Female Genital Mutilation

Dear Editor,

Today female genital mutilation (FGM), a practice that involves injury and removal of healthy female genitalia, is receiving increased attention. This practice is allegedly occurring in Canada. Worldwide, it is believed that over 100 million girls/women living today have undergone FGM. In Metropolitan Toronto, community groups have estimated that there are 70,000 immigrants from Somalia and 10,000 from Nigeria, both countries in which FGM is commonly practised. For progress to be made in eradicating FGM, a comprehensive, intersectoral health promotion approach is needed. Actions should not be separate and discrete but, rather, should interact and support one another.

FGM covers a spectrum of types. Clitoridectomy is removal of the clitoris. Excision is the removal of the clitoris and partial or complete removal of the labia minora. Infibulation is the complete removal of the clitoris, the labia minora, and partial or complete removal of the labia majora.

All communities have a preferred age or period when FGM should be undertaken. The most typical age seems to be between four and ten. FGM appears to be a practice designed to control women’s sexuality and reproductive function. The reasons given to justify FGM are numerous and reflect reproductive function. The reasons given designed to control women's sexuality and reproductive function. The reasons given.

Health promotion efforts initiated and controlled by the local community are important. Affected communities need help to strengthen the capacity of community members to effect change and prevent FGM. Education should be only one part of a multifaceted approach to prevent FGM. Skills development is needed to help individuals cope and resist cultural pressures.

Health problems arising from FGM may occur at different stages in the lives of affected girls/women. Some complications may occur immediately or shortly after FGM is performed; other complications may occur years after the procedure. Health care services need to be responsive to the needs of girls and women affected by FGM. Professionals need to understand the broad determinants of health influencing the practice of FGM. A multidisciplinary approach should be used.

Caring for girls/women who have undergone any form of FGM requires great sensitivity and cultural awareness. A client-centred, community-based approach should be used. A girl/woman affected by FGM may feel that she cannot express her feelings or describe her experiences, or may not understand what is being said. She may feel a lack of privacy when using interpreters, particularly if they are men.

For progress to be made in eradicating FGM, it is necessary to consider a comprehensive, intersectoral health promotion approach, so that one will read about FGM only in history books.

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REFERENCES


Emerging and re-emerging communicable diseases

Dear Editor,

I read with interest the article by Dr. David M. Forrest “Control of Imported Communicable Diseases: Preparation and Response” (Canadian Journal of Public Health 1996;87:368-372) and the accompanying editorial by Dr. Ronald St. John (“Emerging Infectious Disease: Repeat of
an Old Challenge” 365-366). I agree with them that there is a need for a change of paradigm. Indeed, this reinforces Dr. B. Gushulak’s article¹ and the accompanying editorial by Dr. St. John in 1994.²

Emerging and re-emerging communicable diseases surfaced as a high-priority public health topic after the Institute of Medicine report in 1992.³ Dr. Forrest refers specifically to the Centers for Disease Control and Prevention (CDC) goals that soon followed. I might add that the Laboratory Centre for Disease Control (LCDC) also conducted meetings of experts and developed scientific recommendations.

With the increased frequency and speed of travel and the emergence of new infectious organisms there is widespread acceptance of the need for broader international collaboration. I offer the following points in the interests of introducing such a perspective.

In 1992, the World Health Organization (WHO) recognized this issue as a priority, developed a plan for implementation, and in 1994 created a Division of Emerging Viral and Bacterial Disease Surveillance and Control. Closer to home, the Pan American Health Organization (PAHO), and Control. Closer to home, the Pan American Health Organization (PAHO), which is also a regional office of WHO, developed a regional plan of action to address emerging and re-emerging diseases.⁴

The plans of WHO, PAHO, and CDC, not coincidentally, share the same basic goals: improved surveillance, strengthening of public health infrastructure, development of prevention and control protocols, and support for applied research.

PAHO has since held several meetings and training sessions to identify high-priority surveillance needs and to improve laboratory diagnostic standards, particularly with reference to the detection of antimicrobial resistance. Canadian representatives from LCDC have been intimately involved in both planning and training activities in Latin America and the Caribbean. Canadian participation in region-wide initiatives is welcome and important. Canadians could also learn from the examples of their southern neighbours. Indeed, Canada was the last country in the Pan American system to introduce a measles elimination policy, which even today is implemented unevenly nationally.

Those who would like to learn more about specific disease control activities in this hemisphere are welcome to contact me at PAHO.

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REFERENCES

Creutzfeldt-Jakob disease and growth hormone therapy

Dear Editor,

In 1985, Creutzfeldt-Jakob disease was reported in young adults who had received pituitary-derived growth hormone (GH) during childhood. To date, there have been more than 70 cases reported worldwide: 15 in the USA, 15 in Great Britain, and over 40 in France. No cases have been reported in Canada, Japan, or Australia. The continued occurrence of cases worldwide requires vigilance by all physicians in reporting unusual neurological deterioration in any person who has received pituitary growth hormone.

Since 1988, there have been more than 45 cases of leukemia reported worldwide in children and young adults with GH deficiency treated with GH. There have been two cases in Canada. These cases of leukemia occurred de novo and do not include recurrences of primary leukemia. It is not clear yet whether the risk of leukemia is increased in the GH treated population. Pseudotumour cerebri has been reported worldwide in association with early GH therapy, most often in children with chronic renal failure, Turner’s syndrome and GH deficiency with obesity. There have been four reported cases in Canada to date.

Physicians who note any unexplained neurological or hematological changes in persons previously treated with GH are requested to notify Dr. Heather Dean, Chairperson, Canadian Growth Hormone Advisory Committee at (204) 787-4553 or (204) 787-7435.

Heather J. Dean, MD, FRCP
Chairperson
Canadian Growth Hormone Advisory Committee

Evaluating Asthma

Dear Editor,

In “Asthma and Limitation of Activities in Fort Saskatchewan, Alberta” (Can J Public Health 1996;87(6):397-400), Hessel et al. reported the findings of a community survey of parents of elementary school children. To these authors, the findings suggest that residents of the town of Fort Saskatchewan, Alberta, have an elevated prevalence of asthma (13%, both sexes) compared with elsewhere in Canada and with a site in southern Alberta studied by Dales.⁵ Fort Saskatchewan is singled out as possibly being affected by air pollution. A similar survey of communities in the Edmonton metropolitan area (but not Edmonton itself) showed an overall prevalence of about 8.6% (both sexes).³ The reader is left with the impression that Fort Saskatchewan is clearly a “hot spot” for asthma in Canada. This may not be accurate.

Fort Saskatchewan was one of two communities involved in an unfortunate and heavily publicized epidemiologic mistake in 1986.⁴ The mistake involved a miscalculation of cancer incidence data and falsely suggested that the Fort and an adjacent community were at risk. Until the mistake was publicly corrected in 1987, the perception of risk had a great impact on the communities, including such tangible effects as
falling property values. A telephone survey we conducted in 1987 showed that residents of the Fort were much more likely than residents of a comparison community to agree with the statement that members of their family were at risk for health problems (43% v. 1%) and that this was because of their environment (49% v. 4%). As well, they were more likely to believe that they and their neighbours were at higher risk for allergies (46% v. 13%); we did not ask about asthma specifically. When the error was publicly corrected in 1987 many residents did not believe the authorities who announced the correction. Unsupported allegations of health problems have dogged the community since, most recently in association with groundlevel ozone formation.

Dales et al.6,7 in two studies that addressed the prevalence of health characteristics in a similarly traumatized Alberta community,8 proposed that increased awareness of health6 and psychological factors including anxiety7 may be sufficient to explain an increase in reports of respiratory symptoms at levels comparable to those reported by Hessel et al. (in the order of 10% to 30%), particularly among the parents of school children. An equally plausible alternative explanation, therefore, is that parents in Fort Saskatchewan were deeply concerned and were more likely to report the diagnosis of asthma on that basis. This is a classic situation favouring recall bias.

Hessel and colleagues also studied the second community affected by the 1987 epidemiological mistake; this is not mentioned in their article. The prevalence of asthma in the second community was said to be as high as 14.7% (both sexes); the details have had to be gleaned from the local news media because no scientific reports were released at the time.9 This community, near Fort Saskatchewan, had the advantage that several members on its county executive had lived through the 1987 cancer scare and had learned from the experience not to take allegations of health risk at face value.10 They did not passively accept the announcement and immediately requested a confirmation study from Alberta Health. This study found no evidence of increased health care utilization, hospital separation, or mortality for the diagnosis of asthma and/or any related respiratory disorders among the residents of either that community or Fort Saskatchewan, compared with other communities in Alberta (D. Schlopflocher, oral communication, 1996). Thus, there is no confirmation from health care utilization, morbidity, or mortality records to support the findings presented in the article. This has been known since at least September 1996.

Hessel et al. raise the possibility that asthma in Fort Saskatchewan may be associated with exposure to either ambient or indoor air pollution. It is easy to infer risks to health from air pollution in Fort Saskatchewan because the town supports a concentration of industry. However, at this time it is not possible even to say that residents of Fort Saskatchewan have an elevated risk of asthma.

Fort Saskatchewan residents have already been affected by allegations of a health risk that turned out to be incorrect. They, and indeed every community, deserve sensitivity and consideration in how such allegations are handled, how they are communicated, and how they are validated.10 Studies that allege such risks without confirmation or without taking into account obvious sources of bias may do injury to a community.5 In this case, as before, the Fort has been poorly served.

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Dear Editor,

Dr. Guidotti has made several points in his letter: (1) that we have given “the impression that Fort Saskatchewan is clearly a ‘hot spot’ for asthma in Canada”; (2) that the asthma data might not be valid; and (3) that the community has been “poorly served” by the report. There are errors in fact and interpretation in his letter that warrant comment.

Guidotti stated that the prevalence of asthma determined in Fort Saskatchewan was 13%. In fact, approximately 13% of children had a history of asthma; the prevalence of asthma was 9.9%. The distinction is made clearly in the article. He stated that “to these authors, the findings suggest that residents of the town of Fort Saskatchewan . . . have an elevated prevalence of asthma . . . compared with elsewhere in Canada and with a site in southern Alberta”. The rate of 9.9% is elevated in relation to the rates reported by Dales et al1 from a variety of centres across Canada (average: 4.7%, range: 3.3 to 7.4%). It was not elevated in relation to the rate reported for a site in southern Alberta (i.e., 9%),2 nor was that suggested in our article. We noted in our article that the prevalence rate in Fort Saskatchewan was also comparable to the rate found in a similar study in Edmonton.3

Guidotti has contrasted the incorrect rate of 13% with a rate of 8.6% that was found in a “similar survey of communities in the Edmonton metropolitan area.” The rate of 8.6% was not presented in our arti...
Ambient air pollution must be considered as the community is situated east (down wind) of a large industrial complex. The prevalence rates, however, differ little from those found in an earlier study in Edmonton. The potential effect of residential indoor air quality must also be considered as this is a relatively new community with many modern, well-insulated houses. Asthma is a respiratory condition characterized by an exaggerated pulmonary response to inhaled substances. The literature is replete with examples of outdoor and indoor allergens that influence asthma. To suggest that the outdoor air and the indoor air should be examined as possible risk factors for a respiratory condition that affects one in ten children in Fort Saskatchewan or any other place seems entirely reasonable. The statements do not suggest that the authors are assuming knowledge or even suspicion regarding the key risk factor or factors in this community.

The letter by Guidotti underscores the need for clear, unambiguous communication of the results of epidemiologic results — even basic, descriptive data.

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Director, Epidemiology Program
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An Appeal to the Canadian International Health Community

*Dear Editor,*

Over the past decade, donor agencies in more developed countries (MDCs) have gone through a relative shift in funding patterns, from broadly based program support (which permitted greater discretion within the recipient country regarding the use of these funds), to project-specific funding, which is now the norm.

It is, of course, critical that the new pattern of support should focus on projects that reflect the verifiable needs of less developed countries (LDCs), even while taking into account other national and institutional interests. While many issues are important in assessing priorities, one of the most important is accurate information on mortality trends and patterns.

As noted in a recent letter to the editor, non-communicable diseases have superseded communicable, maternal and perinatal conditions as the leading causes of death in all regions of the world except Sub Saharan Africa (SSA) and the Middle East. These diseases now dominate in all age groups over 14 years, except in SSA.

The implications of this continuing shift in the burden of mortality (which is also reflected in estimates of morbidity) must be addressed. To illustrate this, we focus now on premature mortality among women. We believe that myths (false perceptions) are perpetuated about the predominant causes of death among women, which can only be dispelled by reference to these data.

The leading causes of death among women aged 15-64 (by our definition “premature”) are presented in Figure 1. Leading the list is stroke, followed in rank order by ischemic heart disease, diabetes mellitus, cervical cancer, breast cancer, motor vehicle accident, acute respiratory disease, maternal causes, and tuberculosis. This simple distribution of premature mortality should have some bearing on priority setting and funding patterns.

It is possible to take any one of these conditions and advocate projects for their prevention and control. Certainly, stroke and ischemic heart disease should be highly rated in terms of preventability. Similarly diabetes, a condition in which Canada’s advances have led the world, offers great potential for international collaboration to reduce both incidence and complications. To take cervical cancer, another condition for which Canada has a
comparative advantage, this fourth ranked cause of premature mortality in women produces three times the impact of tuberculosis, itself a condition of widely acknowledged public health importance. Both conditions are equally preventable, but cervical cancer has received little systematic attention in LDCs until recently.4,5

This brief overview is intended to provoke questions, which should be grist for debate nationally and internationally. A full discussion is beyond our scope, as we wish simply to allow the mortality data to speak for themselves. Are there any takers?

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REFERENCES

The Validity of Qualitative Research

Dear Editor

My initial delight with the letter from Dr. Larry W. Chambers (“Qualitative and quantitative research methods”, CJPH vol. 88, Jan/Feb issue, pp. 9-10) dissipated upon reading his final remarks about qualitative research.

As one whose research for the past two decades has been based on qualitative methods I can only applaud Chambers’ plea for recognition of the relevance of these approaches to studying health and health care. His claims for the inappropriateness of randomized controlled trials (RCTs) in many circumstances are also laudable, albeit limited: there are many other reasons why RCTs, despite their seeming elegance, are inappropriate means to answer health-related questions, especially when one seeks understanding of a phenomenon. What raises my concern, however, is his implication that in order to “count” as research on a par with the refined RCT, qualitative research must follow approaches such as those set out by Glaser and Strauss and their followers.

In appearing to suggest that qualitative research be judged by its adherence to the techniques of these approaches, Chambers’ letter risks being interpreted as a call to make ethnographic, interpretive and phenomenological studies conform to positivist assumptions in order to be considered valid and/or reliable.

Readers should be aware that Glaser and Strauss’s elaboration of grounded theory offers but one way of doing research, one that has its own limitations. And while medical sociologists have tended to follow the precepts of Glaser and Strauss, medical anthropologists and humanists, among others also studying health-related matters, have developed a whole panoply of approaches from which we have learned much, for example, about the meaning of illness and thus why people behave as they do in the face of disease; about the exchanges that go on between physicians and patients; about people’s perceptions of and responses to risk factors, both internal and external to them (and thus how best to conceptualize public health programs); and so on (for a useful summary of many of these, see Denzin and Lincoln).6

It is essential that all these methods, including the growing application of participatory research approaches that do not strictly conform to the “rules” of grounded theory development, be not just supported but also greatly encouraged. RCTs have been faulted for their idealization of the real world and thus their limited usefulness in day-to-day practice. This makes rich qualitative research, which reveals and assesses reality as perceived by those living it, absolutely essential. As evidence-based medicine becomes increasingly the newest buzz-phrase, let us not forget that experience provides evidence as much as does observing the effects of manipulating some intervention under controlled conditions. There is no one way to interpret an observation, nor is there but one observation that can be made of any situation. May our many observations and our multiple interpretations all flourish.

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REFERENCE