Connexions

Winter 1987 #25 An International Women's Quarterly

The Politics of HEALTH

Woman pour water, Niger, Ruth Massey/UNI

Upstream/Canada

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Statement

Connexions is the collective product of feminists of diverse nationalities and political perspectives committed to contributing to an international women's movement.

We want to go beyond merely providing facts and information, and hope that by passing on—as directly as possible—women's writing generally unavailable in the US, we will be helping women here to understand and connect with the experiences and viewpoints of women in other parts of the world. We also want to contribute to the growth of a worldwide network connecting women working on similar projects by researching, establishing contacts and exchanging information with other women's organizations.

To a large extent, the economic and political conditions under which we live determine the issues to which we give priority. Women do not live in a vacuum, but in what is still largely a man's world. It is essential for us to understand the working of that world if we are to understand each other. We hope that *Connexions* will be one step toward building an international women's movement.

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The Politics of HEALTH

Who is concerned with women's health? Those who have power over women's health issues often show little concern. Because females are in many societies less valued than males, a plethora of health problems arise. One of the most blatant examples is the abuse of amniocentesis in India. A recent Indian report states that 7,999 of 8,000 fetuses aborted after amniocentesis were female. Another example is the forced sterilization of mentally disabled women in West Germany. Such practices as these shatter the common myth of the neutrality of science and technology.

Pressure to conform to certain standards of beauty—beauty being one of the chief societal measures of a woman's worth—can incite women to do great harm to their health. Black women in Senegal, living under the colonial legacy that light-skinned women are the most desirable, use dangerous compounds to depigment their skin. Fat women are urged to become thin by surgical and other means that can damage them permanently. Women working to counter this destructive situation urge that it is *society* that needs changing, not women's bodies.

Women's health is often endangered by something more fundamental than the demands of beauty. Work—both the quantity and the conditions under which it is done—can wreak havoc on a woman's well-being. For example, in India, women do most of the cooking. A lot of cooking in rural areas is done over a wood or dung fire, often in unventilated structures. The woman cook continually breathes smoke, which contains large quantities of pollutants. Respiratory diseases are a leading cause of death among girls and women over the age of five in India; smoke inhalation is thought to be a major factor.

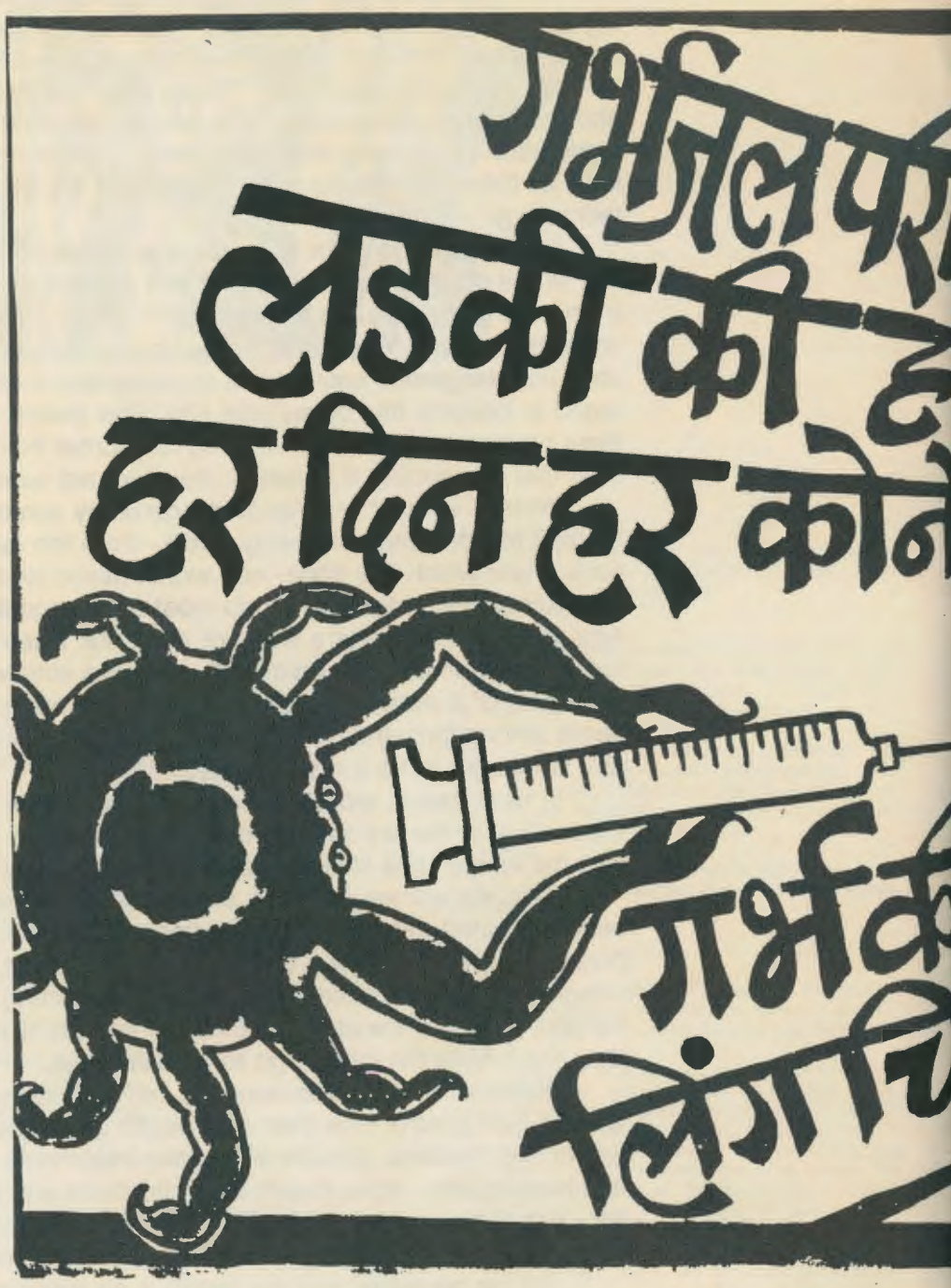
In rural Kenya, women must walk many miles each day to collect water. During the dry season, collecting water can be so time consuming that the woman has little time or energy left for her other duties.

Refugee women, who are already under tremendous strain from being uprooted, often face special health problems as pregnancy and breast-feeding exacerbate their malnourished state. Also, because refugee women are often responsible for collecting fuel and water and for taking care of the children, they are the last to receive health care—they don't have the time to go to a health clinic.

Women's health collectives and self-help projects are helping women gain control over their own health and bodies. They emphasize preventive medicine, provide alternative treatments such as acupuncture and homeopathy, make health care affordable and available, and provide information on contraception and abortion. These groups are committed to creating an accessible network of health resources for women.

Valuing ourselves and our health is an important part of change and of healing. But women also need to regain the power to make decisions regarding individual and collective women's health issues. In societies "where looks and sexuality are used to control women, we need to question all physical *and behavioral* norms imposed on us." Marching against restrictions on reproductive rights, denouncing societal standards of beauty and health, disseminating improved wood burning stoves in India—all are examples of efforts to put women's health and control over our bodies back into the hands of women. □

Eliminate Inequality,



(By Vibhuti Patel, Women's Centre, Bombay, India.)

Amniocentesis is a scientific technique that was intended to be used in detecting genetic abnormalities of a foetus. In India, it is currently being widely used as a means for sex-determination. By comparison to other countries, amniocentesis is quite inexpensive in India. Hence, not only upper class women, but even working class women have access to the test. A recent survey of the slums in Bombay revealed that when women found out their foetus was female, many chose to abort. Many argued that it was better to spend a bit of money now for an abortion than to have to pay a fortune for a girl's future marriage.

The controversy began a few years ago when the results of several investigative reports were published in popular Indian magazines and journals. Many of the results were horrifying. Of 8,000 abortions following amniocentesis, 7,999 were found to involve female foetuses. In addition, between the years 1978 and 1983, it is estimated that 78,000 female foetuses were aborted after sex-determination tests in India.

The government and private practitioners involved in this lucrative trade justify the sex-determination test as a measure for population control. Women have always been the ones burdened with the effects of family planning policies. Harmful effects of pregnancy tests, contraceptive pills, anti-pregnancy injections, and unhygienic camps for mass sterilisation of women are just a few of the drawbacks often overlooked by enthusiasts of family planning policy.

India has a history of killing female children (dudhapiti) by putting opium on the mother's nipple, by putting the afterbirth over the child's face, and by ill-treating its daughters. Even today, female members of the family get inferior treatment as far as food, medication, and education is concerned. When a girl grows up, she is further harassed about her dowry. Many social scientists ask whether or not it is better to die rather than be ill-treated. In the words of Dharam Kumar, "Does the birth of...millions of unwanted girls improve the status of women?" To think that it is better to kill a female child or foetus than to have a child whose sex is not highly valued in society is fatalistic. Next, people will rationalize that it is better to kill the poor rather than let them suffer poverty and deprivation! How horrifying!

But what can be the long-term implications if such trends continue? Won't it further aggravate the already disturbed sex-ratio? There was a large and steady decline in the female/male ratio in India between 1901 and 1971. Between 1971 and 1981, there was a marginal increase in the ratio, although women are still outnumbered by men. [India is one of the few countries in the world where the female-to-male ratio is declining.] Economists often say that if the supply of women is reduced, women's status will be enhanced. According to this logic, women won't be burnt alive because of insufficient dowry—because they won't be an easily replaceable commodity. But the economists forget the socio-cultural milieu in which women have to live. A society that treats women as mere sex objects will not treat women in a more humane way just because they are in scarce supply. On the contrary, in many local communities, there is a negative correlation between the female/male sex ratio and the incidence of rape, abduction,

Not Women

Women's Centre/Bombay, India

"Don't kill your daughter after sex-determination tests."

"Stop sex-determination tests of fetus in the womb."

and forced polyandry.

Another argument in favor of sex-determination tests is one which touts the myth of the ideal "balanced family." It is argued that women who have one or more daughters should be allowed to abort their daughters and try again to produce a son. This concept of "balanced family" is extremely sexist and very frightening. Would a couple with one or more sons undergo amniocentesis to get rid of a male foetus, just so that they could have a daughter in order to balance their family? No, never!

Time and again it is stated that women themselves enthusiastically go for the test out of their own free will. "It is a question of a woman's choice." But, are these choices made in a social vacuum? Indian women are socially conditioned to believe that unless they produce one or more male children, they have no social worth. They are harassed, taunted, and even deserted by their husbands and in-laws if they fail to produce a male child. Thus, their 'choices' are limited by their fear of ridicule by society. It is true that feminists all over the world have demanded the right of women to control their own bodies and choose whether or not to have children. They have also fought for free, legal and safe abortions. But these issues should be viewed in a different context in Third World societies because imperialism and racism are often major forces working to control coloured populations. Population control advocates often endorse women's rights and then divert attention from the real causes of the population problem: the lack of food, economic security, clean drinking water and safe clinical facilities. These factors have created a situation where women must have between two and six children in order to have at least one surviving male child. This is the root of the population problem.

Abuse of amniocentesis shatters the myth of the neutrality of science and technology. Just as the invention of atomic energy was used to destroy Hiroshima and Nagasaki, so could sex-determination tests be used for female extermination.

We at the Women's Centre are undertaking educational campaigns to help combat this problem. Most women's groups feel that amniocentesis should be permitted only under strict governmental control and only for the detection of genetic abnormalities. To consistently campaign against the notorious activities of money-minded doctors and the antipathy of the government, the Forum Against Sex-Determination and Sex Preselection was formed in Bombay in 1986. As a result, the issue has gained nationwide publicity and the government has begun to respond favourably. In March 1987, a committee was appointed to study the proposal to stop the misuse of sex-determination tests. We are hopeful that the government will help to prevent the situation from leading to further female extermination. □

Contact:

• Women's Centre, 104B Sunrise Apt., Above Canary Bank, Nehru Road, Vakola, Santacruz (East), Bombay 400 055, India.

Further Reading:

• "Action Against Sex-Determination and Sex Preselection," *Womennews, newsletter of the women's centre, Bombay, India, August 1987.*

Robbed of Colour

(From "Robbed of Colour," by Sarojini Ariyanayagam in *Spare Rib,* British feminist monthly, #173 December 1986.)

As a Black person, the last thing I would want is to turn white. Yet this is precisely what is happening to me. I am a 33-year-old Tamil woman from Sri Lanka. I am very dark-skinned. At the age of 17, I developed vitiligo, a condition in which cells in the skin stop producing pigment. An estimated 50 million people throughout the world have this condition, yet most people have never heard of it. This is probably related to the fact that, although vitiligo can strike anyone regardless of colour, it is Black people in particular who bear the brunt of its traumatic psychological effects. For sixteen years, I have been waging a battle against a process which is gradually robbing me of my colour and my identity.

When the first white patch appeared above my eye, I assumed it could be treated by a doctor. But the dermatologist diagnosed it as vitiligo, informed me there was no cure, and then dismissed it as a condition I'd "have to learn to live with." I was heart-broken. Every new spot that appeared on my neck, face and arms just increased my anxiety. By 1985, I had lost 80 percent of my pigment. Can you imagine the trauma of this happening to you? Imagine how a white person would feel if she suffered from a hormonal condition and her skin gradually turned black?

Perhaps at this point, I should tell you about the nature of vitiligo. It can affect anyone, at any age. It may be triggered off by emotional stress or physical injury. According to one theory, the body develops antibodies to melanin, the pigment in skin. Common sites of vitiligo are the face, genital areas, hands and hair. It is not infectious and often appears symmetrically. It is generally a progressive condition, although in some cases patches remain the same for years or spontaneously re-pigment. Vitiligo affects 1-2% of any population. Dark-skinned people in the Third World suffer the most from the consequences of this condition since the loss of pigment makes one more susceptible to skin cancer. On the whole, however, still little is known about vitiligo. A parallel can be drawn between vitiligo and sickle cell anaemia: as they both particularly affect Black people, the resources for research into those conditions is not readily available.

As with other skin conditions, like eczema and psoriasis, one of the main conventional treatments for vitiligo is steroid ointments. However, these should only be used for short periods of time as they thin the skin. The alternative is psoralen tablets combined with ultraviolet light (PUVA). This drug makes you very sensitive to the ultraviolet light for a number of hours and can have unpleasant side-effects. Furthermore, prolonged exposure to UV light can cause skin cancer. PUVA is also used for psoriasis. Both these treatments have a very limited success rate and in some cases can aggravate the condition. In Africa and Asia, herbal treatments are commonly used with some success.

In my case, my mother couldn't handle what was happening to my skin; she confused vitiligo with leprosy; so I had to cope with an incurable and rapidly disfiguring condition on my own. At that point, I went into a depression that lasted until my late twenties. I would always wear long-sleeved clothes, and try to cover up my neck. When I saw myself in photographs, I realised that I was "deforming" my shoulder in order to hide my neck. I felt myself changing into a shy, overly sensitive and defensive person. Looking back, I wish someone had encouraged me to get the emotional support and help I needed.

Having tried all the standard treatments various doctors had to offer, I started the rounds of "alternative therapies." I spent a lot of money paying for treatments. After eighteen months, I realised that I wasn't getting anywhere. Recently, however, I've gained some hope. I just returned from Cuba where I was treated by Dr. Cao—he believes that vitiligo is a psychosomatic disorder; however, the physiological consequences are not fully understood. His treatment is based on an extract from the placenta called melagenina. The lotion is rubbed into the skin twice a day, and applied under infra-red lights once a day for 15 minutes. The protein helps speed up the oxidation process in the chemical pathway of melanin production, thus stimulating melanin synthesis and multiplication of melanocytes.

After three months of treatment, my condition improved remarkably. It is hard to believe that only a year ago I had almost given up hope. The effort involved in "making up" for the outside world and trying to look "normal," had exhausted me. It was a lonely struggle, and I was too ashamed to talk about it. I helped to organize the Vitiligo Group because I needed to talk with people whose condition was similar to my own. For most of us in the group, it was the first time we'd met anyone else with vitiligo. We found we were all saying the same things and facing similar frustrations. The silence and pretence was over. Being together, we could take some positive action, and begin research into all aspects of the condition. Meeting in this group has changed our lives.

We are now a national charity of 400 members, including a medical and research team. At least 75% of our members are women even though vitiligo affects both sexes equally. The conditioning we've received as women about the importance of our appearance makes us react to vitiligo differently than men. Everywhere

Ingrid Pollard/Spare Rib

we look, we are presented with images of the model woman, no blemishes, perfect skin, beautiful looks, and almost habitually we adapt to the social norm. Women in the group take "naturally" to camouflaging their "disfigurement," dying their hair. Women with vitiligo often feel very desperate about sexual rejection. A couple of women even tried having their white patches painfully tattooed.

While I was in Havana for three months, I met many other vitiligo sufferers from Venezuela, Mexico and Brazil. Some had already started re-pigmenting which was very encouraging to me. Dr. Cao advised me to give up camouflage make-up in order to keep my skin clean for treatment. I hadn't done that for 15 years! It was wonderful to be accepted as I am. Unlike in this country, people in Cuba didn't stare at me because of my disfigurement. In that society, you're not a freak for looking different. You're accepted for who you are. I was very lucky to receive the treatment free as a reward for my work with the Vitiligo Group.

I have a tremendous amount of hope and believe that there *is* a potential in melagenina for curing vitiligo. With further research and expertise, its effectiveness could be increased and it could be made to work faster. A dermatologist from England has decided to visit Dr. Cao in Cuba to study the progress of his patients and his methods of research. Hopefully, it won't be long before British vitiligo sufferers will have access to the sort of treatment available in Cuba. □

Further Reading:

• Vitiligo and Other Hypomelanoses of the Hair and Skin, *By Jean-Paul Ortonne, Plenum Medical Book Co., New York, 1983.*

Change the Mentality, Not the Skin Color

Senegal

(Translated from *Fippu,* Senegalese feminist trimestrial, no.1 July 1987.)

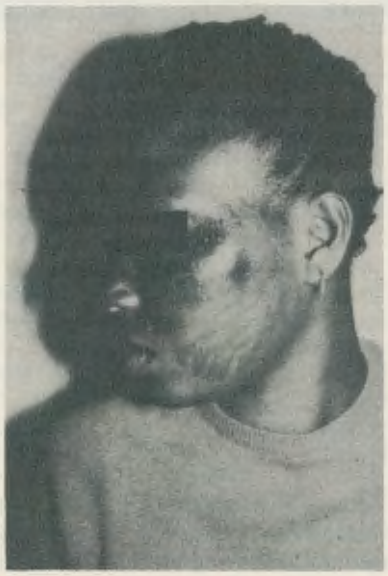
In the 1970s, skin-lightening in Senegal was the cause of much debate, and a source of embarrassment for many. However, now that "Black is Beautiful" has long since ceased to be a rallying cry for the world's blacks, skin-lightening is once again in fashion. Beauty and medical experts alike tell of the wonders of skin lightening, promising a better love life and improved self-esteem. This advice is given much to the dismay of those in the women's and social service communities, who are concerned that these experts never mention the dark scars and blemishes that mar the skin after these often toxic products are applied. They speak only of the glamor of having clear, even-toned skin, not of the mercury poisoning, lupus and blood disease. These are only some of the many ailments that often afflict those who choose to chemically lighten the color of their skin.

Skin is composed of two layers: the dermis and the epidermis. The epidermis, which contains an immense network of nerve endings, is the outer layer which protects the sensitive dermis underneath from extremes of temperature and from the sun's harmful rays. With only basic care, the skin can retain its protective and elastic qualities for years.

The products used for skin lightening, however, break down the skin's natural protective barriers. Skin lighteners contain mercury salts, peroxides, and other ingredients which are unspecified. Some methods involve cortisone injections or topical applications. All of the compounds are dangerous, particularly those whose chemical compounds are not completely known. Treatment of the disorders resulting from the use of these compounds must be given under strict medical guidelines, which is often painful and costly. This is because the products used for treatment in Senegal are either in pommade form (cream), or in solid or liquid soaps, where the methods of application and use can vary greatly from one woman to the next.

Skin lightening is usually done in three steps. First, the product (or products) must be applied and allowed to remain on the skin all night long to facilitate the depigmentation process. The epidermis must be modified in order for depigmentation to begin. Next, on the following day, an even stronger combination of products is applied. The length of time the products remain on the skin depends upon the desired effect. The final step involves the maintenance of the depigmentation process. Creams are not usually used at this stage, since maintenance is achieved by the use of various soaps and skin cleansing products.

Accidents which result from the use of these products abound, in spite of the fact that beauty experts insist that skin-lightening is just another "beauty treatment." In Dakar, Senegal's capital, these accidents account for 1% to 2% of all dermatological consultations. They include toxic reactions to the products, damage to blood vessels and the entire circulatory system, with injuries to one or more major organs such as the heart, liver or kidneys, and to diseases of the veins from the prolonged use of mercury salts, which can bring about many types of neurological disorders. Not to mention what can happen during treatment of these maladies: there is always the risk of serious post-operative infection.



Ball/Fippu

Yet skin-lightening continues to be widely practiced in Senegal. Why? Some apparently feel that beauty is worth achieving at any cost, and to them, ebony-colored skin is not beautiful. Even though some men are now using the skin-lightening products, the majority of the users are women, from all age groups and social backgrounds.

Khady, a 22-year-old Senegalese woman, tells us why she took the risk and lightened her skin:

"...women with clear, light skin have more sex-appeal than others: we notice them more! In fact, I began the skin-lightening process because I know some women who, having naturally dark skin, weren't beautiful, but who became very seductive from using the products."

Many Senegalese women like Khady feel pressured to lighten their skin so they will be more attractive to their mates. A large percentage of women who use the products, in fact, are women whose husbands have brought the skin-lightening techniques home for them to use. Women in Senegal are still valued more for their ability to attract men and bear children than for their other qualities.

Men such as Lamine, age 40, make dark-skinned women feel inferior and unattractive. Lamine, an intellectual, has a dark-skinned wife, but he doesn't miss any opportunity to tell either his wife or his friends that he has a firm intention of marrying a second time, and this time, a light-skinned one!

"I prefer light-skinned women, and that's that!" he says.

While some may prefer light skin and extol the virtues of skin-lightening products, the women's community will continue to speak out against the practice. They say it is threatening to the Black race itself and an embarrassment to the country whose former president, Leopold Senghor, was one of the founders of the Negritude [Blackness] movement. Skin lightening, as Marietou, age 45, says:

"...is sad for a country that has always been on the cutting edge of the war for the revitilization of the black race...and the degree of skin lightening coincides with the degree of alienation: the more light-skinned you are, the more you are considered as an object to covet! We must enlighten the women as well as the men and reverse the canons of beauty...Me, I am black and fit quite well in my skin..."

Marietou's advice to the women of Senegal? "Changer de mentalité et non pas de teint" (Change the mentality, not the skin color). □

Contact:

• Fippu, a Senegalese feminist trimestrial, *B.P. 4163, Dakar, Senegal.*

Fat Women Fight Back

Britain

Radiance/Spring 1986

(From *SpareRib,* British feminist monthly, No. 182, September 1987.)

We are fat women who want to challenge the myths about fat. We want to stress that fat is not always a question of personal choice and control; neither is it a visible sign of failure. The issue for us is not why we are fat, but why we are treated badly because of being fat.

Contemporary Western culture promotes an increasingly thin ideal; we have found no positive images of fat women in the mainstream media. Quite the contrary, women's magazines and the media in general just focus on how to get rid of fat. In a society where looks and sexuality are used to control women, we need to question all physical norms imposed on us. We should work towards self-acceptance and self-love irrespective of the size of our bodies.

A thin woman may suffer because she cannot attain an impossibly thin ideal. Fat women, however, are harassed and discriminated against regardless of how they themselves feel about their bodies: society at large thinks that there is something fundamentally wrong with fat women.

In Britain, fat women are continually pressured to lose weight. Moreover, fat women experience direct and indirect discrimination in job selection and harassment at work. Fear of ridicule often prevents us from taking part in sports and leisure activities such as dancing and swimming. Public transport and the design of public spaces often excludes fat people; seats are too small and there is very little space in pubs, restaurants, cinemas. In school, fat children can be ridiculed by peers and stereotyped by teachers. The majority of clothes shops sell nothing we can wear. The media degrade us, defining us as a problem which needs to be eradicated; we are stereotyped as lazy, pathetic, out of control, stupid, ugly, jolly, maternal, asexual or sexually ravenous.

On top of all this, fat women are often thought of as being greedy. Because body size is often mistakenly linked with food consumption, fat is defined as an eating disorder. While some fat people, like some thin people, are or have been compulsive eaters, many do not have problems with food. In fact, most fat people know that we do not necessarily eat more than most thin people. Yet both the diet and medical industries promote the idea that no matter how little a fat person eats, it is too much if she remains fat. We have to examine whose interests are really being served by this idea. The market is flooded with diet fads, pills and foods. The diet industry is multinational and extremely profitable. Ironically, the highly profitable Weightwatchers is owned by a food company. Furthermore, an increasing number of researchers from the Medical Research Council and the Department of Health Investigating Committee have come to the conclusion that diet foods can be not only expensive and ineffective, but outright dangerous.

Good health is usually cited as the most important reason for losing weight. Fat women are perceived as medical problems; regardless of whether we have a sprained thumb or a common cold, our ailments are automatically attributed to our fat. We are often denied proper treatment until we lose weight; then we are mutilated in the interests of "good health." We know that some fat women have had their jaws wired, many more have used and become addicted to diet pills, and some have even undergone plastic surgery. Such procedures often turn healthy fat people into ill thin people. Side-effects include malnutrition, diarrhea, vomiting, hernias, stomach perforation and spleen injury. It is an indication of the suffering and humiliation fat people experience in their lives that many are prepared to undergo these operations.

So it is not necessarily fat, but fat oppression that can damage our health. We are physically and emotionally hurt by external and internalised oppression, and then we are blamed if this results in ill health—as if health or size were simply a question of individual choice and control and were divorced from social and political issues.

If you have dieted a lot and always end up getting fatter, you learn that you don't have a choice about your size: either you can blame and hate yourself or you can choose to challenge those that oppress you and refuse to be victimised. It is a political act for a fat woman to get angry about the way she is oppressed and to stop believing she deserves such pain and degradation.

Most of us might already be challenging fat oppression in our lives, but it is important that we organise collectively to ensure that our views are made part of a wider political agenda. We can attempt to build a network of support groups and activities. We can set up local swimming and exercise classes for those fat women who choose and are able to participate in such activities. We can challenge the clothes industry, which fails to meet our needs (even though about half the women in this country take a size 16 or over) and encourage the setting up of co-ops that make clothes fat women want to wear. We need to challenge the medical profession and demand our right to adequate health care. We can campaign against oppressive industries which exploit, abuse and humiliate fat women. We can challenge negative representation of us in both the mainstream and alternative media.

We must make ourselves and other people aware of the fact that being fat and beautiful are not mutually exclusive; people should love us for who we are and not in spite of the fact that we are fat. To stop punishing ourselves is just a beginning—we still have to affirm our right to, quite literally, take up space. We demand pleasure and fulfillment as fat women now, not in some thin future. It is society that has to change, not us. □

Further Reading:

• "How Society's Obsession With Thinness is Consuming Women," *Herizons, Canadian feminist magazine, October/November 1986.*

Screaming in the Wind

(From *Makara,* Canadian women's quarterly, Volume three/Number one.)

The following are excerpts from taped conversations between Molly Dexell and MAKARA's Nora D. Randall. Molly spent almost twenty years going in and out of mental institutions.

Q: Why do people go into mental institutions?

A: There are two reasons why people go into a mental hospital. Either they can't function, or they do something that looks crazy to other people. Now suppose you've got a mother of six kids who is so depressed that she can't get up in the morning. There's a two-year-old starving, and the mother still can't get up. Oftentimes the mother will be institutionalized because she can't cope with everyday life. Why couldn't the family just hire someone to help out with the kids and give the mother a chance to get better? She could visit her shrink at the day hospital and come home at night. It is very hard to deal with getting well and raising children simultaneously. It was hard enough for me and I only had one child. They'd be saving money by not institutionalizing her, and they could keep the whole family together.

Q: How do you see the relationship between psychiatrists and mental patients?

A: People who haven't been mentally ill are not totally aware of what the whole thing is about, although some act as though they do. Psychiatrists don't have a chance of being successful at helping mental patients until they accept the fact that only the mentally ill really know what their sickness is all about. Once they have had one year of college psychology, many student doctors diagnose themselves as being "schizophrenic", "catatonic", and all that shit. I've had some of them say to me, "I'm a potential mental patient." Well, sure, the whole world is. I say,"Do you know what it's all about to hear a voice? Do you know what my voice is all about?" It irks me so badly, to hear that kind of drivel. Another thing I've learned from experience is that you don't tell psychiatrists in the hospital about anything important. You don't even tell them you don't like baked potatoes. You talk about all kinds of things you think they want to hear. You have to go to them for your medication, you see, you're tied to them; you need the medication and you know it, and there's no way you can get it without going to a shrink.

The job of getting well has been taken right out of your hands—the psychiatrists handle it. It's really your problem and you're the one who knows it. There isn't a psychiatrist who knows more about me than I do. The only thing that's going to save mental patients is mental patients. The psychiatrists are there to help save themselves. But they take it out of our hands and blow us out with shock treatments and pills and all the rest of it. That is no way to cure mental illness. That's proven by the return to institutions of so many mental patients—old mental patients who have had the problem recur because it isn't properly fixed the first time. You can have a breakdown and another breakdown and another breakdown, and eventually you yourself must work your way out of it.

Q: Don't you think mental patients could work their problems out sooner if the way they were treated in the hospital wasn't so literally sickening?

A: Yeah, it's really a lousy setup. I had hope because I had a good psychiatrist. If you've got a good psychiatrist, someone who values intelligence, she or he is concerned about fear. Fear is the greatest emotion that mental patients have. Anger is another great emotion. And the anger is a result of your fear. The fear is beyond belief...beyond the conception of the ordinary person.

Q: Do you think it is fear of the actual illness itself, or fear of how you'll be treated because you are sick?

A: Well, both. The intense illness is frightening. But I think it's intensified in the hospital.

Q: Knowing what you know now, if a doctor ordered shock treatments for you, would you kick up a fuss?

A: No way. If you kick up a fuss in a mental hospital, you get locked up. I wouldn't kick up a fuss in the hospital. That's the craziest thing I've ever heard. Why, they'd just pick you up and carry you in, that's all. I've seen a 70-year-old woman, screaming and fighting, picked up and carried in. Once you see that happen, people get educated. That's the biggest shock in a mental hospital. I hesitate to compare these—it sounds a little paranoid—but it must be the same feeling that political prisoners had during Nazi Germany, during the extermination. People were picked up and terrible things happened to them, while the rest of the world was ten miles away and didn't know what was happening.

It's the same at Riverview. Totally helpless, cut off, nobody relating to you, nobody understanding what's happened to you, and there's this screaming in the wind. That's a feeling you have, and you don't ever get over it. It never leaves you. I would be very, very slow about putting anyone in a mental hospital for the first time. When you go, you see things and learn things you never forget. No matter what you do, where you go, you're always afraid you'll be put back. Your whole life is taken totally out of your hands and it's put in the hands of ruthless people. When psychiatrists learn to relate to their patients, then they will have learned a little about psychiatry.

Q: Is there a place for mental hospitals?

A: Not called mental hospitals. There should be a place. Someplace restful, where they could have a holiday—Hawaii. □

Beyond Sound

My day is a snare
In which I am caught
Struggling.

At dawn I am revived
To continue
What has become to me
A life outside of life
Where my soul screeches
To unimagined heights
And instinct holds me back,
Puts on the brakes,
Till gathering strength
I quietly descend to the glassy surface
And I remain,
Healing myself
By the steady routine of my existence

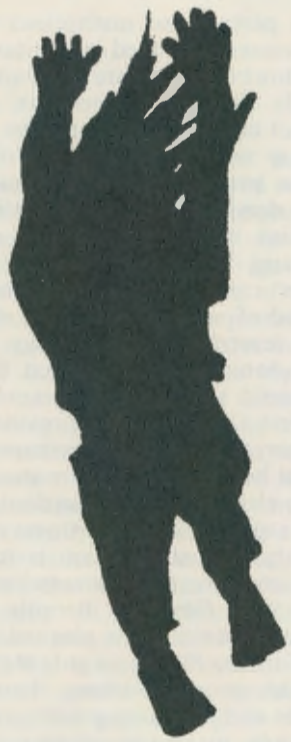
And yet,
I am not healed,
For a word
A distant threatening sound

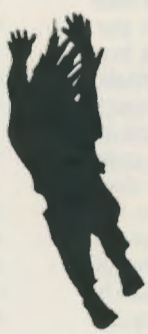
Shoots me off again
Shattering the cobwebs
That enfold me
Encircle me
Bind me
To some hidden sorrow
That lies there in a stupor
At the back of my head.

There is no word
That accurately describes
The feeling of foreboding that I once had
That now slides past like some reptile
Nudging at the corners of my eyes.

Let me look away;
Let me see the things I love.
How wonderful!
How beautiful!
But it is still there!
When will I feel safe again?
Never?

(By Molly Dexell)





All graphics by Marie Falksten ©

Further Reading:
- Women and Therapy, a feminist quarterly, *Hawthorne Press, New York.*
- I'm Not Mad, I'm Angry, *Dorothy Smith and Sara Davids (eds.), Press Gang, Vancouver, B.C., 1975.*

Sterile Without Consent

(Excerpted from *Connexions'* interview with Theresia Degener, December 1987.)

Theresia Degener is an active member of the West German disabled movement. She is particularly interested in the issues surrounding the involuntary sterilization of disabled girls and women. She has published a book about disabled women and has written an article on this subject which was published in *Emma,* a West German feminist magazine, in August 1985. Theresia is currently a law student at the University of California, Berkeley.

In 1984, the West German media started to pay attention to the issue of sterilization. This was partly due to the discovery by historians that many of the girls in schools for the mentally disabled had been sterilized without their consent or against their will. After these findings were publicized, a television program "Panorama" was devoted to this topic. On "Panorama," a mother explained that she had had her disabled daughter sterilized at the request of her daughter's teacher. The teacher requested sterilization because the children were going on an overnight field trip and he did not want to be responsible in the event that the girl engaged in sexual activity and became pregnant.

In fact, many institutions in West Germany require the sterilization of mentally handicapped girls as a prerequisite for admittance. The institutions don't want to deal with the possibility of a pregnant disabled woman. Parents of disabled teenagers are often intimidated by the sexuality of their children and are fearful of a potential pregnancy.

"Panorama" alerted the public to these issues—many Social Democrats and much of the alternative press were horrified at these findings. Many who protest this abuse of sterilization draw parallels between the current situation and the forced sterilization that occurred under the Nazis. An estimated 400,000 people were sterilized against their will or without their consent during the Nazi era. Currently, there is a heated debate about whether or not the federal government should provide compensation for those who underwent forced sterilization.

The present West German criminal code clearly states that sterilization is illegal unless it is performed with the consent of the affected and if this consent is not against ethical principles. Sterilization against a person's will or without her consent is only permissible if there is a present danger to the health of that person. However, some people claim that there is a gap in the law, in that it does not say anything about those who are mentally unable themselves to give consent. Some intermediate courts have ruled that the consent of the disabled can be replaced by the consent of the parent or legal representative in cases where the disabled person is incapable of making her own decision. This is not legal, however, as the law does not allow for this option. The legal system in West Germany is not a case system like the United States where the rule of precedence must be followed. Courts in West Germany do not look to precedents set by other courts, but rather they must find the answer in the law itself.

Lebenshilfe, the largest organization for the parents of the disabled, is one of the main proponents of involuntary sterilization. It was founded in the 1950s and it runs "sheltered workshops"—a place where disabled people are employed. It runs several other institutions and even has its own publishing house. Lebenshilfe and many other parents not organized in Lebenshilfe want a new law legalizing the sterilization of the mentally disabled because they don't want their children to become pregnant. Many of the parents feel that because they have already exerted so much energy raising a disabled child, they don't want the burden of raising their children's children. They claim that sterilization is in the best interest of the kids and that there is no place within the institutions that could accommodate a pregnant mentally disabled woman. The common morality on this subject is that the mentally disabled do not have a right to reproduction.

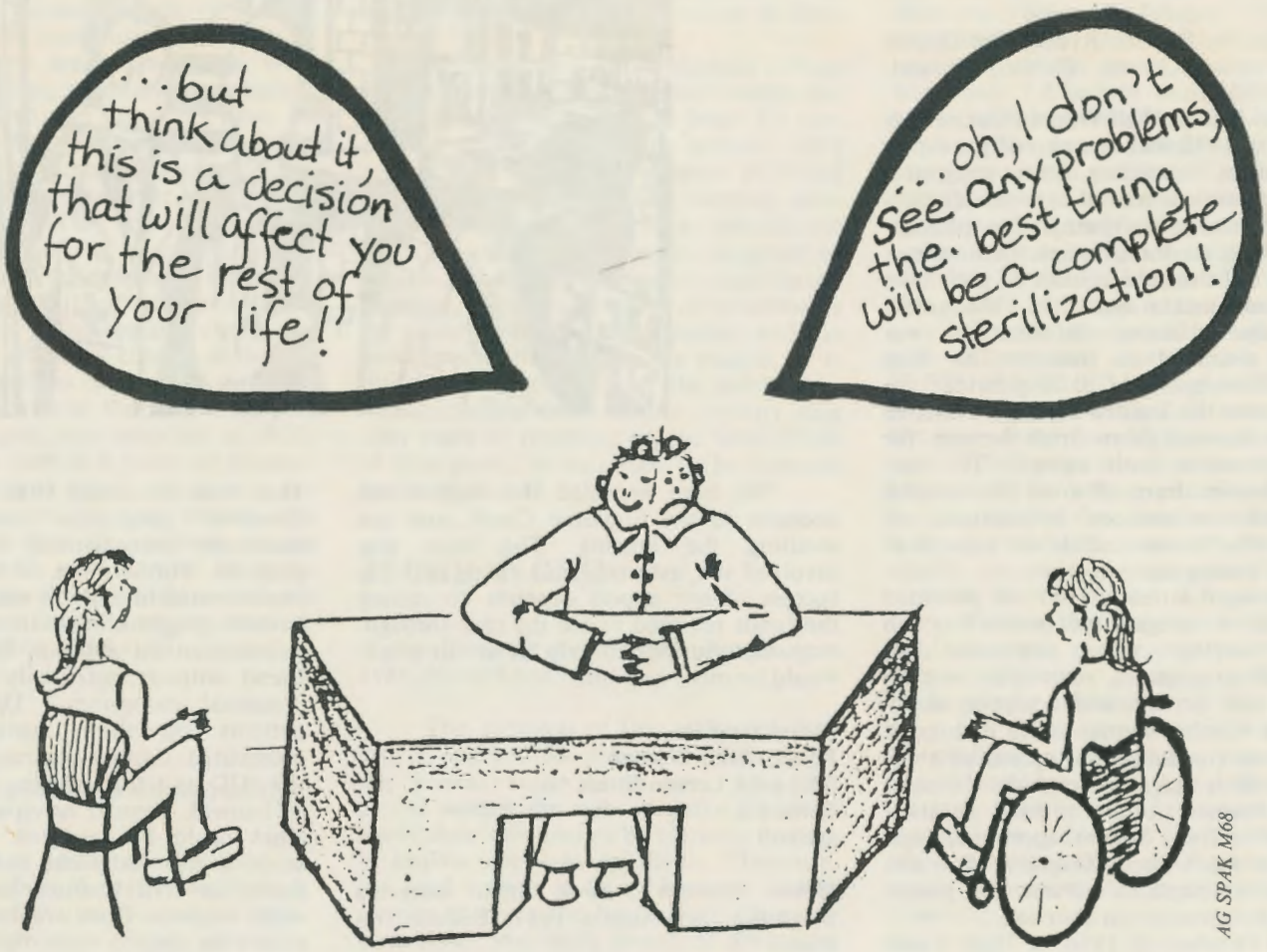
In the 1960s and 1970s, not much was known about how many people were affected by this practice of sterilization, but recently teachers in Hamburg have revealed that about 30% of the girls in special schools for mentally disabled children have been sterilized. These girls are less than 18 years old—most of them are less than 14. It has been easy for parents to have their kids sterilized; doctors agree readily. On the other hand, for able-bodied women, it is very difficult to get a sterilization. If they are under 18, it is illegal.

The federal government started an investigation to find out how the federal states and institutions are dealing with the problem. A special board was created to work out a statute which allows for sterilization without consent. Special education experts say also that what has been done in the past should be made legal.

One major concern parents and institutions have is rape. Many mentally disabled women are raped in institutions, by relatives, and in the streets. However, there are no available statistics on the subject. Mentally disabled women are in particular danger because they cannot communicate the same way we communicate; they can be easy victims. Proponents of sterilization claim that they want to prevent the repercussions of rape, namely conception, since many of them are Catholic and cannot agree with abortion. I think it is very cynical to deal with the problem of rape by sterilizing disabled women.

Eugenics is another concern. There is a big discussion about eugenic thinking and of new developments in the fields of genetic engineering and reproductive technology. Udo Sierck, who is disabled and has done a lot of work on this issue, has discovered that some genetic counseling offices which are provided by the state in West Germany also provide sterilization recommendations for other doctors. The recommendations are most often based on social behavior: If you are in a special institution, if your father is an alcoholic, if your uncle is unemployed, if your brother is also in a special institution, you are diagnosed with an inherited disability, and sterilization is recommended. The eugenic arguments used by these counseling offices are currently a hot topic in West Germany, because they remind people of the population control the Nazis planned. Some papers were stolen from some of these offices and published, which was very embarrassing for the people working there. They had difficulties saving their jobs and justifying genetic counseling.

There are a few people, such as progressive educators and church organization members, who criticize the current approach. They propose that we look to other countries for



examples of possible alternatives. In Denmark, for instance, there is something called "protected marriages"—houses are provided for mentally disabled couples so that they can live together. Special attendants take care of their needs and the needs of their children. The government provides these services—Denmark is much more of a welfare state than West Germany. Similar programs are planned in the Netherlands and at least two similar programs exist in West Germany. Reports indicate that these programs are highly successful. The main drawback to the development of further programs is the lack of available funding. This is a big issue in West Germany right now as the social welfare law does not explicitly allow for funds to be spent in this way. In addition, most of the disabled parents need supplemental assistance as they earn minimal wages.

Until recently, disabled people in West Germany were discouraged from having sexual relationships. Many books have been published that state that the disabled should not have the right to sexuality. In many institutions, methods were used to distract disabled people from their sexual feelings. Although it is currently said that the mentally disabled have a right to their sexuality, people are now trying to regulate the circumstances under which the disabled are allowed to have sexual relationships. There are some people who are supportive of the right of the disabled to sexuality. Several organizations offer services to disabled people who request reproductive counseling. They provide advice on sexual problems and planned parenthood, and help parents to educate their children about birth control.

The conservative West German government is trying to pass a new custody law. There is a provision in that law that states that for disabled people who are unable to give consent for sterilization, the parents or legal representative have the power to approve the procedure. The government wanted to enact this law in September 1987, but was unsuccessful due to the resistance of the Green and Social Democratic parties. These parties are very sensitive to this issue in part because of their work to get compensation for Nazi sterilization victims. The Greens and Social Democrats are supportive of the reforms in the new custody law except the provision dealing with the sterilization of disabled people. The government had therefore excluded the controversial provision in order to pass the reform of the custody law. But the government will continue its fight to legalize the involuntary sterilization of the disabled.

I think that one major problem is that many people believe that the reproductive choices of disabled people are a public issue and not a private right. There is also a prevailing attitude that disability is abnormal and therefore unacceptable. If one examines current developments in the fields of genetic engineering and reproductive technology, one can see that people have

(cont. on p. 28)

Restricted "Choice"

Ireland

Women's News/Ireland

(Submitted by Pauline Ryder: The Dublin Well Woman Centre, Dublin, Ireland, October 1987.)

The Dublin Well Woman Centre was founded in 1978 with the aim of providing medical care, counselling, fitness programs, and other services related to women's physical and mental well-being. Our philosophy is based on the principle that women have the right to take control of their own physical and mental health. In 1978, access to family planning information was severely restricted in Ireland. The Well Woman Centre sought to help bridge the gap between the limited services available and the demand from Irish women for easily accessible birth control. To date, 78,000 women from all over the country have used our services. In addition, we provide educational leaflets on aspects of health including contraception.

Up until January, 1987, we provided non-directive pregnancy counselling to women coping with unplanned or unwanted pregnancies. Our aim was to create a safe, private, and accepting atmosphere in which a woman could discuss all her options (including the option of abortion, which is illegal in Ireland). In cases where a woman decided to have an abortion, we referred her to approved, legal clinics in the United Kingdom. We also acted as a telephone service for people wanting information on abortion.

In October of 1986, a High Court Action was taken against the Dublin Well Woman Centre and Open Line (the only other agency in the Republic of Ireland offering this type of pregnancy counselling) by the Society for the Protection of the Unborn Child (SPUC). This action was the result of an amendment to the Constitution in 1983 which gave the foetus a right to life equal to that of the mother. This amendment was sought by SPUC, which succeeded in winning the support of the main political parties. The outcome of the High Court case has resulted in an injunction on our Pregnancy Counselling Service and the closure of Open Line. Indeed, we are restricted by law from giving any information concerning abortion. Recent statistics suggest that this injunction has done nothing to reduce the numbers of Irish women travelling to England for abortions. The injunction has pushed access to information underground (there is a national campaign which has set up a country-wide network). It has also increased the trauma and stress women have to go through in order to obtain an abortion.

The long term effects this will have on women and their physical and mental well-being are yet to be seen. It is currently a civil offense to give out information on abortion; women are made to feel like criminals. We are being denied a basic civil right—access to information.

We have appealed the High Court decision to the Supreme Court, and are awaiting the hearing. The legal fees involved are astronomically high and the success of our appeal depends on raising the funds required to see the case through. Any contributions to help us in our plight would be most welcome.

Please send to:
Dublin Well Woman
73 Lower Leeson Street
Dublin 2
Ireland

(From *Women's News,* Irish women's magazine, July/August 1987, Belfast, Ireland.)

When the Society for the Protection of the Unborn Child (SPUC) launched its successful campaign to amend the constitution of 26 counties to guarantee the right to life of the unborn, Southern politicians assured us that this was not an attack on women's rights, but merely an action to prevent the courts from declaring the old 1860 Act (making abortion criminal) unconstitutional. However, as many of us feared at the time, the amendment was only the first step in a much longer-term SPUC strategy to deny women access to information on both contraception and abortion. In 1983, SPUC attempted to intimidate women from seeking advice on these matters by picketing family planning centres and women's clinics. In 1986, they went a step further and began a legal campaign to stop women's clinics from providing any services of this nature.

SPUC initiated court proceedings against The Well Woman Centre and Open Line Counselling. The case was heard by Justice Hamilton, who found in favor of SPUC; he ruled that all other constitutional rights are held secondary to that of the right to life of the unborn. The judgment therefore denies women the constitutional guarantee and equal right to life, the guarantee to privacy, and the guarantee of access to information.

Thus, from December 1986, non-directive pregnancy counselling has effectively been banned from twenty-six counties. Furthermore, if the decision is implemented literally, it would mean a distressed pregnant woman could not get information on abortion from her closest friend without potentially engaging in a "criminal conspiracy." Doctors advising patients on these matters could be prosecuted. Certain contraceptives such as the IUD and the morning after pill could be banned. Popular newspapers and magazines could be censored. The fearsome scope of the judgment and the danger it poses for civil liberties has provoked an angry response from women who are determined to defend their rights. It has also brought the realization that SPUC must be stopped now.

The Defend the Clinics campaign began functioning as soon as SPUC's court action was announced. The aim of the campaign is to make the judgment against the clinics unpopular and to create a network of information needed to restore the challenged service. The Dublin-based national committee has now distributed hundreds of information packets (giving in pamphlet form information previously offered by the women's clinics), thus defying the injunction.

We believe that in order to succeed in our campaign, not only must the women's movement of the North and the South unite, but all working class organisations, political parties, and progressive forces in Ireland must fight SPUC's agenda. If SPUC is not stopped, women will suffer yet more defeats at the hands of the right wing, and the outlook for the future of Irish women will be unthinkable. □


Women's News/Ireland

Israel

(Submitted by Awatef Barghut, health clinic nurse, Nazareth, Israel.)

It is impossible to separate any subject in Israel today from the political and social reality in which the economic crisis; continuing occupation of the West Bank, Gaza Strip and Golan Heights; the war in Lebanon; and the continuing oppression of Palestinian people are major factors. With respect to abortion, women's reproductive rights are limited. In order to have an abortion in Israel, a woman must appear before a committee consisting of a doctor, psychologist and social worker, and receive their permission. The only grounds for approval are if there is severe danger to mother or child, if the pregnancy is a result of rape or incest, if there are special religious reasons, or if the mother is mentally incompetent. The "social clause" of the law permitting abortions for socio-economic reasons, by which most abortions were performed in the past, was cancelled in 1978. I can't say that there is a policy of pressuring Arab women to abort, but people say that despite the law, all Arab women can get an abortion when they request one, as opposed to Jewish women, who are pressured to have the child. Jewish women are told they can put the child up for adoption if they don't want to raise it. □

India

(From *Manushi,* Indian feminist monthly, no. 36, 1986.)

Abortion in India was legalised in 1972. The number of legal abortions is increasing steadily each year. Unfortunately, the number of illegal abortions performed is also increasing. The increase has occurred through sustained propaganda. People have been led to believe that abortion is a trivial operation. It is often advertised as something that is cheap and easy to have done on your lunch break. Abortion is projected as a procedure of little financial or physical consequence. Commercial interests have encouraged many illegal practitioners to perform abortions.

Many people see abortion as a simple procedure that a person with any sort of medical qualification—allopathic, ayurvedic, or homeopathic—is competent to perform. It is even said that non-medical persons can easily learn the technique. In spite of all the modern and safe methods of terminating pregnancy that are available in this country, severely damaging and often ghastly methods continue to be used to induce abortion. A spate of reports in the last two years reveal that iron nails, sticks, coconut splinters, and Fetex, a dangerous chemical paste, have all been used by illegal abortionists. The types of injuries inflicted by illegal abortionists are horrifying. Perforation of the uterus and injury to the rectum, urinary bladder, intestines and liver, severe infection of the peritoneum and chemical burning and sloughing of internal organs have all been reported in recent cases.

The havoc caused by septic abortions continues unabated in spite of all the powerful infection controlling drugs available now. There are no beds earmarked for abortion cases in hospitals. Centres for medical termination of pregnancy have to be approved by medical authorities, but many unapproved centres continue to function.

A report from Patna Medical College Hospital reveals that maternal deaths due to abortion have increased from 5.6 percent of all maternal deaths between 1961 and 1965 to 9.0 percent between 1976 and 1980. Fetex chemical paste, licensed, publicised and popularised as an abortificent paste, has caused peritonitis, gangrene of organs and kidney failure in many cases. Doctors recommend that advertisements for Fetex paste should be banned and the product withdrawn from the market. It is due to the inefficiency of the mechanism for controlling drugs in our country that after years of reporting on the fatal effects of this paste, it continues to be licensed and marketed. □

Hong Kong

(From *Women's News Digest,* June-August 1986, Hong Kong.)

The approval of two registered doctors is required for a legal abortion under the present Hong Kong law. This law denies women the right to make decisions about their own bodies by allowing doctors to impose decisions on them. Therefore, the legal system in Hong Kong is forcing women to cross the border into China to seek cheap and easily accessible abortions. In addition, the laws have contributed to the number of women seeking illegal abortions from unlicensed doctors in Hong Kong.

New Year's Woodcuts/Women of China

"One child is enough, and it matters little whether daughter or son, as long as the child is healthy and strong."

Ms. Chan, chairwoman of the Association for the Advancement of Feminism, believes that the trend of seeking abortions across the border is "a result of the insufficient abortion service in Hong Kong." Medical and Health Department statistics show there were 28,130 legal abortions between January 1982 and December 1984. Among these, 70.8 percent were carried out in private hospitals, while only 7.2 percent were carried out in government hospitals. Just over 22 percent were carried out in subsidised hospitals. Ms. Chan points out that "The fact that a high percentage of women are having to terminate their pregnancies in private hospitals indicates the inadequacy of a cheap abortion service." She goes on to report that middle and upper class women have easy access to abortions because they are able to pay the cost, usually between $3,000 and $5,000. Lower middle class women are often obliged to seek cheaper, but more dangerous illegal abortions.

"The only other viable alternative seems to be the service available across the border, despite the possible risks due to lack of follow-up service." "A strong stigma attached to pregnancy out of wedlock shames women into getting abortions, whether they want their children or not." It is this stigma which drives many women, especially young women, across the border for abortions.

Ms. Chan states that it is necessary to challenge and change the hostility against unwed mothers. As a more immediate task, however, she stresses the need to provide sex education and information about contraception to women, a task which a responsible government cannot ignore. □

Mauritius

(From *"Medical Guide—Illness No, Health Yes,"* and *"Women's Minimum Program," Mauritius.)*

According to the Penal code section 235, abortion in Mauritius is illegal. The law originated in the colonial period and should be immediately revoked in order to decriminalize women. This is all the more necessary because according to statistics, every woman in Mauritius has an average of five abortions within her lifetime. According to government figures, four thousand women are hospitalized each year as a result of clandestine abortions. Doctors estimate that approximately 40,000 women each year have an abortion, many of whom seek cheap abortions. Unfortunately, these inexpensive abortions are often done with utensils such as umbrellas, knitting needles, or spokes causing many women to suffer from complications that can be terminal. Among the points listed in the Women's Minimum Program, which the Women's Liberation Movement distributed to all the major parties, was a demand to repeal the Penal Code Section 235 immediately. □

Japan

(From *Asian Women's Liberation,* Japanese feminist quarterly, No. 6 1984.)

Nineteen eighty-three was a crucial year for women in Japan. The Ministry of Welfare proposed legislation aimed at tightening restrictions on abortions. The course of events began in March, when Representative Murakami Masakuni, who is backed by right-wing religious groups, announced: "Vast numbers of abortions continue to be performed for economic reasons despite the fact that Japan has become an economic superpower. This casts doubt on the future prosperity of the Japanese people. Abortion is murder. Allowing it to continue unchecked will result in the moral degeneration of our society. Accordingly, abortion must be strictly controlled."

The first step toward this end was to propose deleting the "economic reasons" provision from the list of conditions contained in the Eugenic Protection Law under which a woman may obtain an abortion. Proponents of the revision launched a huge media campaign and held rallies using such slogans as "Respect for Life" and "Protect Fetal Life." They also methodically collected over ten million signatures to a petition calling for the revision, including those of legislators from all levels of government.

The fundamental law in Japan concerning artificially induced abortions prescribes imprisonment for women who procure unauthorized abortions. Other provisions prescribe varying penalties for doctors, midwives, pharmacists, druggists and others who participate in such abortions. These provisions were first introduced to the criminal code in 1880 as part of the westernization Japan was undergoing at the time. Previously, abortion had not been treated as a legally punishable offense. In fact, during the years 1603 to 1868, both abortion and infanticide (which was often sex selective) were routinely practiced by poor rural peasants as a form of self preservation and a method of population control. (As a result, the overall population remained stable for almost 300 years.)

The criminal abortion laws introduced in 1880 were significant in that they coincided with a new national policy to westernize Japan in terms of wealth and military strength. One aspect of this policy called for boosting the country's population. Especially from around 1930 until 1945, women's bodies became the territory of the state. Motherhood was a public duty; the criminal abortion laws were strictly enforced and even contraception was forbidden. The first priority was to ensure a supply of labor and soldiers for the war effort.

In 1948, the Eugenic Protection Law was introduced. Its purpose was to control the enhancement of desirable Japanese racial qualities primarily through sterilization and abortion. The conditions under which abortion can be performed are divided into three major categories: (1) for eugenic reasons (existence of hereditary physical or mental disorder); (2) for public policy reasons (pregnancy resulting from rape or coercion); and (3) for personal sociological reasons (possible injury to the woman's health from a physical or economic viewpoint). Economic reasons were added to these conditions as a new category in 1949. In effect, this had led to the realization of abortion on demand in Japan. These demands are sometimes based on fictitious claims of economic hardship.

Japan's population needs changed dramatically following World War II. Having lost its foreign territories and facing acute food shortages, reducing the population became a national priority. Also, in order to alleviate the increasing number of back-street abortions and the physical dangers these presented for women, it became necessary to legalize abortion. There can be no doubt that the reduction in the size of Japanese families after the war can be primarily attributed to abortion.

International Women's Year Action Group

One bill to revise the Eugenic Protection Law was introduced in 1972, during the last stage of Japan's period of high growth immediately preceding the oil crisis. The central feature of the bill was the deletion of "economic reasons" and its replacement by the purely medical condition of "mental or physical health reasons." Abortion would also be allowed where the fetus was found to be handicapped. The bill also required young women who had never given birth to receive advice and guidance before an abortion could be performed. A key factor said to be behind the bill was the shortage of young workers to meet the demand for labor caused by Japan's high economic growth. From this need emerged the national priority of increasing the country's human resources. The bill was met with intense opposition and was successfully blocked in 1972 and 1974.

In 1982, reflecting Japan's increasingly conservative political climate, the proposal to strike "economic reasons" from the Eugenic Protection Law once again came to light. Conservatives say that Japan lacks the necessary natural resources for economic development; therefore it is crucial to utilize Japanese people's "superior" native intelligence. They worry that among those fetuses "selfishly" aborted there may have been geniuses who might someday have benefited Japan's economy.

It is not enough simply to have this offensive bill shelved. The opposition movement is starting to prepare its own reform proposals. Feminists have been trying to abolish the Criminal Abortion Law and the Eugenic Protection Law altogether. The Criminal Abortion Law is an unjustifiable governmental intervention into individual privacy and ignores basic human rights. The Eugenic Protection Law is premised on the philosophy of promoting racial purity. The net effect is to deny women through forced abortion the opportunity to have children when they want them, and to penalize women who choose to terminate unwanted pregnancies. It is important that we work for an environment which enables women to choose whether or not to have children, so that men and women together can achieve their full potential as human beings. Contraceptives are very tightly regulated by the government in Japan, therefore, the first priority should be to provide better contraceptive planning and services for couples who choose not to have children. □

Contact:

- Muvman Liberasyon Fam, Lakaz Ros, 8 celicourt Antelme Street, Forest-Side, Mauritius.
- Defend the Clinics Campaign, National Committee, 6 Crow Street, Dublin 2, Ireland.
- The Women's Centre for Advice and Information, 18 Donegall Street, Belfast, Ireland.

Further Reading:

- "Irish Women Defiant Over Abortion Rights," *Outwrite, British women's newspaper, Issue #55, February 1987.*
- Women's News Digest, *Association for the Advancement of Feminism, Hong Kong, June-August 1986.*

The International Meeting on Women and Health

Costa Rica

(From "The International Meeting on Women and Health," by Maria Eugenia Jelencic, *Women in Action,* an Isis International publication, 1987/2.)

About 800 women from five continents met in San Jose, Costa Rica last May for the Fifth International Meeting on Women and Health. The week-long meeting was organized by the Feminist Center of Information and Action (Centro Feminista de Información y Acción—CEFEMINA) of Costa Rica. There was a large representation of Costa Rican women and Latin American women in general — there were very few Asian women (about 20) and even fewer African women (no more than 10).

The Women and Health Movement has developed appreciably since 1977, the year of the First International Meeting on Women and Health in Rome, Italy. For many groups and organizations, it was the first time they had encountered women from different countries doing work similar to their own. The San Jose meeting was a demonstration of the vitality of the movement. There were three central workshops: "Reproduction Rights and Population Problems," "Medicines and Drugs," and "Community Health," and 130 other workshops were proposed by the various groups who took part in the meeting.

The initial program had to be modified and adjusted several times in order to allow a forum for each problem. First there were the specific, daily problems which confront women as a gender. In the majority of the countries represented, women's groups are the only place where these problems can be confronted. The titles of the following workshops are indicative of the issues that women's groups take on: "Circumcision of Women in Sudan," "Women Under Muslim Law," "Mental Condition and Female Condition," "Physical and Mental Illness in Women as Resistance to Patriarchy," "Alternative Sexual Education," "Subjected Body/Despised Body," "Effects of Drugs on Lactation," "Psychosocial Elements of Maltreatment of Women," "Self-Help Groups," "Domestic Violence" and many others. There were also workshops on environmental pollution, the Chernobyl and Bhopal disasters, and on abuses of the new reproductive technologies.

It was generally agreed that the women's health movement must significantly increase its organization and reinforce itself as a pressure group that can promote political change. There is a lack of adequate instruments of communication and of materials with content that effectively supports health programs. The dissemination of information to illiterate women, especially in the rural sectors and inner cities of the Third World must be addressed, as lack of information is the basis of much abuse: forced sterilization and the use of poor women as "guinea pigs" in experiments with contraceptives are just some of these violations.

Isis International is working on improving the communication of health information to all women. In the workshop "Audiovisual Communication as Support for Women's Health Programs," which Isis coordinated, several groups were cited for making progress in this area. One of Isis's own projects is a low-to-medium cost training workshop for health workers in groups in the Latin American region. Ana Maria Portugal of Peru told of a network that has been initiated in her country to provide audio cassettes containing programs for women. Ilet Mujer is also promoting a Latin American radio network, and in India, there have been seminars in video training for Asian activists.

The groups which participated in the workshop on the Health Network of Latin American and Caribbean women indicated how valuable the creation of this network had been in breaking the isolation of groups working at the local level, and how it had also helped towards coordination at a regional level. This network started in 1984 and now includes 500 organizations and groups in the region.

The workshop of the Global Women's Network on Reproductive Rights, which includes about 600 groups, was another confirmation of the effectiveness of the networks. "When we began to coordinate with other Asian groups we discovered that many of the population control policies which were being implemented in India were the same ones that exist in other countries in the region," said one representative from Saheli, an Indian organization.

One great concern for women involved in the reproductive rights movement is drug dumping. "Through the network, solidarity and vigilance among women can be intensified," said one participant in the workshop on Drugs and Medicines. "If we are better coordinated, women in developed countries can exert pressure to make sure that medicines and contraceptives which are prohibited in those countries are not sold in Third World countries as they are today." In a final document, signed by the Third World women present at the conference, severe criticisms were made of the majority of health policies implemented in their countries.

One section of the document reads, "Health policies implemented in our countries are based on profits and on power for elites...Added to this is the deterioration of the economic situation of the developing countries as a consequence of International Monetary Fund tax policies, which are the cause of poverty, hunger, unemployment and lack of housing. In consequence, serious health problems for millions of people, especially women, are created." The situation is complex. Can support for the Women and Health Movement help to improve the situation? Do we help to improve the situation? We think so. In many places the Women's Health Movement is still in its initial stages.

In the next meeting, planned for 1989 in the Philippines, it will be possible to evaluate all the advances achieved in these two years of work. However, in the meantime, we must keep in contact, tighten our bonds and work in a coordinated way. There is no other way to achieve significant advances. □

Contact:

• Centro Feminista de Información y Acción, Apdo. 5355, San José, 1000 Costa Rica.

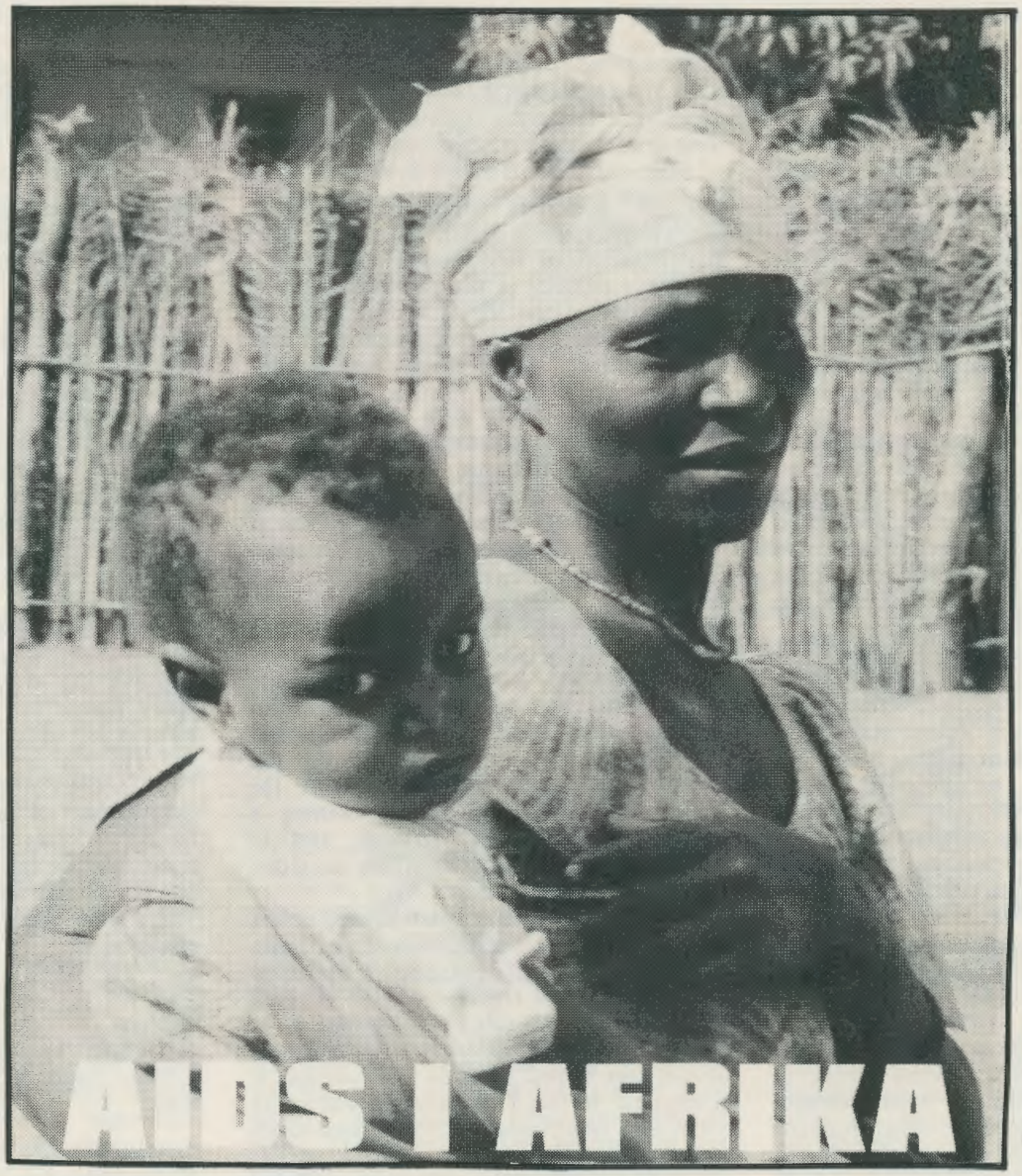
Further Reading:

• "Conference Demands International Health Rights," *Outwrite, British women's newspaper, Issue 60, July/August 1987.*

Marie Falksten ©

Nigeria

AIDS Linked to Genital Mutilation?



Tove Andreassen/Kvinne

(Submitted to *Connexions* by Hannah Edemikpong, coordinator of the Women's Centre in Nigeria.)

The question of where the AIDS virus originated is a matter of intense international debate. Some say that AIDS may have appeared first among the green monkeys of Central Africa or perhaps in some backwater village in the interior of the continent. Whatever the outcome of the international debate, it is indisputable that AIDS is here and is spreading rampantly. Seldom has a single disease put so many people around the world at great risk. The AIDS microbe comes in a variety of strains and has the ability to mutate rapidly, making the development of potential vaccines highly problematic.

Some scientists say that as many as five million Central Africans may carry the virus. The World Health Organization says that the virus is now spreading to other areas in Africa. The overwhelming majority of Western victims still come from two specific groups: male homosexuals and intravenous drug users. But what is happening in Africa is quite a different story. What are the cultural factors involved in the transmission of AIDS in Africa? Uli Linke, an anthropologist and researcher at the University of California, Berkeley, says that there is "a prevailing assumption that the same cultural factors are at work in the transmission of AIDS in Africa as in Europe and the USA...But none of the cultural factors can explain the equal ratio of men and women contracting the virus in Central Africa. The bottom line in the transmission of AIDS is the exchange of bodily fluids, particularly blood, which gave me the idea that it might be related to female circumcision."

In Africa, women are noted carriers. In a recent survey done in Uganda, of the 170 pregnant women tested, 75 percent were found to have AIDS. Half of those found to have AIDS had been genitally mutilated. In Equatorial Guinea, of the 100 women who were tested, 78 of them carried AIDS and 65 of them had been genitally mutilated.

The forces that make people subject girls to genital mutilation are varied. Sexual, religious, and sociological reasons are often cited as causes. Some African societies believe that the operation diminishes a women's sex drive. The decrease in women's sex drive is sometimes ignorantly believed to decrease the incidence of prostitution. Some religions, such as Islam, advocate female circumcision. In some parts of Nigeria, circumcision is a rank of honour and distinction for both the girl and the family. In Egypt, for example, the uncircumcised girl is called 'Nigsa' (unclean). Western efforts to eliminate the practice through missionaries or colonial masters have forced people to hold on to their cultural traditions for fear of being exposed to the ill effects of Western society.

The most extreme form of female circumcision, infibulation, is the complete removal of the vulval tissue including clitoris and the labia. After the tissue has been removed, the sides of the wound are sewn together. This leaves a miniscule opening about the size of a matchstick. No anaesthetic is used and the instruments are not sterilized. [editor's note: Female circumcision can be done in groups, therefore the sterilization of instruments is essential in preventing the transmission of AIDS.] Essentially, sexual intercourse is impossible unless the vagina is reopened. This is often done through forcible entry by the husband, which can lead to hemorrhaging. In women, "infibulation is associated not only with chronic pain, but with lesions in the vaginal tissue which lead to the presence of blood during intercourse," says Linke. He further states that "it is noteworthy that the recent outbreak of AIDS in Africa corresponds geographically to those regions in which female genital mutilation is still practiced." We, at the women's centre, are extremely concerned about the rampant spread of AIDS and its connection with female genital mutilation. We have launched an educational campaign to inform women about the situation by home visits, newsletters, and public speaking events. As a non-governmental voluntary organization without a solid financial base, the greatest problem in our ongoing campaign is funding. Any donations would be greatly appreciated. Please help us to stop female genital mutilation and the spread of AIDS among African women. □

Contact:

• Hannah Edemikpong, Women's Center, P.O. Box 185, Eket, Cross River State, Nigeria, West Africa.

Further Reading:

• The Circumcision of Women, *By Olayinka Koso-Thomas, Zed Books Ltd., London 1987.*

(From the *International Symposium on AIDS in Africa,* Naples, Italy, October 7-9, 1987.)

Uganda:
1983 17 AIDS-cases
1987 1,138 AIDS-cases
1987 6% of prostitutes are HIV-positive

Rwanda:
1981 10 AIDS-cases
1987 705 AIDS-cases, (246 are children)

Zaire:
1987 6-8% of pregnant women are HIV-positive
1987 11% of prostitutes are HIV-positive

Congo:
1987 583 AIDS-cases

Kenya:
1985 61% of prostitutes are HIV-positive

Tanzania:
1987 1130 AIDS-cases

Cameroun:
1987 1.5% of pregnant women are HIV-positive

Ghana:
1987 96 AIDS-cases

Senegal:
1987 14% of prostitutes are HIV-2-positive

Guinea-Bissau:
1987 60% of prostitutes are HIV-2 positive

Tunisia:
1987 11 AIDS-cases

Contact:

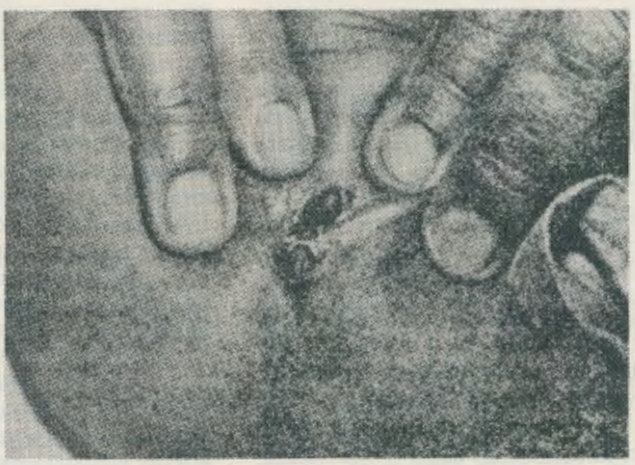
• Ministry of Health
P.O. Box 30016,
Nairobi, Kenya

Further Reading:

• Report on AIDS, *by the Panos Institute, 8 Alfred Place, London, WC1E 7EB, UK.*

• The Politics of AIDS, *The New Internationalist, No. 169, March 1987.*

• AIDS Action, *(International newsletter for AIDS information), Published by AHRTAG, 85 Marylebone High Street, London, W1M 3DE, UK.*



Manushi

Cooking Inside

—The Effect of Wood Smoke on the Health of Women

Madhu/Manushi

(Excerpted from an article by Anil Agarwal in *Manushi,* an Indian feminist monthly, no. 28, 1985.)

Atmospheric pollution has long been regarded as probably the least important of all the environmental problems in rural areas, a problem which is concentrated mainly in major cities and industrial towns. But recent evidence shows that air pollution within homes may be an acute problem, an underlying cause of millions of deaths every year. The burning of cooking fuel envelops the indoor environment with heavy smoke, and women, who have to do all the family cooking, may be daily exposed to more pollutants than even industrial workers in extremely polluted environments on smoggy days.

For thousands of years, people have cooked using firewood and cow dung. Even today, over 90 percent of households use wood, dung and crop residues as fuels. Environmental protection agencies in developed countries commissioned a number of studies to assess the impact of firewood use on air pollution. These studies revealed that biomass fuels, particularly in small scale combustion as in residential stoves, emit several important pollutants in high quantities compared to gas, oil, and even coal—the most polluting fossil fuel.

But what about homes in a country like India where cooking is commonly done on open and inefficient *chulhas* with few arrangements to funnel the smoke out of the house? A pilot study in four villages of Gujarat was carried out in late 1981. The woman cook in each household was asked to wear a sophisticated air sampler which was clamped to the collar, so that the measurement device could move around with the cook and measure her actual exposure to major pollutants in wood smoke.

The results were shocking. The average exposure of women to the pollutants was over fifty times greater than the safety levels set by the World Health Organisation. Women cooks receive a larger total dose than would residents of the dirtiest urban environment. Even an industrial worker would rarely be exposed to the levels found in the Gujarat study.

A number of factors make the level of exposure to pollutants worse. Dwellings in villages are small and badly ventilated. In one of the Gujarat households, when the holes in the roof were closed, as is done regularly in monsoon conditions, ventilation was so reduced that it became impossible for the researchers to remain in the kitchen for more than a few seconds because of the discomfort caused by heavy smoke. The woman cook, however, stated that such conditions were normal during the monsoon.

What does this mean for the health of women who cook? The most powerful evidence for the ill effects of wood smoke comes from a survey of a heart disease called cor pulmonale, in which the right lower chamber of the heart enlarges and fails because of a disorder in the lungs. The survey was carried out over a period of 15 years on hospital patients in Delhi. The authors, Dr. S. Padmavati and Dr. S. Arora, concluded that because of the fact that women are exposed to smoky primitive fireplaces from early ages, domestic air pollution accounts for the higher prevalence of cor pulmonale in women than in men.

In Ahmedabad, another study of the incidence of cough, cough with expectoration, dyspnoea (difficulty in breathing) and lung abnormalities, found a statistically higher incidence among women cooking with smoky fuels. Furthermore, studies in Nepal have shown a strong association of domestic smoke with chronic bronchitis.

Exposure to carbon monoxide (CO), a colourless and odourless gas which is highly toxic if inhaled in sufficient quantities, is also a health problem for Indian women. Evidence points to a strong link between chronic CO exposures and both heart disease and impaired fetal development. Recent evidence points to a strong association of CO with heart diseases.

Indian Express/Manushi

Any condition which results in reducing the blood's capability to carry oxygen to the tissues, like anaemia, will also make a person more susceptible to carbon monoxide toxicity. This is particularly bad for Indian women, who are anaemic in large numbers. Chronic lung diseases will further reduce the capability of the blood to rid itself of carbon monoxide during periods of low or no exposure. There are several factors that make women particularly susceptible to CO exposure. Women generally have less haemoglobin reserve than men, which makes them more prone to anaemia, and also makes them more vulnerable to lower doses of CO than men. During pregnancy, there is additional demand on haemoglobin, further lowering their reserves and making them even more sensitive to CO. This exposure can also affect the unborn child, leading to reduced birth weight and increased perinatal death rates. It is not surprising that respiratory diseases are a leading cause of death among women and girls over the age of five in India.

Women begin cooking as young girls and continue for much of their lives. Young girls may receive significant exposure at their mothers' sides even before the often tender age at which they begin cooking full time. In the case of cooking smoke, inhalation is inevitable because exposure to smoke comes with every breath. Pregnant and nursing mothers generally have no option but to cook and so remain exposed to smoke.

There is general agreement that the health of rural women is significantly worse than that of the rural male population. A number of reasons have been presented to explain this phenomenon: high fertility rates, less access to health care, inadequate diets, and differences in economic roles. Smoke exposure could also be one of the major factors.

There are many steps to be taken that will cut down the exposure to smoke and reduce its adverse impact on women's health. One aspect of the wood smoke solution is to increase ventilation in the homes of the poor. Ventilation improvement could be the least expensive, short-term way to reduce smoke exposure. Unfortunately, house designs are usually decided by the males in the house who do not spend endless hours cooking under these horrid conditions. In addition, certain species of trees known to give off less smoke when burnt should be grown in special forestry programmes.

Improved stoves are also a key factor in solving the problem. The new Nada stove, which former architect Madhu Sarin helped to pioneer, evolved spontaneously out of the traditional stove in the village when Sarin worked closely with the stove users. Sarin works closely with the beneficiaries of the new technology, even at the design stage. For Sarin, involvement of women in stove dissemination programmes is crucial. She argues that women seldom make decisions even about their own technological needs and the little cash that would be needed to purchase new technologies is denied to them by men. Thus, stove dissemination programmes must be undertaken in a way that they support and increase the confidence of rural women. Sarin is today the most successful disseminator of improved stoves in India.

There are serious implications for health policy planners in these findings. Just as supply of clean water is now considered an extremely important domestic need in the rural areas, the supply of clean air is also a matter of high priority for rural women. □

Further Reading:

• Looking at Appropriate Technology, *Women's World, an Isis International publication, Geneva, Switzerland, June 1986.*

UNICEF/Campbell

The earth's population is now over five billion. The majority of these people live in developing countries where the quality of the water supply and sanitation is poor. The World Health Organization estimates that 80 percent of human sickness and disease in developing countries is related to inadequate water supply and poor sanitation. The United Nations therefore declared that the decade of the 1980s would be devoted to providing these countries with adequate water supply and sanitation.

Where water quality and sanitation are problematic, women are greatly affected. Some Third World women expend up to 27 percent of their caloric intake through the heavy work involved in transporting water. This work causes more than fatigue—pelvic disorders and complications at childbirth are often a result. In addition, mothers must contend with the fact that children are disproportionately the victims of water- and sanitation-related diseases. For example, water-borne diarrhoea illnesses kill over five million children in developing countries each year. Other water-related illnesses, such as parasite worms and cholera, also claim many children's lives. Because of women's special role with regard to water supply and sanitation, it is imperative that women be actively involved in all aspects of planning and implementing water projects.

Water: An Obstacle for African Women

(Excerpted from a talk by and subsequent interview with Bibi Hamisi, an extension worker with the Kenya Water for Health Organization and Hilda Paqui, a United Nations Development Program Information Officer from Uganda. Recorded for *Connexions* on Nov 2, 1987.)

Q: How has the Water Decade affected the world population?

Hilda: Due to efforts associated with the Water Decade, 345 million people have gained access to clean drinking water and about 170 million have gained access to better ways of disposing of their waste products. But because of population growth, the number of people without access to clean drinking water at the end of 1985 was the same as in 1979; so we have hardly made a dent. Without the projects of the water decade though, the situation would obviously be much worse.

Q: Besides population growth, what are the other factors which negatively affect water supplies and sanitation?

Hilda: Shifting populations, for one; due to migration, fifty percent of the Third World population will soon be living in urban slums. While water and sanitation are often poor in rural areas, it is even more difficult to find solutions for people living in urban slums and squatter settlements.

Q: What role do women play in this scenario?

Hilda: In 1986, the United Nations resolved that attaining self-sufficiency with regard to food is a top priority in order to help Africa eliminate its current economic bind. In Africa, women are responsible for 80% of the food production. Therefore, unless we release women's time and energy, this goal cannot be achieved. In rural Africa, women must put forth tremendous efforts in order to obtain water. For instance, in Burkina Faso during the dry season, women walk to distant water sources after sunset, sleep there, and then return at dawn carrying 25 kilos of water. You can imagine how physically exhausted a woman must feel after spending at least seven hours collecting water and also after having slept outside. She will have little energy to work in the garden, grow and process food, take care of her family, or generate income. She certainly won't have time to take care of herself. It is also important to train women in agricultural methods and to obtain better seeds and farming tools (for which financial credit is necessary). But time and energy is the most crucial factor in African women's lives. If they do not have the time, they cannot take advantage of training and improved farming equipment.

Q: In which project are you involved?

Bibi: We train women to maintain newly installed, hand-operated water pumps. My major role in this project is to train and mobilize the community.

Q: How did this project get started?

Bibi: Before the water pumps were installed, women had many health problems. Women had to walk four or five kilometers away from home in search of water. The little water they do find is often contaminated. In 1979, we had an outbreak of cholera. The situation was so bad that in 1983 the Ministry of Water Development came up with a plan for providing clean water to help communities control such diseases; the Ministry drills boreholes and we mobilize and train the community. The real challenge of providing villages with water does not lie in drilling wells and installing pumps, but in making sure that the pumps continue to work properly. The community must be trained to do preventive maintenance and to properly care for the pumps, if the project is to be successful.

Q: How do you involve local communities?

Bibi: Before a drilling, community members consult with us about the water availability in their area. After that, we do a household survey to find out how many permanent residents there are in that area. There should be a well and a pump for every 125 residents. Otherwise, they will break frequently from overuse. Then, the community members form water committees whose purpose is to make suggested improvements about the project. We require the community members to contribute money to the project in proportion to their incomes. They get together to discuss how much to contribute either on a daily, weekly or monthly basis. They also select a secretary, a treasurer and a chairperson, who are in charge of financial matters. These three people are usually women, particularly the treasurers. We show them how to make deposits and withdrawals from their banks. Then we hold workshops to train the women in water pump maintenance. After the women learn how to assemble and dismantle the pumps, they get a chance to practice out in the fields and to train other women to maintain the pumps. We do follow-ups to see how they are doing. If they are successful, we finally provide them with a pump. So far, we have provided pumps for fourteen communities, and they are being run well.

UNICEF/Bernard Pierre Wolff

Q: What has led you to give priority to training women?

Bibi: The men are not trustworthy. We had a lot of problems when men took care of the money. For example, in one community we suggested that they get a box in which to store contributions. Although the box could not be opened from the outside, the men found ways to crack it open. That was really upsetting! Our experience in Kenya shows us that men are interested in money more than anything else. Often they care little about the welfare of their own families. Sometimes families have to live without husbands and fathers for several months. We have found that it was of no use to train men to look after pumps because problems would occur, and the man in charge would not be there to take care of them. At one point, the men in the community complained that we were selfish; they wanted us to include more men in the training. We did not want to show them that we did not like them. We have had to begin choosing one man for each training session so that they would feel recognized. Currently, one man and five women maintain each pump.

Q: Who elects the maintenance workers?

Bibi: The communities do. We want them to choose their own people because they know who is good.

Hilda: When the villagers select women to train for hand pump maintenance, there are certain criteria they use. For example, they might choose somebody who lives closer to the well so that she can walk over to the water pump with her children.

Q: Are you working with different women's groups?

Bibi: Oh yes, we work with fundraising groups. First, they register themselves, then they find a way of generating some income.

Q: Have women's roles and status been improved by their involvement in the maintenance of the water pumps?

Bibi: Oh yes, of course, especially because women now engage in income generating activities. Some groups have even started building shops for grinding machines. People walk ten to twenty kilometers to use their grinding machines.

Hilda: When I visited Bibi's project two years ago, another thing the women were doing was growing vegetables around water pumps—using run-off water. By doing so, they can sell the vegetables and raise money for pump maintenance and, in five or ten years, pump replacement. Growing and selling vegetables in the community also helps improve community nutrition. So water pumps have all kinds of spin-off advantages.

Q: In what other ways has the installation of water pumps affected the health of the community?

Bibi: Well, cholera has been eradicated. We have fewer cases of bilharzia. Malaria has remained a problem because there is still stagnant water—it is not spread by drinking water. Diarrhoea is also less of a problem.

Q: What about sanitation?

Bibi: We are in the process of implementing a project that improves sanitation. The Ministry of Health provides the labor, the communities provide the construction materials, and we coordinate the activities of the Ministry and the communities. They have started to construct pit latrines in public areas, such as the health center, mosques, schools, and markets; in some villages groups of ten to thirty people are digging pit latrines for every household. We are trying to use local materials in the construction of the latrines. Local materials are inexpensive. In addition, community members are involved in the construction; thus they have an investment and they also acquire the expertise to maintain the latrines properly. But most importantly, this project, like the provision of water pumps, is improving the health and well being of the women of Kenya. □

Contact:

- International Drinking Water Supply and Sanitation Decade, Hilda Rwabazaire Paqui, United Nations Development Programme, Room DCI-1902, One UN Plaza, New York, NY, 10017.

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- "Women and Water," *Women's World, an Isis International publication, Geneva, Switzerland, June 1986.*
- "Water Well," *Connexions #6, Fall 1982.*
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UNICEF/Campbell

Women and Substance Abuse

Marie Falksten ©

(Translated from an article by Marie-Claire Dumas in *La Vie en Rose,* a Canadian feminist monthly, October 1986.)

Two hundred women gathered at a 1986 conference entitled "Women and Drug Addiction" in a town north of Toronto, Ontario. Women addicts and ex-addicts themselves were the main participants. Most of these women were searching for help—not only with their addictions, but also with the pain that has in so many cases been responsible for the onset of their addictions. All kinds of drug abuses were addressed, from heroin and cocaine to tobacco and alcohol.

Alcoholism is now having a profound effect on young women, single women, and women who live and work in large cities. For these women, alcohol works as a mechanism to help relieve the stress that comes when they don't receive "compensation—financial, psychological, or social—that is their due." Women who are especially at risk are those working in jobs that are menial, repetitive, and low-paying. They face constant battles against low self-esteem and the frustration that comes from doing monotonous work. Since these women have little or no support network, their negative feelings can be repressed, at least temporarily, by drinking alcohol. Unfortunately, alcoholism in Canada is the third leading cause of death among women ages 33 to 55 *(Women's Health).*

The other "legal" addiction which is having a devastating effect on the women's community is tobacco addiction. Cigarette smoking has been increasing among women since the 1960s. In contrast to previous studies, it is now reported that in the 12 to 19 age group there are more girls smoking (25 percent) than boys (20 percent). There are many factors which can account for this historical change. Studies have shown that cigarette smoking is associated with the repression of negative emotions such as anger and anxiety. Unfortunately, women are often discouraged from expressing these negative emotions, and then turn to cigarettes for a release from frustration. In addition, ever since the late 1960s, cigarette smoking has been commercialized as an empowering tool—a habit which signifies women's equality with men. The tobacco industry portrays women smokers as self-assured, strong, and confident. But what the tobacco industry does not tell us is that women in Canada are dying in record numbers from lung cancer and other diseases caused by cigarette smoking.

Women must pay particular attention to the risks of drug addiction, says Louise Nadeau, a toxicologist at the University of Montreal. She believes that women are more at risk because of the nature of women's role in society. The characteristics of the feminine role—self-sacrifice and subservience to others—have brought about a feeling of loss of control over the environment. This loss, she says, "plays an important role in the distress so uniquely felt by women, a distress manifested in certain cases by depression, anxiety, and the use of *mood-altering drugs."*

Another factor which often plays a part in women's addictions to drugs is sexual abuse. Statistics indicate that violence and sexual abuse have been part of the lives of at least 70 percent of Canadian women who abuse drugs. Most women at the Canadian conference felt that 80 to 90 percent are more accurate figures as many cases of sexual abuse go unreported.

What are the best ways to help these women break their cycle of addiction? Many individual treatments were discussed, but the participants agreed that in order to be effective, any approach must be comprehensive. A group in Southwest Ontario, The Women Being Well Project, says that the approach must be positive, but holistic. No treatment program is likely to work unless the causes of the addiction, as well as the addiction itself are treated. Detoxification must include treatment of past sexual abuse and must be tailored to meet the individual needs of the women it serves.

The problems associated with drug abuse are particularly poignant for women of color. Maggie Hodgson explains the toll that alcoholism takes on families of color, "It is easy to understand why the tolls of alcoholism are so high when one examines the degree of personal and collective misery that are ours." Drug addiction treatment centers which cater to white women often cannot address the issues of concern to women of color; consequently the treatments are ineffective. Ms. Hodgson explains what has been done to meet the needs of women of color: "We have formed our own program called *Nechi* (translation: my soul touches yours). Between 60 and 80 percent of our participants are survivors of sexual abuse."

Ms. Hodgson espouses a philosophy of healing that all women would do well to remember: "We reclaim our spiritual center and we work in concentric circles towards the family, our women friends, our community, and towards political action."

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- "The Politics of Quitting Smoking," *by Patricia Rawson and Debbie Holmberg Schwartz, Herizons, a Canadian women's news magazine, December 1984.*

Together We Are Strong

Piers Cavendish/Reflex

Switzerland/Nicaragua

(Excerpted from "Support through Self-Help" in *Women's World,* an Isis International publication, no. 8, December 1985, and "Internationale Kontakte des FFGZ" in *Clio,* a West German feminist self-help magazine, no. 26, March 1987.)

The Dispensaire des Femmes in Geneva is an autonomous women's health center set up in 1978. The sixteen women of the Dispensaire work as a collective. The aim of the center is to provide preventive health care and information and to help women gain better control over their own bodies and health. They do research into and provide alternative treatment, including naturopathy, acupuncture, homeopathy, and nutrition. One of the members of the collective, Rina Nissim, has written a highly successful book on natural healing in gynecology. On visits to Nicaragua, Nissim established contacts with various women's groups there.

Many women in Nicaragua are ill-informed about their bodies and their fertility. A study conducted at the Berta Calderon maternity clinic in Managua showed that 10% of the women who had an illegal abortion died of the ensuing complications, and that another 25% remained permanently sterile as a result of abortion-related infections. Nicaraguan women are working toward reform of the law that declares abortion illegal, and they are trying to make information on contraception and sexuality more readily available. They asked the women from the Geneva Health Collective to share their experience and knowledge with Nicaraguan women.

The women from Switzerland and Nicaragua decided to collaborate on a health project. They traveled around the country in a car equipped with informational material, specula, diaphragms, gel, surgical utensils, gauze, etc. During the summer of 1987, this "mobile women's health center" visited various women's groups in Nicaragua in order to acquaint women with basic knowledge about health and contraception and to support them in their demand for self-help.

This movable project makes it possible to transmit knowledge from one self-help group to another in spite of limited resources. Through the travel of one woman equipped with the necessary materials, many women can be reached.

Mauritius

"Disease NO—Health—YES: A Medical Manual," is a booklet published by four progressive Mauritian organizations: the Bambous Health Project, the daily LALIT, the Women's Liberation Movement, and the literacy program "Education for Work" in 1986. The literacy program, which compiled, printed and distributed the booklet, also used it in their courses. The booklet, written in Creole (which is spoken by 52 percent of the population), explains in an accurate and accessible manner how local diseases come about, how to to cure them, and most importantly, how to prevent them. It covers a range of illnesses including amoeba-related illness, appendicitis and AIDS. With regard to the latter, the manual stresses the fact that anyone, not just male homosexuals, can be affected by the disease.

The Bambous Health Project is a cooperative founded in May 1975. An executive committee takes care of organizational tasks. The project employs a full-time doctor and 350 families participate. In 1978, a pharmacy with all essential medicines was set up. In addition, a one-year training course for health volunteers was instituted. The course trains villagers in basic knowledge of health and hygiene in order to break the monopoly of the medical profession—once they go back to their village they organize their fellow villagers to eradicate various diseases. The courses are taught in Creole. The syllabus comprises functions of the body, first aid, nutrition, occupational disease, women's diseases, contraception, pregnancy, alternative care and preventive medicine. According to the manual, 25%-35% of all diseases could be prevented. The Bambous Health Project considers itself an alternative to both the private medical establishment and the National Health Service. Private medicine is prohibitively expensive, and state-controlled health care is afflicted with bureaucratic control, corruption and political favoritism.

Bangladesh

(Translated from "International Contacts of the FFGZ" in *Clio,* a West German feminist self-help magazine, no. 26, March 1987.)

In 1976, Rokeya Begum founded a women's self-help project called "Self Reliance Development Society" in Netrakona, Bangladesh for women from the nearby slums. Over the course of seven years of organizing and lobbying, Rokeya gained the support of the better-off women in Netrakona. She even received a government credit of $US 5000. With this money, she built a small building to house the project and bought two sewing machines, a knitting machine and an embroidery machine. Seventy women found paid jobs in the project. They manufactured clothes and batiks, sisal wall hangings, bamboo furniture, etc. Soon afterwards the project was expanded. A day care center for children from the slums was set up—the children receive milk at the center once a week. The center offers courses on health-related issues and contraception as well as basic literacy programs. The demand has been so high that the women can only work for a few hours at a time; they have to alternate and many women cannot even be admitted.

The center has often been the target of state control; it was shut down several times for political reasons. In 1985, the machines were confiscated because the women refused to have their project turned into a propaganda instrument of the government. In 1986, the women had to start again from scratch. Rokeya and other women worked tirelessly on the reconstruction of the center. The women have started to work there again, and they plan on setting up a small women's health center.

Monique Jacot/Dispensaire des Femmes/ISIS

Berlin
(Translated and excerpted from "Feministische Selbsthilfe und Gesundheitsarbeit im Rahmen konservativer Sozialpolitik—Eine Standortsbestimmung" in *Clio,* West German feminist self-help magazine, no. 23, May 1985.)

The Feminist Women's Health Collective was founded in 1977. The Collective was organized as a politically motivated self-help group. Our purpose is to make sure that women become fully acquainted with their bodies and become responsible for their health. We encourage women to work with other women to set standards of health and sexuality. We also want to reinforce the awareness that health and disease are intimately related to the overall living condition of women.

We work to provide this service for little or no pay. We publicly demand that women should not have to do any unpaid labor, but have been unable to realize this goal for ourselves. As an autonomous project, we depend on income generated by the Collective and on donations. Most of us must have other income in order to pay our bills. But we do find that working to better women's lives is very satisfying and meaningful work.

Our services at the health collective help to balance the deficits of the state-controlled health system. We have always considered our work not only a reaction to existing shortcomings or a correction of gaps in the state-controlled health system, but also a necessity in the movement toward control by women of their own bodies. We did not expect financial assistance from the government, as we believed that self-determination for women could only take place in an autonomous group. We deliberately disassociated ourselves from traditional patriarchal institutions such as the government health care system. Ironically, that same system has recently begun to praise the women's self-help movement. The government intends to reduce state-sponsored care to a supplemental resource and eventually plans to abolish it altogether.

The government's new alliance with the alternative health movement is highly suspicious. Conservative government officials have finally assessed the economic value of the alternative projects—they conceive of the services as an effective means to save government money. During the recent economic crisis, many women were laid off. The unemployment rate among women doubled from the years 1981 to 1983. Instead of having paid jobs, women were expected to perform some form of social work. Ultimately, this means that the government is unjustly making money off of women's unpaid labor.

The budget for social services has been cut and self-help groups are suddenly deemed important in supplementing state services. How does this translate into daily politics? While the state-run hospitals in Berlin cut two thousand jobs (which saves the state 100 million DM), state agencies encouraged private non-profit organizations to create 467 jobs for social workers (which costs the state 5.2 million). The pseudo-progressive rhetoric surrounding these drastic measures suggests that social services are being qualitatively improved, whereas in actual fact the measures represent regressive social politics implemented mainly at the expense of women.

In June 1982, women's and alternative projects were supposed to receive 10 million DM. In the fiscal year 1983, this amount had shrunk to 7.5 million, and was further decreased in 1984 to 6.5 million. Only half of these monies were directly allocated to various projects; the other half mysteriously disappeared into the state bureaucracy. Moreover, the intention was by no means to gradually provide salaries to more self-help workers, but to allocate just enough money for a part-time or a full-time position; one of the main functions of the recipient of that job was to mobilize and organize volunteers. The privatization of public services is presented as a solution to social problems, but in essence, current social politics will result in the exploitation of self-help health workers.

Further Reading:

• CLIO, a West German feminist self-help magazine, *FFGZ, Bambergerstr. 51, 1000 Berlin 30 (West).* Natural Healing in Gynecology, A Manual for Women, *by Rina Nissim, Routledge and Kegan Paul, London 1986.*

Clio

WOMEN IN THE BAY AREA
We need more volunteers to help with upcoming issues. If you are interested in working on our project, have language, editing, layout or fundraising skills, we'd like to hear from you. See our address on the inside back cover.

Shorts

Canada

(From the proceedings of the Coalition of Provincial Organizations of the Handicapped's Workshop on Disabled Women's Issues; edited by April D'Aublin/Research Analyst; March 1987, Reproductive Rights Workshop by Maria Barile.)

I want to make it clear that when I talk about "choice," I am talking about choice in all areas—the choice to have children, to have an abortion, or to adopt children.

The reproductive rights of women involve four areas. All women must be free to prevent and end unwanted pregnancies regardless of their economic means. "Reproductive rights" also implies that women should be able to choose if, when and how to have children. This means that no woman should be forced into abortion or sterilization, or to risk infertility due to dangerous birth control methods such as Depo Provera and the Dalkon Shield.

Disabled women in particular are discriminated against with respect to reproductive rights. Many people believe that disabled women are psychologically incapable of conceiving and bearing children—that disabled women must decide not to have children. From a very early age, women are made to feel that they have a responsibility to produce healthy children—a disabled child is seen as a woman's failure. Because some disabled women have a greater chance of having a disabled child, disabled women are often coerced into unwanted abortion and sterilization. In addition, disabled women are often sterilized without first having been given the facts about the procedures involved.

If a disabled woman chooses to have children, then the questions arise: Who will care for the infant? Who will pay for extra help or specialized technical aids? When it comes down to it, it is a socio-economic question that our able-bodied sisters do not need to consider. A disabled women is always made to feel that the choice is not hers and her partner's but that of the state.

On the question of abortion, disabled women share with every other woman the concern for safe and economical abortion. Most often disabled women, unlike able-bodied women, are encouraged to have abortions when they become pregnant, even if they are pregnant by choice. The Office of the Handicapped does not have any plan for dealing with childbirth or children. Disabled women are also able to get an abortion more easily than most other women. Now I don't mean to sound pro-life, but our private choice is limited because we are disabled.

There is another problem that comes with reproductive "choice". Through amniocentesis, women are now able to find out if their fetus is disabled. Women can then abort the fetus if they choose. It is a responsibility of those of us who have lived as disabled people to make sure that women find out that it is O.K. to live as a disabled person, and that we have good lives regardless of our disabilities.

UNHCR/A. Diamond

Switzerland

(Submitted by Elizabeth Ferris, World Council of Churches, Geneva, Switzerland, November 1987.)

"I had the feeling that I was dirtying the boat by my mere presence. The others left me more room—either out of pity or because I was 'dirtier' than they were. I was glad if they avoided looking at me." These words, spoken by a Vietnamese refugee about her rape by pirates, convey some of the pain that many women refugees face during flight. Although this

young woman received medical care and counseling when she arrived in Pulau Budong, Malaysia, the physical and emotional consequences will last for many years. The many victims of pirate attacks are but one example of the violence that many refugee women face during their flight to safety. The violence takes many forms: from abuse at European airports to forced prostitution along the Mexican border to sexual exploitation by border guards in Djibouti. The scars of violence run deep, leading to physical and emotional trauma—trauma compounded by the experiences of exile.

It is difficult to generalize about the world's 15 million refugees. But, most refugees around the globe are women and girls and they do face particular health problems. Like all refugees, women often cross borders in a state of exhaustion. Some have experienced pursuit, others have walked for days with little food or water. For refugees arriving in camps or settlements, often times there are inadequate water supplies and poor sanitation facilities. These conditions are conducive to breeding many diseases—refugees are particularly susceptible because of their poor physical state upon arrival. Women often experience malnutrition especially when they are pregnant or breast-feeding. Also, if the food supply is limited, mothers may neglect their own needs in order to feed their children first.

But along with the physical conditions, other factors, less understood by relief officials, influence the health of refugee women. Women are the traditional guardians of culture and are often the ones trusted with keeping families together. Because of this, refugee women feel disoriented by having their culture uprooted and families separated—they are unsure of their role in the new environment.

Although the vast majority of the world's 15 million refugees are women, health services are not set up to meet their needs in many countries. As a woman working with Ethiopian refugees explains, "because the women are responsible for collecting fuel and water and for taking the children to health care and feeding programs, they are the last to receive health care. When the out-patient department was finally set up, men made up 67 percent of the patients. The women did not have the time." For Moslem refugees, cultural factors also limit women's access to health care. In Pakistan, for example, most of the 2-1/2 million Afghan refugees are women and girls. Yet, they can receive medical treatment only from women doctors, who are in woefully short supply. This contributes to further malnutrition and disease.

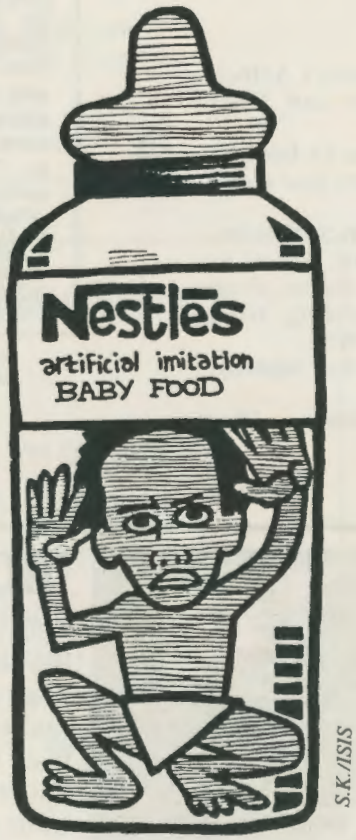
Refugee women not only have serious health needs, but also have an important role to play in preventing disease, promoting nutrition, and in educating the community about the importance of safe water. Their knowledge and experience in traditional medicine is a resource to be used by the community. Refugee women must continue to demand a greater role in making the decisions that affect their health and the health of their children.

Malaysia

(From *Women in Action,* an Isis International publication, Supp. n.6, December 1986.)

The Malaysia-based Third World Network has issued an urgent call for action to pressure the World Health Organization to reverse a policy decision on breastmilk substitutes for newborn children. The policy threatens to undo some of the hard-won gains of the decade-long, worldwide campaign by women's and consumer advocates groups to limit multinational corporations' promotion and marketing of breastmilk substitutes, particularly in developing countries.

The policy came as a result of a request by many countries for guidelines clarifying the intent of the International Code on the Marketing of Breastmilk Substitutes, a model code for national legislation adopted by the World Health Organization in 1981 for limiting the marketing and promotion of bottled milk products. Though grassroots groups consider the code a crucial victory in the struggle to protect breastfeeding from unfair commercial competition, one criticism they have raised all along is that the code still leaves sizable loopholes for infant formula companies.



S.K./ISIS

Partly for this reason, health and policy experts from eight countries met with WHO and UNICEF staff in December 1985 to draft guidelines for implementing the code. One of the most important provisions they agreed upon was that maternity wards and hospitals should not be the recipients of free or subsidized supplies of breastmilk substitutes. (One gaping loophole in the Code has permitted infant formula companies to continue giving large amounts of free milk supplies to hospitals and clinics.) However, this crucial provision was omitted from the final guidelines published by the World Health Organization in May 1986. Anonymous sources inside WHO admitted to the daily newspaper *International Herald Tribune* that the provision was omitted because of pressure from the United States and baby food manufacturers.

The development represents a blow to the pro-breastmilk movement after so many years of fighting for the WHO/UNICEF International Code and launching a highly successful campaign against the Nestlé corporation, one of the major infant formula companies.

The Third World Network asks individuals and groups to write letters expressing their concern over the matter and urging the agencies to reinstate the provision regarding free supplies.

Contact:

• Third World Network,
87 Cantonment Road,
Penang, Malaysia

New Zealand

(From *Women in Action,* an Isis International publication, Supp. no. 6, December 1986.)

The New Zealand Women's Health Network is a national network of feminists concerned about health. The group, created ten years ago, aims to provide a forum for women, especially non-health professionals, to discuss and educate one another on health problems and develop responses to local and national health policies. The network defines health in the broadest sense, encompassing social and economic issues such as alcohol abuse, disabled women's sex problems, lesbian motherhood, incest, industrial health, and patient's rights.

The group carries out a series of regular activities, including publishing a bimonthly newsletter, organizing occasional conferences and workshops, and distributing resources such as a friendly and accessible booklet *Coping with Menstruation: Information for Disabled Women.* Besides dealing with the concerns of disabled women, the group's publications and programs also focus on the health situation and needs of the islands' indigenous Maori women. Finally, the network puts New Zealand women's health groups in touch with women's health groups in other countries.

Contact:

• New Zealand Women's Health Network,
P.O. Box 2312,
Tauranga, New Zealand.

(cont. from p. 11)

little tolerance for abnormalities, diseases and disabilities. I think the motivation behind this intolerance is related to the desire to keep a "superior" gene pool in German society—a desire which has a historical base in eugenic actions taken by the Nazis.

In fact, research indicates that many of the women who were sterilized by Nazi orders led lives that today we would call "feminist." In the special Nazi courts that dealt with forced sterilization, these feminist women were labeled "socially disabled" and therefore candidates for sterilization. It is very frightening to see that involuntary sterilization of women continues in West Germany. But now the issue is being debated with a historical perspective that I hope will motivate people to eliminate the attack on disabled women's reproductive rights. □

Contact:

• Theresia Degener
2318 Parker #A
Berkeley, CA 94704
or
Prozessionsweg 8
4417 Altenberge, Federal
Republic of Germany
• Anneliese Mayer
C/O AG SPAK
KISTLERSTR. 1
8000 München 90
Federal Republic of
Germany
• Judy Heumann
World Institute of Disability
1720 Oregon Street #4
Berkeley, CA 94703

Further Reading:

• With the Power of Each Breath, A Disabled Women's Anthology, *Edited by Susan E. Browne, Debra Connors, and Nanci Stern, Cleis Press, Pittsburg, PA, 1985.*
• Geschlecht: Behindert, Besondered Merkmal, Frau, (A book by and about disabled women), *C. Ewinkel, G. Hermes, and others (eds.), AG SPAK M68, München, 1985.*
• Krüppel-Tribunal, Menschenrechtsverletzungen im Sozialstaat, (A book about violations of disabled peoples rights), *Edited by Susanne V. Daniels, Theresia Degener, Andreas Jürgens, Frajo Krick, Peter Mand, Anneliese Meyer, Birgit Rothenberg, Gusti Steiner, and Oliver Tolmein, AG SPAK, München, 1983.*
• "Das Böse Erbe," *Emma, a West German feminist monthly, November, 1984.*
• "Die sollen—und die anderson dürfen nicht," *Emma, a West German feminist monthly, August, 1985.*

DEAR CONNEXIONS...

Thank you so much! I think *Connexions* is wonderful—it helps to transcend boundaries and barriers...I wish only the best for the collective.

Sincerely,
Joanne M. Ursino
Ottawa, Ontario
Canada

Greetings! I received my very first issue of *Connexions* on women in the visual arts and needless to say, I've enjoyed it tremendously! I am proud to be on the *Connexions* mailing list. "Nakedness: Movement and Confrontation" made me realize that our bodies are such wonderful works of art. Too bad one can't be seen without all the negative additives.

The article on "Shared Moments with Working Children" was great too —very enlightening. It's a sad affair how little children are exploited.

The article "Agents of Change" was like a breath of fresh air! Beautiful. This article holds my ideal concept of progressive change. I personally feel that it would be nearly impossible to convince many men of the importance of women in our society, but we can teach our sons and daughters that men and women are of equal worth. Perhaps if the same approach that "Agents of Change" demonstrates is utilized in our country, we might see progressive change happen in our lifetime. Oh how I wish the feminist movement success and pray for an awakening in the minds of men.

In Solidarity,
Comrade Charles Logan
Jackson, Michigan

(Submitted By Marisella Veiga, Santurce, Puerto Rico)

Woman Waiting

Her eyes are miniature globes, in them there
is a country, one she visits while she
rocks and hopes the country disappears.

She sits on the cold shore, tugging her hair,
watching the clouds strain rain over the sea;
her eyes are miniature globes, in them there

is a country. That one she tried to tear
out of an eye. All day she watches, sleeps,
rocks and hopes the country disappears.

With her hands she covers her eye, the glare
of the sun deranges her diminutive dreams.
Her eyes are miniature globes, in them there

are castles with rooms, but they are bare
Staring at the dark stones, she violently
rocks and hopes the country disappears

behind the rainstorms, into the blue air
yet it doesn't. She sits, waiting for weeks.
Her eyes are miniature globes in them there—
rocks and hopes; the country disappears.

ERRATA for VISUAL ARTS # 24

on p. 3—Doris Lotch should read Doris Lötsch

on p. 25—par. 1: April 27, 1987 should read April 27, 1986

on p. 26—GSMG+K should read GSMB&K Gesellschaft Schweizer Malerinnen, Bildhauerinnen & Kunstgewerblerinnen (member IAWA)

on p. 27—Centre Audiovisuel, Simone de Beauvoir should read Centre Audiovisuel Simone de Beauvoir

on p. 27—Christa Biedermann, artist should read Christa Biedermann and Krista Beinstein, artists

on p. 27—Rahnuma Ahmed, artist should read Rahnuma Ahmed, Nari Shongoti, Dilara Begum Jolly (CONTRIBUTORS), Center for Social Studies, Arts B1 Dhaka University, Dhaka, Bangladesh

on p. 27—Jin Sook Kim, artist should read Jin-suk Kim and In Sook Kim, artists

on p. 27—Duloe Maria Lopez Vega should read Dulce Maria Lopez Vega

on the back cover, the caption and credit should read "Witch" from the series "Witch-Pictures," Krista Beinstein, camera and Christa Biedermann, in front of camera

We apologize for any inconvenience our inconsistencies may have caused.

Health Resources for Women

Argentina

Mabel Bianco, Coordinator of the Women, Health, and Development Program, Defensa 120-4piso, of. 4080, (1345) Buenos Aires, Argentina

Australia

Adelaide Women's Community Health Centre, 64 Pennington Terrace, North Adelaide 5006, Australia

Leichhardt Women's Community Health Centre, 164 Flood Street, Leichhardt, New South Wales, 2040, Australia

Liverpool Women's Health Centre, 273 George Street, Liverpool, Australia

Austria

Österr AIDS Hilfe, Lenaug. 17, A-1080, Vienna, Austria.

Bangladesh

Consumers' Association of Bangladesh, 320/2A West Dhanmandi Road, No. 8A, Dhanmandi RIA, Dhaka, Bangladesh

Belgium

Aimer á Louvain la Neuve, Cour des 3 Fontaines 31, 1348 Louvain la Neuve, Belgium

Brazil

Centro Informação Mulher, (contact for further listings of women's health groups in Brazil), Caixa Postal 11.399, 05499 São Paulo, SP, Brazil

Sexo Explicíto, (a feminist publication often concerned with health issues), Casa da Mulher: Rua Debret, 23/1316 CEP 20030, Rio de Janeiro, R.J., Brazil

Coletivo Feministe Sexualidade e Saúde (feminist health center), Rue Baltezar Carrasco 89, Piuheiros, São Paulo, S.P., Brazil

SOS Corpo, (feminist health organization), Rue do Hospício 859/14, Recife, P.R., Brazil.

Canada

Women Health Sharing, 101 Niagara St., Suite 200 A, Toronto, Ontario, Canada

Coalition of Provincial Organizations of the Handicapped, 926-294 Portage Avenue, Winnipeg, Manitoba R3C 0B9, Canada

Coalition of Provincial Organizations of the Handicapped, Women's Caucus 456 West Broadway, Vancouver, B.C., Canada

Centre de Santé des Femmes du Quartier, 16 Est Bd., St. Joseph, Montreal, Canada

The Immigrant Women's Centre: Mobile Health Clinic, 348 College Street, Toronto, Ontario, Canada M5T 1S4

Calgary Women's Health Collective, 2340 1 Ave. N.W. Calgary, AB T2N 0B6 Canada

Dis-Abled Women's Network, 122 Galt Avenue, Toronto, Ontario, M4M 2Z3, Canada

China

Institute of Chinese Medicine, Gynecological Research Department, Zhang Jingling, Hunan Province, People's Republic of China

Colombia

Grupo de Ajude e Informacion, (AIDS Information), c/o Manuel Antonio Velanda Move, Apdo. Aereo 25770, Bogotá 1, Colombia

Costa Rica

Centro Feminista de Informacion y Accion, Apdo. 5355 San José 1000, Costa Rica

Dominican Republic

Colectivo Mujeres y Salud, Apartado 22248, Santo Domingo, D.N., Dominican Republic

France

Groupe Pratique Santé, 15 Rue J.B. Say, 69001 Lyon, France

Hong Kong

Asian Community Health Action Network, Flat 2A, 144 Prince Edward Road, Kowloon, Hong Kong

India

Women's Centre, (information about amniocentesis and other women's health issues), 104B Sunrise Apts. Nehru Rd., Vakola, Santa Cruz (East), Bombay 400 055, India

Voluntary Health Association of India, C-14 Community Centre, Safdarjung Development Aera, New Delhi 110 016, India

Rural Women's Health Group, Rural Development Society, 15/1 Periya Melamaiyur, Vallam Post, Chingleput 603002, South India

Ireland

Dublin Well Woman Centre 73 Lower Leeson Street, Dublin 2, Ireland

Ulster Cancer Foundation, 40/42 Eglantine Avenue, Belfast BT9 6DX, Northern Ireland

Defend the Clinics Campaign, National Committee, 6 Crow Street, Dublin 2, Ireland

Marie Falksten ©

Radiance/Spring 1986

Italy

Gruppo Feminista per la Salute Della Donna, Vicola San Francesco a Ripa 17, 00153 Rome, Italy

Japan

Soshiren, (Committee Against Revision of the Eugenic Protection for Reproductive Freedom, C/O JOKI, Nakazawa Bldg. 3F, 23 Arakicho, Shinjuku, Tokyo, Japan

Women's Health Action Network of Japan, C/O Japanese Women's Council, Products Bldg., 1-33-3 Hongo, Bunkyo-ku, Tokyo, Japan

Sapporo Group to Stop the Retrogressive Revision of the Eugenic Protection Law, C/O Hirahira, 2F, Nishi 5-chome, Kita 18-Jo, Kita-Ku, Sapporo City, Japan

Women's Health Center, 2-6-2 Tamatsukuri, Higashi-Ku, Osaka, Japan

Feminist Therapy, 93-3-24 Okanouemachi, Toyonaka City, Osaka Prefecture, Japan

Women's Body's Network "Maimai," C/O Hayakawa, 1-44 Yasakacho, Nishi-Ku, Nagoya City, Japan

Feminist Therapy, "Nakama," Rm. 302 Kihara Bldg., 17 Saneicho, Shinjuku-ku, Tokyo, Japan

Asian Women's Association, 14-10-211 Sakuragaokacho, Shibuya-ku, Tokyo, Japan

Kenya

National Council of Women, P.O. Box 43741, Nairobi, Kenya

Breast Feeding Information Group, P.O. Box 59436 Nairobi, Kenya

Malaysia

Health Action International, P.O. Box 1045, 10830 Penang, Malaysia

Consumer's Association of Penang, (publishes information on women's health issues), 87 Cantonment Road, 10250 Pulau, Penang, Malaysia

Mauritius

Muvman Liberasyon Fam, 5 Rue Street, Therese, Curepipe, Mauritius

Mexico

IXQUIC, (published a pamphlet on women and health in Guatemala, May 1987), Apartado Postal 27-008, C.P. 06760 Mexico, D.F., Mexico

The Netherlands

Women's Global Network on Reproductive Rights, P.O. Box 4098, Minahassastraat 1, 1009 AB Amsterdam, Netherlands

Vrouwengezondheidscentrum Utrecht (women's health center), Maliesingel 46, 3581 BM Utrecht, Netherlands

Vrouwengezondheidscentrum Amsterdam (women's health center), Obiplein 4, 1094 RB Amsterdam, Netherlands

Vrouwengezondheidscentrum Katelijne (women's health center), Walstraat 5, 4531 ED Terneuzen, Netherlands

Platform Vrouwen en AIDS (women's AIDS information centre), Maliesingel 46, 3581 BM Utrecht, Netherlands

New Zealand

Hecate Women's Health Collective, P.O. Box 11-675, Wellington, New Zealand

New Zealand Women's Health Network, C/O Sarah Calvert, P.O. Box 2312 Tauranga, New Zealand

Nicaragua

Festasalud, Matagalpa, Nicaragua

Nigeria

Hannah Edemikpong, Women's Centre, (information on AIDS and genital mutilation in Africa), Box 185, Eket, Cross River State, Nigeria, W. Africa

Peru

Centro de Documentacion Sobre la Mujer, Av. Arenales 2626, Lima 14, Peru

Puerto Rico

Taller Salud, Apartado 2172, Hato Rey Station, Hato Rey, Puerto Rico, 92172

Philippines

Gabriela, Room 221, PCI Bank Bldg., Greenhills Commercial Center, San Juan, Metro Manila, Philippines

South Africa

Critical Health, Central Printing Unit/University of Witwatersrand, 1 Jan Smuts Avenue, Johannesburg, South Africa

South Pacific

Maternal and Child Health Department, Central Administration, P.O. Box 149, Niue Island, South Pacific

Switzerland

World Council of Churches, Elizabeth Ferris, Refugee Service, P.O. Box 66, 150 Route De Ferney 1211 Geneva 20, Switzerland

AIDS-Hilfe Schweiz, Postfach 1054, CH-8039, Zürich, Switzerland

Dispensaire des Femmes, 4 rue du Mole, 1201 Geneva, Switzerland

Fraungesundheitszentrum, Sulgeneckstralle 60, 3000 Bern, Switzerland

Frauenambülatorium, Mattengasse 27, 8005 Zürich, Switzerland

Thailand

Women's Information Centre, 113/9 Charasanitwong Road 46, Bangkok 10700, Thailand

Rini Templeton

United Kingdom

Women's Health Information Centre, 52-54 Featherstone St., London, EC1Y 8RT, United Kingdom

The New Internationalist, (an English progressive monthly which often includes articles on women's international health issues), 120-126 Lavender Avenue, Mitcham, Surrey CR4 3HP, United Kingdom

International Contraception, Abortion, and Sterilization Campaign, 374 Grays Inn Road, London WC1, United Kingdom

United States

National Women's Health Network, 224 7th Street S.E., Washington, D.C. 20003

Women's Occupational Health Resource Center, Columbia University, School of Public Health, 600 W. 168th Street, New York, NY 10032

Feminist International Network of Resistance to Reproductive and Genetic Engineering, P.O. Box 441216, West Somerville, Mass. 02144

Reproductive and Genetic Engineering: Journal of International Feminist Analysis, Phyllis Hall, Vice President, Pergamon Press, Maxwell House, Fairview Park, Elmsford, NY 10523

World Health Organization/Pan-American Health Organization, 525 23rd Street, N.W., Washington, D.C. 20037

Boston Women's Health Book Collective, Box 192, West Somerville, MA 02144

International Drinking Water Supply and Sanitation Decade, Hilda Rwabazaire Paqui, United Nations Development Programme, Room DCI-1902, One UN Plaza, New York, NY 10017

Uruguay

Colectivo Maria Abella, Ma. Stagnaro de Munar 105, Barrio Ciccsa, Paso Carrasco, Canelones Uruguay

West Germany

Pro Familia, a health counseling centre, Deutsche Gesellschaft fur Sexualberatung u. Familienplanung, e.V. Beratungsstelle Schluterstr. 14, 2000 Hamburg 13 West Germany

Berliner AIDS-HILFE, (AIDS Information Center), Meinekestr. 12, 1000 Berlin (West) 15

Clio, Eine Periodische Zeitschrift zur Selbsthilfe, a feminist self-help magazine, Feministisches Frauen Gesundheitszentrum, e.V., Leignitzer Str. 5, 1 Berlin 36 (West)

Yugoslavia

Women, Society and Health Group, Student Cultural Centre, M. Tita 58, 11000 Beograd, Yugoslavia

Zambia

African National Congress, Women's Section P.O. Box 31791 Lusaka, Zambia

Zimbabwe

Women's Action Group, (Publishes information on women's health issues), Box 135 Harare, Zimbabwe

★★

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Penpals

Call for international penpals! Wishing to exchange letters with other women. Let's share our experiences. Sherry Hudson, 3060 Marshall Avenue, #314, Cincinnati, OH 45220.

Lesbian Woman, 25 years old, seeking lesbian support. Contact: Ebere Chukwu, c/o Dopa Fashion, 4 Kenneth Road, Awkunanaw, Enugu, Anambia State, Nigeria.

Lesbian of Color, 30, seeks to connect with others age 25-35, who share interest in art, farming, true appreciation for any peoples of color; their culture respected. Please write Marie Douglas, 200 Vassar Drive, S.E., Albuquerque, NM 87106, USA.

Instruction

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★★★

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