

Winter/Spring, 1993  
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# Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

## Female Genital Mutilation A Tradition of Pain

## Mothers: The First Environment

## Selective Abortion





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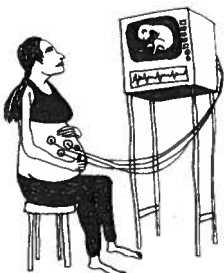
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# Healthsharing

Vol 13:4 Winter/Spring, 1993

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## Unimaginable? Not really...

The first time I read Virginia Mak's article on female genital mutilation (FGM), my blood ran cold. I kept trying to picture going through the procedure myself; kept trying to imagine how young girls manage to survive such brutal mutilation.

Imagine having your genitalia removed entirely; worst, imagine being forced through this procedure as part of a cultural tradition which supposedly prepares you for marriage. Imagine having your body mutilated to make you more attractive to men.

For many of us living in North America, FGM may seem unimaginable. But if we look closely at the underlying cause for this procedure it may not seem so far-fetched. It is true that FGM is at the far end of a continuum which has young girls and women having their bodies redefined in order to be more attractive or pleasing to men. It is also true that, FGM is performed on girls so young they are unable to fight back or object to the mutilation on their bodies. But in North America, we are starving ourselves with unhealthy diets, having our faces stretched to erase the signs of aging and having breast implants surgically inserted to enhance our breast size, all to reach some unrealistic and unreasonable image of beauty; an image created by men.

This quest for "perfect" beauty is mutilation, albeit in a different way. We may not see it exactly that way and when we read about women undergoing such procedures, it may not have the

same impact as FGM (and shouldn't). But anyone who has heard the stories of the women who have had breast implant surgery and are now experiencing problems, will know that the effects can be physically and emotionally damaging in their own way.

What joins the survivors of FGM with the experiences of North American women is that all of these traditions, and the voluntary surgical or cosmetic adjustments are created around the wishes and fantasies of men.

As FGM gains worldwide attention, women and health activists are calling for an end to this procedure. We need to align our efforts with these groups to ensure that this goal is achieved.

Before, we dismiss FGM as being something that happens to "them" and not to "us," I beg you to re-examine the things we do here that also have us changing our bodies, voluntarily. And before we conclude that any form of mutilation in our environment is unimaginable....

I am off for a one-year leave of absence to enjoy the pleasures of motherhood and to catch up on all the writing I have been putting off for too many years. While on maternity leave, **Janet Creery** will step in as Managing Editor. Janet comes to *Healthsharing* from a similar position at *Peace Magazine*. We are all looking forward to the vision and creativity Janet will bring to future issues of *Healthsharing*.

This issue was guest edited by **Megan Williams** and **Colleen Ferguson**. Both women are regular members of our Editorial Board. I wish to thank them for their hard work and commitment to this issue of *Healthsharing*.

HAZELLE PALMER

## On Our Cover



As a visual artist and commercial illustrator, Lori Dell has exhibited her work in many galleries and her illustrations have appeared in various Canadian and US publications.

Although her work has taken her into set, costume and interior design, Lori places emphasis on large-scale paintings and mixed media works that call for creative innovation and expressiveness in both execution and concept.

Lori resides in Toronto with her two children, and can be reached at (416) 463-7898.

*We encourage readers to write. Your comments are just as important as the original articles and columns published in the magazine. Please take the time to share your opinions with other readers.*

*Healthsharing reserves the right to edit letters for length, and print them, unless they are marked "not for publication."*

## **HPV Linked to Cervical Cancer**

In criticizing what she sees as an overemphasis on women's sexual behaviour in cervical cancer research, Jan Darby in *Sex & Punishment* (Summer/Fall, 1992) seems to reject any role of sexual behaviour in causing cervical cancer.

There is no question in my mind that Human Papilloma virus (HPV) is linked to cervical cancer. The various types of existing research, when considered together, make up a coherent and overwhelming case linking sexual factors to cervical cancer. For instance, data from four well-designed laboratory studies show that HPV 16 or 18 was detected overall in 51% on tissue specimens of advanced lesions and in situ cancer and in 63% of invasive cervical cancer samples. The same studies found that HPV is much less likely to be found in conjunction with low-grade cervical abnormalities.

I agree with Darby that existing research suggests that other factors—such as individual biology, environmental exposures (e.g. smoking, oral contraceptives, chemical toxins) and microbial exposures—play an important role in the development of HPV-associated cancer. These additional concerns don't affect HPV's role as a co-factor.

In rejecting the attitude of the medical practitioners cited in her article, Darby seems to tar all medical and health workers with the same brush. Articles in the *Lancet*, *Cancer* and *Cancer Research* have explored male roles in transmission, both as an active agent and as a reservoir for HPV.

Darby rightly criticizes the insensitivity and misogyny of numerous medical researchers and practitioners. Unfortunately, the article seems to imply that women

shouldn't take part in medical studies. It would be more constructive to argue for more women-centred and women-influenced study designs, such as breast cancer activists are now seeking.

*C. Clement  
Health Promotion & Advocacy  
Section, Department of Public Health  
Toronto, ON*

## **Well Done!**

Please begin my subscription with the Atlantic Region issue recently published. It was a beautiful issue. Well done Alex and everyone!

*H. Atkins  
Charlottetown, PEI*

## **Tackling Relevant Health Issues**

Thanks for providing such excellent reading to women on relevant health issues! I truly cherish your magazine and have been a subscriber for many years. I constantly inform my female clients of your magazine with great enthusiasm.

As a health care professional and woman, your publication is indispensable to me and I hope *Healthsharing* continues for a very long time in spite of our governments' policies.

Thanks to the "collective consciousness" behind it all... Good health to you all and keep up the great work!

*E. Krechowicz, CST  
Toronto, ON*

## **Cystic Breast Disease**

Regarding your issue on breast disease, (Politics of Breast Cancer Winter/Spring, 1992), I wondered whether you had seen the chapter on cystic breast disease in Carolyn de Marco's book, *Take Charge of Your Body*. My personal experience on following their recommendation is that it does seem to work.

Thanks for your magazine.  
*B.M. Newsmall  
Lillooet, BC*

## **Boring**

I found it very difficult to sustain any interest in the "regional" issues. I couldn't find much there for me. I personally hope that you will stay with issues/topics/concerns of more specific interest to

all women no matter where they live. Other than that, I continue to look forward to every new issue.

*D. Eyolfson  
Lundar, MB*

## **What About Free-standing Birth Centres?**

We were pleased to see the article *Birth Centres—give women another option* (Summer/Fall, 1992).

Certainly, the importance of choice respecting reproductive care cannot be under emphasized. However, we felt that your readers might have been left with the impression that the birth centre concept is limited to in-hospital facilities. The full meaning of choice with respect to location cannot be appreciated unless recognition is given to the free-standing birth centre.

The Toronto Birth Centre, a group of parents, midwives, physicians, child birth educators and other committed individuals, has been advocating since 1979 for the establishment of free-standing birth centres in Ontario.

Unlike the in-hospital birth centre that is formally linked to hospital governance, a free-standing birth centre is community-based and governed and is physically and financially independent of the hospital setting. Such centres will serve healthy pregnant women and their families and supporters. They are designed to provide the client with continuity of care, informed choice, and the opportunity to play a major role in the provision of her care.

*W. Sutton, President  
Toronto Birth Centre Inc.  
Toronto, ON*

## **Full of Inaccuracies**

*Aids in the Atlantic*, which appears in your "Update" section (Fall/Winter 1992) contains grave inaccuracies.

I have been teaching in Newfoundland Catholic schools since 1977. I have been teaching about sexuality since 1977; I have been teaching about drugs since 1977; I have been teaching about AIDS since 1985; Catholic school boards (not all, but most) have had AIDS education in place since 1987, and most now have comprehensive

policies on AIDS awareness.

I would say that if it were not for religion classes, most of our students would receive little, if any, opportunity to explore life issues such as sexuality, family relationships, morality, self-worth, compassion, affirmation.

I know that there are some teachers who are uncomfortable with and neglect sensitive issues, such as AIDS, but they are the minority. Sexuality is an integral part of our family life *Fully Alive* program from grades one through eight. Sexuality (and all the issues surrounding it) is an integral part of our religion courses in grade nine and 11. We also use the ICE (Institute for Catholic Education) materials on AIDS education developed in Ontario. We use guest speakers, pamphlets, videos and media reports to promote information on AIDS and compassion and fellowship towards those of us who are HIV positive. There are some speakers or videos or other items which we find objectionable because they are inaccurate or

contrary to our Catholic values or both. Some AIDS education material, I find, gives messages such as "Of course all teenagers are engaged in sexual intercourse..." or "Sexual intercourse for adolescents is perfectly acceptable (or perfectly safe) as long as they use condoms."

A periodical which has as its goal the promotion of women's health should be careful not to unjustly vilify people who are working toward knowledge and wholeness and integrity for the young and old of Newfoundland and Labrador.

Much of the material on page six of the Fall/Winter *Healthsharing* is terribly inaccurate and offensive to people who have expended much time and energy in developing and delivering information on drugs, AIDS and sexuality.

Who gave you this misinformation? Who was responsible for checking its accuracy? How many schools are visited or otherwise researched and had their AIDS education materials examined?

Sincerely, I wish you well in your endeavour to promote women's health issues in Atlantic Canada. In fact, I am working with you in this regard. But please, check your information more carefully.

J. Maher  
Manuels, NF

*I appreciate the supplementary information provided by John Maher for our readership. I regret that the phrasing of my article was more definitive than it ought to have been. I should have said that there are limitations in the discussion of such subjects as drug use, condoms, abortions and homosexuality in some schools in Newfoundland.*

*The documentation which provided the background for this article included the Newfoundland and Labrador AIDS Committee 1992 fact sheets and articles from the St. John's Evening Telegram. Unfortunately limited resources prohibit site visits.*  
Nicci Cohnstaedt

## Women crime victims as often as men

Statistics Canada is finally saying what feminist activists have long known: women are the victims of violent crime as often as men.

In fact, advocates for battered and sexually-abused women say a recent Statscan report is still understating the existence of violence in women's lives. The report says among crime victims, 80 per cent of women were victimized by someone they knew, in particular by husbands or ex-husbands. Men, however, tended to be victimized by strangers.

Kathleen Gallivan, a legal analyst for the Toronto-based Metro Action Committee on Public Violence Against Women

and Children (METRAC), says the report has some serious flaws.

"It's about time this started to get recognized," Gallivan said, but, "there are concerns about methodology and a general concern about what the policy responses are. That's something we'd really like to see."

The report analyzes 1991 data from 15 police departments across Canada.

"The results are highly coloured by the police's own unacknowledged biases," Gallivan said. "Lots of women may be subjected to violent crime [and] not even aware that they have been victimized."

She added that al-

though women often know their assailants, the policies across Canada regarding violence against women still focus on strangers.

Other findings of the report show that 67 per cent of female murder victims were killed in their homes, versus 41 per cent of men. From 1981 to 1990, 48 per cent of the women killed were murdered by spouses or former spouses; and a further 27 per cent were killed by acquaintances.

The statistical data of the report is inadequate since many incidents of male violence go unreported, Gallivan said.

"Police still do not take seriously the threats

women hear from former intimate partners," she said. "They often do not respond adequately. Harassing behaviour can often escalate to threats and ultimately, physical harm and even death."

The report leaves a lot to be desired, she added, and much of the data is not realistic. References to race, class or disability are absent from the victim crime statistics.

"This is an official government report that is nowhere as nuanced and contextualized as we would want."

KAREN HILL

# Sexual harassment an international problem

Sexual harassment plagues working women throughout the industrialized world, yet many countries do not have laws in effect to combat the problem. This is the conclusion of a report recently released by the International Labour Organization (ILO).

Only seven of 23 nations surveyed—Canada, Australia, France, New Zealand, Spain, Sweden and the United States—have statutes that specifically refer to sexual harassment.

"Sexual harassment is one of the most offensive

and demeaning experiences an employee can suffer. For those who are its victims, it often produces feelings of revulsion, violation, disgust, anger and powerlessness," Michael Rubenstein, a consultant on sexual harassment to the European Community, writes in the report.

Surveys showed that 21 per cent of French women, 58 per cent of Dutch women, and 74 per cent of British women said they had experienced sexual harassment at work. Twenty-seven per cent of Spanish women

said they had encountered strong verbal advances and unwanted touching.

Sexual harassment is defined differently by nations due to cultural variances. For example, the French have a new law that targets supervisors who make unwanted advances, but excludes co-workers because "they don't want to break up the [workplace] romances."

In Canada, sexual harassment is specifically mentioned in the human rights acts of the Yukon, Manitoba, Newfoundland and Ontario. It is defined by the Canadian Human

Rights Commission as "verbal threats or abuse, unwelcome remarks, leering or other gestures, and unnecessary physical contact."

Although the report brings attention to a long ignored problem, the ILO believes the statistics reveal only a fraction of the problem. Constance Thomas, an ILO civil rights lawyer agrees. She estimates that 60 per cent of harassment cases go unreported.

SANDY McMILLAN

## Breast cancer research funded at last

The tireless lobbying by breast cancer action groups has at long last

paid off. In December, Canadian Health Minister Benoit Bouchard announced a 20 million dollar commitment to breast cancer research on the part of the federal government. The money is to be spent over the next five years with another five million allotted for the establishment of a national breast cancer support network.

Pat Kelly, spokeswoman for the Canadian Breast Cancer Action Group, says she applauds the decision although there are no guarantees the research will yield breakthroughs.

"What is really significant about the funding is the

acknowledgement from Bouchard and the Canadian Cancer Society of the strong, vocal lobbying on the part of women," Kelly says.

Jacques Cantin, president of the Canadian Cancer Society admitted at the Toronto news conference announcing the funding, that "without their incessant lobbying... I don't think this cause would have gone as far as it has."

Current breast cancer statistics show that an alarming one in eight women will contract the disease at some point in her life. In 1993 alone, an estimated 15,700 women will be found to have breast cancer, a third of whom will die from it. Until now, the federal government has spent less than \$900,000 a year on breast cancer research—a fraction of its overall cancer research budget. The Canadian Cancer Society has allot-

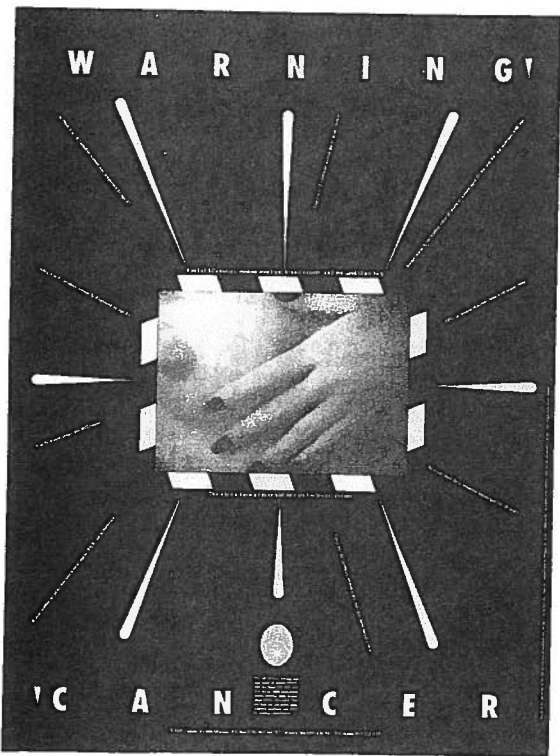
ted less than eight per cent of its annual research budget to studies that may have an impact on breast cancer.

Although Kelly welcomes the funding as a step in the right direction, she sees the involvement of breast cancer survivors as key to the success of research.

"We have a promise from Bouchard that the survivors will be represented on the research management committee. We want the research to be survivor directed, not based on the current medical model of the Canadian Cancer Society," she says.

Kelly urges women with breast cancer to take action across the country by forming a network of active local groups.

MEGAN WILLIAMS



This poster was designed and produced as a donation by Sutton/Javelin Communications Inc., Moveable Type Inc., Olympic Scanning, Sutton Film Services, Johnstone Print and Litho, and Select Papers.

## New genetic screening program launched in Ontario

An Ontario hospital is planning to introduce a screening process to identify genetic abnormalities in fertilized ova, but women with disabilities say the technique may unwittingly further bias against disabled people.

University Hospital in London will be the first in Canada to offer the procedure developed at Hammersmith Hospital in England.

Jeffrey Nisker, head of University Hospital's early pre-implantation cell-screening program, says the technique can detect severe mental retardation, as well as sex, hair and eye colour.

Nisker also hopes to use the procedure to screen for other disabilities such as muscular dys-

trophy. Ethics committees will be established to ensure screening is solely for genetic disabilities.

Proponents of the procedure say it will save women the traumas of abortion by detecting disabilities before ova are implanted in the uterus.

But Pat Israel, chair of the DisAbled Women's Network Canada (DAWN), says the procedure opens up a whole range of issues.

She says doctors must give women unbiased counseling about having a child with a disability, but it is the woman's right to choose whether to proceed with the pregnancy or not.

The most common screening process currently in use is amniocentesis,

in which a woman's uterine fluid is tested in the 16th week of pregnancy to detect disabilities such as spina bifida or Down's syndrome. If the test is positive, women may choose to undergo a therapeutic abortion.

"I've sat right beside feminists who said this kind of procedure is unacceptable for sex, and then turn around and say, 'Yes, that's all right for disability,'" Israel said. "A lot of disabled people would say, 'It's okay, I

would have the child," if they got a positive result.

Israel says new reproductive techniques such as this screening process must be questioned and challenged.

"It's like they want to get rid of a whole class of people," she said. "We are becoming so medicalized."

WHS

(See "Selective Abortion" by Ingrid Deringer p. 14 in this issue)

## New one-step ovulation predictor test

An easy, new ovulation predictor test hit the Canadian market last year. Conceive, a product of the American company Quidel, is a one-step, five-day ovulation predictor that shows its results in a mere three minutes.

Unlike its predecessors, which allow women to predict the ovulation period of their next cycle through measuring body temperature, Conceive reads the leutenising hormone (the hormone that induces ovulation). A woman will ovulate from 24 to 48 hours after the hormones are shown to peak.

Conceive is most effec-

tive when used as close as possible to the middle of a woman's cycle. Testing can be done any time throughout the five day period, as long as it is done around the same time each day.

To take the test, women must urinate into a cup provided in the kit. With a dropper (also provided), a small amount of the urine is placed in a test cassette which then changes colour to indicate the hormonal level.

Conceive retails in Canada from \$40.00 to \$45.00.

SANDY McMILLAN

## Breastfed babies different

Results from a Scottish study comparing the mental development of breastfed infants with bottle-fed babies seem to indicate breastfeeding is the better choice.

Researchers analyzed 22 infants who died within 43 weeks of birth from illnesses not related to their diet. The breastfed babies were found to have a higher level of docosahexainoic acid (DHA), a polyunsaturated fatty acid, in their brains. DHA made up 9.7 per cent of breastfed infants' brain weight, compared with 7.6 per cent in bottle-fed babies.

The study's results were reported in the November issue of *The Lancet*, a British medical journal.

Although the precise role of DHA remains a mystery, it is seen by experts as an important substance for nerve-cell conduction and cell-

membrane fluidity.

The researchers said, however, the differences in the brain did not necessarily affect brain function. Nonetheless, James Farquharson, a biochemist who participated in the study, told the *Globe and Mail* "it seems unlikely that we'd spend all this evolutionary time to produce fats in breast milk if they weren't important."

Farquharson says the results should encourage women to breastfeed.

WHS





## Supreme Court overrides limitations act

The Supreme Court of Canada recently overruled the Ontario Limitations Act, supporting a woman's right to sue her father who sexually abused her as a child.

The Ontario Limitations Act requires that civil suits be filed within four years of the assault. If at that time the plaintiff is a minor, the time restriction begins when she or he reaches the age of 18.

"The court's decision is a tremendous step forward in recognizing the realities of childhood sex-

ual abuse and in removing the barriers to civil action," said Helena Orton of the Women's Legal Education and Action Fund (LEAF).

The court ruled the limitations period should not begin until the plaintiff is aware of the harm she or he has suffered, and its connection to the sexual abuse. This will usually only happen after the survivor receives some type of therapeutic assistance.

"This is an important development in law be-

cause it recognizes the tremendous abuse of authority involved in incest and offers the potential for greater recognition of the harm caused," said Orton.

During the case, LEAF argued that the limitations law must reflect the complex injuries involved in sexual abuse that affect a survivors' ability to bring legal action against abusers. Often, many years are needed to recognize they have been abused and to gain the emotional and psychological stability need-

ed to take legal action.

British Columbia has recently amended its limitations law so that survivors of sexual abuse can pursue legal action at any time. Similar amendments have been recommended by the Ontario Attorney General.

Orton said the reform in the limitations law is important since, "the availability of civil action for victims will have value as a deterrent of sexual abuse."

COLLEEN FERGUSON

## Toxic pollutants: the key to endometriosis?

After decades of dead-end research, the Endometriosis Association is hailing a recent discovery linking the disease to toxic pollutants as a tremendous breakthrough.

Endometriosis is a puzzling disease affecting women in their reproductive years. It consists of tissue that is found outside the uterus, in the form of nodules, tumors, lesions, or growths. These can cause pain, infertility and other problems.

The recent study reveals a significant con-

nection to dioxin exposure. Dioxin is one of the most poisonous chemicals known to humans. It is formed when chlorine bonds with organic substances in lakes and rivers. In Canada alone, pulp and paper mills dump over one million tonnes of chlorine into waterways each year.

The study, sponsored by the Endometriosis Association, compared groups of monkeys: two were exposed to dioxin in different doses, and one had no exposure

(the control group). The group with no exposure was not likely to develop the disease; the group exposed to a low dose was likely to develop the disease; and the higher dose exposure group was most likely to develop endometriosis.

A perfect dose-dependent relationship occurred between the amount of dioxin and the severity of the disease. In other words, the higher the dose of dioxin, the more likely the monkeys were to develop severe

endometriosis.

In their latest newsletter, the Endometriosis Association advised women to stay away from chlorine-bleached tampons and pads.

For more information, contact Barbara Mains, Director of Canadian Projects at (416) 651-2419 or write to the Endometriosis Association's International Headquarters, 8586 N. 76th Place, Milwaukee, WI, 53223, USA.

MEGAN WILLIAMS



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# Hair treatments for Black women can have damaging effects

Black women who straighten, braid or weave their hair may, over time, develop hair or skin disease, according to the American Academy of Dermatology.

The findings, reported in a recent issue of *Ms.* magazine, are the result of work by Patricia Treadwell, a doctor and associate professor of dermatology at the Indiana University School of Medicine in Bloomington. While overprocessing can damage any type or texture of hair, Treadwell warns there is a ten-

dency for black people's hair to be more porous, and therefore more likely to become brittle.

Treadwell says that hair can be damaged, sometimes permanently, by constant twisting, straightening, colouring, and hot combing. Straightening (or curling) hair is achieved when bonds in the hair shaft are broken down with heat or chemical treatments.

"In order to restructure the bonds, there is some damage that occurs to the hair," said Treadwell. "It's a question of how

much damage."

Chemicals can dry hair and cause it to break. Some treatments can even cause scalp burns. To minimize damage, Treadwell suggests women wait at least six to eight weeks between straightening treatments or perms. After the treatment, hair should be conditioned and treated gently, she added.

Pomades, which are a mix of oils, are also used to straighten hair. But pomades can inflame hair follicles, and if they come in contact with the

face, they can result in acne, Treadwell says. Hot combing can also cause scalp burns.

Other hair styles such as corn rows, which involve constant tension and twisting, may further weaken the hair. "If the hair is pulled tight, there is undue pressure put on the follicle. The more tightly the corn rows are braided, the more chance of damage," said Treadwell.

More information about hair damage can be obtained from the American Academy of Dermatology at P.O. Box 681069, Shamburg, Ill., 60168.

SUSAN ALLEN

update

## Is aspartame safe?

Aspartame is consumed by more than 100 million people in the United States, and millions more in Canada but is it safe? Not according to H.J. Roberts, an American physician of internal medicine and a diabetes researcher. Roberts who has published more than 200 articles and five books has recently released *Aspartame (NutraSweet): Is it Safe?*, where he delves into the potential risks of this chemical.

Aspartame has become virtually omnipresent in commercially-prepared food today, contained in over 1,200 products including soft drinks, fruit drinks, tabletop sweeteners, puddings, gelatins, cereals, hot chocolate, gum, breath mints, frozen novelties, flavoured sprays and some over-the-counter medicines for treating fever, headache and infection in children.

By 1985, 800 million pounds of aspartame were used yearly in the United States.

Although the public has become increasingly concerned about food additives, very few of us know just what aspartame is.

Yet, we are reassured by manufacturers, the U.S. Food and Drug Administration (FDA) and other reputable institutions that it is safe.

The FDA has approved aspartame as an 'additive' rather than a drug. As a result, this synthetic chemical, consisting of 50 per cent phenylalanine, 40 aspartic acid and 10 per cent methyl (wood) alcohol, has not come under the same intense scrutiny as other drugs. Nor has it been tested extensively on humans.

The tally of complaints from consumers about aspartame products is alarming. In 1985 alone, the

FDA received 6,000 complaints about adverse reactions to food ingredients—80 per cent of which concerned aspartame.

In his book, Roberts shows, through case studies, the appalling effects of this seemingly harmless additive. Roberts employs three criteria: firstly, the subject had begun consuming aspartame products, or had dramatically increased her consumption before the onset of symptoms; secondly, the subject's condition improved dramatically within several days or weeks after avoiding aspartame; and thirdly, the same set of problems promptly re-occurred after the subject consumed aspartame products again either knowingly (for self-testing) or accidentally.

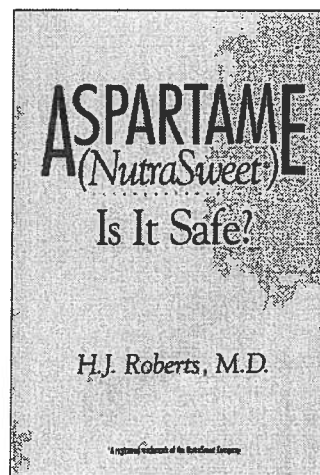
His findings were distressing. The most common medical problems attributed to aspartame products range from severe headaches, dizziness, con-

fusion or memory loss, and decreased vision or eye pain to severe depression, extreme irritability, anxiety attacks, severe drowsiness, paresthesia or numbness and convulsions.

Roberts thinks it would be a tragedy if the effects from aspartame are ignored since "we could be inviting disastrous medical, psychological and neurological problems.

"I hope I'm wrong. But let's look at the problem now instead of in five or 10 years when we might have a medical plague on our hands," writes Roberts.

VIRGINIA MAK



# FEMALE GENITAL MUTILATION

# A PAIN of Tradition

By Virginia Mak

At the age of four, Kowser Omer was prepared for marriage.

"A group of women came to my home. I was told to sit on the floor. One woman sat behind me to support me. She opened my legs and two women held them down. My mother supervised the procedure and told the woman with the razor blade to remove everything.

"She injected some fluid into me, which was supposed to be an anesthetic. Then she cut off my clitoris, my labia majora, and part of my labia minora while I screamed in pain. Then she stitched my vulva closed, leaving an opening the size of a corn kernel for urine and menstrual blood."

A celebratory gathering followed the procedure. Women brought sweets to her home and Omer was given a piece of jewelry. This marked the beginning of her womanhood: she was now "prepared" for marriage.

Omer, who was raised in Hargesia, northern Somalia, is just one of the millions of young girls who have undergone this procedure. It's called female genital mutilation (FGM) and it continues today.

Twenty-seven African countries; parts of Arabia, Yemen, Oman, the Arab Emirates; some Muslims in Indonesia, Malaysia, India, Pakistan; and newcomers to Australia, Europe and North America are believed to practice FGM. One hundred million women worldwide have been affected, and that figure increases by more than a million each year.

Three types of FGM are practiced worldwide today. *Sunna* is the procedure where the prepuce (hood) or tip of clitoris is cut.

*Excision* involves removing the entire clitoris and all or part of labia minora. *Infibulation* is the scraping away of the entire external genitalia - the clitoris, labia majora and labia minora. Infibulation is performed in Somalia to girls of every class. Paid to perform this procedure are elderly women from an economically-disadvantaged clan called Meetgo. In Omer's case, her mother paid for the extra expense of anesthetics, stitches and antibiotics.

"My grandmother pressured my mother to have the procedure done to me since a young girl is not marriageable unless she has been infibulated," recounts Omer, who now works at the Birth Control Venereal Disease Information Centre as a Community Health Educator and Counselor in Toronto.

Omer says her own experience was under comparatively favourable conditions. For other girls, unsterilized knives and broken glass are sometimes used. Some have even been infibulated without washing. Up to eight women have been known to hold down a young girl during the procedure. Instead of stitches, thorns are often used to close the vulva. Cloth knots are tied at the end of the thorns to hold the stitching in place. Ash may then be used to close the wounds.

Despite the war and disruption in Somalia, women continue to infibulate their daughters, hoping to protect them from rape. The procedure is sometimes performed on the run — in refugee camps and often under unhygienic conditions.

Hawa Mohamed, who recently immigrated to Canada from Somalia, is the former director



“Female genital mutilation is criminal.  
It’s a women’s rights issue.  
It’s a human rights issue.  
It’s torture, and it should stop.”



of the Human Education Department at the Ministry of Education in Somalia. She was responsible for sex education, including the topic of female genital mutilation. Much of her work involved speaking out against FGM.

Recently, Mohamed spoke to the Toronto Women's Health Network about the history and beliefs that rationalize female genital mutilation.

"The origin of this practice is not clearly known. Many believe that it dates back to 500 BC.

Mummies from ancient Egypt have been found with signs of mutilation. Some speculate the practice was used to distinguish aristocratic women from slaves. In the Ninth and 12th century in Britain, it was used as a treatment on women with perceived psychiatric disorders.

Since Muslims, Christians and Jews in different countries practice FGM, it is based on culture rather than religion, although many people still see it as a religious requirement."

The first time FGM was discussed was at an international forum in Khartoum, India in 1979. In 1987, in Addis Ababa, Ethiopia, the International African Committee for the Eradication of Harmful Traditional Practices changed the name from female circumcision to genital mutilation.

## Health Effects

Adverse health consequences range from injury of the urethra, bladder infections, hemorrhaging, and trauma from the extreme pain, to long-term psychological scars. Young girls can die of bacterial infection, or simply bleed to death.

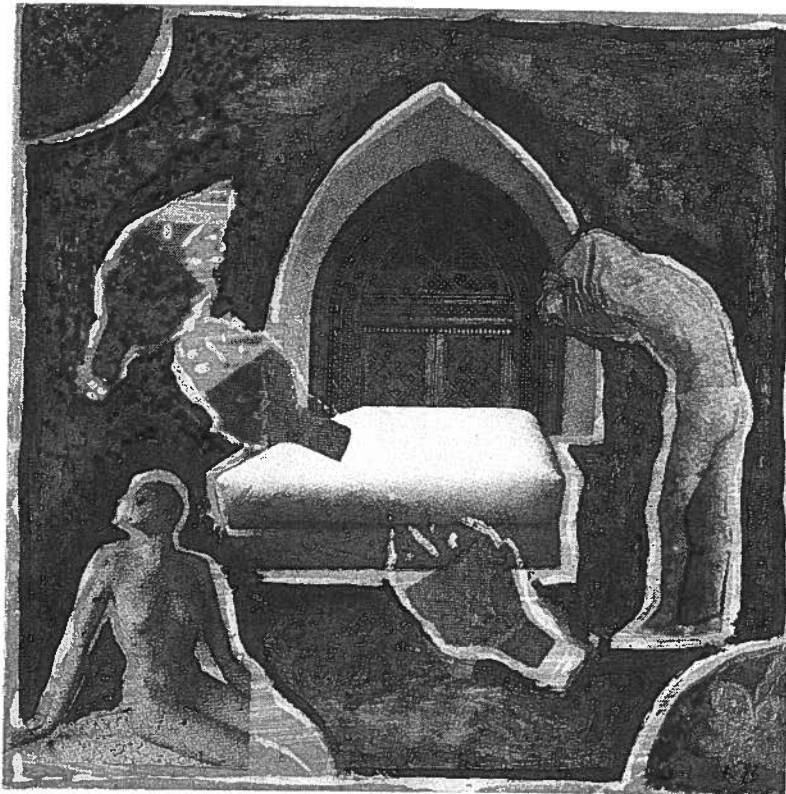
Omer recalls the aftermath of her own infibulation.

"My legs were tied together from my waist to my feet. I stayed bound like that for nearly three weeks so my vulva could heal shut. Urinating was

excruciatingly painful. I had to be turned on my side so the urine could drip out of an opening."

During a girl's first period, blood clots block menstrual flow, causing infection. A keloid scar (a tough, raised scar) can form on the vulva, where cysts as large as a grapefruit are also not uncommon.

The vaginal opening of FGM women remains small until marriage. Omer describes what commonly



occurs on the day before the wedding.

"Women from the groom's family visit and examine the bride. They check to ensure that infibulation has been done and that she is a virgin. The genital area should be smooth as the palm of one's hand. To make intercourse easier, the vulva may be cut open slightly. Otherwise, during the wedding night, the groom widens the opening with his penis which is painful for him as well as for the bride."

This "tailoring" of the vagina to the size of husband's penis is meant to ensure monogamy on the part of the wife. Having too large an opening is grounds for divorce in Somalia.

On the wedding night, a cloth is placed under the bride's genital area. After intercourse, the cloth is displayed to members of the groom's

family as proof of the bride's virginity. If the groom refers to the sexual experience as "falling into a ditch", he may annul the marriage the next day.

## Men's Attitudes

There are conflicting accounts of Somali men's attitudes towards FGM. Although many men dismiss FGM as women's business, they refuse to marry an uncut woman. Fathers have an equally ambiguous outlook.

"My father, like other fathers, pretended to be unaware the procedure was being done to me, although he paid for it. He did not visit me at all while I recuperated," Omer explains.

Virginity and chastity play a significant role in this perpetual practice. An infibulated woman is ensured to be chaste, clean and virginal, and therefore marriageable. Paradoxically, infibulated women can become infertile, and as a result are divorced by their husbands.

The rationales for FGM are as varied as the countries in which it is practiced. They include decreasing the

risk of nymphomania, reducing female sexuality and masturbation, improving cleanliness, increasing fertility, and rendering the genital area smoother, hence more appealing to men. It is also said to remove any obstruction to sexual intercourse, and to increase a man's pleasure by tightening the vagina.

## Childbirth for FGM Survivors

For many women, the greatest price of FGM is paid during childbirth. To make it easier, midwives in Somalia cut the undamaged skin beside the previously stitched vulva area (anterior episiotomy). A lateral incision may be also performed along the sides of

Lori Dell

the perineum (medio-lateral episiotomy). These procedures were developed because Somali midwives found that a damaged perineum caused the loss of bladder control.

After giving birth, the women are stitched up to keep their vaginal opening small. Thus, women who bear numerous children will be cut open and stitched repeatedly.

Because labour and delivery are difficult for an FGM survivor, many women die during childbirth. In addition, babies are often born brain-damaged or dead. The exact cause of the deaths remains unknown, as very little has been documented.

In Somalia, the maternal mortality rate is 1,100 per 100,000 births, compared to a rate of 24 per 100,000 births in industrial countries. In Ethiopia, including Eritrea, where about 90 per cent of the girls are 'circumcised', the mortality rate is 130 per 1,000 live births. In Ghana, where 20 per cent of the girls undergo the procedure, the rate is 86 per 1,000 births.

## FGM in Canada

Is infibulation or other forms of FGM performed here in Canada? Since there are nearly 70,000 Somalis in Canada — 45,000 in Toronto alone — the likelihood exists.

Although the College of Physicians and Surgeons of Ontario banned genital mutilation in 1992, Mohamed says rumours of its continued practice persist. In its March 1992 press release, the college acknowledged that it "had received inquiries from concerned physicians being asked to perform this procedure."

In addition, it has a policy paper which states, "In the event that a physician learns of a person performing female circumcision, excision or infibulation, the matter should immediately be brought to the attention of the college."

Medical professionals and the public alike need to be educated about the plight of FGM survivors. Omer urges health workers to be particularly sensitive to their needs. Intrusive questions such as whether or not orgasms are possible, or requests to display the patient's genital area to another colleague, are highly inappropriate. FGM survivors often experience shame and guilt due to their

mutilated genitalia and would be further traumatized by such behaviour.

Physicians or other health professionals who are not familiar with the subject should do their homework before treating FGM survivors. For instance, when administering a pap test, a physician should not insert a standard speculum as the vaginal opening is too small. A pelvic examination with a standard speculum can be painful for an FGM survivor since their pubic skin lacks elasticity. When an infibulated woman gives birth, many physicians insist on a cesarean section. Omer, an experienced midwife, says an anterior or medio-lateral episiotomy is adequate.

As a counselor at the Toronto Birth Control Venereal Disease Clinic and an anti-FGM advocate, Omer answers inquiries and provides education material on the issue. She also counsels FGM survivors on sexuality, birth control, and birthing.

She says there is a need to establish an informal network of women who have undergone genital mutilation. This way, survivors would be able to share their experiences, lend one another support, and channel information to health workers.

To date, only the City of Toronto Department of Public Health has produced brochures on the issue.

In the past year, Mohamed has been working for Women's Health in Women's Hands, a community-based health centre for women in Toronto, which educates health professionals about FGM. Twelve community volunteers have been trained for this process and the group provides access to over 300 items of resource materials, including slides, books, tapes, articles and flip charts. As well, the Toronto Women's Health Network plans to continue educating health workers and midwives in the coming months.

"Female genital mutilation is criminal. It's a women's rights issue. It's a human rights issue," says Mohamed. "It's torture, and it should stop."

*Virginia Mak is a writer of fiction and non-fiction. Born in Hong Kong, she now makes her home in Toronto. In her spare time, Virginia sings unassumingly in an amateur choir and is a member of Healthsharing's editorial board.*

## Bound by Beauty

Many Westerners are quick to condemn practices such as FGM while ignoring equally questionable customs in their own culture. Women all around the world accept and encourage, pain, sickness and surgery as legitimate sacrifices for "beauty".

Here are just a few examples:

- nose job
- tummy tuck
- tattooed eye make-up
- high heeled shoes
- false nails with corrosive glue
- eye lift
- bulimia
- breast implants
- tight jeans
- face lift
- collagen injection
- face peel
- electrolysis
- hot waxing
- anorexia
- stomach staples
- liposuction
- suntanning

# SELECTIVE *Abortion*

By Ingrid Deringer

**I**n Nazi Germany, state officials worked hard to create a society free of “defectives”: Jews, gays and lesbians, gypsies, and communists. Women with disabilities are drawing chilling parallels between that campaign and present day prenatal screening of fetuses to detect disabilities. Like the victims of the Holocaust, disabled fetuses are regarded as flawed, imperfect versions of humanity, and therefore less deserving of life.

Today, the unquestioned acceptance and celebration of reproductive technologies is reminding many feminist activists of the uncritical embrace of eugenics by scholars, legislators and physicians earlier this century. For women with disabilities, amniocentesis—the process of withdrawing and testing the uterine fluid of a pregnant woman to determine whether the fetus has a disability—is not a routine, benign procedure. Its growing popularity, particularly for older, pregnant women, is contributing to the increasing number of selective abortions with disabled fetuses as the targets.

The DisAbled Women’s Network (DAWN) Canada, an advocacy group, reports that 90 per cent of women who have a fetus that tests positive for a disability choose to abort. There are presently more than 40 disabilities that can be identified prenatally, in-

cluding Down’s syndrome, spina bifida, Huntington’s disease and cystic fibrosis.

The amniocentesis procedure is most often performed at the 16th week of pregnancy to discover a genetic disorder (it can also be used to determine the fetus’s sex). According to statistics, 95 per cent of all amniocentesis tests indicate the fetus does not have a detectable disability.

While amniocentesis was originally used for women deemed to be “at high risk” of carrying a disabled fetus, more physicians are recommending the procedure for women who are “low risk”.

It is seen as a practical payoff: massive prenatal screening is less expensive than paying for the care of disabled people. Supporters say aborting “abnormal” fetuses compensates for the ones that aren’t weeded out by nature through spontaneous abortion. Parents are opting for this testing because it is available and they want a so-called normal child. Because the procedure is expensive, it is proving to be lucrative for the medical establishment.

But it is precisely because of the widespread use of amniocentesis—and the assumption that the detection of a disability would lead to the termination of a pregnancy—that abortion of disabled fetuses is gaining greater acceptance.

DAWN Canada reported to the



Royal Commission on Reproductive Technologies that, "some doctors require women to agree before amniocentesis that they will abort if there is a "defect" in the fetus." The problem is not that prenatal testing exists, but that it exists within a coercive framework. Abortion of disabled fetuses is becoming compulsory.

Even feminists fighting for reproductive rights, perhaps unwittingly, are contributing to the mindset that disabled fetuses should be aborted. When they argue in favour of choice by saying anti-abortionists would force women to give birth to disabled children, they paint the birth of a disabled child as a disaster. This attitude makes many women with disabilities feel uncomfortable with the abortion rights movement.

And while many people consider selective abortion based on the sex of the fetus unacceptable, the same tenet does not hold true when applied to disabilities. Abortion rights should focus on abortion being "safe, legal and funded" and not whether a fetus is disabled or not.

In *Voices from the Shadows: Disabled Women Speak*, one woman poignantly says, "I wonder...if I were born today, would I be given the right to live? That concerns me a lot.

"I wonder when does it stop? Does it stop at the blind, deaf child? Does it stop because a child may limp? Does it stop at minor brain damage? I just wonder where is the cut-off line going to be?"

DAWN Canada says doctors are providing biased information to women with disabled fetuses: they are rarely told about people with disabilities who live full, happy lives.

In their report to the Royal Commission on Reproductive Technologies they stated women needed information that, "gives the facts—not the stereotypes!"

In a Canadian study, young women with disabilities were asked how they felt about selective abortions. Not one said she would never consider abortion, but, most admitted to mixed feelings. They said they wouldn't mind having a disabled child, but they would be terrified for the child's sake. The women said they would want to spare their offspring the problems they had faced.

Issues around selective abortion

have cropped up in surrogacy contracts as well. Surrogate mothers have become more common in the United States and Canada since reproductive technologies have become more accessible. In these contracts, it is often stipulated that the birth mother undergo ultrasound or amniocentesis. If the fetus is found to have a disability, the contract may demand that the surrogate terminate the pregnancy and forego her fee.

*Changing Patterns: Women in Canada*, reports some surrogacy contracts include, "extensive control over diet, lifestyle, and activities," and require a "quality product."

It describes surrogacy as an example of the commercialization of reproductive capacities where "the child becomes a commodity, the recipient parents become the consumers, and the donors and surrogates become the suppliers." When the goods are defective the consumer does not want the product anymore.

In the famous Baby "M" case, the contract between Mary Beth Whitehead and William Stern stated that if the fetus was found to have a disability, Whitehead would be paid \$1,000 if she had an abortion. If she did not, Stern's obligation to her was over.

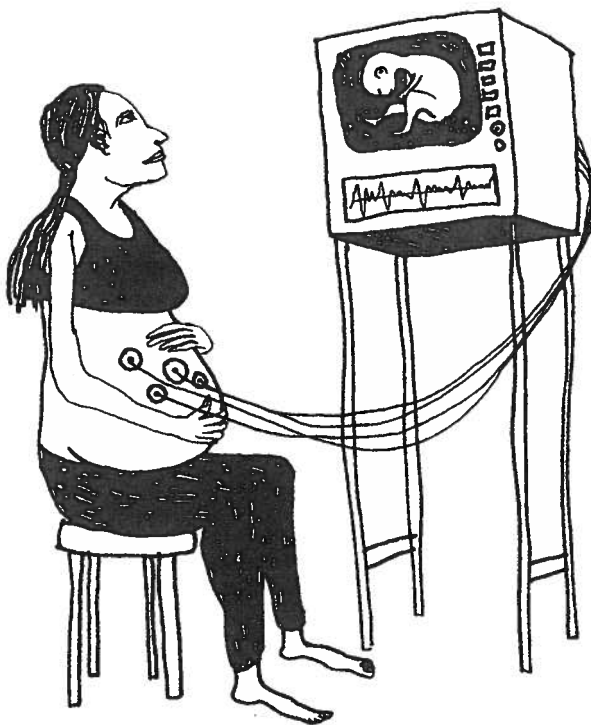
The heavy hand of the law does not stop at surrogacy contracts. Ruth Hubbard, author and legal theorist, says there are cases in the U.S. where, "parents sue physicians claiming that they should have been warned more forcefully about all the available resources for prenatal detection."

She sees a future where, "a child who is born with a health problem that might have been detected and improved prenatally can probably sue the mother if she refused to be tested when pregnant."

Hubbard's prediction may not be as far fetched as it seems. At least one attorney, Margery Shaw, urges courts and legislators to, "take all reasonable steps to insure that fetuses destined to be born alive are not handicapped mentally and physically by the negligent acts or omissions of others.

"Carrying a disabled fetus to term is an example of negligent fetal abuse resulting in an injured child," much the same way as abuse of alcohol or drugs during pregnancy would be.

The possibility of mandatory prenatal screening looms large, suggesting a future where pregnant women could lose a fundamental right—the





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right to refuse medical treatment.

Where eugenics and selective breeding once were perceived as ways of dealing with people with disabilities, the pressure is now on women to selectively abort fetuses with a disability. But advocates of selective abortion cannot meet their goal of a "flawless" society: many inherited disabilities cannot be predicted or prevented. Environmental factors such as exposure to chemicals or radiation, or simple accidents, will not soon vanish. Disability is not something that is going to go away.

With that in mind, a new emphasis should be made on providing services to disabled people so that they may enjoy a life free of discrimination. The goal should be for society to take more responsibility for the welfare of disabled people, and become more informed to see disabilities in a positive light. Until disabilities are accepted, instead of being greeted with fear or misunderstanding, selective abortion will continue to be accepted uncritically.

Many women, myself included, went through a phase in their pregnancy when they feared they would give birth to a disabled child. Most of the fear stems from the fear of having

your child suffer. Another reason for this fear is that mothers are often the sole caretakers of children with disabilities and since there are few resources available to mothers, they become very isolated. In this way the fear of being solely responsible for a disabled person is a valid fear in our society.

Society has shut out the voices of the disabled and has historically kept them behind closed doors. By doing so, society has lost the chance to understand and learn from them. Our exposure to people with disabilities has been so limited that most people only see them as helpless, unhappy and weak. It is becoming evident as disabled people become more visible, that society has a lot to learn from them.

*Ingrid Deringer is a women's health and disability counselor, consultant and educator in Calgary. She became interested in the issue of disability when she developed an illness in 1984. She has since recovered, but devotes her life and work to issues of concern to women, particularly to women with disabilities.*



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## The Price of Drinking: What Every Woman Should Know about Alcohol

by Rosalie Chappell

A 1989 survey by Health and Welfare Canada shows that 70 per cent of Canadian women over age 15 drink alcohol, compared to just 55 per cent in 1979. Although more women are drinking than ever before, men are still the predominant consumers of alcohol and it is generally men who suffer most from alcohol-related illnesses.

However, some experts believe that even small amounts of alcohol can put women's health at risk. They say given the same amount of alcohol, the consequences of drinking are far greater for women. Why this is lies partly in the biological differences between men's and women's bodies, and how each reacts to alcohol.

### Gender Differences in Response to Alcohol

Alcohol is not soluble in fat, and since women usually have a higher ratio of fat to lean muscle tissue, alcohol tends to remain in their bloodstream. In contrast, men generally have more lean tissue than fat in their bodies, and therefore, have more mass in which to distribute the alcohol. This means, given the same amount of alcohol a 115-pound man will have less alcohol in his bloodstream than a 115-pound woman. And the more alcohol in the bloodstream, the more impaired an individual becomes.

The higher the concentration of alcohol in the bloodstream, the stronger the intoxicating effect is for the drinker. Since men have more water in their systems than women, their bodies are more effective at diluting the effects of alcohol. Also, women tend to have smaller blood volumes than men so the concentration of alcohol in their bloodstream will be higher. As a result, women tend to get drunk faster than men on the same amount of alcohol.

While a man's reaction to alcohol remains fairly stable, many women report they respond differently depending on when they drink. Some studies suggest that on a premenstrual day, when estrogen levels drop suddenly, a woman is likely to get the biggest jolt from alcohol than at any other time of her menstrual cycle. The least effect from alcohol is felt during the menstrual flow.

Our bodies recognize alcohol as a toxin that needs to be eliminated. Consequently, the liver begins to metabolize it, or break it down, as soon as it enters the body. Because women metabolize alcohol faster than men, its intoxicating effects are short lived. This may tempt women to drink more. But be careful, because the more alcohol consumed at one time, the harder it is on the liver.

### Physical Risks

It is not just the intoxicating effects of alcohol that differ for men and women; their separate physiologies mean health risks also vary. Some of these potential problems include liver disease, high blood pressure, cancer, osteoporosis, miscarriage, and fetal alcohol effects.

Women who drink heavily are at higher risk for liver disease than men. Liver disease also seems to advance more quickly in women, and according to some reports, this can lead to cirrhosis of the liver (irreversible damage) after as few as two to five drinks a day.

Women are naturally about 25 per cent more likely to have high blood pressure than men. Some reports suggest that as few as three drinks a day can raise a woman's blood pressure, putting her at higher risk for stroke, blindness, kidney disease, and heart attack.

Research also suggests that

alcohol and cancer may be connected. A 1987 study by Schatzkin concludes that drinking up to five grams of alcohol a day increases the risk for breast cancer by 40 to 50 per cent. Another study found that when drinking is combined with smoking tobacco, the chance of developing cancer of the mouth or throat is 15 times greater than with drinking alone.

Women are naturally at a higher risk for osteoporosis than men. Since alcohol interferes with the absorption of calcium in the body, the risk rises with the number of drinks. With age, bones weaken and women become more vulnerable to falls and fractures.

Women have also been warned against drinking during pregnancy altogether because it is still unknown exactly how much alcohol can cause fetal alcohol syndrome in the developing child.

### Prevention Tips

For women who have chosen to drink, it is important to know not only the risks involved, but also how to minimize them. Below are some of the ways to reduce the harmful effects of alcohol. The goal of these suggestions is to lower the concentration of alcohol in the bloodstream and vital tissues. But remember, the only way to fully prevent health problems from alcohol is to stop drinking altogether.

1. Dilute alcoholic drinks with water. The lower the concentration of alcohol in your body, the less damage to vital tissues. But avoid diluting drinks with carbonated mixers such as soda and ginger-ale since these send alcohol into the bloodstream faster.

2. Don't drink water on an empty stomach before drinking

*continued on page 24*



**NATIVE**  
*in*  
*Sexual Abuse*  
*Healing*  
**THERAPIST TRADITIONS**

**By Cyndy Baskin and Charlene Avalos**

**B**ehind any treatment of sexual abuse is a philosophical base which guides the therapy. The Mooka'am program at the Native Child and Family Services of Toronto (N.C.F.S.T.) combines contemporary approaches to healing with Native traditional teachings, beliefs and practices.

The Mooka'am program, named for the Ojibway word meaning new dawn, was established when staff at N.C.F.S.T realized Native survivors of sexual abuse were not making use of mainstream agencies. Cultural differences, a negative history with social workers and a lack of trust in the system combined to make many Native people wary of conventional therapies.

In response to that concern, every attempt has been made to make the Mooka'am program culturally appropriate and sensitive. Current sexual abuse literature and traditional Native healing practices were extensively reviewed when the program was designed. As well, a number of traditional teachers and Elders in Ontario were consulted for guidance, wisdom and direction.

Mooka'am emphasizes traditional values and practices. Clients learn the history of Native people to help build self-esteem and restore lost dignity—key components in healing and ending all forms of abuse.

Similar to contemporary approaches, the Mooka'am program is based on the intimate relationship between client and therapist. However, unlike psychoanalysis, Mooka'am therapists develop a relationship with their clients based on equality, some self-disclosure, and sharing. Healing circles are held every two weeks and conducted by a traditional teacher. In these circles, both therapists and clients share their experiences, pain and desires.

A strong value within Native culture and a central part of Mooka'am's treatment is non-intrusiveness. Therapy is client directed and can be very slow. We allow women and children ample time to deal with the layers of issues they present to us. Although it is sexual abuse that brings women to Mooka'am, it often takes six months to one year to begin work on this issue.

Clients and therapists attend cultural events together such as the sweat lodge and full moon ceremonies. Again, this is part of the cultural undertone to therapy and follows the tradition of Native Elders and teachers by providing guidance and healing to people while living in the same communities.

At Mooka'am there is no florescent lighting, and wall lamps are very dim. Chairs and couches are comfortable and Native art decorates the rooms. Candles are usually lit

and one of the four sacred medicines, tobacco, sage, sweetgrass and cedar is always available for clients to light.

The treatment environment for children is equally important. The playroom is a safe, comfortable space with soft lighting. Toys, such as anatomically-correct Native dolls are used in play therapy. Included in the room is a braid of sweetgrass which, when burned, provides a purifying smoke used in a ceremony called smudging.

One time, a nine-year-old boy who comes from a particularly abusive background, used the sweetgrass ceremony to help him overcome the pain of his abuse. After an intensely violent role play session, he lit the braid of sweetgrass and smudged his toys, the playroom, himself and the therapist. When asked about his actions, the boy explained he needed to clean everything in the room of the evil he had just played out.

The relationship at Mooka'am between the child and the therapist is of primary importance. Developing a trusting relationship is crucial. In many cases, the therapist may be the first safe adult in the child's life. Role modeling is therefore a major aspect of the treatment process. Children need to feel good about themselves, not only as sexual abuse survivors, but as young Native people.

Therapists help the children reach a positive identity so they come to have pride in traditional teachings and culture. There are several ways in which this is achieved. For example, one therapist took some of the children to the Native ballet production of "In the Land of Spirits," which was written by a Native composer and featured several Native dancers. Each summer the children are invited to participate in a camp in Northern Ontario. It is an opportunity for children to spend time with their therapist and other appropriate Native role models, and to participate in spiritual activities. An Elder or traditional teacher educates the children about the values, beliefs and practices central to a traditional way of life. Children also participate in the sweat lodge ceremony which is a ceremony of healing.

The children who come to treatment are often from multiple abuse backgrounds, i.e., sexual abuse is not

the only abuse they have suffered. What tends to happen is that once the child grows to trust the therapist, he or she will disclose other painful events. As therapists, we have come to realize that for the child, the most harmful aspect of his or her life may not be sexual abuse, but rather the on-going problems of alcoholism in the family. If necessary, all these issues must be addressed.

**At Mooka'am there is no florescent lighting, and wall lamps are very dim. Chairs and couches are comfortable and Native art decorates the rooms. Candles are usually lit and one of the four sacred medicines, tobacco, sage, sweetgrass and cedar is always available for clients to light.**

Sexually-abused children are often re-victimized throughout their lives, so the Mooka'am program also includes prevention. To help accomplish this, a poster, that combines both contemporary preventative teachings with Native traditional ones, has been designed to tell children to trust their feelings, to say "no" to a bad touch. It also includes the Native circle of life with four directions, four sacred medicines and four races of people.

Another Native cultural and spiritual component of the Mooka'am program is a healing circle for adolescent girls. Led by a traditional teacher, the girls go through puberty rights, learn about the traditional roles and responsibilities of women in our culture and are taught to respect and care for themselves.

Mooka'am's philosophy of healing

is based on the importance of restoring balance in a holistic manner. Therefore, treatment focuses on healing all parts of the individual—spiritual, psychological, emotional and physical. A holistic approach helps clients understand all elements in the universe are related. Consequently, treatment must not focus solely on the individual but it must include the family, the community and the Native

nations.

Mooka'am gives workshops and presentations on sexual abuse treatment to the various communities.

Although there is no standard indication of success, an attempt to evaluate the program is underway. A Native researcher is conducting a study wherein clients evaluate success for themselves. The process not only helps the therapists understand and evaluate their approach to

treatment, but it is highly therapeutic for clients as it maps out their own healing journeys. This too is in keeping with the Native belief that people learn all their lives, and that healing is a lifetime process.

*Cyndy Baskin is presently completing her Bachelor of Social Work at York University. A Métis from the East Coast, Cyndy has worked at the Native Child and Family Services of Toronto (N.C.F.S.T) for over four years. She recently published her first novel, The Invitation, about children of alcoholics.*

*Charlene Avalos, MSW, has worked at the N.C.F.S.T. for over four years as a family service worker and therapist. She is currently the co-ordinator of the Mooka'am Program.*

**Wise Beyond My Years**

by Anita Sachanska

I was eleven years old when my mother presented me with a pink booklet called "What Every Girl Should Know About Growing Up". It was full of pictures of smiling girls, swimming, dancing, riding horses. It also showed diagrams of our reproductive organs—something that looked like a thick-trunked palm tree. From the booklet I learned that any time now I would become a woman. My periods would begin and I would bleed every month until I was old and then I would stop bleeding.

The time when the bleeding would stop was in the distance, far away in my middle age, long after I would get married and have children; long after I would become a famous poet.

Six years ago on a flight to Toronto from New York City, I experienced flushes during which I felt terribly hot and my face became red. I dismissed it. I always felt uncomfortable on planes. Maybe there was something wrong with the air conditioning?

**I was only thirty-five**

But the hot flushes continued. I took little notice of my periods being irregular, since they always had been. Less than a year later, my periods stopped altogether. I was only thirty-five.

At the result of a blood test, my doctor shook her head at my hormone levels.

"You're too young," she said and sent me to a gynecologist.

The gynecologist gave me another blood test. He too shook his head with disbelief.

"You're very young, but it happens to some women." He returned to the paperwork on his desk.

I heard the hollow sound of doors shutting: the door to the baby nursery I had planned for the middle bedroom since I moved into the house; the door to the closet where I kept boxes

of knitting patterns for baby clothes; and the door to the bedroom I shared with a man 10 years younger than I. He was at the beginning of his life and I was afraid he would see me as someone with shriveled ovaries, at the far side of middle age.

The gynecologist took another blood test. When I returned several weeks later for the results I had some happy news: my period had returned. When I tried to share this good news, he crumpled his brow and shook his head. He said the results remained the same and I couldn't be having a period. Just to be safe, I should consider a D and C (dilation of the cervix and curettage of the uterus), since I could be hemorrhaging from cancer.

I fled to a woman gynecologist for a second opinion. Thus began a series of treatments by doctors and naturopaths, and my concentrated efforts to convince them and myself that I was not going through menopause. I clutched at any straw that presented itself: stress, an underactive thyroid, an underactive pituitary gland, and overwork.

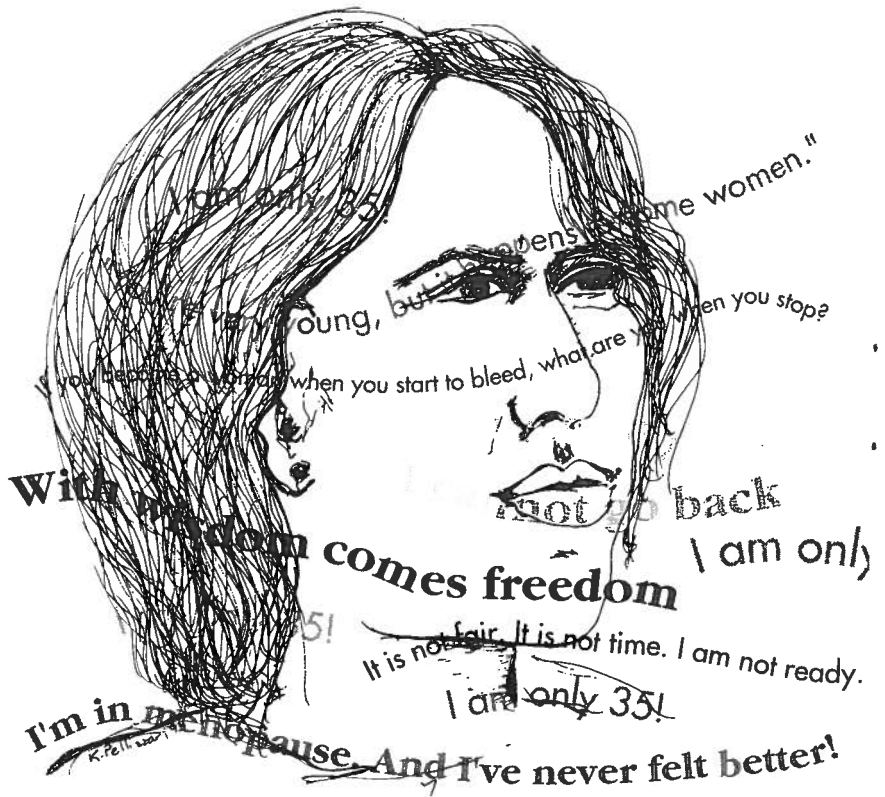
Suddenly there I was, faced with what should be "far away". But there was no pink booklet with smiling older women swimming, dancing and riding horses. It was not fair. It was not time. I was not ready.

At the bottom of it all, hidden in the muck and weeds, was the thought: if you become a woman when you start to bleed, what are you when you stop?

**My greatest acceptance**

Although I've had several light periods since then, I have finally come to accept the truth that I am a 40-year-old menopausal woman. I still have hot flushes, but I keep them under control with herbs. Yes, I'm still with the younger man. We realized that babies would have prevented both of us from pursuing our creative work. But its been through women's writings on menopause and talking about the subject that I have come to my greatest acceptance—menopause is the beginning of an exciting phase of my life.

Jungian analyst Jean Shinoda



Katie Pelizzari

*If you  
become  
a woman  
when  
you start  
to bleed,  
what are you  
when you  
stop?*

Bolen, believes that in ancient cultures both a young girl and her society celebrated her initiation into the time when she was able to give birth, that is, when she bled in rhythm with the moon's cycles. For this, she was regarded as special. The only time she stopped bleeding was during the nine months when it was believed she retained the blood to create babies. Then came the time when she retained the blood permanently to make wisdom.

Through the cycles of menstruation, pregnancy, and menopause, women cannot help but be aware of how their bodies are influenced by the rhythms of the moon and the seasons. As women, we all share these experiences of the body, no matter how different our cultural or individual lives.

We tend to live according to our senses and intuition. Traditionally we are society's nurturers and caregivers. We participate in important life experiences such as nursing the sick, caring for the children, and dealing with the death of loved ones. We learn the father's wisdom.

**Too busy to enjoy the rhythms**  
but with wisdom comes sadness.

When I was younger, I wasted so much of my life feeling uncomfortable with my body. I spent hour upon hour at a ballet barre wrenching my body into positions which I later learned were physically impossible for me. I denied myself food in my desire to become thin beyond my genetic ability. When I failed, I always believed that I lacked self-control. I assumed I could work as much as I wanted. My body would support me without rest just because I willed it.

I only saw my periods as an inconvenience. Now that they are gone, I miss them. I was too busy to enjoy their rhythms. I never stopped and looked at the moon and felt her tug at my body.

A friend said that once she reached her 40s, her periods stopped hurting. No longer distracted by pain, she now has more energy and feels more productive when she is menstruating. Other friends experience an opening to the world around them.

#### **With wisdom comes freedom**

I cannot go back, but I'm going to do things a lot differently in the second half of my life. For with wisdom comes freedom—the freedom to live for today, to be eccentric, creative, innocent and childlike. Ask any woman crawling on the floor with her grandchildren. Just as some babies are thrust out into the world before others, we menopausal "preemies" have been thrust into the next phase of our lives. Spanning two generations of women, we are truly wise beyond our years.

It used to be when other women asked me, "Aren't you planning to have children?" I'd respond, "Not yet...I'm too busy." When my periods stopped, I said, "I have a medical problem. I can't have children." Now I am going to say, "I'm in menopause. And I've never felt better!"

*Anita Sachanska has published short fiction in Acta Victoriana, Feminie, Tyro, and The Dalhousie Review as well as poetry in an anthology edited by George Bowering. She teaches creative writing, feminism and animal rights in Toronto.*

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By Katsi Cook

# MAM others the first environment

*Native Elders know that the body of a pregnant woman changes to accommodate and nurture new life. For them, pregnancy is a re-enactment of the creation of the world. A child's birth changes both the family and the whole community.*

*In pregnancy, our bodies sustain life. At the breast of women, the generations are nourished. In this way, the elders believe the earth is our mother. In this way, we as women are earth. We are the first environment.*

Our Native American traditions tell us that our unborn see through our eyes and hear through our ears. In the dream days just before their births, they learn from our thoughts and our emotions. And now, when they are born, they inherit a body burdened with toxic contaminants.

Where the St. Lawrence River meets the Canadian border at the 45th parallel, the Akwesasne community of 7,000 Mohawk people has drawn its subsistence from the local food chain for centuries. Generations have eaten fish

from the river and birds from its banks.

But the beautiful St. Lawrence River carries with it chemical contaminants, dumped by industries all along the Great Lakes. Indian fishermen feel the effects of these toxins and have long-complained about the depletion of fish and other wildlife.

The Akwesasne Mother's Milk Project, initiated by Mohawk women themselves in 1985, has also been concerned with the problem of toxic contamination of their water, air, soil and food chain by local industries.

Toxic chemicals like PCBs, DDT, mirex, and HCBs dumped by industries into the water and soil move up the food chain—through plants, fish, and wildlife—into our bodies. These contaminants resist being broken down by the body, and are stored in our fat cells where they collect and become more dangerous as time passes.

The only known way to excrete large amounts of toxins is through pregnancy, when they cross the placenta and contaminate the fetus and

during lactation, when they move out of storage and flow into breastmilk. This means each succeeding generation inherits an increasing amount of toxins from their mothers.

The Akwesasne Mother's Milk Project was created because Mohawk women were worried about the reproductive health effects of toxic contaminants, including high miscarriage rates and birth defects. Our aim is to give momentum to the search for answers about the effects of toxic exposure in our drinking water, and to learn its full impact on reproductive and family health. Since Akwesasne borders the U.S. and Canada, we have been appealing to governments in both countries to restrict dumping by local industries.

The project also conducts community-based research that focuses on the analysis of organochlorines in mothers milk, fetal cord blood, and maternal and infant urine. To date, over 100 Mohawk women have served as participants in the study, which is funded by the state of New York and State University of New York (SUNY), Albany. So far, the Canadian government has not provided any funding.

Principle investigator of the study, Ed Fitzgerald, is an epidemiologist with the N.Y. state's Department of Health and an assistant professor at the School of Public Health at SUNY, Albany. Brian Bush, another faculty member at the school, and analytical chemist for the mother's milk study, examines different forms of PCB compounds for the health department's Wadsworth labs.

The Akwesasne Mother's Milk Project works in unison with the Akwesasne Task Force on the Environment, which is made up of tribal and Mohawk Council officials, members of the traditional longhouse, and concerned community individuals. Its aim is to strengthen community efforts in response to environmental issues.

The project is working with the St. Regis Mohawk Tribe Environment Division. It began in response to the August 1990, U.S. Environmental Protection Agency (EPA) guidance document designed for "typical" industrial sites. This document states that soil with 500 ppm (parts per million) of toxins is acceptable, despite

N.Y. state's policy that 50 ppm is considered toxic waste. This is an indication of how good the industry lobbyists are in Washington.

One site of great concern is a landfill made by General Motors on the New York side of the reservation. Researchers say this dump is contributing to the high levels of toxicity found on Cornwall Island, Ontario.

Chemicals of concern at the GM site include PCBs, such as phenols, and volatile organic compounds. In 1983, the EPA placed the site on the U.S National Priorities List of the most hazardous waste sites in the United States. That same year, the company was fined \$500,000 by the EPA for violations of federal environmental laws.

The U.S. Food and Drug Administration sets a limit of two ppm of PCBs in fish and a limit of three ppm of PCBs in poultry. Samples taken near the GM site included three ppm in a lake sturgeon, 318 ppm in a mallard duck and 11,000 ppm in a small rodent.

So far, the Akwesasne Mother's Milk Project has created a Native American presence in the environmental movement and has trained women in health research. There is much more to be done. Canadian initiatives are needed, and stricter regulations on both sides of the border are imperative. But the environmental work being done at Akwesasne is a big jump ahead.

The next phase is to include men in the study, especially since they tend to eat more fish at Akwesasne. We are really only getting half the picture by concentrating on women and children alone. In order to see the full effects of toxic contamination we must examine the entire food chain.

The Mother's Milk Project provides a good example of how a community can respond when there is an environmental need—something communities around the globe will have to face more and more.

*Katsi Cook is a Mohawk midwife and childbirth educator. She is the Project Director of the Akwesasne Mother's Milk Project.*

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## healthwise

Continued from page 17

alcohol. Although diluted drinks will slow the rate of intoxication, adding alcohol to only water in the stomach will speed up its absorption into the bloodstream. The result will be quicker intoxication.

3. Eat before or while you drink. Food in the stomach slows the absorption of alcohol into the bloodstream, and in turn, the rate of

intoxication. Also, the more food in your stomach, the less likely that alcohol will irritate and damage your stomach and intestinal linings.

4. Keep track of what and how much you drink. One standard drink is equivalent to 12 oz. of beer (at 4.2 per cent alcohol), 4 oz. wine (at 12 per cent alcohol), and 1.25 oz. of liquor (such as whisky, vodka or rum at 40 per cent alcohol). It is a myth that beer and wine contain less alcohol than liquor—each of these standard drinks all have the same

alcohol content.

5. Learn how to calculate the amount of time you need to metabolize drinks. The liver can metabolize about one half to two-thirds of a standard drink every hour. If you drink at the same rate the liver metabolizes, the amount of alcohol in the bloodstream will be minimal. Gulping down several drinks over a short period of time will raise your blood alcohol content, and hence the degree of drunkenness.

6. Beware of weight loss! Adjust how much you drink accordingly. The effect of alcohol is directly related to body weight, so the lighter you are, the faster you'll get drunk. Don't combine a low-carbohydrate diet, and physical exercise with alcohol, since all of these can lower your blood sugar levels. The result may resemble drunkenness, such as dizziness and poor coordination, however these are actually symptoms of hypoglycemia.

7. Be aware of your menstrual cycle. You may want to keep a record of when you're more sensitive to alcohol, and avoid or curb drinking during these times.

8. If you are pregnant or nursing, don't drink. There is still considerable debate about how much alcohol can damage the fetus or newborn, it is probably safest for pregnant or nursing mothers to avoid drinking entirely.

9. Do not drink before exercising. The body requires extra energy to metabolize alcohol and, therefore, depletes the energy reserves needed for exercise. Alcohol also reduces muscle strength, and interferes with the body's ability to process oxygen and regulate body temperature.

10. Avoid drinking while on medication and other drugs. Alcohol can have an unpredictable and possibly lethal effect when combined with other drugs. Many depressant drugs, such as barbiturates and minor tranquilizers, can exaggerate its effects.

*Rosalie Chappell teaches social work at the University-College of the Fraser Valley in B.C. She has worked as an alcohol and drug counselor for the Alberta Alcohol and Drug Abuse Commission and for Perspectives Substance Abuse Services in B.C.*

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Salaries are modest but cover overseas living costs. To apply, send your resume, outlining your qualifications, to: CUSO FH-7, 135 Rideau Street, Ottawa, Ontario K1N 9K7.



## Looking Good

Marion Crook, (NC Press Ltd.),  
Toronto, 1992, \$12.95, 108 pp.

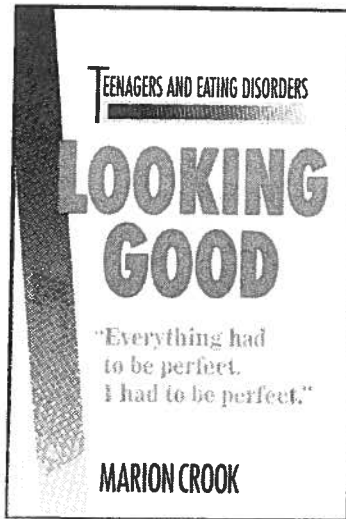
Reviewed by Karen Hill

Eating disorders among girls and young women are so common these days they have almost become a rite of passage. Grapefruit diets, manic exercise or outright starvation—behaviours that are clearly unhealthy—have taken on the sheen of normalcy. After all, if so many are doing it, can it really be wrong?

*Looking Good* delves into the minds of 22 young women and girls to try and get a sense of why they are starving themselves. This is a book for people who are struggling with an eating disorder, and it gives them the tools to stop their self-destructive behaviour.

The author, Marion Crook, clearly finds it painful to interview the bright female adolescents and adults who have shared their stories with her. The portrait she paints depicts the slow, senseless, and deliberate wasting away of these hunger strikers. Their unattainable goal of "perfection" demands these young women put their lives on hold. What comes through as each tells her tale is haunting self-loathing and shame. The women stopped eating as a way to control their lives, only for it to become yet another reason to feel inadequate.

*Looking Good* examines the forces that drive young women



to this very symbolic act of rebellion: family life, societal pressure and weight prejudice. The mainstream ideal of feminine beauty is dissected and exposed, and it is all done in an accessible manner, without the ideology and buzzwords that often turn young women off.

The concepts of patriarchy, capitalism and sexism are discussed, but not named as such. The book is soft-peddled feminism: more concerned with helping the reader than indoctrinating her. Considering the high number of young women who are eager to profess their support for "equal rights for women," but resist the term feminism, it is perhaps a wise choice.

A discussion rooted in family systems theory would be a useful addition to this book. Helping adolescents understand that their behaviour is not only

a symptom of a sick society but also of an unhealthy family is critical for insight into bulimia and anorexia. The quest for perfection may be a young woman's way of trying to hold her family together.

A critical component that is missing from *Looking Good* is an examination of the role sexual abuse plays in the development of eating disorders. Crook states that 11 of the interviewees said they had experienced sexual abuse. That is 50 per cent of her sample group who remember and know they are survivors. With all of the work that has been done by feminist activists and clinicians, it is likely the statistics for the group are even higher.

But Crook backs away from the subject, perhaps feeling that she does not have the necessary expertise to deal with it. She states that she is unwilling to draw a direct, causal link between the abuse and subsequent eating disorders. However, she does encourage survivors to deal with their past abuse in order to heal their eating disorder.

*Looking Good* succeeds as a primer for young women who are struggling with an extremely isolating problem. By concluding with a chapter of advice from those who have trod this path of self-denial, Crook manages to dispel the sense of freakishness that sufferers often feel. Although it is tough to put the book down and not despair over the terrible suffering of young women due to self-imposed famine.

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## **Menopause**

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The Regional Women's Health Centre of Women's College Hospital has produced a booklet on menopause. The booklet describes the hormonal and biological changes that occur and the options that are available to women to help them cope with the changes associated with menopause. The booklet is available in English, Spanish, Portuguese, Chinese, and Greek. It will also be available in Farsi in the near future. The cost of each booklet is \$2.00 (translation, production and postage included). To order or receive more information write to Regional Women's Health Centre, Menopause Booklets, 790 Bay Street, 8th Floor, Toronto, ON M5G 1N9; or phone Gail Weber at (416) 586-0211.

## **Post Partum Stress Program**

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Women's Health Clinic in Winnipeg offers support for mothers of babies or children under three years of age. You can call the Mother's First Help Line at (204) 947-3472 to talk to someone who understands from her own experience what you are going through. Individual counseling is also available for women who prefer to talk to the same counselor on a regular basis. Contact Mother's First, Women's Health Clinic, Third Floor, 419 Graham Ave., Winnipeg, MB., R3C 0M3 or call the above number for more information.

## **Getting Beyond Weight**

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As the majority of women today find themselves preoccupied with weight and dieting, the Women's Health Clinic is pleased to be offering Weight Preoccupation Workshops. These two-hour sessions are open to all women and are free of charge. The workshops explore body image and self-image, the connection between weight preoccupation and eating disorders, and more. This is not a dieting group. Sessions are every third Thursday of each

month, the next session is March 25, 1993, 7:00-9:00 PM at Women's Health Clinic, Room 202, 419 Graham Ave., Winnipeg, MB., R3C 0M3. Phone (204) 947-1517 for more information.

## **Sorrow & Strength: The Process**

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Learning Networks (formerly Creating Connections) presents Sorrow & Strength: The Process. The third annual conference about childhood sexual abuse for adult survivors, professional helpers, teachers, and other support people, April 28, 29, 30 and May 1, 1993 in Winnipeg, Manitoba. For more information contact Learning Networks, 160 Garfield St.S., Winnipeg, MB., R3G 2L8, (204) 786-1971.

## **Recreating a Breastfeeding Culture**

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The third annual breastfeeding seminar, Making Breastfeeding the Norm, will be held in Toronto, Thursday, June 3, 1993. Sponsored by La Leche League, INFACT Canada, Women's College Hospital and Humber College. For more information, please call (416) 595-9819.

## **Health-O-Rama '93**

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Health-O-Rama '93: Full Spectrum Health, sponsored by the EDTA Chelation Association of British Columbia, will be held August 14th and 15th, 1993 at the Hyatt Regency Hotel, Vancouver, BC. Exhibits will open from 1:00-7:00 pm daily. For further information please contact Nancy Ostrander, Show Manager, Health-O-Rama '93, 100 - 1093 West Broadway, Vancouver, BC, V6H 1E2. Phone (604) 731-4569 or Fax (604) 734-6909.

## **Health Issues Congress**

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International Council on Women's Health Issues presents the 1993 North American Congress on Women's Health Issues to be held in Toronto, ON, October 7-9, 1993. The theme is

Women's Health: Building Alliances for the 21st Century. For further information about the Congress, please contact Rita Schreiber, 10 Badgerow Ave., Toronto, ON, M4M 1V1, (416) 466-8014, or, Dr. Jeannette L. Sasmor, P.O. Box 1630, Sedona, AZ, 86336 USA, (602) 284-9897.

## **Sexual Health Resources**

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Two new educational pamphlets are available from Planned Parenthood of Toronto: The Morning After Pill (MAP) and Acquaintance Assault. The MAP provides clear and concise information on how and when to use the Morning After Pill and outlines its effectiveness in preventing pregnancy. The pamphlet on acquaintance assault is geared toward teenagers. It provides the reader with information about legal, medical and counseling services in Metropolitan Toronto, and identifies the many forms of and explains what constitutes acquaintance assault. To order these or other Planned Parenthood sexual health education resources write Planned Parenthood of Toronto, 36B Prince Arthur Ave., Toronto, ON, M5R 1A9, phone (416) 961-0113, or fax (416) 961-2512.

## **Taking Charge**

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The Mount Sinai Hospital Auxiliary's Fifth Symposium on Women and Health entitled Taking Charge: Cancer in the 90s and Beyond will take place on Wednesday, April 28, 1993 from 8:45 am to 3 pm. It will be held in the auditorium at Ontario Institute for Studies in Education (OISE), 252 Bloor St.W., Toronto, ON. Speakers representing the patient, the health care team and government will provide information aimed at helping cancer patients and their families take charge of their situations. Cost of the event is \$20. For further information, please call (416) 586-8290.

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