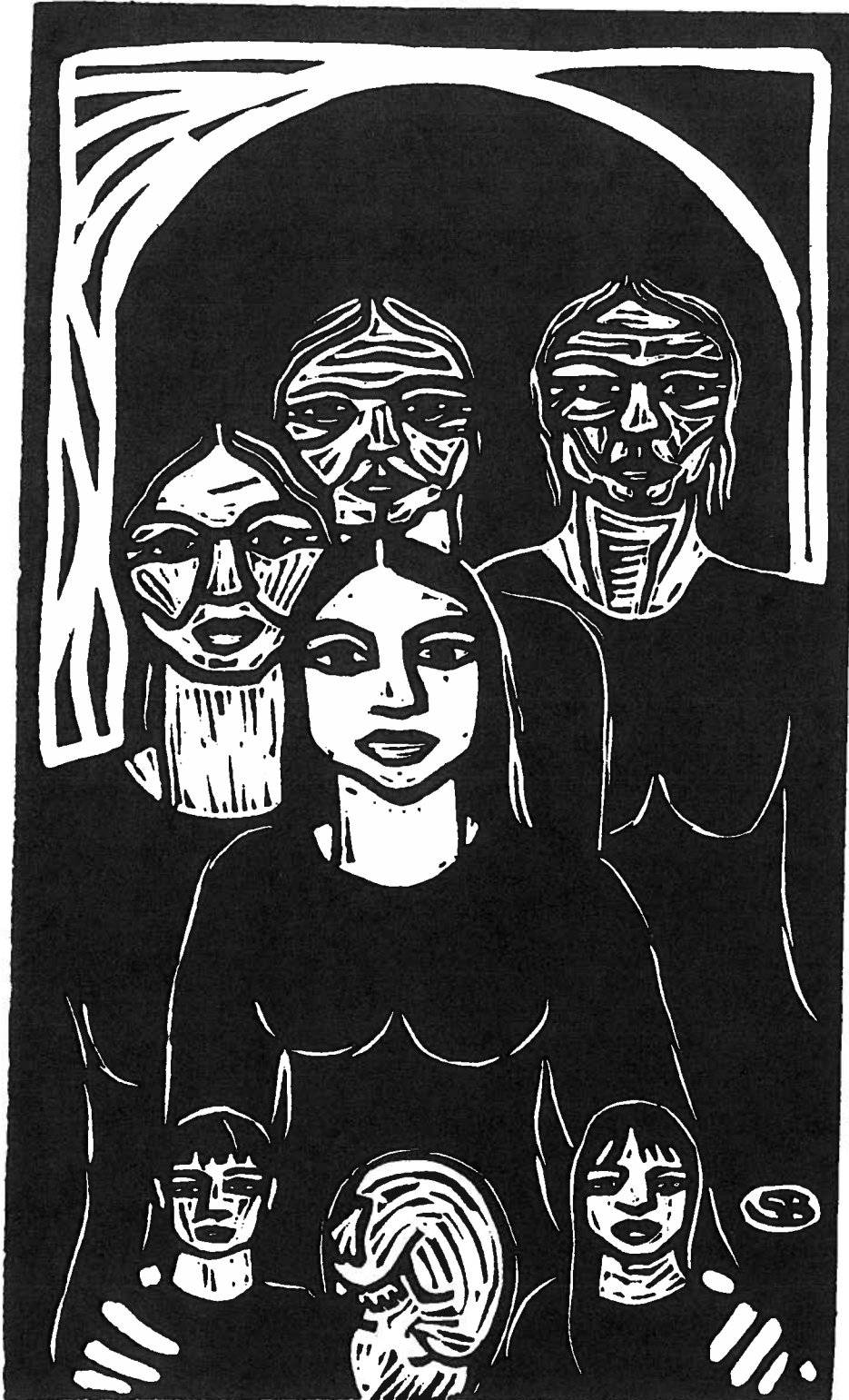
Fatherhood is an idea, a knowledge of cause and effect which must somehow be brought into the reality of the historical world. And what patriarchy is, in my view, is the historical effort of men to reunify themselves by their own action with the species. To assert themselves as what Marx called "species beings." And, of course, they have done that. What is much less clear is why that process should involve the oppression and privatisation of women.

I think we can note as a historical fact that it is not enough for men to be fathers in general, but they have to be particular fathers of particular children. Universal man can not arise above his particularity until he knows he has some child in particular — dad. And the condition of guaranteeing that state is, of course, the incarceration of women, the exclusion from women of access to other men. And, furthermore, the taking over, the appropriation of women's children.

Women's children are affirmed as women's children by labour. Men's children are affirmed as men's children by man's historical right to name the child, to say, "I know this child is mine — never mind the evidence."

These are very different things. And it does seem to me that unless we can understand these fundamental dialectics of reproduction which have been obscured by patriarchal history, we cannot understand our past, and we cannot understand our present.

PATERNITY IS THE appropriation of women's work which then gives the patriarch the power to describe and



HELP US HELP YOU

Dear Reader:

Over the past four years Healthsharing has undertaken to bring you timely and critical information on the many serious health issues facing women today. Thank you for your warm, encouraging response to our efforts, through subscriptions, letters and donations.

Now, to better meet your information needs we need to know more about you. We need your evaluation of what we are doing and your suggestions on how we could do it better.

Please take five minutes to fill in this questionnaire and return it to Healthsharing. Knowing what you want will help us create the best magazine for Canadian women who, like you, are concerned about their own and each other's health.

We will share survey results with you in an upcoming issue of Healthsharing.

YOUR INTRODUCTION

1. How did you find out about *Healthsharing*?

- A friend Bookstore Conference Gift
 Ad in a magazine Library Brochure mailed to you Other _____

2. Do you: Have a subscription Buy it at a bookstore
 Read a Library copy Read a friend's copy Other _____

If you subscribe, how long have you been a subscriber?

- One year Two years Three years Four years

If you buy, how often do you buy *Healthsharing*?

- Every issue Twice a year Occasionally

3. How many other people usually read your copy? _____



YOUR READING PATTERN

4. What do you do first when you receive a new issue of *Healthsharing*?

- Read the cover story Check table of contents Read cover to cover
 Leaf through for the most appealing piece Read a specific section. Specify: _____

5. How do you rate our regular columns and departments?

	Great	O.K.	Not useful/ interesting	Rarely Read		Great	O.K.	Not useful/ interesting	Rarely Read
Collective Notes	—	—	—	—	Reviews	—	—	—	—
Newsfronts	—	—	—	—	Regional Reports	—	—	—	—
Healthwise	—	—	—	—	Letters	—	—	—	—
My Story, Our Story	—	—	—	—	Resources & Events	—	—	—	—

6. Below is a list of 13 articles published in *Healthsharing*. For each article please check one space on the left and, if you read the article, one space on the right.

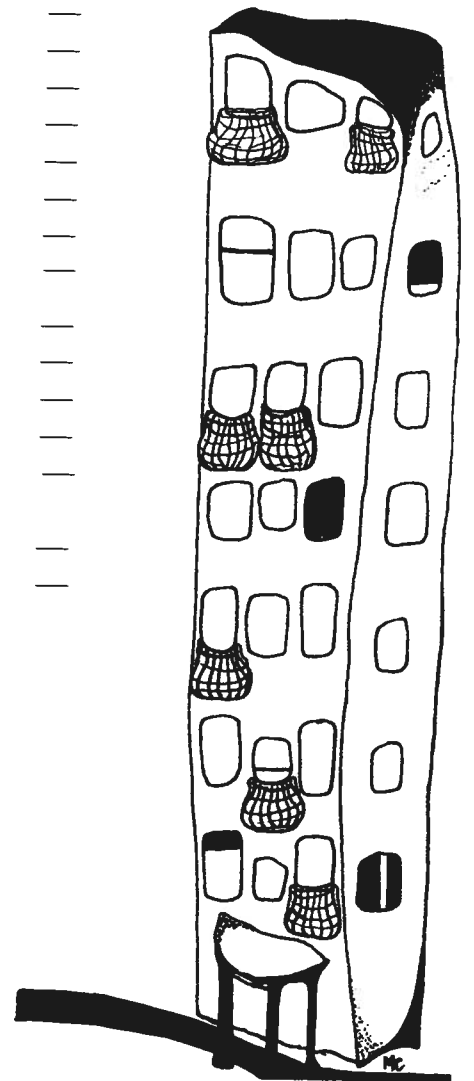
Read all	Read part	Didn't read	Don't recall		Liked a lot	Liked a little	Didn't like
—	—	—	—	<i>Birth Options</i> (Winter '80)	—	—	—
—	—	—	—	<i>The Perils of Pain Killers</i> (Summer '80)	—	—	—
—	—	—	—	<i>Endometriosis: Healing with the Mind's Eye</i> (Spring '81)	—	—	—
—	—	—	—	<i>The Fight Against the Dalkon Shield</i> (Summer '81)	—	—	—
—	—	—	—	<i>Women & Medicine: Will It Make a Difference?</i> (Fall '81)	—	—	—
—	—	—	—	<i>Resisting Womanhood</i> (Winter '81)	—	—	—
—	—	—	—	<i>How to Research Medical Topics</i> (Winter '81)	—	—	—
—	—	—	—	<i>VDTs — Very Damning Testimony</i> (Spring '82)	—	—	—
—	—	—	—	<i>Unmasking the Incest Advocates</i> (Fall '82)	—	—	—
—	—	—	—	<i>Lesbians in Therapy</i> (Winter '82)	—	—	—
—	—	—	—	<i>Tranquility Can Kill</i> (Winter '82)	—	—	—
—	—	—	—	<i>Not a Medical Emergency</i> (Spring '83)	—	—	—

7. Please check your preference for each of the following subjects.

	Want more	Want less	Good coverage
Aging	—	—	—
Feminist health care alternatives	—	—	—
Fiction	—	—	—
Fitness	—	—	—
Health care delivery	—	—	—
Health care in other countries	—	—	—
Holistic medicine; natural healing	—	—	—
Layhealers, herbalists, midwives, masseuses	—	—	—
Mental health	—	—	—
Nutrition	—	—	—
Occupational Health	—	—	—
Parenting	—	—	—
Reproduction: childbirth, contraception	—	—	—
gynecological problems	—	—	—
Violence against women	—	—	—
Women working in the medical system	—	—	—

8. Please check the space on each line that shows, in your opinion, how often articles in *Healthsharing* fit that description.

Articles Are:	Always	Mostly	Sometimes	Never
Too long	—	—	—	—
Too short	—	—	—	—
Superficial	—	—	—	—
Too technical	—	—	—	—
Too negative	—	—	—	—
Inaccurate	—	—	—	—
Too political	—	—	—	—
Not political enough	—	—	—	—
Not analytical enough	—	—	—	—



9. Do you feel your area is well represented in Regional Reports? Yes No

Please comment: _____

10. Which types of article do you prefer? (Number in order of preference)

Personal accounts Research findings Technical Interviews
 How to General information Theoretical Other

11. Which of the following phrases do you feel best describes the graphics in *Healthsharing*?

	Always	Mostly	Sometimes	Never
Appropriate to content	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amateurish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Innovative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frivolous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-descript	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pleasing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offensive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. What changes would you like to see in artistic treatment?

	Want more	Want less	Good selection
Photographs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illustrations/drawings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Charts/diagrams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. What other publications do you read regularly?

- Feminist publications (e.g. *Kinesis*) Specify: _____
- Mainstream women's publications (e.g. *Chatelaine*) Specify: _____
- Progressive magazines (e.g. *Mother Jones*) Specify: _____
- Other Canadian publications (e.g. *Harrowsmith*) Specify: _____
- Professional publications (e.g. *Canadian Nurse*) Specify: _____

YOU

14. Are you: Female Male

15. Do you: Live alone Live with one other person Live with two or more

16. Where do you live? Rural area Town Suburb City

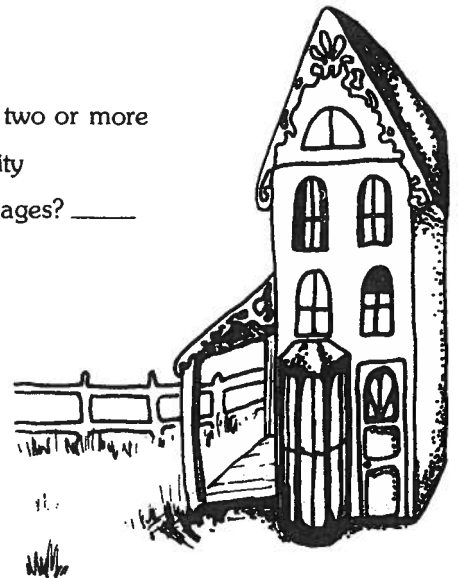
17. Do you have children? Yes No How many? _____ What ages? _____

18. What is your education? (Please check highest level)

- Some high school
- High school graduate
- Some college or vocational training
- College graduate
- Masters degree
- Ph. D.

19. Your age:

- Under 18
- 18-25
- 26-35
- 36-45
- 46-55
- 56-65
- Over 66



20. What kind of work do you do?

- Artist or craftsperson Blue collar Business Clerical/sales
 Education Health services Homemaker Social services
 Student Unemployed Other _____

21. What is your approximate household income? _____

22. If you *had* to use labels, which one(s) would best describe you?

- Apolitical Conservative Environmentalist Feminist
 Lesbian Activist Liberal Pacifist Progressive
 Socialist Spiritualist Other _____

23. List any health related groups or activities you are involved in:

WHAT YOU BUY

24. What do you frequently buy at natural/health food stores?

- Vitamins Food supplements (yeast, kelp, etc.) Toothpaste
 Bulk foods Cosmetics Shampoo Organic produce Whole grains
 Equipment (blenders, distillers, steamers, etc.) Other _____

25. What activities or seminars did you take part in during the last 12 months?

- Exercise classes Nutrition/holistic health course
 Sports (tennis, skiing, jogging, etc.) Vegetarian cooking
Other _____

26. Do you seek out: Women's books Women's art Women's theatre/music

YOUR VIEWS ON ADVERTISING

27. Regarding advertising in *Healthsharing* would you prefer:

- No advertising Minimal advertising Any reasonable amount
 Only selected products/services Any products/services

YOUR COMMENTS

**Thank you for taking part in our readership survey. Please remove these pages and mail them to us at:
Women Healthsharing, P.O. Box 230, Station M, Toronto, Ontario M6S 4T3.**



define women's being. Why have women put up with it? They have put up with it, of course, because patriarchy has been sustained by force. They have also put up with it, I think, because the one essential moment of reproductive experience for women is the involuntary nature of labour. It is true that women know what they are doing, as I said. But it is also true that once the child is conceived, they cannot help but expel it into the world in labour.

Now, in our time, very problematically, the notion of being like men, a parent by virtue of one's will, choosing to be a parent, begins to open up at least as a possibility, not only as a remote or contingent possibility, but as a universal possibility for women. And in my view, that knowledge, imperfect and dangerous though contraceptive technology is, does for women open up a range of possibilities of being in the world which can transcend the notion of childbirth as necessary, and transform it into the notion of "I will have a child if I choose."

Now, it doesn't guarantee that. And it's of course true, unfortunately true, that many forms of contraception are, in fact, more dangerous than early

forms of childbirth. But, nonetheless, the possibility of thinking about motherhood as free choice presents itself to this generation in a far more immediate, practical, historical way than it ever did to our poor mothers. And what we are faced with historically is the need to deal with a new existential condition of our being as women. Our being not only free to choose motherhood, but to extend that freedom as men have done (I mean only extending it, not what they've actually done with it). To extend that freedom to a new perception of the world in which the conservation of the species is perceived as a historical and human project of the utmost priority and importance.

To redefine reproductive consciousness as historical consciousness, rather than biological consciousness, to assert that it is not our historical fate, but our historical task, to reorganize the social relations of reproduction. To make a world fit for children to live in and grow up in and become parents in. To destroy all this nonsense about universality, and recognize that our universality is our humanity, our universality is the one thing that we all share. Or perhaps the two things that we all

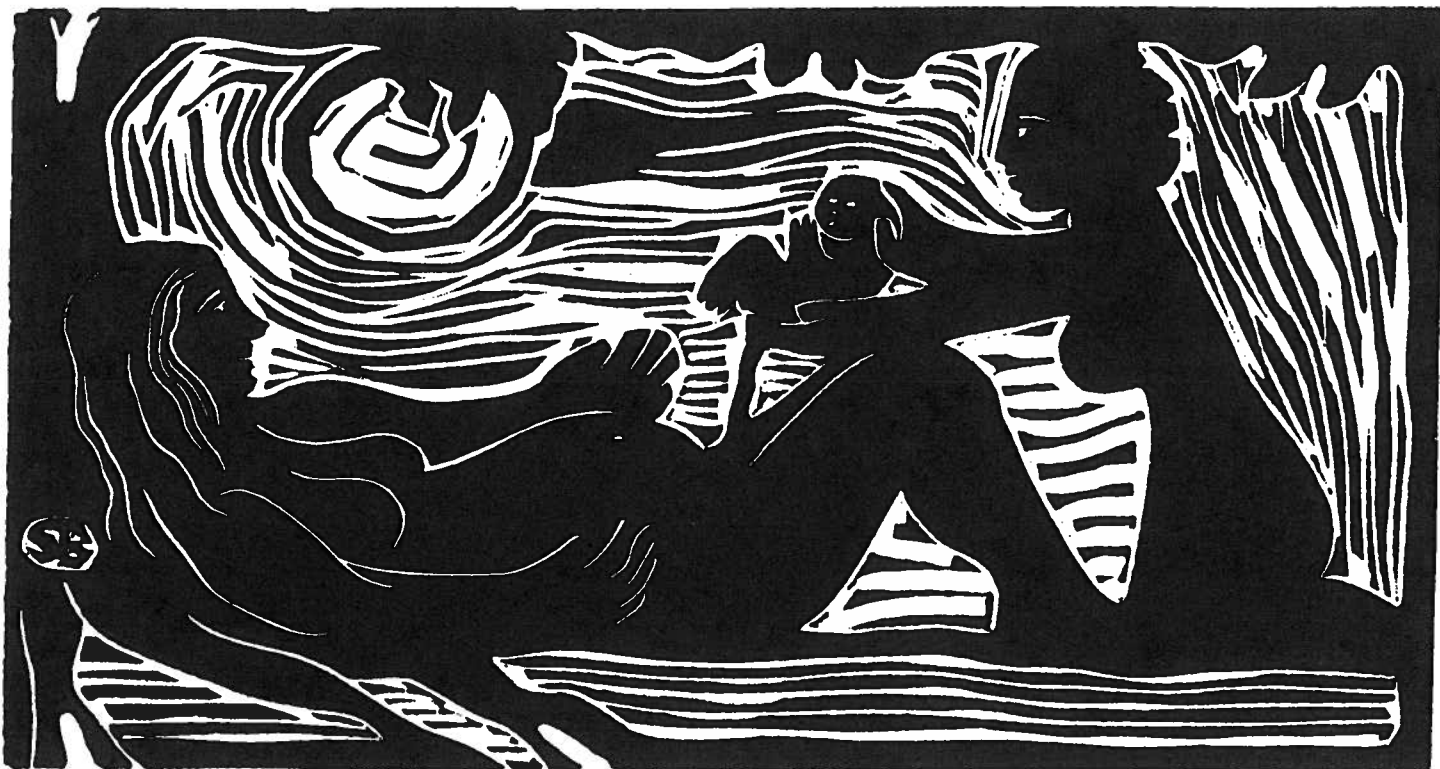
share: the one, that men have always worried about — we shall die; and the second, that although we shall die as individuals, universally the species will live on.

But to do that we have to make haste. This is a political issue. Partly because we must assert the conditions of exercising that right. Partly because we must stop the patriarchs from making contraceptive technology as destructive as the other technologies they've made. Partly because we must redefine, I think, humanity in the concept of caring. *Caring* for the natural world, *caring* for the human world, rather than in the concept of fighting and struggle and overcoming and putting nature to the torture.



Kathleen McDonnell is a Toronto freelance writer and playwright.

Mary's lengthy lecture was carefully transcribed by Victor Schwartzman, a friend of Healthsharing.



GENITAL MUTILATION

by Paulette G. Roberge • drawings by Mary Firth

The little girl, entirely nude, is immobilized in the sitting position on a low stool by at least three women. One of them has her arms tightly around the little girl's chest, two others hold the child's thighs apart by force, in order to open wide the vulva... The *daya* (traditional midwife) takes her razor and excises the clitoris. The infibulation follows: the operator cuts with her razor from top to bottom of the small lip and then scrapes the flesh from the inside of the large lip. The little girl screams and writhes in pain, although strongly held down. The opening left for urine and menstrual blood is miniscule. A paste is then applied and the vulva is sewn together with acacia thorns and thread.

M.A.S. Mustafa, recounted by Dr. Alan David in his thesis *Infibulation in Djibouti*, 1978.

"It's our business, and we will decide what to preserve and what to be rid of. No law will change this."

With these angry words, Aissatou Diop, 46, a Guinean who teaches at a private school in Oka, Québec, adds to the emotional debate over the circumcision of African females. The debate is accelerating, as traditional African women cling to the dangerous practice in their own communities and increasingly import it into industrialized countries.

Not all Western feminists agree with Diop and other highly educated African women living in Canada, who say the custom is none of the business of the outside world and that naturally it will appear barbaric if taken out of its cultural context.

"We're told we are savages. It's starting to be aggravating," said Diop.

"Excision has a sense about it, an importance," said Marie Jeanne Ki, the 32-year-old whose husband is the

ambassador to Canada from Upper Volta. "When this sense is removed, then it appears immoral."

For millions of African women, circumcision continues to be a fact of life. It is estimated that between 20 and 74 million babies, girls and women have undergone some form of genital mutilation. The term "circumcision" is used to refer to different types of operations, all involving the complete or partial removal of the female external genitalia. The term is misleading because it describes only the mildest form of the operation, and affects only a small proportion of the millions of women who are operated on.

Circumcision involves cutting off the hood or prepuce of the clitoris. Known by Muslims as "sunnah" or traditional circumcision, it closely approximates the commonly-practised circumcision in males. Excision or clitoridectomy involves cutting off part or all of the clitoris and part or all of the labia minora, and can be followed by

infibulation, or Pharaonic circumcision, in which part or all of the medial section of the labia majora is also cut off.

The two sides of the vulva are then pinned together with acacia thorns or stitched together with catgut or silk sutures. Only a very small opening is left (preserved by the insertion of a tiny straw or a piece of wood) for the passage of menstrual blood and urine. The girl's legs are then bound together until the wound heals, usually in a month's time.

The age at which the mutilations occur varies. Recent studies show that, as legislation and public opinion mount against the custom, and as more girls, especially those in urban areas, object to these mutilations, they are carried out at an earlier age.

The medical consequences can be grave and multitudinous. They include tetanus from unsterilized instruments, chronic vaginal infection, extremely painful menstruation and a host of obstetrical complications, such as

perineal tearing during childbirth.

Cysts as large as grapefruit have frequently been diagnosed, as have scar formations on the vulval wound, which makes walking painful and difficult. Pain during intercourse is common and damage to the urinary system can cause incontinence so that mutilated women are dribbling urine continually.

The woman is re-opened by a traditional midwife or in a clinic before the wedding night. In some cases, she is opened through repeated attempts at penetration by her husband over several days, often with the aid of a sharp instrument to gain access. Because, in many communities, a woman is sewn up after each delivery to make her "tight" and is re-opened by her husband's penetration when it is safe to have intercourse again, she may go through the process ten times or more.

One woman described this process to Perdita Huston, author of *Third World Women Speak Out*: "The opening is so small it takes a long time for the man to penetrate — sometimes one month, sometimes two weeks. The man enjoys it being tight, and after one or two years he will help you go and rearrange yourself — to have the operation that makes you tight again."

The operation is characteristically a women's affair in most countries, performed and perpetuated by the women themselves. There are many accounts of

mothers refusing to have their daughters undergo the same pain they had to experience, and the child's grandmother or a maternal aunt arranging to have the operation done without the mother's knowledge or consent.

African women, such as Ki, point out that the custom is perpetuated and carried out almost exclusively by women, in angrily rejecting any suggestion that the tradition is continued in accordance with men's demands.

The traditional midwives who most frequently perform the operation have a vested interest in opposing its demise. The function confers on these women prestige and influence within the community, apart from the income they derive from their work.

The origins of the practice are obscure, but it is known to predate Islam. Practised by the Phoenicians, Ethiopians, Hittites and Egyptians in the fifth century B.C., it is thought to have spread to other parts of the world. Some form of excision is practised among the Muslim populations of Indonesia and Malaysia, and in the southern part of the Arabian peninsula, in Oman, the United Arab Emirates and the two Yemens. Some form of clitoridectomy was practised by the aboriginal peoples of Australia until 50 years ago, and cases have been infrequently reported in Latin American countries.

Today it is practised principally in Africa by hundreds of tribes in at least 25 countries, forming an uninterrupted

belt across the centre of the continent along and just north of the equator. Practising tribes may have neighbouring tribes who do not practise the operation at all. For example, in Nigeria the Ibo, the Hausa and the Yoruba practise excision while the Nupes and the Fulanis do not.

Infibulation is practised in southern Egypt, parts of Ethiopia, especially the Red Sea coast, Djibouti, northern Kenya, northern Nigeria, many parts of Mali and all over the Sudan, except among the non-Moslem people in the south. Somalia's entire female population, called the "Sewn Women", is infibulated.

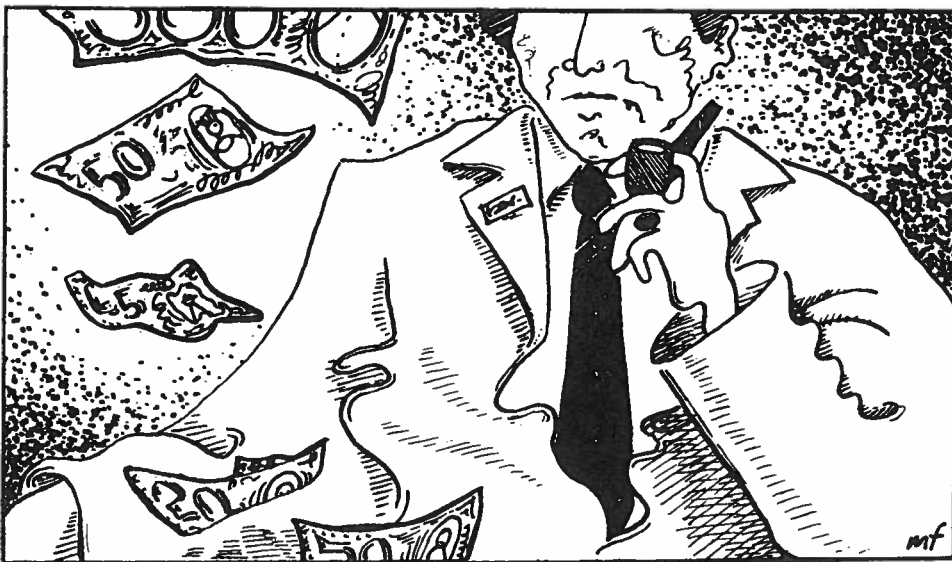
The custom cuts across religious, geographical, economic and political lines and reasons for its practice are many and contradictory. Most often cited are religion, family honour, initiation into adulthood, protection against spells, esthetics, hygiene, insurance of virginity at marriage and prevention of female promiscuity after marriage through supposed attenuation of sexual desire.

The principal reason for the custom is to ensure virginity at marriage. Removing a girl's clitoris is assumed to reduce her sexual desire and sewing her up will prevent her from engaging in intercourse. In societies where economic necessity dictates that a woman marry for her very survival, virginity is highly prized. Many men refuse to marry unexcised girls and parents of a daughter will see that she is made marriageable.

Partial or total removal of the clitoris may reduce sensitivity, but will not diminish desire, which is a psychological state. "Excision doesn't cause frigidity. There is no cause-effect relationship," said Ki.

In the face of such testimony, clitoridectomy does not appear to be a very effective way of reducing or controlling sexual desire. What of infibulation? Although it would appear to eliminate sexual activity and guarantee virginity at marriage, it does not necessarily do so: a woman can have herself resewn to look much like she did before intercourse.

For millions of Muslims, the reason lies in their religion. It is written in the



Koran, they say. Leading Islamic theologians have refuted this, saying that circumcision is advocated for males but not for females, and point to the incontestable fact that no form of female circumcision is practised in leading Arab countries such as Saudi Arabia, the cradle of Islam.

However, as a Somalian diplomat in Canada, who asked not to be named, said, "Religion is not just what it says in the Koran, but what religious traditions get passed from one generation to another."

Female circumcision is practised for reasons of cleanliness and hygiene in some countries, where the female external genitalia are considered unclean and unsightly. But the odors of accumulated menstrual blood, urine and infections caused by an obstructed passage can hardly be considered hygienic.

In many societies, female circumcision is traditionally associated with special coming-of-age ceremonies and is regarded as a necessary educational experience that marks entry into womanhood.

Initiation ceremonies have largely disappeared in many urban communities and the notion of entry into adulthood is not mentioned at the time of the operation. As it is increasingly carried out in hospitals and clinics without the special coming-of-age ceremonies, the custom is becoming stripped of its ritual meaning.

Education of a girl entering womanhood can still occur without cutting off a perfectly healthy organ, the central organ of her sensory pleasure, and stitching her up amid blood and fear and secrecy, while she is forcibly held down and told that if she screams she will cause the death of her mother or bring shame on her family.

Other beliefs and myths, too numerous to describe, are given for the practice. One notable one is that which considers childbirth the main vocation of women and therefore the clitoris is not perceived as a useful organ because it is purely an organ of pleasure and is not linked to fertility. This view is not unique to Africa. Another belief is that when a child is born, it is both male and female: the clitoris is the male organ, while the foreskin is the female organ. The girl must rid herself of her "maleness" to be purely female.

After all the explanations for mutilation are refuted and shown to be based on erroneous information, one is left wondering why women cling so tenaciously to a custom that causes them to take serious risks with their own bodies and those of their daughters.

Mental Health for the World Health Organization (WHO), at WHO's 1979 conference in Khartoum, Sudan.

Meanwhile in the West, feminists such as Fran P. Hosken crusade for the abolition of female circumcision. Hosken, who has organized a worldwide



The answer seemingly lies in the custom being just that, a kind of conformity.

"This ancient custom, which seems to have been developed as an initiation rite, continued from one generation to another primarily because of cultural conformity and community identity, which have been reinforced by unconfirmed religious doctrine and false beliefs," said Dr. Taha Baasher, the Eastern Mediterranean Advisor on

campaign aimed at preventing the operation from being introduced into modern facilities in Africa and the Middle East, has recently returned from Africa where she was espousing family planning clinics and better health education as alternatives to circumcision.

Many other Western feminists retreated when they saw how emotional the issue is. When they proposed programs for the eradication of the custom, African women, wounded and

defensive, reacted violently against what they perceived as the rape of their cultural tradition, an ill-disguised form of neo-colonialism. The turning point for many was at the World Conference of the United Nations Decade for Women, held in Copenhagen in July, 1980. African women stormed out of workshops on the subject, wanting no interference by the industrialized world and angry that discussions on the issues were chaired by non-Africans.

Many Western-based organizations, including WHO, now feel their role is to provide support, through human and financial resources, for educational projects devised and implemented by the African communities concerned, and only if and when they choose to abolish this deeply rooted tradition.

"Canadian women's groups haven't taken it up at all, partly out of respect to African women," said Jeanne Mayo, president of Match International, an Ottawa-based, non-governmental women's development organization.

People in the industrialized world may be able to appreciate that the custom has to be looked at within its cultural context. But when the practice is carried out in their midst, the clash of cultures is almost inevitable.

In just one case of this increasing phenomenon, last October a couple from Mali stood in a Paris courtroom, charged with criminal negligence. Wanting their daughter excised, but not knowing who to turn to in the French capital, the father removed his three-month-old daughter's clitoris with a pocketknife. After attending to Batou Doucara when she was rushed to hospital with a severe hemorrhage, doctors called the police. The case is still pending.

Doucara said he was merely honouring an ancient custom of his people. But some European countries, faced with these fundamentally different cultural values, feel they cannot condone such a practice within their borders. Norway, Sweden and Denmark have banned the operation.

In Great Britain, however, where no such law exists, some doctors in London's reputable Harley Street

clinics recently admitted they were pocketing as much as \$2,000 to excise young African girls.

It is likely that excision is performed in Canada, said Teresa Hibbert, who is researching the subject for a doctoral dissertation at York University in Toronto. Hibbert told the writer that a Nigerian woman confided in her last year that several of her Sudanese friends had been excised by two doctors in Toronto. The Nigerian woman has since returned to her country and the Sudanese women and doctors named could not be located.

Any suggestion that the practice represents a general subjugation of women in their societies outrages many African women. They use the term 'feminism' derisively, saying its proponents speak only for women and do not address the whole community and family unit so fundamental to their social structure. They insist they are equal to men in their societies and that circumcision in no way represents the domination of women by men. And they scorn those among them who espouse feminist ideas and behaviour for having been corrupted by Western thought.

Mary Tadesse, who works at the African Training and Research Centre for Women in Addis Ababa, Ethiopia, has been mocked for her views on the subject.

"I have spoken to women in villages in southern Ethiopia through an interpreter, and asked them why they circumcise their daughters," she said in an interview in Ottawa. "I tell them I too am Ethiopian and I have a daughter who is not circumcised. They answer that I have been corrupted by Western values and thought."

"There will be lots of African women who will laugh if you suggest that the problem should be approached by an equality of the sexes argument," said Diop. She has addressed Montréal audiences on the subject, arguing that the health of the African woman is placed in greater danger by the effects of those products 'dumped' on her by the industrialized countries than by excision.

"If we really care, there is a more fundamental problem: pills, needles against contraception and other products that can't be sold in North

America," she said.

But African women's groups are slowly managing to impress upon political leaders and Africans generally that the situation is serious and requires attention. Groups such as Guinea's National Committee of the Revolutionary Union of Women, the Women's Federation of Upper Volta and the Somali Democratic Women's Organization are attempting to compile data indicating the scope of the practice and the reasons for its persistence.

Their task is made difficult, and necessary, by the fact that the custom is shrouded in secrecy and seldom mentioned. In fact, authorities on the practice argue it is this secrecy that permits the practice to persist. Its highly personal nature makes women reluctant to discuss it openly.

Rendering the subject even more sensitive is the fact that African society as a whole does not openly discuss sexual behaviour. The subject of sex, and therefore circumcision, is so private that even Tadesse's co-workers are loath to discuss it or set up a program to combat it.

Dr. Gail Price of Ahfad University College for Women in Omdurman, Sudan, told participants at the 1979 WHO conference in Khartoum that women she had interviewed said that the medical rather than the sexual problems caused by circumcision must be emphasized.

Past attempts to impose a strict ban on the practice have proved unsuccessful. The laws were never accepted by traditional social groups and it became impossible to apply them effectively. Despite this record, Mali and Kenya banned the operation last year.

Many African women view the legislation with great apprehension. Some, like Ki, warn that making the practice illegal will only drive it further underground resulting in even more serious medical consequences. They argue against moving too fast by enacting legislation before education, claiming that if the operation is no longer available in hospitals and clinics, people will turn to the aid of unskilled operators or even do the tasks themselves.

Some African women go so far as to say the solution, at least for the short term, is to allow the operation in hospitals, even in the West. This would, in their view, at least prevent fatalities and such trauma as that experienced by little Batou Doucara in Paris.

"Do you think it will stop that easily when it is still being practised in Paris practically into the twenty-first century?" asked Diop.

"If it has to be done, then society should at least let people do it under better conditions, proper medical circumstances," she said. "Otherwise it will continue to be done in secret and there will be problems."

Some Westerners, like Hosken, decry the introduction of the operation into hospitals, claiming it will only legitimize an ancient and dangerous practice.

Nearly everyone concerned about circumcision agrees that action to eradicate it must centre around fostering better means of education by providing instruction in human anatomy, sexual organs and their functions and in the harmful consequences of genital mutilation.

The recommendations coming out of the Khartoum Conference — hailed as historic because it drew together delegates from many African health ministries, hospitals, universities and women's groups for the first time — were drawn up in this spirit.

The four recommendations were: the adoption of clear national policies for the eradication of female circumcision; the establishment of national commissions to coordinate activities, including the enactment of abolition legislation; the intensification of general education on the dangers and undesirability of the practice; and the intensification of education programs for birth attendants, midwives, healers and other practitioners of traditional medicine, with a view to enlisting their support.

Some want to take the matter further than health education. They argue that the problem cannot be treated in isolation, out of the total social, economic and religious context in which it exists. "It is, in the end, the whole of society which must evolve. But first, both sexes must become aware of the



equality of the rights of woman and man without confusing equality with identity," writes Dr. J.G. Taoko in *Famille et Développement*.

Western-style feminism may not be applicable to those African communities where the practice persists. But an extreme case of the subjugation of women such as this practice exemplifies demands that basic and universal human rights be respected, including the rights of the child. An unknowing, innocent child should not have to suffer grave, permanent damage, even death, all in the name of tradition.

The United Nations Declaration of the Rights of Children, adopted in 1959, says that children *should have the possibility to develop physically in a healthy and normal way in conditions of liberty and dignity. . . . They should be protected from all forms of cruelty.*

There is overwhelming evidence that genital mutilation is cruel and certainly it is not dignified.

Paulette G. Roberge is a Canadian freelance journalist based in London, England. She lived in Kenya in 1978-79.

Another version of this article was recently printed in *The Globe and Mail* without prior knowledge of the Healthsharing collective. It continues to be our policy to print only original articles that have not been published elsewhere. We hope that the misunderstanding which led to the appearance of similar articles in both *Healthsharing* and *The Globe and Mail* has not led to any confusion regarding our policy.

MY STORY, OUR STORY

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

A Difficult Path to Health

by Mary M. Spies

I was diagnosed celiac as a baby of less than a year old.

Celiac disease is a condition in which the absorptive surface of the small intestine is destroyed by gluten, a protein found in wheat, rye, and to a lesser extent in barley, oats and buckwheat. The effects of eating gluten are devastating for the celiac. We do not derive benefit from most of the food we ingest. Important nutrients, such as proteins, fats, vitamins and minerals, pass through the body as fatty diarrhea.

Children with celiac sprue, as gluten sensitivity is called, do not outgrow the condition. They often suffer from chronic fatigue, learning disabilities, irritability and they do not grow properly. Adult celiacs cannot gain or maintain body weight. At its worst, we suffer debilitating illness all our lives.

This will be the celiac's state as long as she continues to eat glutinous foods. The disease is treated by eliminating gluten from the diet. There is no other course of action available; no wonder drugs or miraculous surgery to cure this disease.

The cause of the disorder is not known. It is generally accepted that our immunological system does not function properly and rejects gluten. Heredity is considered a factor, but it is not known whether a dominant or recessive gene is responsible. The health and nutrition of a pregnant woman is thought to effect the health of her celiac child.

My mother had a nauseous pregnancy and subsisted largely on milkshakes. I am also milk allergic as is often the case with gluten allergic people. For many months my diet consisted of soya formula; later on, it was bananas and rice. Cottage cheese was also recommended, but I wouldn't eat it. It has always seemed strange to me that my pediatrician only recognized my allergies to a limited extent. Why

would my mother have been told that I could eat cottage cheese when I couldn't digest milk?

The same pediatrician believed I would grow out of the condition; he convinced my mother thoroughly. I remember being told to drink my milk because I was a growing adolescent. I detested it, and would sit at the table for hours rather than drink a small glass of milk. I also ate lots of white bread and processed cheese sandwiches.

My memories of my adolescent years are intense recollections of suicidal depression, of feeling alienated from my ugly, uncoordinated body. I needed a lot of sleep, was anaemic and moody, and thought flatulence and diarrhea were mine for life. I was constantly ill. If I drank two bottles of beer at a party, I was gastro-intestinally upset for three days to a week. In university, I fell asleep in class and found it very difficult to concentrate; I lapsed into continual depression. I had left home by then and ate a lot of Kraft dinner.

A few years later, I began to listen to my body's messages. I read some information on health and nutrition and realized that sugar and starch do not agree with me. I became vegetarian for both health and moral reasons. I stopped drinking alcohol as it made me physically ill and depressed. My frame of mind slowly began to improve.

I consider it extremely good timing that at this point I had the opportunity to work in a whole foods business. The people were understanding and encouraged me to take responsibility for my physical and mental well-being. I entered group and individual therapy. I began to explore alternative methods of health care.

My first visit to a naturopathic physician is memorable. He diagnosed many of my health problems. Years of taking various prescription drugs had worsened my already ill-health. He recommended a gluten-free, low carbohydrate and dairy-free diet. I was deficient in B vitamins, vitamins A&D, zinc, calcium, magnesium, and iron. My severe acne was directly related to lactose intolerance.

I had to learn to cook all over again. It became very difficult to eat in

restaurants. Who would ever have imagined that monosodium glutamate contains gluten; that coffee, ketchup, baking powder, tomato juice, rennet, curry, mustard, and peanut butter are not permissible on a gluten-free diet? I said goodbye to pasta, ice-cream, fresh whole wheat bread and carrot cake.

It is unfortunate that the path many people are encouraged to take consists of using gluten-free flour (derived from white flour) and putting Lactaid in their milk and stomachs. I don't believe we should attempt to alter our bodies' biochemistry or eat empty calories because we are conditioned to believe that dairy products and breads are essential foods.

Fortunately, as more and more people's food allergies are diagnosed, their families, friends and co-workers are becoming aware as well. I am also allergic to lettuce, green peppers, cayenne, oranges, and possibly beef. Lists appear on refrigerators and friends remember that the green vegetable I'm allergic to is *not* spinach. Most importantly, they begin to accept and stop thinking that if my attitude changed I'd miraculously be cured. This support is essential to me.

I have also learned that "I am not the only one." More and more children and adults are learning that they are allergic to many foods. It has also amazed me that gluten-free diets have been successful in the treatment of a wide range of disorders including diabetes, multiple sclerosis, regional enteritis (a disorder of the lower bowel), rheumatoid arthritis, and even schizophrenia! It is interesting to note that these are predominantly diseases of western society.

Since leaving the whole foods business and the community of people I worked with, my struggle has become more difficult. My work in a collective is demanding. I have also awakened politically and am involved in many organizations. Making time to care for myself as I know I should has become a problem as meetings and overtime fill many of my evenings. Money is tighter and alternative health care and supplements are expensive. My health has deteriorated. I sometimes wonder if I can work full-time. I am now in the process of slowing my pace; I recognize

that my being ill is of no benefit to our collective or the groups I work with.

Learning about my food allergies has meant many things for me. I no longer feel as though my body has betrayed me. Occasionally I wish I didn't have to deal with it, and I lapse into eating foods I shouldn't. A bout of ill-

ness and depression quickly reaffirms the needs of my body and mind. I no longer feel the hopeless kind of depression I suffered for so long, that is, when the state of this misogynist, heterosexist world isn't getting me down. Most importantly, I am learning to care more about myself and am striving to

become a whole person.

Mary M. Spies is a celiac feminist-lesbian who aspires toward writing more and breathing deeper. She lives with her three cats in Kitchener, Ontario, where she is a member of the Dumont Press Graphix collective.

REVIEWS

The Monthlies Reviewed

Cramps, Mobius International, produced by Marilyn Belec, 16mm, colour 26 minutes, 1982. Purchase: \$575.00; rental: \$50.00.

The Menopause Story, Mobius International, produced by Marilyn Belec, 16mm, colour, 30 minutes, 1982. Purchase: \$595.00; rental: \$50.00.

Reviewed by Connie Clement

If Parke Davis and Company were to engage the best public relations services available to promote Ponstan, their fast selling anti-menstrual cramp, anti-arthritis drug, they would do well to hire just one person: Penny Budoff, M.D. and author of *No More Menstrual Cramps and Other Good News*.

If Parke Davis were to go one step further and fund a film about menstrual cramps, they would surely want that film to assert that painful periods are caused by overproduction of prostaglandins, hormone-like fatty acids. The film would probably include a success story about their product and make only passing mention of other treatments.

I should tell you right off that Parke Davis had nothing to do with producing *Cramps*, Marilyn Belec's recent exploration of pain accompanying menstruation. If you were to judge by the above considerations, however, it would not be surprising in the least if you suspected corporate involvement.

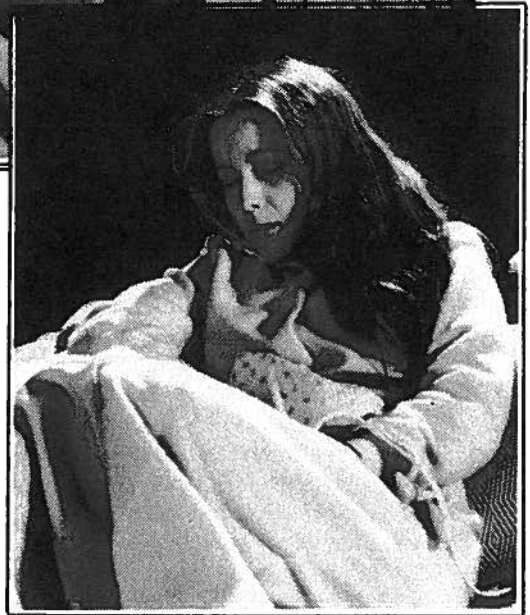
The Menopause Story, Mobius' other recent production, avoids such overtones. It is a balanced exploration of issues relating to the 'change of life'. The women portrayed in the film are both menopausal and premenopausal, allowing sharing of anticipatory fears as well as actual symptoms and strategies.

Both films follow what is by now



familiar Belec format. You may remember from *Taking Chances* (1979) the juxtaposition of group discussion, vignettes with sparse props to set the stage and a sprinkling of technical or expert information. The format is appropriate; unfortunately, the skits opening *Cramps* and those throughout *The Menopause Story*, while intending to provide comic relief, are narrow to the point of negative stereotypes, and the women portrayed are all middle-class.

In spite of similar format, the balance struck in the two films is remarkably different. The difference in bias level results as much from the manner of presentation as from the information presented. The visible experts in *The Menopause Story* — Judith Golden, sex therapist, and Christine Derzko, obstetrician/gynecologist — explore the impact on menopausal symptoms of keeping diaries, of life changes such as a parent's death and of support groups. They seriously discuss the benefits of ginseng, calcium and exercise. While recognizing Estrogen Replacement Therapy as a sometimes appropriate treatment, Golden and Derzko clearly delineate the drug's limitations. The balance in the film results in large part because of the discussion between



two professionals with differing viewpoints.

In *Cramps*, by contrast, possibilities such as herbal tea or joining a women's health group are mentioned in passing in the vignettes. The only apparent expert testimony is Budoff who tells us unequivocally that prostaglandins cause menstrual cramps.

The different treatment of the two topics addressed in *Cramps* and *The Menopause Story* may also reflect, at least in part, the growth of feminist theory about each issue. In research and in action, feminists have focused more attention on the cessation of menses than we have on the process of menstruation. Witness the number of

courses and discussion groups about menopause, the small but growing number of menopause-related films, slide tape shows, etc. Compare this to the lack of discussion groups about painful periods and premenstrual tension.

The Menopause Story, which I will

my ability to get pregnant. From the limited studies available, we know that women and men exposed to lead or radiation experience lack of sexual interest, infertility, higher rates of miscarriage and birth defects. We do not have such clear research on some other exposures but we do have expe-

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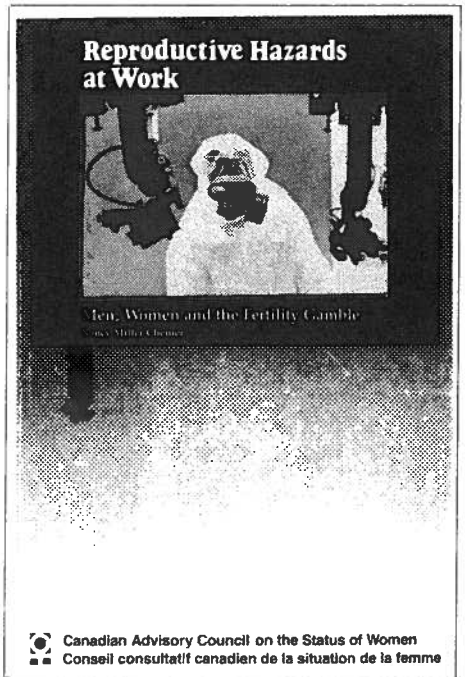
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extensive research of workplace conditions. Third, given employer and government intransigence the only realistic strategy to safeguard reproductive rights is a vocal, aggressive and angry mass movement of the unions, health and safety activists and the women's movement which forces research to be done and workplaces to be cleaned up. Until conclusive evidence is in, workers have the right and the obligation to refuse work which they believe may result in reproductive damage.

The need for such a movement grows daily ever more necessary. From the birth defects born of exposure to VDT's, to the horror of Love Canal and the death of Lake Ontario, pollution in and outside workplaces is causing massive health and reproductive damage. A deadly race is on between those of us who want to safeguard the environment and the health of our bodies and children, and the blind expansion of productive forces which, if left unchallenged, will destroy any possibility for a healthy future.

Debbie Field currently lives in Toronto and works with the Development Education Centre.



...d to read *Reproductive Work*, my fear turned unable to get pregnant xposure to coke oven cinogen, I will be oute re of the women who ar, I would be furious scientific, business and nunities who reject nce as acceptable evi g a situation or sub ;.

by Miller Chernier's angry one. In the g scientific she avoids, o far into the book to ction between work- d employer's refusal to o clean up the work- would be more useful material were situated l political understand- we live in, and if early or at least clearly in her following points were first, we live in a soci- olumes more for profit of ever "new" and oducts than for the ers. Second, govern- gly terrified of indust- ant closures, are hesit- workplace clean-up or

REGIONAL REPORTS

NOVA SCOTIA

**Susan Hower
Winnifred McCarthy**

Midwives Case: The three midwives charged with criminal negligence causing bodily harm in January are receiving strong support and nation-wide interest. The preliminary inquiry for the case of Sharleen MacLellan, Donna Carpenter, and Linda Wheeldon is set for June 2 in Halifax. If convicted, contrary to the report in *Healthsharing* (Spring, 1983 Newsfronts), the *maximum* sentence is ten years.

The Association of Parents and Professionals for Safe Alternatives in Childbirth (APSAC) — Nova Scotia, has started a legal defence fund (19 Fairmont Road, Halifax, B3N 1H5; (902) 479-2969), and will be hosting a public talk on home birth. Another support group, originating from the Kings County area, is growing. Their goals are to raise funds for the midwives' case and to inform the public about home birth, midwifery, and the rights of parents in childbirth.

Conference Time: "Women and the Economy" was a highly successful conference organized by Cape Breton women in celebration of March 8th. Presented by the International Women's Day Committee, the 3-day event offered a potpourri of activity: a panel discussion, films, and a concert of women's talent; a full day of workshops; and the conference highlight, Kate Millet as the guest speaker.

W.H.E.N.: "Our Future" is the title of the Women's Health Education Network annual conference. Sharing sessions (reports from women involved in community health activities around the province), exhibits, and seven workshops featuring women's health issues are on the agenda. A panel discussion on Current Controversies in Midwifery takes on particular significance in light of the midwives' case.

Battered Women's Program: The Pictou County Women's Centre has developed two projects for women: the Information Service and the Outreach Program. The Battered Women's Information Service co-ordinator and 20 trained volunteers staff 2 phone lines six days a week for a minimum of seven hours per day. The Battered Women's Outreach program employs two women who conduct public information sessions and advocacy work. They also initiate and facilitate support groups. This program will evaluate the need for a county transition house and coordinate community efforts if one is to be established. (P.C.W.C., Box 750, Stellarton, N.S. (902-755-4647))

QUÉBEC

Clara Valverde

Nutrition Guide for Cancer Patients: The Québec Cancer Foundation has just published a nutrition booklet for cancer patients. This self-help book covers such topics as cancer and its treatments, the importance of good nutrition during cancer treatment, and how to deal with specific side effects of radiation and chemotherapy through

changes in eating habits. Throughout, the book's authors (nurses, doctors and dieticians) take into account the realities of many cancer patients, such as fatigue, isolation and economic hardships. The authors offer suggestions on: the best recipes for times when a person's energy is very low, how to organize eating patterns when one is alone, and groups to contact which deliver meals. Unique among the slick books available on cancer, the Foundation's unpretentious nutrition guide is down-to-earth, helpful and straight-forward.

The foundation is hoping to get funds for English translation of the booklet which has been a huge success in its French version. Copies (in French) may be obtained from La Fondation Québécoise du Cancer, 1372 Sherbrooke East, Montréal, Qué. H2L 1M4. It's free, but they would appreciate a donation.

Crisis in Québec Health Care: Cutbacks and the drastic policies of the Parti Québécois Government have, in the last few months, dealt major blows to the health care system in Québec. In addition to staff cutbacks, hospitals have suffered from laws which outlaw strikes, force wage cutbacks of 20 percent and require other major reductions in services. These laws, which affect the whole Québec public sector, were passed under the guise of getting public sector workers to help fix the Provincial Government's debt (as though the workers had invented the crisis). In actual fact, the laws have been effective tools in demobilizing and intimidating union members, setting their struggles back 20 years. The end result? Under-staffed wards, inadequate care, demoralized workers.

Now, more than ever, in Québec, it is very important to stay healthy and to fight back.

ONTARIO London Women's Health Collective

Women's Health Conference: Women need access to reliable information about the health issues which concern them and an opportunity to share their questions, knowledge, skills and support around these issues. In response to these needs, London Women's Health Collective, in conjunction with London Status of Women Group (LSWAG), recently presented a conference entitled "Women and Health: A Forum for Practical Approaches to Well-Being."

The London Women's Health Collective was born out of connections established among London women at the "Strategies for Well-Being" Conference held in Toronto in April, 1981. We realized that we could support one another in our efforts to provide quality care as nurses and mental health professionals. And we felt a common need to integrate some of our community health concerns with feminist thinking and activities. The next year we spent establishing ourselves as a collective, strengthening connections with other women involved in health care and gathering information.

By the spring of 1982, we felt anxious to do something concrete. With the financial and emotional support of LSWAG, we planned and facilitated a day-long event in November, 1982.

MANITOBA

Lissa Donner

Abortion Clinic Creates Controversy: The Government of Manitoba has refused to approve Henry Morgentaler's Winnipeg abortion clinic as a hospital as provided for under the Criminal Code. In the absence of Government approval, there is every expectation that doctors performing abortions at the Winnipeg clinic will be charged.

Members of the Coalition for Reproductive Choice, representing 20 Manitoba organizations, suggested to Roland Penner, Manitoba's Attorney General, that, rather than prosecute, he should refer the question of the constitutionality of the abortion provisions to the Courts. With the law itself under scrutiny, it could be considered inappropriate to proceed with prosecutions under that law. Luckily, the Canadian Abortion Rights Action League has already commenced an action in Ontario in which they assert that the abortion law is unconstitutional.

A pro-choice rally, held in Winnipeg on April 20, was attended by over 800 people. A group of 33 Manitoba doctors held a press conference in support of Morgentaler. There is ample evidence of the support for the Winnipeg clinic, but this is likely not enough to stop the laying of criminal charges and attempts to shut down the clinic.

Occupational Health Centre Opens: At a ceremony on April 8, the Manitoba Federation of Labour's Occupational Health Centre was officially opened. In opening the Centre, Premier Pawley announced that the provincial government would provide funding for its operations, through the Manitoba Health Services Commission. Funding for 1983-84 was set at \$246,000.

ALBERTA

Ellen Ticoll

Activity on Both Sides: A number of Edmonton women concerned about pro-choice have formed a chapter of Abortion-by-Choice. The aim of the group is to increase public awareness of the pro-choice position, to improve the climate for women seeking abortions in northern Alberta and to work to have abortion removed from the Criminal Code.

Meanwhile, Campaign Life has declared the week of May 8 "Respect Life Week." They have successfully obtained the endorsement of Mayor Cec Purves of Edmonton and are planning to run a full 50 page supplement in many Alberta newspapers during that week.

Further Erosion of Medicare: Back at the Alberta legislature, Hospital Minister Dave Russell is trying to smash Medicare single-handedly. After raising Medicare premiums by 46%, he announced that hospital user fees of up to \$20 per day will be instituted in October. Perceiving this as a giant break for conservatism, Mr. Russell has invited other Canadian provinces to take similar measures. Even many who normally support the Conservatives are among those protesting Mr. Russell's actions. Will the pressure continue and force Mr. Russell to back down? Or will everyone in Alberta have forgotten about it by the time this report is published? I've lived here nine years, but I won't hazard a guess.

BRITISH COLUMBIA

VICTORIA

Susan Moger

Red Hot on Trial: Victoria's very own Red Hot Video outlet became the first in B.C. to be charged with possession of obscene video tapes for the purpose of distribution. Three video cassettes — Candystripers, The Filthy Rich and Band Girls — were named in the charge. Red Hot Video pleaded not guilty; the trial is set to begin May 9. Meanwhile, Women Against Pornography, the group that spearheaded the campaign against Red Hot Video, continues to keep a high community profile. The fight is far from over.

Self-Care-Network: Victoria is home to the Self-Care-Network, a new mega-project funded by National Health and Welfare. The project's mandate is to provide information, support and network-linking to organizations, professionals, consumer groups and individuals interested in the concept of self-care throughout B.C. and Alberta. The project is a composite of three interlocking parts — a network, a clearinghouse and a magazine.

An advisory committee has been established in both B.C. and Alberta and your intrepid reporter is representing women's health on the B.C. committee. Armed with issues of *Healthsharing* (and subscription forms), I recently attended our first meeting. The 13 members of the committee seem to have been chosen to represent different regions of the province, as well as different perspectives/interests of health and self-care.

I am looking forward to the formidable work ahead for the committee, not the least of which is defining what we mean by self-care! I described myself as an umbrella-person and explained that being asked to represent an entire segment of the health care, self-care field is no small task and I would try to get as much input and information from other women as possible. I hope to use *Healthsharing* in this regard. And unsolicited by me (for a change), came feedback that people read and enjoy our magazine and find it quite helpful.

VANCOUVER

Lorna Zaback

Midwifery Conference: The second annual "Midwifery — The Labour of Love" Conference was held February 18-20 in Vancouver. About 200 delegates from across the country met to share their individual knowledge and experiences, to hear internationally acclaimed speakers and to outline some common goals. According to Mia Stark, who covered the conference for *Kinesis* (Vancouver, March '83), these goals include: uniting to work toward the legalization of midwifery "to develop a safe and humane system of maternity care in Canada"; forming a National Association of Midwives; and developing communication and co-operation between midwives across the country.

Several speakers emphasized the need for midwives and their supporters to begin publicly dispelling the myths and clarifying some of the issues surrounding midwifery. "Spreading the word" can enhance the credibility of midwifery as a profession and be a step toward its eventual legalization in Canada.

LETTERS

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

Politically Correct Humour

I was dismayed by Frances Rooney's letter in the last issue regarding the graphics that accompanied her article to lesbians in therapy, and by the Collective's response to it. I am concerned that Dawna Gallagher's integrity as an artist and a feminist has been publicly called into question. Those who know her work realize that she is most emphatically not anti-lesbian or insensitive to their concerns.

I think there is a fundamental misunderstanding here of just what humour is. To say that something is funny is not at all the same thing as saying that it is frivolous. Though frivolity surely has its place in life, the best humour is often profoundly serious, driving home its points with a sharpness that all the sober political analyses in the world cannot muster. I think that Dawna Gallagher's work in general, and her drawings for the lesbians in therapy article in particular, are excellent illustrations of this fact. I hate to accuse Frances Rooney of having no sense of humour — an accusation too often levelled at feminists — but I do think she has missed the point of the illustrations. Of course, "lesbians are not dirty old men in raincoats exposing themselves to gawking strangers." Did she think that the artist was seriously suggesting that they are? Has she not heard of irony? Or can irony never be used in relation to lesbians? Regarding the second drawing, I don't see anything silly or politically retrograde about depicting a woman wondering why men make her tense. They sure make me tense! This drawing, in fact, struck me not as funny, but as a straightforward depiction of the strain that exists between men and women. The tension of the people in the drawing is almost palpable. I cannot fathom the objection to the third drawing,

of the dyke in the dress. It clearly reinforces the very point made by the woman in the article, when she discusses her therapist's reaction to her wearing a dress.

I disagree with the Collective's decision to pull the drawings for the subsequent printing, but that is your decision to make, not mine. I wish, however, that your response had made it clearer that Dawna's drawings are not in any way an attack on lesbians, and that your decision to pull them was made out of respect for the feelings of the author and the women she interviewed.

Please accept this criticism the way it's offered, with love. As a feminist and an artist I am concerned about the demands that political "correctness" make upon the artist, and I felt compelled to put in my two cents' worth.

Kathleen McDonnell
Toronto, Ontario

Correction

We were most pleased to have had our conference on "Incest & Family Sexual Assault" publicized in the last quarterly (Nova Scotia Regional Report, Winter, 1982). We would, however, appreciate your making note of one correction to the information provided: It was stated that Carol Wambolt was the chairperson for the conference, where in fact Marilyn Peers, Director of Children's Aid Society of Halifax, assumed that role. (Carol Wambolt chaired the Planning Group to organize the conference.) Since Marilyn has put much effort into the work of the Interagency Staff Development Group and was excellent as the conference chairperson, we feel that she should be credited for this role.

You may wish to note that the IASD Group are now making plans for their third conference, to take place in late April or early May. This will be on "Physical and Emotional Abuse in Interpersonal Relationships." *Carol Wambolt for IASD Group, Halifax, Nova Scotia*

Professionalization of Therapy

We would like to offer our tremendous appreciation for the past issue of *Healthsharing* (Winter 1982: Women and Therapy)

The articles *Seeking Help* and *Feminist Therapy* were both encouraging and supportive to women considering therapy for the first time and wanting guidelines and a sense of history and affirmation. The interview with Linda Rauch Peregal about her Valium addiction was especially important as a first hand account of a woman's experience with drugs which are so frequently given to women in the name of help.

What we found surprising about the issue as a whole was the omission of a discussion of professionalism. This criticism is not meant to encourage differences or as a judgment about doing therapy for money as an isolated issue. We do not at this point disagree totally with doing therapy for money. We recognize that there are times when it is necessary to call on the resources of people who are paid to do emotional care work and therapy. We also acknowledge the difficulty presented for women therapists who trained for years and are now in their fifties and sixties, to retrain themselves for other work or to do their present work in a different way. The issue here is the implications of professionalizing emotional care work.

What we mean by "professionalism" when we talk about the medical profession is the system by which the skills and knowledge of health care that doctors have are kept mystified and hoarded and therefore kept unavailable to us. "Professionalism" also implies a setting apart (and above) those few people who have a monopoly on certain areas of knowledge. What the women's health movement has done about this is to teach each other thoroughly and carefully. This is self-help.

There is a parallel between the medical system and the therapy system and the way in



which knowledge is mystified and withheld. We need to look carefully at the myth which says that because therapists are trained in a certain modality or possess a degree in whatever, they are the only experts in helping us through emotional crises or in maintaining and increasing our emotional health and integrity. The inverse part of the myth that also needs to be explored is that because we do not hold a degree or certificate, we do not possess the skills to be able to help each other through emotional crises and in our emotional growth. The more we believe in experts, the less credit we give ourselves for being able to listen to each other, support each other, problem-solve with each other and grow in understanding our feelings and needs.

We believe that the work of therapists can and should be removed from the professional model. If we look at the work of therapists in a new way, i.e. as educators rather than as healers, the tools and processes of therapy could be demystified in ways that would promote understanding and sharing of the skills. Ideally, the aim of therapists should be to work themselves out of their jobs; teaching people how to listen to and help each other is movement in this direction. The skills then move from being a saleable commodity to being tools for change to keep us all healthy.

Sally Batt
Annette Clough
Vancouver, British Columbia

Breast Screening Study Controversy

I write to address women who are curious about the National Breast Screening Study (NBSS), or who are genuinely uncertain or confused about the issues involved.

Nothing is more misleading than incomplete data. The letter written by the Vancouver Women's Health Collective in your Winter 1982 issue said of the 1977 U.S. National Cancer Institute Committee that it

"published guidelines recommending that mammography screening be confined to women over 50...". Women should know that in 1979, a committee appointed by the same institute made recommendations which clearly state: "Randomized controlled studies in screening for breast cancer should be started on questions... (which) include the magnitude of the benefit and net benefit-risk in the use of mammography, the benefit in screening women 40-49 years of age..."

As an idea of how out-of-date the 1977 report is, it states of mammography, "the dose in the average situation is probably still in excess of one rad per examination." In the NBSS, the total cumulative exposure over five years with five examinations will be under one rad.

Furthermore, the Health Collective does not appear to understand that with mammography one hopes to detect lesions which are so small that they cannot be felt. These lesions are not 'benign cysts and lumps' but rather tiny areas of microcalcifications which require special combinations of radiological and surgical skills to remove accurately. Two to three percent of women who are screened have biopsies recommended to them by the NBSS. Whether or not the recommendation is followed is a matter for the woman and her private physician to decide. To have a biopsy and find out it's benign should cause joy, not sorrow.

As of March 1, 1983, more than 36,000 women aged 40-59 have entered the NBSS. Many of them realize that in their age groups, the risk of getting breast cancer in the next five years is one in twenty-five. They have obviously decided that early detection far exceeds the risk offered by radiation exposure at such low levels.

Every woman who enters the study signs an informed consent document which states:

"X-rays are a form of radiation that can cause cancer. Studies have shown that large amounts of radiation can cause breast cancer ten or more years later, but that the risk is low with small amounts of radiation. In this study, radiation dosage will be kept as small as possible but, I realize there is still a risk."

Every woman who has entered the study therefore knows about the risks as she enters. Should anyone change their mind about the acceptability of the risk, they are free to withdraw from the study at any time.

Cornelia J. Baines
National Breast Screening Study
Toronto, Ontario

The letter from the Vancouver Women's Health Collective (Winter 1982) raised some excellent questions concerning the use of mammography in the National Breast Screening Study. This screening study has much import for proving the value of early detection and specifically to identify the role of mammography. But often the welfare of the individual women who take part in such research projects takes second place to the larger goal that will benefit all women. Here are some additional concerns based on the U.S. experience.

In 1972, the U.S. National Cancer Institute (NCI) and the American Cancer Society began a massive nationwide Breast Cancer Demonstration and Detection Project (BCDDP). This was not a study, but a project intended to demonstrate the value of early detection, specifically of mammography. The BCDDP got off to a slow start but gained a sudden surge of participants when Betty Ford and Happy Rockefeller were both diagnosed as having breast cancer in 1974. Over 250,000 American women took part in the BCDDP.

In 1977 serious concerns were raised about the safety of including women under 50 in the BCDDP. It was feared that the radiation involved in a mammographic examination given yearly may cause more

breast cancers than would be detected. Such concerns were verified by an NCI-appointed committee of experts and the younger women were withdrawn from the BCDDP. To this day, there is no scientific evidence to show that the risks of exposing women under 50 to a yearly mammography are outweighed by any benefits.

The media attention focused on the BCDDP at that time led to a review of the tissue slides of 506 women who had been diagnosed as having "minimal cancer" as a result of the BCDDP. These women represented the *raison d'être* for mammography because their cancers were found before they were large enough to be discovered during a professional breast examination.

The NCI-appointed expert committee of pathologists determined that 48 of the 506 women had been erroneously diagnosed as having cancer; 37 of them had already had some form of mastectomy. From this tragedy came the realization that mammography can identify such small lesions that pathologists have great difficulty in interpreting them accurately. Moreover, little is known about the natural history of these minimal cancers that most likely will remain latent for a lifetime.

May your own NCI treat women less cynically than ours did. The 48 women were never told directly of their revised diagnoses. Instead, a physician-dominated NCI committee decided that their surgeons should be given the news and advised in turn to tell their patients. The NCI still has not furnished any proof that the 48 women in question ever heard that their cases had been reviewed and their diagnoses changed.

I would suggest that a consent form for your National Breast Screening Study be requested and scrutinized with all of the above in mind. I would be glad to work with anyone on this.

Maryann Napoli
Center for Medical Consumers;
National Women's Health Network
New York, New York

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RESOURCES & EVENTS

Pre and Peri-Natal Psychology Conference

The First International Congress of Pre and Peri-Natal Psychology will be held in Toronto from July 8 to 10, 1983. The multi-disciplinary program has been designed to present research and to explore the origins of mental and emotional development, the vulnerability of the fetus, the psychological needs of the unborn, etc. For further information, contact Conference Office, O.I.S.E., 252 Bloor St. West, Toronto, Ont. M5S 1V6.

Osteoporosis Society

The Osteoporosis Society of Canada has recently been formed to develop patient self-care programs, to increase public awareness of the disease and to support new and on-going research. If you wish to be on their mailing list, write The Osteoporosis Society of Canada, Suite 1500, 320 Bay St., Toronto, Ont. M5H 2P6.

Mothers on the Move in Montréal

Project MOM is a group which has been sponsored by the Adult Services of the Protestant School Board of Greater Montréal to help sole-support mothers on fixed incomes, teenage mothers and displaced homemakers over 45, as well as mothers who want to return to school or the work force. For information on workshops and confidence-building sessions, contact Ruth Flicker at the High School of Montréal, 3449 University St., Montréal, Que. H3A 2A8 or by phoning (514) 849-3677.

Breast-Feeding Booklet

A general information booklet on breast-feeding, offering an international perspective, is available free of charge from The World Health Organization, 1211 Geneva 27, Switzerland. The booklet, entitled *Women and*

Breast-Feeding, examines the changing patterns in breast-feeding and offers guidelines for women's organizations wishing to elicit more community support for the practice.

Psychosynthesis in Helping Professions

The Ontario Institute for Studies in Education in Toronto is sponsoring an "International Conference for Psychosynthesis in the Helping Professions: Now and for the Future," from June 29 to July 2, 1983. For more information on the conference, contact John Weiser, Dept. of Applied Psychology, O.I.S.E., 252 Bloor St. West., Toronto, Ont. M5S 1V6.

Fitness Leader

This is a new journal for fitness, dance and movement leaders, coaches and phys-ed instructors. Each issue (10 issues/year) contains a feature article, a related hand out, new exercises, aerobic and dance sequences and resources. The loose-leaf format enables the formation of a reference manual.

The cost is \$43.50/year; you may want to have your library subscribe. More information is available from Fitness Leader, c/o Pitters Publishing, 251 Bank St., Suite 405, Ottawa, Ont. K2P 1X3.

Well Women Clinics

Nova Scotia's Women's Health Education Network has published the *Well Woman Clinic Project Organizational Manual and 1982 Report* (107 pp.), a revision of the 1977 *Bass River Manual*. The W.W.C. Project team also developed a slide/tape show (French and English versions) about the well woman clinic — what one is and how to organize one. Direct inquiries to WHEN, Box 1276, Truro, N.S. B2N 5N2.

Birth Control Guide

It's Your Choice: A Personal Guide to Birth Control for Women . . . and Men is a book by R.A. Hatcher et al which includes detailed information on birth control options, abortion, menstruation and fertility cycles. The 133-page book is distributed for \$5.00 a copy by The Planned Parenthood Federation of Canada, 151 Slater St., Suite 200, Ottawa, Ont. K1P 5H3. A bulk rate is available for clinics.

Menopause Resource Groups

Workshops for women anticipating or experiencing the menopausal process offer information, support and an opportunity to share. Location: North/Central Toronto; cost: \$50 for four weekly sessions. Contact Sidney Elizabeth Thomson at (416) 424-1655.

Pap Test Information

The Vancouver Women's Health Collective has published a 12-page supplement on Pap tests for women. It includes a political perspective as well as alternative and conventional medical practices for dealing with abnormal Pap tests. Available for 50¢ (postage) from The Vancouver Women's Health Collective, 1501 West Broadway, Vancouver, B.C. V6J 1W6.

Question of Video Display Terminals

This videocassette has been used to inform policy makers of legal firms, unions, insurance companies and compensation boards of the health hazards of VDTs. The production is 27 minutes long and is in a 3/4 Vu-matic cassette format.

It is available from the Planetary Association for Clean Energy for \$195. For more information, write 100 Bronson/1001, Ottawa, Ont. K1R 6G8.