Summer, 1986
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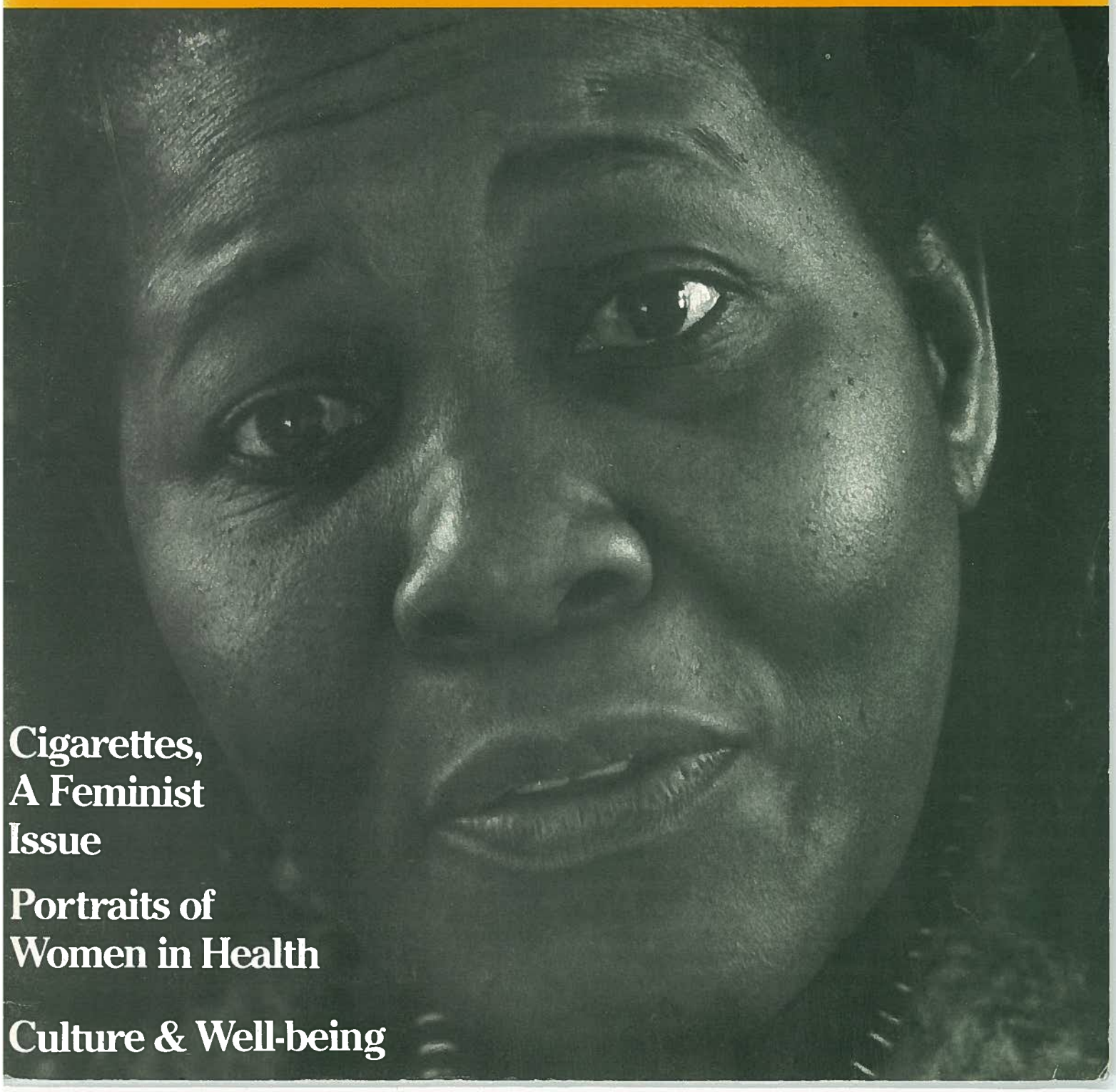
# Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY



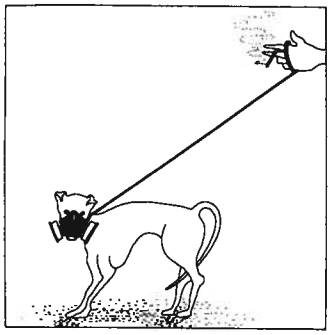
## Cigarettes, A Feminist Issue

## Portraits of Women in Health

## Culture & Well-being

# INSIDE

## FEATURES





## ALWAYS IN HEALTHSHARING




**Vol 7:3**

**Published by**
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**Printing**
Delta Web Graphics

Healthsharing (ISSN: 0226-1510) Volume VII, Number 3, June 1986. Published quarterly by Women Healthsharing Inc., 101 Niagara St.,No. 200A, Toronto, Ontario M5V 1C3. Telephone: (416) 862-1791. Women Healthsharing endeavours to print material with which we agree; however not every article or column reflects the opinion of all collective members.



Unsolicited manuscripts or artwork should include a stamped self-addressed envelope. Subscription rates are $8/year, individuals; $15/year, organizations and groups. Add $1.50 to all foreign subscripitons, including subscriptions to the United States. Second class mail registration no. 5327.

# COLLECTIVE NOTES

## Women and Smoking

"I had to spend a few minutes in the kitchen collecting myself," said a woman who had for the first time refused a dinner guest permission to smoke in her house. She was flustered, she said, because although she wants to claim her right to a smoke-free environment, especially in her own home, she has sympathy for people in the grip of the tobacco habit — it would be more accurate to call it an addicition.

We at *Healthsharing* have a deep concern for both individual and public health, and a commitment to combat smoking. But we agree with Peggy Edwards (see *Cigarettes, a Feminist Issue*) that it is both unhelpful and inappropriate to blame the victim of the smoking scourge. Many women we asked said they got hooked on cigarettes when they were 13 or 14 years old and have never broken the habit.

As the Canadian cigarette industry pours hundreds of millions of dollars yearly into billboards and magazine ads, new smokers are being recruited as quickly as former smokers either quit or die. Advertising that equates smoking with sexiness, maturity, glamour and health is aimed at attracting new young smokers. Studies quoted in Edward's article cite an alarming increase in the number of teenage women smoking. The results are all too clear: lung cancer is about to overtake breast cancer as the leading cancer in women.

What can be done? Be aware of the risks. Inform and question yourself if you are a smoker or considering smoking.

We must demand provincial and municipal legislation to ban smoking in the workplace. Workers must insist on a safer working environment from employers. Some action has already been taken.

At Action Daycare in Toronto, smokers were paired with non-smoking buddies who kept the cigarettes. If she wanted to smoke, the smoker had to ask her buddy for a cigarette. The request was never refused, but the tactic forced the smoker to break the pattern of unconscious smoking.

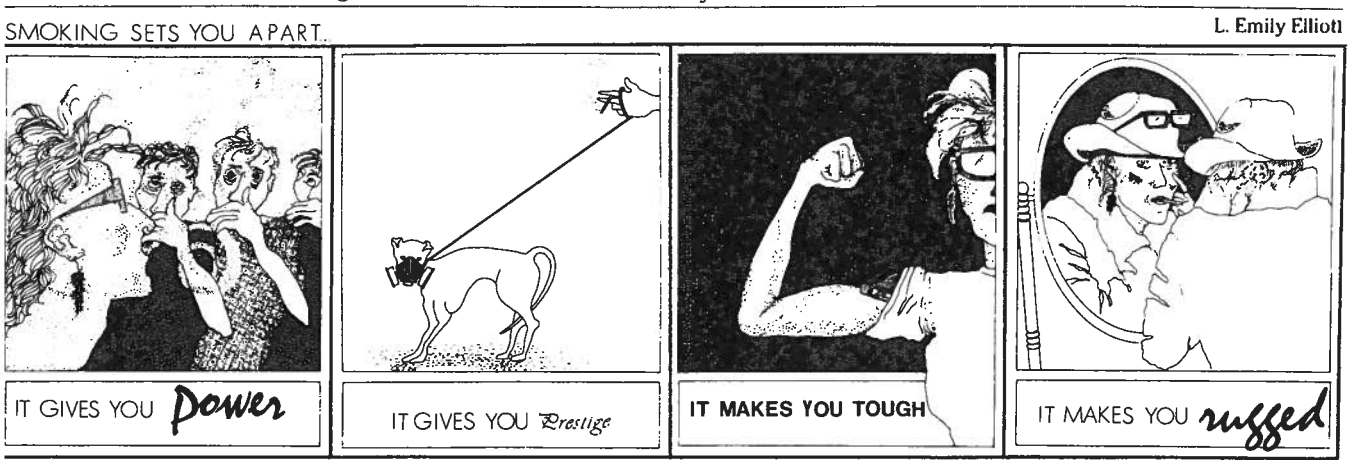
In January 1985, the daily newspaper, *The Kingston Whig Standard* became the first Canadian workplace to relegate smoking to a designated area. Workers were permitted to spend unlimited time in the smoking room but were not allowed to smoke at their desks. At first the smoking room was always packed. The smokeless lunchroom was used only by the apple-cheeked few. Gradually the balance shifted as the air cleared and fewer smokers consumed fewer cigarettes. By all accounts the policy has been a great success.

Campaign for strict enforcement of the Federal Excise Act and the Tobacco Restraint Act, laws which prohibit the sale of cigarettes to minors. Some Canadian retailers still sell single cigarettes to children. We must challenge the bogus cigarette advertising code. Cigarette advertisers pledged more than 10 years ago to adhere to a code forbidding them to try to recruit new young smokers. Most recently, R.J.R. Macdonald's Tempo ads, aimed straight at a glamourous, chic and very young population, have shown this code to be a sham.

Speak to your doctor about the strategy of some British doctors, who printed postcards addressed to members of Parliament. Each time a patient died of lung cancer (every 90 minutes in Canada, Peggy Edwards reports), the MP received a postcard saying "Your constituent has just died of lung cancer. Please rush to legislate smoking controls."

At Healthsharing we have a no-smoking policy. We recognize that the cigarette habit is a true addiction and we encourage smokers to join support groups so that they can meet the challenge of quitting with the help of other determined people.

*Elizabeth Amer, Amyra Braha, Connie Clement, Susan Elliott, Connie Guberman, Diana Majury, Lisa McCaskell, Heather Ramsay.*



# UPDATE

## Abortion coalition re-forms

MONTREAL — The Coalition pour l'avortement libre et gratuit (Coalition for free and accessible abortion) announced its re-formation at a Montreal press conferenced on February 18th. This followed their February 8th founding meeting which was attended by over 150 people from more than 90 groups — representing clinics, women's groups, unions, hospitals, religious groups, political and student organizations. Despite relatively good access to abortion services in Quebec since the mid-70's (compared, that is, to the rest of Canada), a number of events have occurred in the past year which have heightened the need for a coalition to ensure the survival of abortion services in Quebec.

In Ste. Therese, a small town north of Montreal, Pro-Vie (pro-life) groups managed to take over the administrative council of the CLSC (community clinic) and so succeeded in cutting off all local abortion services. Pro-Vie groups have also announced their intention of taking the CLSC's which perform abortions to court and may be targeting another hospital for takeover of the board of directors. Reggie Chartrand, a well-known ex-boxer, has threatened to take Dr. Morgentaler to court (again!). Meanwhile, the new Liberal government's position on abortion remains unclear.

The Coalition agreed on two overriding principles: that women have an inalienable right to make decisions about their bodies and that women have the right to freely choose their pregnancies, which includes the right to free, accessible abortion. More specific objectives are as follows: the abrogation of articles 251 and 252 of the Canadian criminal code (the present abortion law); complete and accessible family planning services in all regions of Quebec; education on sexuality beginning in the first years of school; complete, safe services for voluntary termination of pregnancy in all regions of Quebec; that all these services be paid for by the state.

Plans are underway for a public tribunal on the Canadian abortion law to be held in Ste. Therese, and a submission will be made to the Rochon Commission, currently holding hearings on the organization of health-care services in Quebec. Many other local and nationally linked actions were discussed, as the Coalition mobilizes to counter the small but vocal anti-choice minority. For information on the coalition call: Denise Larochelle, (514) 598-2092, or Lise Gratton, (514) 270-6883.

LESLIE MYERS
DEBORAH VAN WYCK

## Naturopaths deregulated

While many Ontario doctors are upset about government intervention, one group of Ontario health professionals are upset with their now deregulated status. On April 3, Ontario Health Minister Murray Elston announced that naturopaths will be excluded from new provincial health care legislation.

Recommendations for regulatory reform were made by a legislative committee which has been studying various health occupations since 1983, mainly to determine which ones required statutory regulation to protect the public interest. The committee decided that naturopaths, who have been providing government regulated alternative care for 61 years, do not pose a risk of harm to the public and therefore do not need regulation.

According to Elston, naturopathy is based on a philosophy of natural healing, and it is extremely difficult to define standards of practice. Patricia Wales, a Toronto chiropractor and naturopath, says that it is difficult to define standards of practice but not impossible.

"Taking away legislation means the public loses the ability to find out who is trained and qualified to do what they do," said Wales, who is president of the Ontario Naturopathic Association (ONA). Registered naturopaths usually have seven years of post-secondary education: three years of university and four years at a recognized naturopathic college.

Despite deregulation, naturopaths will be allowed to practice. But Wales fears that, without legislative regulation, there is real danger of prosecution for practicing medicine without a licence.

M.M. CRAPPER

## Iron overdose dangerous for children

HAMILTON — Canadian children are being given excessive amounts of vitamins each year a research team from Hamilton has concluded.

This is not only a waste of money since most of the excess is eliminated rapidly from the body, but in the case of multiple vitamin pills containing iron there is the danger of overdose poisoning. Iron is toxic at a dose of 60 milligrams per kilogram of body weight and at 200 milligrams per kilogram it is lethal. At present there are no studies on the long-term effects of subtoxic doses of iron or vitamins.

This study noted that 71 per cent of parents gave their children vitamins, sometimes of several varieties during the peak winter flu and cold season. Dr. Robert Issenman states that children on average consume several times the recommended daily requirement of most vitamins and that the emphasis should be on the deficiency of fibre and the excess of salt and sugar in children's diets rather than vitamin and iron supplements.

SUSAN ELLIOTT

# Canadian Women Celebrate International Women's Day


Jan Skeldon design, Sally Gibson

# lew screening method for genetic defects

ıe Medical Research Council Canada is funding a study of orionic villi sampling (CVS) 13 hospitals affiliated with edical schools across Canada test the safety and accuracy this newest method of tecting chromosomal normalities. Unlike mniocentesis, which cannot done until the sixteenth eek of pregnancy, CVS can be ne in the ninth to twelfth eek of pregnancy and a erapeutic abortion if cessary can be performed in e first trimester when it is sier and safer for the woman. sults from CVS are available 8-10 days as opposed to 3-4 eeks from amniocentesis. For /S a small sample of the orionic villi or frond-like tissue surrounding the embryo is removed through the cervix and vagina using ultrasound for guidance. The cells removed are prepared for microscopic analysis to determine the presence of Down's syndrome, Tay-Sachs disease and other genetic defects.

CVS has been widely used in the United States and many European countries for approximately two years but up until now has not been available in Canada. A comprehensive study of diagnostic accuracy and complications such as miscarriage arising as a result of the procedure has not been undertaken in any country to date although it appears that the miscarriage rate for CVS is higher than for amniocentesis.

Researchers are planning to include about 2,100 women who are less than 12 weeks pregnant and are 35 years of age or older in the Canadian study. Half the volunteers will be tested by CVS and half by amniocentesis, with the individual method being determined by random selection. Volunteers will not be able to choose which group they will be in. Although there will always be women for whom CVS will not be suitable, if it proves to be safe and accurate, it may become an attractive alternative for early detection of genetic abnormalities. Interested women should contact the Genetics Department at the participating university nearest them. To date McGill University, the University of Ottawa, the University of Toronto and the University of British Columbia have begun taking patients. The other centres which include the University of Calgary, the University of Alberta, the University of Manitoba, the University of Western Ontario, McMaster University, Queen's University, the University of Montreal, Laval University, and Dalhousie all plan to be fully operational by mid-summer 1986.

SUSAN ELLIOTT

# Walkman at work

The Canadian Centre for Occupational Health and Safety in the March 1986 issue of its newsletter "At the Centre" warns that wearing stereo headsets on the job could be an occupational hazard. The biggest problem with headsets is that they isolate the listener from the sounds of the workplace — sirens, fire alarms, whistles and even shouts of warning which could be crucial if working around heavy equipment such as trucks or forklifts. When operating automated equipment, the worker is less likely to be aware of unusual equipment noises that may be a clue that the machine is malfunctioning. Even if sitting in one position for long periods, as for example when sorting out mail or operating a keyboard, a worker with a headset will be less aware of the sound 'cues' around her — cues that are often one of the first indications that something is wrong in the workplace. The other great danger is long-term hearing loss caused by exposure to high volumes sound levels above 85-90 decibels over prolonged periods. Most headset users turn the volume up to drown out surrounding sound. If workplace noise levels are already high this could be a dangerous practice.

British Columbia recently took steps to banish all stereo headsets from the workplace. The Industrial Health and Safety Regulations under the British Columbia Worker's Compensation Act, Section 13.29 states: "Workers in any work area shall not wear muff-type hearing protectors or headsets which have been designed or modified to accept AM or FM radio or other music sources." While at work headset music should be turned off and the sounds of the workplace turned on.

"At the Centre" is published quarterly and is available without charge by contacting: The Canadian Centre for Occupational Health and Safety, 250 Main St. East, Hamilton, Ontario, L8N 1H6 or calling their toll-free number 1-800-263-8276.

# Breast cancer risks

The risk of developing breast cancer increases dramatically if a woman has both a mother and a sister with the disease.

Researchers from the Center for Disease Control in Atlanta, Georgia have completed a study comprised of 4,735 women aged 20 to 54 years who had newly diagnosed primary breast cancer and another 4,688 age-matched controls drawn from the general population of the various study areas. The relative risk of breast cancer was 2.3 times higher in women with one first degree relative (mother or sister) with the disease than in women with no family history of breast cancer, 1.5 times higher in women with an affected second degree relative (aunt or grandmother), 2.2 times greater in women with both a first and second degree relative with breast cancer and 13.6 times higher in women whose mother and sister were both affected.

SUSAN ELLIOTT

# Interstitial cystitis

Interstitial cystitis is a little-known bladder ailment, frequently misdiagnosed as the common bladder infection and treated with antibiotics. But while bladder infections can be cured with antibiotics, interstitial cystitis cannot. In fact, some researchers believe antibiotics may intensify the condition. Its symptoms, which are indistinguishable from those of the usual bladder infection, include severe lower abdominal pain and an urgency to urinate up to 70 times a day. But IC is not an infection. Urine tests show no bacteria or fungi. In IC the lining of the bladder is inflamed, causing irritation and scarring.

Because urine tests show no infection, patients are often told the problem is imagined, says Vicki Ratner, MD. Ratner, who herself suffers from the disease, says the ailment is poorly understood and rarely recognized. IC was once thought to be a postmenopausal disorder, but it is now being recognized in significant numbers of women under 40 years of age. Women account for 90 per cent of all cases. While Finnish physician K.J. Oravisto estimates two in 10,000 people have IC, Ratner believes more exist undiagnosed.

Although little is known, researchers believe IC may be caused by damage to the bladder wall from recurrent infections, antibiotics or allergies. No known cure exists for IC, but various medications have been found to relieve symptoms.

Further information is available from the Interstitial Cystitis Association, P.O. Box 4178, Great Neck, N.Y. 11027.

ANNA KOHN

# Post polio

The Ontario March of Dimes which was originally established to help people with poliomyelitis has reported a disturbing phenomenon — the occurrence among polio survivors of a new series of health problems. Epidemics of the polio virus struck in the late 1930s, 1940s and early 1950s. About one in five of the people who recovered from the disease are now experiencing terrible fatigue, muscle weariness, respiratory problems, pain and disability — 25 to 30 years later. A voluntary registry, which to date has over 1600 names of post polio survivors, has been set up by the organization. Registrants receive a complete information package at no charge as well as details about post-polio support groups.

As well, two new publications are available which are useful both for individuals in the health care professions and polio survivors interested in learning more about post-polio syndrome. "A Survey of the Late Effects of Poliomyelitis" is a 45 page report on recent health and functional problems obtained from 600 polio survivors in a 1984 survey. "The Proceedings of the Roosevelt Post-Polio Seminar" is a 38 page publication focusing on discussions at the mid-1985 seminar of the same name. It contains a U.S.-Canada overview of post-polio issues; a discussion of the late effects of polio; and current concepts of the cause and treatment of post-polio syndrome. Both are available for $5.00 each by writing to The Ontario March of Dimes, 60 Overlea Blvd., Toronto, Ontario, M4H 1Z6.

Sally Gibson

ıdy Rebick, O.C.A.C., Michele Harding, Ontario Health Coalition and Bob White, U.A.W.-Canada news conference to protest extra billing held at the Ontario Legislature in March.

# :xtra-billing ban?

nce elected a year ago, the ntario Liberal government ıs been promising to end :tra-billing by the province's )ctors. Extra-billing is an nount paid by a patient over ıd above the rate that is imbursed by the Ontario ealth Insurance Plan. The ınada Health Act, introduced 1984 by then health minister onique Begin, requires all ıysicians to accept provincial surance payments as full es. Ottawa has been thholding transfer payments those provinces that refuse comply with the Act in the nount roughly equivalent to what doctors are extra-billing their patients. In Ontario this adds up to $53 million annually and it is estimated that as of January 1, 1986, the province has lost the use of over $79.2 million. Ontario, Alberta and New Brunswick are the only provinces that still allow extra-billing.

It was Tommy Douglas, then NDP premier of Saskatchewan, who in 1959 first introduced the principle and practice of a provincial health insurance plan. With this successful example Mr. Justice Emmett Hall in 1964 was able to introduce Canada-wide medicare, stating "Health services were no longer items to be bought off the shelf and paid for at the check-out. Nor was their price to be bargained for at the time they were sought. They were a fundamental need, like education, which Canadians could meet collectively and pay for through taxes." The majority of Canadians apparently still agree since seven provinces have now banned extra-billing. A 1985 poll commissioned by the Ontario Nurses' Association, a member of the Alliance to End Extra-Billing, found that 70 per cent of 600 Ontario residents disapproved of the practice.

# ]enign breast disease and diet

nign breast lumps can be ccessfully treated without edication, according to a cent article in volume 255 of e Journal of the American edical Association.

Studies have shown that noval of cigarettes, caffeine, ocolate, meat, fish and ultry from women's diets eatly reduces benign breast sts. These items all contain )stances that can act in conjunction with the body's own hormones to activate the breast's milk production system. With repeated exposure certain areas of breast tissue develop into fibrous or fluid-filled lumps. There are a number of other potential stimulators including emotional, hormonal and physical factors that can also contribute to the problem.

But caffeine, cigarettes and meat seem to be important causes. In three-month treatment plans these items were removed from women's diets and daily supplements of vitamins A, B complex, C and E as well as iodine and selenium were added. Reduction of painful symptoms was impressive, especially the time response to discontinuation of caffeine.

ANNA KOHN

## Threatened Mobile Unit

TORONTO — The Mobile Health Unit, an outreach project of the Immigrant Women's Centre, may have to discontinue its service to immigrant women by the end of June, if permanent or interim funding is not secured from the Ministry of Health.

The Mobile Health Unit is a 28-foot, self-propelled vehicle equipped with two counselling areas and one examination room. The Unit visits factories, upon approval from management, to provide multilingual counselling on family planning and preventative health care to immigrant women and to give women the opportunity to be examined by a female physician. It has been in existence for close to two years and represents a unique approach to health care in Canada. Responses from the women, factory supervisors and doctors have been excellent.

Given that the Mobile Health Unit provides family planning and related services to hard-to-reach and high risk immigrant women and that its objectives fall within the mandate of the Health Protection and Promotion Act, (1983) Ch. 10, Sect. 5, Subsect. 4, to ensure good family planning care for everyone, *the Unit must continue and its funding be secured from the Ministry of Health.* The Unit needs $55,000 yearly to continue its operations.

Peggy Edwards

# Cigarettes
## A Feminist Issue

I remember my university days in the late sixties when I joined a small group of women who had begun to speak out on women's health issues. Secure in the belief of our own immortality, we bonded together to break new ground, to laugh, to share experiences and to smoke. Little did we know that the health hazards associated with smoking would in the long run earn us the equality in death we fought for in life.

In Canada today, a woman dies every three hours of lung cancer — an incurable smokers disease that 10 years ago was considered rare in women. Like men, female smokers also risk increased rates of emphysema, stroke and heart disease. Unlike men, women who smoke face a cluster of additional health problems linked to reproduction. At the Fifth World Conference on Smoking and Health, Dr. Mary Jane Ashley, an epidemiologist at the University of Toronto, presented evidence that female smokers using oral contraceptives are 39 times more likely to suffer heart attack or stroke than non-smoking, non-users of the pill. Other recent research indicates that a woman who smokes is slower to conceive and 10 times more likely to miscarry than a non-smoker. She may also experience an early menopause — a factor that can accelerate the onset of osteoporosis.

Despite these facts, Canadian women are smoking more than ever. Counted among them are several of my sixties friends, who try as they may, cannot break free from tobacco.

"Many women who are active in the women's movement still smoke," suggests Annette Clough of the Vancouver Women's Health Collective. "That may be one of the reasons why the feminist health community has been relatively silent about tobacco. It's a lot easier to take a position on something that is not so personal."

**Cigarettes are smoked by 2.5 million Canadian girls and women. They cause more illness and death than any other drug.**

Francis Ennis, Director of the Women's Health Education Project in Newfoundland, speaks candidly about her experience. "I started smoking when I worked at the telephone company because everyone else did. We didn't think it was dangerous then. Later at university I became a regular smoker. It was a way to cope with the stress of exams and a small way of rebelling. I always rejected the traditional 'blame the victim' attitude about smoking." Francis did quit smoking on Jan. 22 of this year. Though she misses cigarettes so much "I could eat them," she's determined to stay smoke-free.

Like Francis, many of us have argued passionately against messages that "blame the victim" by overstating personal responsibility and discounting societal influences in issues such as wife battering or sexual abuse. It seems ironic that we have been so slow to challenge tobacco by acknowledging that changing roles, market exploitation, economic status and social pressures may be critical factors in why women "choose" to smoke. We have campaigned tirelessly against pharmaceutical products that endanger women. Yet tobacco — an addictive product with over 50 carcinogens and a host of other noxious agents — has remained in our minds as a legitimte product of personal choice. "If cigarettes were drugs and tobacco companies were drug companies," asserts Annette Clough, "feminists would have made tobacco a political issue long ago."

It is time to recognize tobacco as a feminist concern. Cigarettes are a deep political issue with roots in the changing social context of women's lives. According to a Health and Welfare report, *Smoking Behaviour of Canadians 1983*, cigarettes are smoked by 2.5 million Canadian girls and women. They cause more illness and death than any other drug.

## )minous Trends

etween 1970 and 1983 male smoking eclined 15 per cent while female noking declined only 4 per cent (all ges). Teenage girls now smoke more ıan boys the same age (25 per cent nd 21 per cent respectively), and 'omen account for the greatest rela- ve increase in heavy smoking (25 lus cigarettes a day). Eleanor homas, a policy analyst on women's sues for Health and Welfare Canada, xplains that "because of the lag-time etween smoking and disease (20 plus ears in some cases), it takes a long me to see the health consequences." lore than any other disease, lung ıncer parallels the incidence of smok- ıg. In the past ten years lung cancer ıortality among women has in- 'eased by 45 per cent; within the next ve it will exceed breast cancer as the ading cancer in women.

Tobacco also discriminates against ıildren. Recent evidence confirms ıat babies born to smokers are at reater risk for low birth weight, respi- ıtory disease and Sudden Infant eath Syndrome. One British study ınd that children aged seven and 11, 'ho were born to women who noked 10 or more cigarettes daily uring pregnancy, lagged an average f three to five months behind children f non-smokers in reading and math.

Yet recent data suggests that there is substantial increase in the number of :gular female smokers in the child- earing years. According to the latest allup poll conducted by the Health romotion Directorate of Health and /elfare Canada, the percentage of 20 ) 24 year old women who smoke aily increased from 40 per cent in 1983 to 52 per cent in 1985 and the percentage of 25 to 29 year old women smoking daily increased from 34 per cent to 47 per cent.

## Why are Women Smoking More?

In the face of irrefutable evidence that smoking causes illness and death to both the smoker and those close to her, why are women smoking more? Bobbie Jacobson, in her book *The Ladykillers: Why Women Smoke*, suggests that women smoke under stress or to hide negative feelings such as anger, frustration or sadness, in contrast to men who smoke more for pleasure and relaxation. "Tobacco Smoke is a chameleon," says Neil Collishaw, Chief of the Tobacco Products Unit at Health and Welfare Canada. "While the initial reaction is one of euphoria and satisfaction, 20 minutes later its effect on the sympathetic nervous system makes the smoker feel edgy and anxious. So the same cigarette can act as a tranquilizer or as a stimulant, depending on the way the smoker perceives her situation."

Added to the physically addictive nature of nicotine is the psychological addiction-learned behaviours, such as lighting up with a cup of coffee, that become triggers for another cigarette. Cheryl Moyer, Director of Public Education for the Canadian Cancer Society, points out that while there is a multitude of reasons why women smoke, "weight control is clearly a factor in why some girls start to smoke and fear of gaining weight is a real barrier to quitting." "It's not enough to say you can be glamorous and slim without smoking," asserts Margaret Clarke, a Winnipeg based Program Officer with Health and Welfare Canada. In a culture that glorifies female slimness and eighty per cent of high school girls think they are too fat, "weight control and body image must be addressed in a no smoking health promotion campaign directed at women."

It is often suggested that smoking rates among women reflect the double stresses of family and work responsibilities that are, in most cases, different from men. Striving to be the perfect mother, career woman, homemaker and wife (dubbed the "Superwoman Syndrome") leads to high levels of chronic distress — one of the most significant factors in predicting smoking relapses. According to the Newfoundland Women's Health Education Project, women in that province identify stress, particularly as it relates to unemployment, as foremost in their minds. Many of them find smoking has a calming influence. "Smoking provides a little bit of an outlet," says Francis Ennis, Director of the Project.

## Cigarettes As Symbols

"Cigarettes are more than just a break," says Eleanor Thomas, who was once a heavy smoker. "They are such an integral part of your life that they become symbols of the way you live.


## Percentage of Young Canadians Who Smoke Daily, 1982-85

| Female | 1982 | 1983 | 1984 | 1985 |
|---|---|---|---|---|
| 12-29 | | 32 | 36 | 39 |
| 12-19 | 24 | 25 | 25 | 25 |
| 12-14 | 10 | 12 | 13 | 6 |
| 15-17 | 30 | 30 | 29 | 34 |
| 18-19 | 37 | 36 | 40 | 36 |
| 20-29 | NA* | 36 | 43 | 49 |
| 20-24 | | 40 | 45 | 52 |
| 25-29 | | 34 | 42 | 47 |

*NA = Not available

It is estimated that the percentage of 20-24 year old women who smoke daily increased from 40 per cent in 1983 to 52 per cent in 1985 and the percentage of 25-29 year old women increased from 34 per cent to 47 per cent.

For example, when a harrassed young mother lights up, it is a symbol of her separation from the children's world, her time to be herself." When Eleanor finally quit for good 15 years ago it symbolized something else: "the feeling that finally I was in control."

At the turn of the century, the negative moral connotations attached to women smoking set the stage for the cigarette as a symbol of emancipation — an image that the tobacco industry actively fosters to this day. In the early 1920s defiant young flappers who smoked were commonly expelled from college. In the years that followed, the social revolution of women's emancipation began to break down the taboo on female smoking. Two world wars saw women gaining further entrance to the man's world. Smoking was linked with patriotism and women moving into non-traditional jobs. Rosie the Riveter, a symbol of the new age, is credited with asserting that "a woman doing a bang-up job wants a bang-up smoke."

The tobacco industry was quick to ride the wave of social revolution, responding to women's growing independence with increasingly seductive ads including testimonials from movie stars and athletes. In a brilliant marketing manoeuvre, American Tobacco introduced a significant new slogan "Reach For A Lucky Instead of a Sweet." Lucky Strike sales soared and the cigarette has remained the companion of the weight-conscious modern woman to this day.

While smoking has been linked to emancipation, it is not synonymous with the woman's movement. Although early feminists may have smoked in defiance, Dr. Mary Jane Ashley presented evidence at the Fifth World Conference on Smoking and Health, that non-smokers in the 1980s were just as likely to identify with the women's movment as smokers; indeed, well-educated emancipated women are less likely to smoke.

What is the social meaning of cigarette smoking for the contemporary woman? For many young girls, beginning to smoke may still signify rebellion and independence. Once hooked, smoking takes on quite a different meaning. Susie Orbach, in her book *Fat Is A Feminist Issue*, points out that "Feminism has taught us that activities that appear to be self-destructive are invariably adaptations, attempts to cope with the world." In 1986, smoking is an act of self-destruction — a coping mechanism for women who, in most cases, would desperately like to stop.

In today's world women earn less than men. Sixty-eight per cent of Canadian women who are working outside the home are employed in clerical or service industry jobs which offer them little recognition or control over their working lives. These occupations have the second highest proportion of regular smokers. Transport, mining and construction (which largely employ male blue-collar workers who similarly have little control over their careers) have the highest number of regular smokers.

Over 80 per cent of single parent families are headed by a female. American studies have found adolescent smoking rates are approximately double in a single-parent household.

If feminists are to play a part in tobacco control, we must show women alternative ways to deal with their world, while striving to attain the social and political changes that will better all our lives.

## Trying to quit?

In most cases cigarette smoking is a true addiction. To get off tobacco requires great determination. Many smokers find they can't do it alone. If you are among these women, contact a women's health group, community health group or a private clinic or practitioner in your area. Listed below are organizations which stress prevention but also provide some support and information for smokers trying to quit. If you have no access to a support group, contact The Lung Association which provides a do-it-yourself booklet at a minimal cost.

The difficulty with some clinics and practitioners is prohibitive cost. (One group charges $500 up front, with no guarantee of success.) Some health groups are responding by pressing for the "medicalization" of anti-smoking treatment, making the costs eligible for government medical plans/benefits.

A recent breakthrough by pharmacologists is the invention of a nicotine gum available only by prescription. *The Medical Post* of March 11 reports a two to three times higher quit rate among doctors' patients who used gum and those who did not. While the responsible use of nicotine gum can help some smokers to quit by separating nicotine addiction from smoking "habits", *Healthsharing* cautions that some women have reported an addiction to the gum.

### Organizations involved with the prevention of smoking

Non-smokers Rights Association
Suite 308,
334 Bloor Street West
Toronto, Ont. M5S 1W9
416-928-2900

Canadian Council on Smoking & Health
725 Churchill Avenue
Ottawa, Ontario K1L 5G7
613-722-3419

### Also contact local and provincial offices of

The Canadian Cancer Society
The Heart Foundation
The Lung Foundation
The Heart & Stroke Foundation
The Addiction Research Foundation
Provincial and Federal Ministries of Health
Municipal Departments of Health
Provincial Interagency Council on Smoking and Health

## Social Acceptability is The New Battleground

Pat Zipchen, an active member of the Canadian Council on Smoking and Health, thinks that the irrefutable evidence of the harmful effects of second-hand smoke and the growing acceptance of the non-smoker's right to clean air are the catalysts to another social revolution. She likens it to her experience with spitoons, which were

opular and acceptable in her days as young nurse. "It was only after the ›itoon was identified as a carrier of B and people were fined for using ne that it became a socially unaccept-›le habit. Like the spitoon, we now now that tobacco not only hurts you - it affects your neighbours health as ell."

Exposure to second-hand smoke is ssociated with a long list of health roblems including eye irritation, ausea, headache and an increased cidence of bronchitis and allergic actions. A recent Health and Welfare anada report estimates that up to 500 on-smokers die each year from lung ncer, caused by second hand smoke.

Pat points to the growing demands r a smoke-free workplace as a criti-l step forward. "Young people in the hools are responding to the fact that nployers prefer non-smokers. It's coming a consideration in whether not they choose to smoke."

## he Politics of Tobacco

aced with the prospect of gradual ecline in smoking behaviour in the dustrialized countries, the tobacco dustry has stepped up its efforts to cruit women and young people and open up new markets in the Third orld.

The industry, which is controlled by ve transnational tobacco conglomer-es, spends over $12 billion worldwide n its enormous, image-based adver-sing campaign. While denying that ey direct advertising to youth, the dustry brazenly admits to targetting omen. A front page article in a 1981 lition of Advertising Age quotes the esident of R.J. Reynolds as describ-g the female market as "probably e largest opportunity for the com-any." He goes on to say that the work-g woman, under stress, is the ideal ndidate for their product.

Tobacco advertising is particularly gnificant in women's magazines, an portant health information source. izabeth Whelan, author of #A Smok-g Gun: How The Tobacco Industry ets Away With Murder, suggests that e editorial policy of these magazines stricts reporting on the health conse-ences of smoking. *Ms. Magazine, ew Woman, Redbook* and *McCalls* cept over 12 per cent of their adver-tising revenues from cigarette com-panies. A review of these magazines by the American Council on Smoking and Health revealed a paucity of artic-les on smoking, despite their compre-hensive coverage of other health is-sues.

In contrast to traditional health education campaigns which often emphasize women in their roles as wives and mothers, cigarette adver-tisements have consistently presented women as individuals who are glamor-ous, active, independent and modern. At a quick glance at the March 1986 issues of three Canadian family maga-zines: *Homemakers* (3 ads)f, *Chate-laine* (2 ads) and *Canadian Living* (1 ad), reveals the latest campaign — advertising that insidiously blends cigarettes with health and fitness. A beautiful fit young woman fresh from her fitness workout sits on the gym floor, enjoying her Matinee Slim (they're *milder* because they're *slim*). My 14 year old daughter found 10 ads in her latest edition of *Games*, a monthly magazine featuring contests and games for young people. The majority of the ads were for Marlbor-ough, the number one selling cigarette among children.

It seems unbelievable that we would "buy" the image that cigarettes im-prove the quality of life. Women who smoke heavily have nearly three times as much bronchitis, 75 per cent more chronic sinusitis and 50 per cent more peptic ulcers as non-smokers. Smokers are absent from work or school almost twice as many days as non-smokers.

Tobacco promotion is not limited to advertising in magazines nor is it sub-ject to legal restrictions in Canada. Instead, the tobacco industry has agreed to self-regulate under the terms of a voluntary advertising code. A recent report from the Non-Smokers Rights Association documents how 11 of the 19 codes have been violated in a variety of recent promotion schemes. The allegations include sponsorship of televised sporting events although the code bans all television advertising; and, offering prizes in violation of another rule against incentive pro-grams. Thanks to Mark Ten cigarettes, a woman who smokes a pack a day for 27 years can collect enough coupons to get a baby carriage.

## Breaking The Silence

"If we are to avoid a female epidemic of death and disability, women's health groups must break the silence" asserts Pat Zipchen. "Persuading young girls not to start and helping women to quit must become a priority."

There are four ways that the women's movement can work toward the eventual elimination of the tobacco hazard. One way is to advise and inform women of the harmful effects of smoking, particularly as they relate to the addictive nature of tobacco and the synergistic effect of oral contraceptives and smoking.

Secondly, we can press for more research on the specifics of why women smoke and lobby for prevention and cessation interventions tailored to women. For example, some researchers have shown that cessation groups restricted to female membership are more effective for women than co-ed groups.

Thirdly we can support the changing social climate for a smoke-free environment. By quitting ourselves, we make a public statement. By sensitizing women to the social and political nature of tobacco, we begin to push public consciousness. By ensuring smoke-free spaces at our own functions, we can help each other find different ways to cope. By participating in inter-agency programs to reduce smoking we add our support to a growing coalition of groups who are actively seeking a smoke-free environment.

Lastly, we can enter the political arena of tobacco control. In so doing, we come into conflict not only with one of the world's most powerful industries but also with the political forces that reject the intrusion of government in the free market. Free from these political constraints, women's groups have always been strong advocates for women's health. We can begin by pressing for a comprehensive approach that includes educational programming and legislation that restricts the tobacco industry and its deadly product.

As feminists we know that changing political opinion requires imagination, drama and commitment. As women, we know that personal concern can collectively blossom into public outrage. And public outrage can go a long way to changing our world.

*Peggy Edwards is a health and fitness consultant currently employed in the Tobacco Unit, Health Promotion Directorate, Health and Welfare Canada. She welcomes your comments. Write to her c/o Health Promotional Directorate, Health and Welfare Canada, Jeanne Mance Building, Tunney's Pasture, Ottawa K1A 1B4.*

### Further Information

Bobbie Jacobson. *The Ladykillers: Why Women Smoke.* Eden Press. Montreal, 1983.

Elizabeth Whelan. *A Smoking Gun: ow The Tobacco Industry Gets ay With Murder.* The Peoples Health Library. Philadelphia, 1984.

*Smoking Behaviour of Canadians 1983.* Available from the Health Promotion Directorate, Health and Welfare Canada, Jeanne Mance Building, Tunney's Pasture, Ottawa K1A 1B4.

# WOMEN IN HEALTH

Afua Cooper

# Portraits

**photograph by Pamela Harris**

*Everbody recognizes that new Canadians and Native Canadians face bias when they come to deal with the health-care system. Most often the bias is attributed to language barriers. Too often we ignore the cultural factors that affect beliefs, behaviours and symptoms. The follqwing portraits show how some immigrant women, women of colour and native women are working to eradicate the bias and enrich the existing system by incorporating the wisdom of other cultures.*

## Thompson Women's Shelter

Eunadie Johnson, an ex-police officer from Dominica, came to Canada, alone, in 1967. Although she knew little about the country and no one in Manitoba, she decided after a brief consultation with a Canadian immigration official to head west. Now, almost 20 years later, she is an executive director of the Women's Shelter in Thompson, a Manitoba mining town more than 700 kilometres north of Winnipeg. The area is populated mainly by native people.

Eunadie first worked in Winnipeg as a companion to a disabled woman. She then moved on to an administrative job in a local hospital — a position she was later fired from because of her complaint about sexual discrimination. "The four top persons were men and the 400 workers were women. I felt that the women workers should have a representation at the top that reflected our numbers. I protested and they let me go."

She was married while in Winnipeg and moved to Thompson with her husband. She soon began doing volunteer work at the women's shelter. "As part of my volunteer work," Eunadie says, "I did a lot of public education, that is, making the community more aware of wife abuse." Because of her impressive work, she was later appointed executive director of the centre.

Women who use the shelter have often been badly beaten. "Some of the women have to be taken to the hospital as a result of their physical wounds," says Eunadie. Others may have drug or alcohol problems. Shelter workers discourage the use of drugs. Instead, they provide counselling and self-help groups and put the women in touch with doctors sensitive to their needs. Health care in Manitoba is free which makes it easier for women to get the necessary care.

At the shelter specific health issues like pregnancy and birth control are dealth with. Abortion counselling is also available. However Eunadie contends that getting an abortion in Thompson is almost impossible. Women must travel to Winnipeg and be reviewed by the therapeutic abortion committee of a hospital with no guarantee of approval. If the pregnancy is 12 weeks or more, the woman must travel to the United States. "For women who are poor, this can be quite stressful," Eunadie says.

Eunadie Johnson

In addition to health counselling, the shelter has developed assertiveness and self-development programs. "The women come here with low self-esteem, with negative self-concepts. We try to teach them to be assertive, we allow them to discover their own self-worth, we encourage them," Eunadie states. She also feels that development counselling is crucial as 80 per cent of women coming from abusive situations eventually go back. "We want them to be able to say no, we want them to be more assertive."

Central to self-development is skill development. Women who come to the shelter are often unskilled and are encouraged to take part in Manpower training programs. Some women do academic upgrading and several have become nurses, social workers and teachers.

The shelter is open 24 hours a day and has a staff of 14, including two

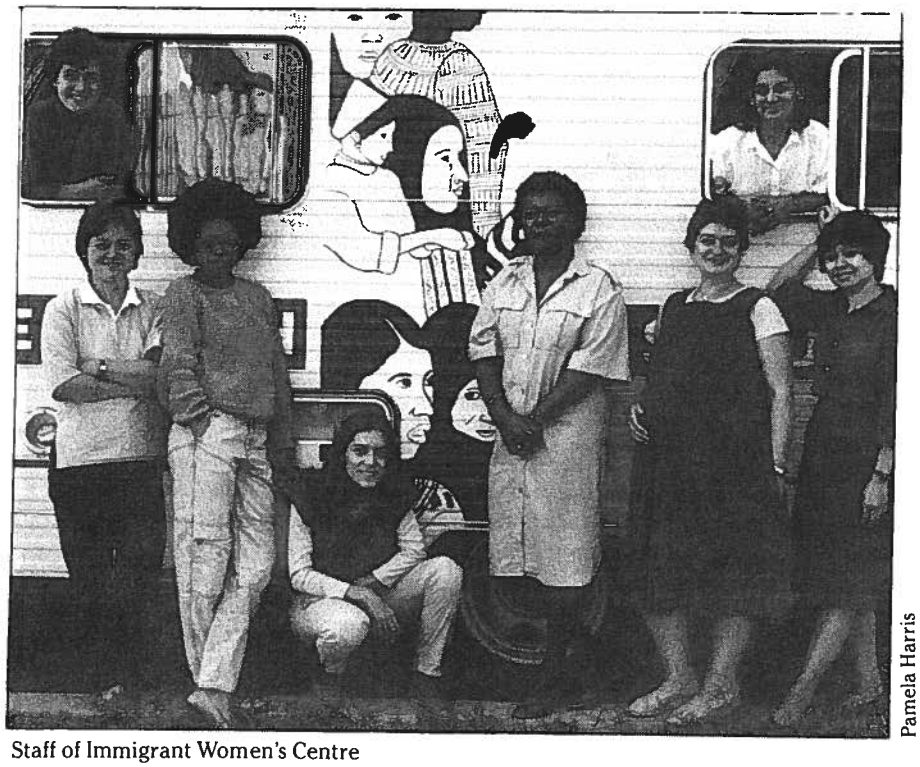
# WOMEN IN HEALTH

outreach workers. It's 20 rooms are always full. Most women remain at the shelter for only a short time but they can stay for up to six months if necessary. Funding comes from the provincial government and the women also pay a minimal fee if they can afford it.

Eunadie would like to see more shelters and safe houses. "What I mean," she says, "is that there should exist in the women's communities safe places where they can remain while waiting to come to the shelter. Sometimes it is difficult to get to the shelter as lakes are frozen, so the women cannot get a boat to come across. Some communities in northern Manitoba are very isolated and thus I feel that it is crucial to establish safe places where the women can run for refuge."

Eunadie Johnson is happy in Thompson. Although she admits that she misses Caribbean cultural events and foods, there is an Afro-Caribbean association in Thompson. There are about 20 families of Caribbean background in town. "We have our own events like cultural shows and picnics and there's a strong bond between us."

"I like Thompson," says Eunadie, "I can live anywhere provided I'm involved in the work I want to do and enjoy doing that work."



Pamela Harris

Staff of Immigrant Women's Centre

## Immigrant Women's Shelter

The Immigrant Women's Centre is a community-based health service which promotes health among immigrant women. It has adopted a holistic approach focusing on well-being, not just on the absence of disease. Dionne Brand, a counsellor at the centre says they do not just "give the women information and services but also that these services are designed specifically to empower immigrant women to take control of their bodies."

Counsellors at the centre identify language, culture and race as vital components to be considered in any communication or education process. Accordingly, staff is multilingual and multiracial.

The IWC was established in 1975 to fill the need that existed among immigrant women for proper health care. Services are used mainly by women of Caribbean, Chinese, Spanish, Italian, Portugese and Vietnamese backgrounds. Counsellor Patricia Hayes states that immigrant women did not and still do not have access to professional health care, not only because of language barriers but also because of their specific jobs. "Immigrant women," she says, "tend to be concentrated in service occupations or as textile and garment workers. These jobs tend to be among the lowest paid and women are reluctant to take time off to have routine examinations. After the working day is done, medical services are relatively unavailable."

Many of the counsellors have backgrounds in community health. Some are nurses. The centre operates a clinic every Tuesday evening staffed by a doctor, usually a woman. Hayes says the centre provides counselling, information and referrals on a variety of health matters — detection of breast and cervical cancers, pregnancy and childbirth, gynecological infections, family planning, good nutrition, stress management, patient rights. "We stress the concept of preventive health care," she says, "since many women seek medical attention only in crisis situations." On average, about 200 women use the clinic each month.

Although the centre was very successful, staff realized that many immigrant women were not and could not make use of the services. They were unable to take time off work, and after work had to rush home to attend their families' needs. In an attempt to bring health services to these women, a mobile clinic was opened by the IWC in January 1984. Like the centre, the Mobile Health Unit places emphasis on reproductive and preventive health care.

When a work site is selected, the major language group or groups are identified and the appropriate counsellors travel with the clinic. Before the mobile clinic sets up, IWC counsellors come to the factory or shop and, in lunch break presentations, tell the women what the clinic is and does,

# WOMEN IN HEALTH

and start to identify their problems. The women themselves usually determine topics for discussion. Counsellors give out pamphlets and schedule appointments.

The clinic usually stays in one place for four or five days and operates five hours a day. Women who attend do so without loss of pay. This is arranged by the Mobile Health Unit, the local Board of Health, the union involved and management and owners of the work site. Patricia Hayes says that most employers agree "the women should be given the time to attend to their health." Each woman meets first with a counsellor to discuss her health problems. They go together to see the doctor where the counsellor serves as a translator.

Dionne Brand describes the work of the Immigrant Women's Centre and the Mobile Health Unit as "consciousness raising." She sums up their work: The women do have knowledge and information of their own health, their own bodies. We do not play God, we do not act as the source of all knowledge. We try to demonstrate to the women that the information on their health is not exclusive, not the sole property of the medical profession. We want women to take their health in their own hands, to take control of their own bodies. That in itself can have deep social, economic and political ramifications."

## Marjorie Beaucage

Marjorie Beaucage is a Metis woman who lives in Winnipeg, Manitoba. She works as a training consultant on popular education and is deeply committed to a spiritual and holistic definition of health.

Majorie defines health as "being whole in mind, body and spirit." "What I strive for," she says "is a complete balance, therefore I approach health in a holistic manner." Majorie speaks from a spiritual base which has put her kept her in touch with her body.

Pamela Harris

Marjorie Beaucage

"My body is a messenger of my spirit and emotions, it tells me what is happening. It is a teacher. Through my sensesI get in touch with my energy which is an important part of my spirituality."

Majorie describes her spirituality as being "creation centred." "A lot of my concepts and the way in which I view the world is Native in orientation. Traditional religions like Christianity have become fixed and rigid. They are more interested in form than in the truth, and part of the truth for me, is being a woman — not many religions honour that."

In her work and life, Marjorie works for social changes. Her spirituality has guided her in this process. A process which means, among other things, creating organic links with other members of her community, especially women. They meet on a regular basis and share their experiences whatever these might be. "We explore ourselves, parts that are not usually explored and we share our findings." One way is by creating rituals. "Sometimes we simply burn sweetgrass or perform extroverted meditation like sculpture. We do a lot of work with clay which is a way of getting in touch with the earth. What we produce is usually a mirror of ourselves. We also draw and paint mandalas. Rituals allow us to get in touch with our own energy. It is a way of centering," she says.

These group experiences are very important for Marjorie. "It is a way of finding and naming our power, thus making us feel less victimized. It is also a celebration. As women we do not affirm ourselves enough, we tend not to see ourselves in a positive light. The group experiences affirm our "womanness." The act of coming together, sharing and discussing their problems and experiences is a kind of therapy for Majorie and her sisters. It helps to release stress and tension, making the women more prepared to fight the daily battles of life. "By helping each other we help ourselves."

Majorie points out that women tend not to take care of themselves. "Health is a question of balance and women today do not balance. When work becomes the determining factor in our lives, when it becomes the dominant force, then our health suffers."

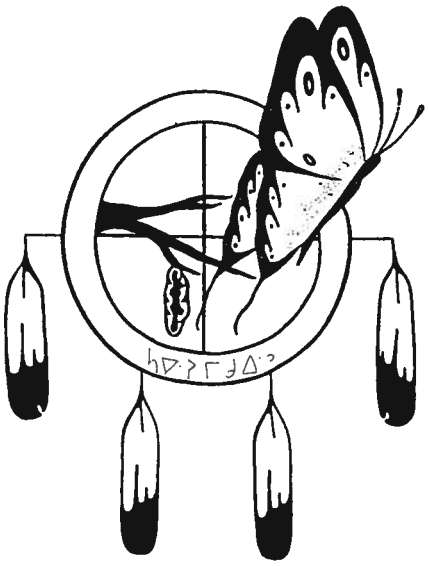
Majorie has had first hand experience of this. "For 10 years I worked for the government, training Native trainers in the area of job and family services. I travelled a lot and had tremendous responsibilities. All my energy was going into my work and I had no time for myself nor my friends. I quit the job to work for myself on a part-time basis. Now I make less money but what I have gained compensates a great deal for the monetary loss."

*Afua Cooper is a Toronto poet, author of a book of poetry,* Breaking Chains.

*We are grateful to the staff of the Health Promotion Directorate.*

Candia Alexander

# The Cultural Basis of Well-being



*Not too long ago, a Plains Cree woman knew she was dying of cancer and yet most of the nurses around her seemed oblivious to that fact or were deliberately ignoring it. As often happens in modern hospital settings, they appeared unable to face her death squarely and resorted to a facade of faked optimism. Even when a person is dying they want to feel that they have control over their last moments. In the Indian person with traditional beliefs there is a deep sense of the spirit. This is as important to their well-being as their physical self. In this hospital there was one young nurse who possessed a spiritual understanding of life and death that enabled her to accept death in a way that the dying woman needed. This one nurse understood the Indian belief that aging, illness and death are all part of a developmental process. Because she herself accepted the fact that her patient was dying, she was able to enrich the experience for the dying woman and to help the woman's friends and family grow through what they as Canadian Indians view as another step in the circle of life.*

— From an interview with Candia Alexander

My working experience in Saskatchewan in the last year has been an immersion in another culture — the Canadian Indian and more specifically the Plains Cree. I have been involved in the development of a curriculum to train native Indian nurses to meet the requirements for RN licensure at the Saskatchewan Indian Community College. As a result of this process my awareness of my own culture and the true meaning of culture has been heightened.

The Saskchewan Indian Community College is one of a number of Community Colleges governed by the Federation of Saskatchewan Indian Nations which is a government of the Indian bands in that province. It has the responsibility to serve the rural communities from several Saskatchewan Indian Training Institute (SITI) centres in different districts.

I was a member of a curriculum development team hired by SITI which included a director, a nurse, a cultural researcher and a linguist, two of whom were native Indian. My own background is in nutrition and I have had experience developing scientific education programs in Grenada and other areas of my native West Indies. Our goal was to develop a nursing education program which Indian students can relate to and at the same time which meets the needs of the Canadian multi-cultural society.

Nursing education programs in Canada are developed on the basis of a stated philosophy or beliefs about human beings and society, well-being, the teaching-learning process, nursing and nursing education. Because all education programs, whether we are aware of it or not, are based on a philosophy, in most cases not stated, programs reflect the beliefs and values held by the people developing them. The methods used to achieve set goals and the learning resources to be used are all influenced by the belief and value system of the program developers. This means that most existing nursing programs in this country are based on a philosophy which arises out of aspects of the Anglo-Canadian culture.

After conferring with other colleges that had attempted to develop Indian education programs in Alberta and Manitoba, we learned that students suffered from a lack of self-concept. We felt that by building upon the Indian existence, with respect for Indian values and beliefs, we could nurture a positive self-concept. We did not feel we could use the philosophies of standard nursing programs, not because they are in conflict with the beliefs of Indian people, but because they do not include those beliefs. We felt that this particular program should have a cultural base generated by the people for whom it was being developed.

The basic philosophy of the program was based on the Plains Cree Indian culture because of the dominance of that culture in the North Battleford district of Saskatchewan where the program is to be taught. We followed the premise that the beliefs and values of a people can best be told by the people themselves. Accordingly, we talked to the elders, to the women, to

the men; we listened to them and they listened to us. We read material written by Indian people, we participated in their spiritual ceremonies and most importantly, we respected their traditions and beliefs.

One of the fundamental beliefs of the Plains Cree concerns the human-environment relationship. They feel that everything belongs in a circle and that no one person is above another. There is an inseparable relationship between humankind and the environment around us and that "environment" includes the extended family, the community, the land and the sea. They recognize the fact that the environment has to be looked after and believe that illness can result from attempted domination of the environment. We used a quotation from the 1850s made by one of the great Indian chiefs, Chief Seattle, to develop a poem and a logo for the program. The logo represents the idea that well-being has four dimensions — spiritual, physical, intellectual and emotional. In a healthy individual all four are in harmony and balance. An imbalance in any of these four aspects causes ill feeling and leads to illness. But in treating any illness all four must be included. Good relationships with other people and with the "animate" world are part of that balance. The goal of health is, then, to maintain harmony and balance within the total being.

Incorporating these beliefs, the philosophy of the nursing program will stress the nurse's role in producing a harmonious environment for the patient. The nurse herself will be considered a part of that environment. Her role will be to communicate with the patient effectively and to enhance the environment for that patient.

In classes of a more academic nature, for example, anatomy or physiology, we will try to transmit some of the Indian philosophy by emphasizing group learning, highlighting the interrelationships of the parts and the whole and the inseparability of the human being and the physical environment. The "relational model" which we derive from Indian philosophy emphasizes group activity over the one-way communication patterns of the traditional college system, as in lectures. We hope that this teacher/student relationship will influence the nurse/client relationship. In our model the teacher is both instructor and learner and the student learner and teacher. In the mathematics program I am developing, for example, students work together in groups to better understand their weaknesses and strengths. Peers in a group can often help simplify problems and encourage fellow students.


Sally Gibson
Candia Alexander

In addition to process, we will be teaching the Cree language — not so much for the conversational skills as for the philosophy. We feel that language transmits philosophical beliefs. For example, there is no distinction between "him" and "her" in Cree. The Cree translate the word "man" as meaning "humankind." Over 50 per cent of the students will already speak Cree and correlations between their own language and Cree ideas will be made for students from other tribes. We plan to develop translations of medical terminology so that the nurses will understand these words. This will be particularly helpful in hospital situations with patients who do not speak English.

The elders particularly have a problem in the modern setting. The ones who grew up on the reserves are still very spiritual. They explain that illness is caused by something bad they have done, such as a lack of balance in relationships or something that someone has done to them. They relate it to what they call "bad medicine." This is very similar to my own Caribbean culture where it is believed that illness can be caused by someone who is vindictive casting a spell. We feel that it is very important for nurses to understand the belief that there is "good medicine" and "bad medicine." We don't want them to change people's perceptions, but we do want them to be able to relate to individual beliefs. We teach nurses to focus on the client and not on the health system. All available resources must be used in order to assist the client.

We are very careful to limit the use of the word "patient." It suggests a passive individual who is being looked after. One of our philosophies is that the traditional power relationship between health professional and patient must become a mutual relationship. We don't want the "patient" to be helpless. So we use the word "client." Even though it is not the best word, it describes someone who is actively involved in their own care. The progress toward well-being depends upon the client's own decision to move to-

## Beth Cuthand

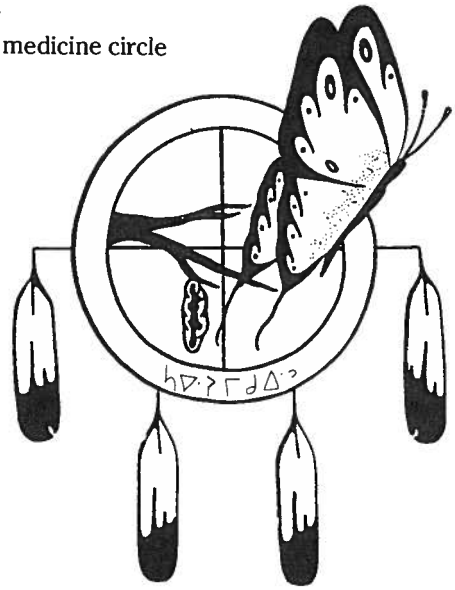
## Our logo

The butterfly emerges
from her cocoon
changed
new
free to fly
from plant to plant
gathering medicines
here and there
here and there

The butterfly displays
her symmetry
one wing the mirror image
of the other
a multi-coloured dancer
balanced
in harmony
reminding us of
that which we
strive to be.

The butterfly is
a beautiful blessing
emerging from the medicine circle
reminding us
of all our relations
and the wholeness
of the circle
where no-one is
above the other
and where there
is not beginning
or end.

The feathers tell
us stories
of the virtues
we strive for
learning
to nurse others
stories of loving
caring
sharing
and unselfishly serving the people,
so the people may live.



ward well-being, and that decision must be made by the client, not by the health worker.

There is no word for "patient" in Cree, nor is there a word for "nurse." The closest to "health-giver" is the tradition of the "medicine man" or "medicine woman." These individuals are thought to possess a "gift" and perform their services with no thought of compensation. The first activity of the medicine man/woman is to relax the sick person so that the natural healing can occur. Sometimes they tell mythical stories to take the person far away into their imagination. They work on the mental, spiritual and emotional aspects of well-being in this way, and they use herbal medicines to relieve physical ailments.

We intend to teach our students to look at the whole environment when dealing with clients. The tendency in most hospitals is to view the nuclear family as the patient's support — we will try to emphasize the importance of the extended family.

There is also a tendency for modern industrialized societies to assume that present medical practices are the answer to all of our health problems. Our society dismisses the validity of many traditional practices. As a health practitioner in the Caribbean, I was often confronted with the attitude that "bush medicines" were no good at all. I believe that traditional medicines have their place if used wisely and in a balanced way.

Even though the program has not yet begun (the first students will be accepted in September 1986 if all goes well), there has been great interest in it and many enquiries from potential students across Saskatchewan.

Through developing this nursing education curriculum I developed a deeper understanding of culture in its broader sense — more than as simply the artistic expression of a people but as the belief and value system of a people. For the health worker, the true meaning of culture can only be understood by that person gaining a deeper understanding of herself and her own culture; by examining its environmental base, including geographical, political, sociological and spiritual aspects; by studying its historical development and how that relates to survival and well-being. On the basis of this understanding health workers will learn about other cultures with an attitude of respect and caring which will be translated into good nursing care. She will recognize that every human being is unique, each having her own set of experiences which provide information about her well-being.

*Candia Alexander is a nutritionist and educator now working for the Association of Canadian Community Colleges.*

*We are grateful to the staff of the Health Promotion Directorate, Health & Welfare Canada who provided the financial assistance for the development and distribution of "Culture and well-being."*

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# MY STORY, OUR STORY

## A Psychiatric Patient's Story

**By Cathy Smith**

There are times when I think about the two weeks I spent in a psychiatric ward and wonder how I was able to become a whole person again. I guess I'll never lose this mental picture of myself, a writer and editor, bursting into tears at the prospect of keeping a journal. Keep a journal? I could barely string two sentences together verbally, let alone commit them to paper. I was so frightened I thought that I'd never be a writer again.

My story starts with my arrival in Toronto in May of 1981. I'd been working as a journalist since my graduation from university two years earlier. As the co-ordinator of a national news service I had become accustomed to doing 10 things at once. I was no stranger to deadlines or pressures. I was used to problem solving and seeing concrete results from my work.

Coming to Toronto was a big decision. Although I'd been away from my family and closest friends for two years, I had always been close enough to catch a bus and be home within three hours if I needed emotional support. Now I was 500 miles from home, trying to establish a new home and life for myself. I wanted everyone to see me as a capable and independent woman.

The first few months were anxious and lonely ones. I was living on unemployment insurance and unsure of how much longer I could receive benefits. The book I was writing was going well, but I knew that after I completed it I would need a full-time job to support myself. Although I was making friends with kind and supportive people, I still felt I was alone. Even the presence of a new lover who seemed sympathetic and understanding did not calm me. Instead, I was afraid of driving him away from me if I depended on him too much. The usual concerns about a new relationship were magnified by my other anxieties. All these forces caused me to start worrying about things that I had never given a second thought to before.

In late August my father became very ill. Seeing my father in a hospital bed was another source of unhappiness for me.

I returned to Toronto in an anxious and emotionally distraught state. I had been sleeping badly since my visit to my parents but now it was a major problem. I was also unable to concentrate on my work, and this made me worried about meeting my upcoming deadline. My nerves were raw and I found simple explanations confusing. I decided that the best course of action was to see a professional therapist. My first mistake, as I see it now, was believing that I couldn't help myself to grow and change with the assistance of the people around me. I was sure I needed outside intervention.

Since I didn't have a doctor in Toronto, and didn't know how to go about finding a psychiatrist, I decided to choose one at random from the phone book. I quickly learned it was impossible to see a psychiatrist, any psychiatrist, without a referral.

I felt utterly hopeless and alone. Who could help me? It occurred to me that I could go to the emergency wing of any hospital and if they couldn't help me, they could tell me who *could*. I was sure that this was an appropriate thing to believe, and I felt quite pleased with myself for figuring this out. Amid the scattered thoughts and anxiety there was still that logical, clear thinking woman that I was proud to be. I felt better already.

I was led to a small room by a doctor who listened sympathetically to my rambling account of the last few weeks. I told her I wanted a sedative and a place to lie down.

I soon found myself in the intensive care unit of the psychiatric ward and was given some medication — I later learned it was Haloperidol (Haldol). I was very tired and I agreed to go to a bed. I couldn't understand why I was in intensive care. Surely there were people in worse shape than myself? "We want to watch you carefully at first," they said, and I accepted that.

I didn't want to accept there was a man sharing the same room with another woman and me. When I asked about this I was told he was an old, senile man and not to worry about him. He was held to the bed by restraints and, they said, he was "harmless."

I was horrified by the thought of this man being treated in such a manner. I wanted to protest that I needed some privacy but didn't press the point too much although I was unhappy and puzzled. The nurses all seemed so sure of themselves and they seemed to think I was nine or 10 years old! I remember wanting to tell them my age and then realized they already knew it. I began to feel uneasy about being there but decided to go to sleep instead of arguing. Maybe things would be better in the morning.

The next morning I expected to see a doctor but the nurses said he wouldn't be around until the following day. What was I supposed to do all day? There didn't seem to be any scheduled activities for the patients. They aimlessly roamed the halls (known as "the track" to both patients and staff) or stared vacantly at the television. I seemed to be the only patient who wasn't constantly nagging for my cigarettes.

By now I was being given Haldol three times a day. I began to notice some disquieting side effects — my mouth was dry, I drooled when I talked, my vision was blurred and I had difficulty remembering things. I found reading difficult since I couldn't follow the simplest plot line; even the newspaper seemed complex. I was often drowsy and walked with a shuffle. My arms and legs felt stiff. When I asked about these side effects I was given a drug to control the drooling and dry mouth. It didn't help very much.

It seems incredible to me now that even though I was scared and worried

about what was happening to me, I still wanted to give the hospital the benefit of the doubt. I kept repeating to myself, "be patient and they *will* help you." At the same time, I felt that I was in a very strange place and didn't belong there. Because I couldn't articulate these conflicting ideas (thanks to Haldol), I began to lose control. I became more anxious and disoriented.

On the second day my lover came to see me and I clung to him like a frightened child and begged him to take me away. His questions to the nurses went unanswered. Because he wasn't a relative they wouldn't tell him anything about my treatment. I began to get hysterical and I cried and begged to be allowed to leave the hospital.

One of the nurses explained that I couldn't leave because the doctor had committed me. Although I had voluntarily entered the hospital, a doctor had judged that I was no longer able to make decisions without assistance and the duration of my visit would depend entirely on how he assessed my situation. I was no longer able to leave of my own free will. I have learned subsequently that doctors can commit you for an initial period of two weeks. They must assess your development within that period and if you wish to leave after two weeks they must at least consider your wishes. Of course, I didn't have any of that information at the time. For all I knew I would never be allowed to leave.

My lover was told to leave and I was guided to my bed. I struggled free from the orderlies' grasp. They pushed me onto the bed and tied me down with restraints. They gave me a needle while I kicked and fought.

I was not going to accept this treatment and as soon as the doctor, nurses and orderlies had left my bedside, I leaped from the bed and ran into the nurses' station. Before I could ask for my clothes I was picked up by an orderly, carried to my bed and the restraints were buckled on again.

Before the needle could take effect, I had wiggled out of the restraints and jumped over the bed rail. By now I was hysterical and my desire to escape had increased ten fold. But the drugs took over and I passed out.



The next three days exist in my memory as a blur of confrontations and anxieties. I know I wasn't given hourly injections but it sure seemed like it. I would wake up wrapped in fear, unable to tell if it was day or night. I would desperately try to piece together the things that had happened to me before I had either fallen asleep or been knocked out by drugs.

The original reasons for my voluntary admission were no longer important. Now my problem was how to escape this nightmare and I concentrated, as best I could under heavy medication, on getting out.

During those two weeks I was asked many questions. Usually it was the same ones over and over again: age, date of birth, address, phone number, and the very popular, why did you come to this hospital?

Each time my answers were the same. I began to ask two of my own. When can I see a doctor? and When can I leave?

When I finally did see a doctor his heavily-accented English was difficult to follow and I didn't want to ask him to repeat himself. I was afraid he might think I was crazy and I'd never get out!

Was I really only there for two weeks? It seemed so much longer then. The days were long and the lack of activity was unbearable. Finally I asked a friend to bring me my typewriter and my book manuscript so that I could do some work. Of course it was difficult to concentrate on my writing, but I felt that if I acted normal they'd treat me as if there was no reason for me to be there and they'd release me. When visitors came I always made a point of introducing them to the nurses. Occasionally I would play ping-pong or scrabble with a friend. Throughout my incarceration I attempted to maintain a degree of normalcy, which wasn't easy with so much medication in my system.

One day I was summoned by the nurse and asked if I would like to dress in my own clothes. I rushed to my room with my knapsack and quickly put on my jeans and sweater. As I stood up I felt ashamed that I had allowed this place to make me excited about getting dressed. I realized that I had been stripped of my identity and I

# TIPS

## Shop carefully for shades

If you are planning to buy a new pair of sun glasses this summer look for lenses that absorb ultraviolet radiation in order to avoid injury to delicate eye tissue. Although many of the popular polarized lenses cut reflective glare, they screen only visible light and allow invisible ultraviolet rays into the eye. Potential damage from ultraviolet light ranges from simple irritation to "sunshine" cataracts. Especially susceptible are individuals taking medications which increase sensitivity to the sun such as the antibiotic tetracycline and certain antirheumatic drugs. Check to make sure the sun-glasses you purchase will absorb at least 95 per cent of the ultraviolet rays.

## Calcium best taken with meals

If you are among the increasing number of women relying upon calcium supplements to prevent osteoporosis you should be taking the supplement with meals or with food for maximum absorption. Studies have shown that a significant number of postmenopausal women, the same age group at risk for osteoporosis, have achlorhydria or reduced stomach acid which inhibited their absorption of calcium carbonate supplements when taken on an empty stomach. When the supplement was taken with meals absorption was normal. Absorption from calcium-rich foods presented no problems.

L. Emily Elliott

was dependent on others to give it back to me.

Yet no one had attempted to find out why I had come to the hospital in the first place. Ten days had passed and I had seen doctors for a total of one hour. While there had been many questions asked of me, I had not heard explanations for my behaviour or my unhappiness. I felt trapped and afraid. All I wanted was to leave that place.

The day after I was allowed to dress, I was told that the doctors wanted to see me. He introduced me to two other doctors who joined him in asking me the usual questions. This time there were new questions thrown in and I had a sense that my answers would count. When the interview was over I asked if I could be discharged. They said they would let me know. I have since learned that once you are committed by a doctor, you cannot be released without undergoing a review by a committee of doctors.

So there I was, having spent two weeks in a hospital, and seen doctors for one hour, being sent home, full of Haldol and all the effects it produced, to function in the real world.

After I left the hospital, I continued to take Haldol for two weeks, although I was unsure about its ability to help me. I was still trying to convince myself that I would be better off if I followed the instructions of the hospital staff. But part of me didn't buy this theory, and my body was frightening me. The drooling had subsided considerably but my inability to concentrate, and the shuffled walk and dry mouth continued to plague me. I wanted to believe that the drugs were helping me, but I knew in my heart that they weren't. On top of everything else, I was afraid to be alone.

After a week of misery my lover and I agreed that it would be better for me if I moved in with him temporarily. But nothing changed for me, I was still alone all day. One day I got hysterical while he was leaving for work and he phoned his GP and asked him if he would see me.

The next morning I paced the doctor's office while he talked to me. His practical approach and disdain for drug therapy convinced me that he could help put my life back together. He advised me to stop taking the Haldol immediately and asked me to keep a daily journal. At the prospect of keeping a journal I began to sob. I realized that I couldn't bear the thought of writing even my own name.

Over the next two months my doctor helped me to see my own strengths and weaknesses more clearly and I taught myself an important lesson: I could be a trusting and open person with those who care about me, and not everyone had my best interests at heart.

I began to tell my story to friends, acquaintances and anyone else who would listen. I was stunned by how often women told me they too had contemplated checking themselves into hospitals. I was shocked to discover that many people had had similar hospital experiences. My shock turned to anger. Now I wanted to prevent others from making the same mistake.

I began to read about Haldol and its side effects, and I picked up *Phoenix Rising* magazine for the first time. As I began to read and do research on psychiatry I was overwhelmed by the eerie similarity of treatment. Lots of bright and capable people who were having trouble growing up (don't we all?) had been pumped full of drugs and left to cope alone.

I have often been called courageous. But I don't think it was an act of courage to enter a hospital. It was courageous of me to fight the system and rely on my own inner strength.

What happened to me is by no means unique. It could happen to anyone. We shouldn't be so trusting of a system that can't help everyone. Some would say it can't help anyone. I know it can't help women who need emotional support in their lives and want positive reinforcement for their choices. Although I was only institutionalized for two weeks, and some might say I only saw the tip of the iceberg, I do know that I'll never forget how I was treated.

*Cathy Smith is a Toronto writer and editor who now works in publishing. She did promotion and circulation work for* Healthsharing *in the summer of 1985.*

# REVIEWS

## Nutrition: A Key to Health

**The Nutrition Detective — A Woman's Guide to Treating Your Health Problems Through the Foods You Eat**, *Nan Kathryn Fuchs, Ph.D., Jeremy P. Tarcher, Inc., Los Angeles, 1985, $14.50, paper, 183 pp.*

**Reviewed by Pam Bristol**

In her book on nutrition for women, *The Nutrition Detective*, Nan Fuchs draws on several years' experience as a practicing nutritionist to encourage women to take a closer look at what may be the real root of recurring health problems — their diet. Using a great volume of studies and writings from health professionals, she attempts to demonstrate that everything from headaches and depression to osteoporosis is directly related to diet. Women, by becoming their own nutritional detectives, she says, can determine the foods that may cause or relieve their particular health problems and alter their diet accordingly.

She appears well qualified as an expert, with a PhD in nutrition and a private practice in California. She was involved in setting up a holistic health centre in Los Angeles and is currently taking part in a study into the causes of premenstrual syndrome (PMS). Two years of exhaustive research for this book gives it a solid scientific base. Yet, as the author herself admits, her approach to nutrition "has not been proven unconditionally" and is still in need of more research.

The book has two main premises: every woman has her own vitamin and mineral requirements, contrary to the teachings of the Four Basic Food Groups Plan; and eating the proper nutrients is not enough if they are not being fully digested. Fuchs criticizes the tendency to take one vitamin or eat one type of food to solve a health problem without looking at the overall effect on the digestive system.

Her biggest and most controversial criticism is the frequent use of calcium supplements to treat everything from menstrual cramps and PMS to osteoporosis. She labels this the "calcium overkill." While acknowledging a woman's need for calcium, she points out, "The issue is not how much calcium you take, but how much you are able to absorb and utilize." Without enough hydrochloric acid in the stomach or the proper level of magnesium in the body, she says, calcium will not be absorbed no matter how many supplements are taken. For problems such as the brittle bones caused by osteoporosis, she recommends a diet relatively low in calcium and high in magnesium, since magnesium is needed to transport calcium into the bone. Women are more likely to be short of magnesium, found in whole grains and legumes, than in calcium, she says, because today's diet is so high in calcium-rich foods.

Fuchs goes further in reporting findings that unabsorbed calcium in the body can lead to mood swings, anxiety and other menstrual symptoms; it can accelerate arthritis and atherosclerosis. City of Toronto public health nutrition consultant, Lorna Barbro, recommends against using some calcium supplements such as bone meal which may contain toxins. She says evidence available thus far shows proper supplements are a good preventive measure against osteoporosis. She adds that supplements are more necessary if a woman's diet lacks calcium-rich foods, such as dairy products.

While Barbro agrees with Fuchs' premise that every woman has individual dietary needs, she cautions that women of a certain age and height need set amounts of nutrients which have been determined by scientific research. Fuchs, however, does not recommend widely varied diets for different women. Her book sets out one basic diet, The Anti-Illness Diet, based largely on whole grains and legumes and calling for reduced amounts of protein. She then alters this diet and adds specific vitamins to create such variations as the Menopause Diet, the Birth Control Pill Diet, and the Blood Sugar Diet, to name a few. Fuchs' basic diet makes sense, says Barbro, since the body better adapts to a diet high in the complex carbohydrates found in whole grains. Too much protein, she adds, does put a strain on the body, especially the kidneys.

Fuchs is especially adamant on cutting down on protein-rich dairy products, calling them a double-edged sword. Because they are high in calcium, she writes, they can contribute to premenstrual anxiety, mood swings and arthritis; their high fat content makes them undesirable for women with breast cysts or high cholesterol. Allergies, digestive problems, headaches, and overeating are also associated with dairy products, she adds. While Barbro is concerned with the high fat content of dairy products, she says there is no conclusive evidence that they contribute to menstrual symptoms or arthritis.

For reproduction related health problems, Fuchs has a number of specialized diets and recommends that vitamins be used in place of hormone treatments. The Menopause Diet uses a combination of vitamins E and C instead of estrogen therapy to combat hot flashes and prescribes B complex vitamins to help relieve moodiness and depression. Fuchs maintains "poor or unbalanced diets are often the cause of PMS." In her research on PMS, she concludes that the illness is related to a deficiency of B6 and magnesium. Although many doctors are recommending progesterone therapy, Fuchs says taking B6 and magnesium gets to the real root of the problem and helps raise the low progesterone levels characteristic of PMS.

At times Fuchs seems overzealous as she champions her dietetic remedies to women's health problems. However, her basic assertion that nutrition is a medical solution often

overlooked rings true. Despite the amount of research done, she notes, the majority of doctors are slow to recognize the value of nutrition in treatment and prevention of illness. Fortunately, Fuchs sees a reverse to these attitudes developing with members of the medical establishment calling for more emphasis on clinical nutrition for medical students. However, while most of her assertions appeal to common sense, the reader should guard against being swept away by the author's own enthusiasm for her theories.

*Pam Bristol is a journalist now working in business writing. She recently moved to Toronto from Saskatchewan where she worked for two newspapers. While attending the University of Regina, she researched and wrote several fact sheets for Regina Healthsharing and updated their women's health services directory.*

## The New Technology: Canadian Women Meet the Microchip

**Who's in Control?**
*The Participatory Research Group, 1986. Purchase: $150; rental: $25.*

**Reviewed by Paula Rochman**

Have you ever been frustrated by the anonymous voice on the other end of the phone who could not figure out why you were sent a mysterious bill because, "After all, the computer did it?" Or have you ever wondered why the Bell telephone operator was snappy and curt, when all you wanted to know was a newly listed phone number? Or did you ever wonder why the bank teller glared at you while you used the instant cash machine, which "After all, had been designed to make her work much easier?"

While consumers in today's service industries may have become accustomed to anonymous and curt voices, *Who's in Control?* is a thought provoking slide-tape show which puts faces, facts and lives to the voices of workers we encounter every day. It documents both the history of computerization in the workplace and the impact it has had on three specific sectors of workers — bank and library workers, and Bell telephone operators.

*Who's in Control?* recognizes that the question is no longer if microtechnology is going to happen, but how is it going to affect the female dominated service industries?

*Who's in Control?* takes us inside Bell Canada with one of its operators where we find out that there are only 5,000 phone operators in Ontario and Quebec as compared to 10,000 a few years ago. It is estimated that Bell will be able to further "streamline" this number by 40 per cent. Because technology allows centralization, this streamlining has had a great impact on smaller communities, where Bell can totally eliminate its offices. But not only do operators have the stress of wondering if they will have a job. They must also cope with the routine monitoring of their work which assures Bell that an operator spends only 24 seconds on each phone call. Not much time for friendliness.

From banktellers we learn that any hope they had for a decreased workload or increased leisure time due to the introduction of automatic teller machines has disappeared about as quickly as their jobs. Banks are hoping to displace all part-time staff in this way.

While it is true there are jobs making the high technology hardware, many of these jobs are in Third World countries where cheap labour can be exploited. For example, in the Philippines, young women earn $35 a month working 14 hours a day making microchips. But no matter where the factories are, the number of jobs generated in no way compensates for the number of workers displaced from the work force.

This information can be frightening, but *Who's in Control?* powerfully takes it a quantum step. We see women organizing to protect the quality and health of their workplace.

*Who's in Control?* shows us the concrete work women have done through their unions that allows workers to have a basic and needed say in how microtechnology should be implemented. They are demanding regular breaks from video display terminals to relieve any eye and back strain, and consideration of room design so a worker sees more than just a machine all day. They want access to retraining programs which would qualify workers to use the new technology rather than be displaced by it. And they want their unions to be told of new microtechnology before it is introduced so that workers can have a say on how it is implemented.

The emphasis that the Participatory Research Group has put into constructively addressing one of the major problems affecting workers today is to be applauded. So is the choice of medium: a slide-tape show. A slide-tape show, such as this, allows a group of people to come together to learn the basic issues and encourages them to start working together. While books can play a role, a book is often read alone and doesn't lend itself to organizing in the same way.

Effectively delivering an action-oriented, "let's do something," message is difficult. PRG's slide-tape show has done this and done it on a subject area which many of us see as hopeless. *Who's in Control?* is an effective tool for starting to address what needs to be done.

*Paula Rochman is a staff person with the Ontario Public Interest Research Group — Toronto, a graduate student group at the University of Toronto.*

*Who's in Control?* is available through the Participatory Research Group, 229 College St.,Toronto, Ont. M5T 1R4. Other resources on microtechnology available from PRG at the cost of $4 each are *Short Circuit: Women in th automated office* and *Short Circuit: Women on the global assembly line.*

## Turning Away from Alcohol Abuse

**The Recovery Series, Debby & Sharon, Lorri, Delia, Ruth.**
*National Film Board of Canada Pacific Region and Studio D, Directed by Moira Simpson, 1984.*

**Reviewed by Alexandra Keir and Mary Petty**

*The Recovery Series* from the NFB is a valuable tool for any women's group as it documents yet another side of the experience of women. Four separate

reels introduce us to five women who are recovering alcoholics. We meet them in their offices and in their homes. We sit on a couch or a chair and face each woman as she tells us her story. We listen to each woman's voice; no background music diverts our attention.

The interviewer's questions are usually inaudible and presumably intended to be so. However, every once in a while the question almost, but not quite, comes through. This is frustrating and distracting when it occurs and left us wondering if perhaps we were meant to hear that particular question. Generally the content of the question seems unimportant. Each woman's dialogue is self-contained; each woman tells the viewer her complete story.

As each woman finishes an idea or a piece of dialogue, the screen goes black and then flashes back to the woman as she carries on. The black spaces are long enough for the viewer to digest some of the things the woman has said but short enough that we're still right with her when she starts speaking again.

Two native women, Debby and Sharon, are sisters who appear on the screen together. They describe bitter memories of their childhood, growing up on the reserve with parents who were alcoholic. Both women started drinking in their early teens. Through support groups and detox centres, these women have learned to accept and forgive themselves and to establish a sense of self-pride and cultural pride.

Lorri is middle class, a lesbian, a professional and an alcoholic. She identifies the problem of alcohol abuse in the lesbian community in which the social life of some women is restricted to bars. Lorri felt isolated and alone, not recognizing that there was help available for her. She finally did find support to stop drinking through self-help support groups, both lesbian and mixed. Although the mixed groups were vital to her recovery process, it was when she found lesbian only groups that Lorri found a base of support which enabled her to reveal more of who she really was.

We learn from Delia that she is a single parent who works as a therapist. Her work exposed her to knowledge of alcoholism and access to resources to help others, but no resources to help herself. After being confronted by a friend, she started to think in terms of her own problem. She found a treatment centre which allowed her to take responsibility for herself, giving her the time and space to begin healing. She talks poignantly of the long haul from acknowledgement to picking up the pieces. She makes us understand the meaning of "one day at a time" for the recovering alcoholic.

Ruth is a woman who reminds us that, against all odds, we can be strong and we can change. Recovering from multiple drug and alcohol abuse, Ruth articulates the psychological pain and the grieving involved in withdrawal. She discovered the possibility of help through a detox centre and halfway house, was treated and left the house with a sense of elation and high expectations for herself. She discusses her expectations for a wonderful life after withdrawal, coupled with the harsh realities on facing each painful day unassisted by drugs. She now says to her friends, "when I slip, say that you can't be around me."

The series can provide insight to women's centres, support groups, women's studies groups and professional groups. For women who feel alone and isolated with their alcoholism, the women in this series say to them, "you are not alone." Support and self-help groups may find these films helpful in articulating and clarifying points of discussion.

The simplicity of this presentation is very powerful. Although each reel could be used individually, the four films together present a richer and more complete picture. The series shows us that alcoholism is not limited to women of particular social classes or skin colour. The message from these diverse women is, like them, strong and empowering — I am taking control of my life, it is sometimes very difficult, but I am changing and growing, one day at a time.

*Mary Petty and Alexandra Keir work on women's health issues at the Pictou County Women's Centre in New Glasgow, Nova Scotia.*

# LETTERS

**Midwife Education**
Betty Burcher in her review of the book by Eleanor Barrington entitled: *Midwifery is Catching* makes the comment that "no teaching schools exist in Canada."

There is mention in the above publication of the nurse-midwifery education program which has been in existence at this University since 1978.

This program provides for a complete course of studies in advanced nurse-midwifery as many of our graduates select to work in the Canadian North or developing countries.

I might also add that the University of Alberta has had a nurse-midwifery program since 1943. This program was terminated in 1984 and the School of Nursing is now offering a Master's degree in Nurse-Midwifery. The first entrants will commence their studies in September of this year.

*Hope Toumishey, SCM, BN, MSc*
*Associate Professor*
*School of Nursing*
*Memorial University of Newfoundland, St. John's*

**Hope for *Healthsharing***
It was encouraging to read your Spring '86 editorial and learn that you intend to portray women as "... positive, strong and diverse ." I was beginning to feel like Pat Johnson (Letters) — that your "main focus seems to be on *woman: the victim*." In fact, I renewed my subscription only after reading your Winter '85 editorial where you stated, "We are trying to improve the diversity and depth of our content." That sentence offered hope!

A few comments on the content: **Sterilization common** (Update): since "sterilization is outranking the pill as the contraceptive of choice in Canada," readers would be interested to learn that, as the director of a health teaching service for women, I am hearing from increasing numbers of women who report that their menstrual irregularities, bouts of pelvic congestion, menstrual cramps and backaches began after tubal ligation. Tubal ligation can cause pelvic varicosities. I wonder how many women are informed that this *simple procedure* may very well have serious consequences? In his book *Premenstrual Syndrome And You*, Niels Lauersen, a New York gynecologist and obstetrician, devotes a page to the description of post tubal ligation syndrome (PTLS) because of the many letters he has received "from women who had undergone tubal sterilizations and felt awful afterward."

**Urinary infections can be reduced** (Update): Susan Elliott has reported on a common aggravating problem: UTI. It is significant to mention that, in the process of wiping the perineal area after urination and/or defecation, some women need to be informed of the importance of wiping from front to back. This may seem a ridiculously obvious bit of advice yet my experience as a nurse in hospitals has taught me that numerous women wipe from back to front, unaware that they may be transferring germs from the anal area to the vagina and the urethra.

Coloured toilet paper can also cause irritation of the mucous membranes in the perineal area because some women are sensitive to the dyes in the paper. This irritation can lead to skin breakdown which compromises the body's ability to ward off potentially harmful microorganisms.

**In Poor Health** by Anne Rochon Ford, was a well-researched, well-written, thought-provoking piece which would serve as a great leap for women if it were required reading for medical students.

The magazine cover redesign is an improvement. I look forward to my next issue.
*Mary Margaret Steckle*
*Toronto*

*Look for our upcoming article on post tubal ligation syndrom. — ed.

**Body Work**
I am more than pleased to respond to your request to renew my subscription early. Not receiving your fine magazine would leave a significant gap in my access to information on women's health issues. I have enclosed copies of three of the back issues you need and applaud the generosity of your offering to extend subscriptions accordingly. Thank-you!

The Winter/85 issue was timely! My sister-in-law appreciated the article on lower back pain during pregnancy, as she has been suffering during her second pregnancy. It was most helpful, she tells me.

As for myself, Phyllis Jensen's article describing her experience of Feldenkreis body work was impressive. I found it helpful, affirming and interesting as I've been struggling toward written exploration of my experience of Rubenfeld Synergy work which incorporates Alexander and Feldenkreis body work with Gestalt therapy in recognition of the intricate relationship between body and emotions. This modality has helped me to move through blockages in my physical being that years of chiropractics were not able to release other than in the short term. And it is so gentle that you'd hardly know your body was re-aligning if it weren't for the emphasis placed on awareness of and attunity to our body's experience of the exercises.

I highly recommend this method to anyone who struggles with multiple structural problems or who wishes to let go of emotional trauma as it manifests in the body.

If you're interested in exploring the Rubenfeld Synergy Method, Ilana Rubenfeld can tell you of trained practitioners in your areas. Her address is: 115 Waverly Place, New York, N.Y. 10011.
*Mary M. Spies*
*Kitchener, Ontario*

## In Memory

Enclosed please find a donation of $65 from the staff at Marbek Resource Consultants in Ottawa. This donation is made in memory of Pauline Smith of Sault Ste. Marie, mother of one of our associates, who recently died of cancer.
*David B. Brooks*
*Ottawa, Ontario*

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# RESOURCES & EVENTS

## Safe Travel Guide

*Reservations for One: Women's Guide to Safe Travel* is a brief, informative pamphlet offering tips on what to do before leaving home, transportation, accomodation, recreation, assertiveness, self-defense, and what to do in case of assault.

The publication is available at the cost of 25c per copy, plus postage and handling, from the Women's Sexual Assault Centre, 1045 Linden Ave., Victoria, B.C. V8V 4H3. Bulk rates are also available.

## Assaulted Women's Newsletter

*Switchboard* is a newsletter published by the Saskatchewan Battered Women's Advocacy Network. News, information and practical suggestions on the issue of wife battering and other forms of violence against women are provided.

For more information, contact the Network at 2149 Albert St.,Regina, Sask. S4P 2V1, or phone toll-free (800) 667-9876.

## Day Care Documentary

*Our Children, Our Selves* is an audio-visual documentary which examines the issue of child care from both a personal and political perspective. Parents, day care workers and activists speak out on the urgent need for dependable, affordable, quality care for Canadian children.

The documentary is slide projected with a sync-pulsed cassette tape and is 35 minutes long. To screen *Our Children, Our Selves*, contact CUPE National Day Care Committee, 21 Florence St.,Ottawa, Ont. K2P 0W6.

## Eating Disorders Information Centre

The Health League of Canada has recently opened Canada's first National Eating Disorders Information Centre in Toronto. It will maintain a cross-Canada resource list of professionals, publications and self-help groups for victims and their families.

A newsletter entitled *Bulletin* is available by contacting the National Eating Disorders Centre, 1560 Bayview Ave., Suite 304, Toronto, Ont. M4G 3B8. For more information contact the centre co-ordinator, Joan Faulkner, at (416) 486-6023.

## Essential Drug Information

The World Health Organization (WHO) has produced several publications on essential drugs, including: *The Selection of Essential Drugs* (Technical Report Series 641); *The Use of Essential Drugs* (Technical Report Series 685); and the entire July 1984 issue of *World Health*. Essential drugs are the 250 drugs out of between 100,000 and 200,000 products available on the world market which WHO considers essential to the treatment of most illnesses.

The publications are available from WHO regional offices or by writing to WHO Distribution and Sales Service, 1211 Geneva 27, Switzerland.

## Women's Health Conference

The Second International Congress on Women's Health Issues will be held in Halifax from Nov. 6-8, 1986. For more information write to Phyllis Noerager Stern, International Council on Women's Health Issues, School of Nursing, Dalhousie University, Halifax, N.S. B3H 3J5.

## Healthy Cleaning

*Household Worker's Rights* includes a useful and informative guide to non-toxic cleaning tools in the May-June 1985 issue of the newsletter.

For a copy write *Household Worker's Rights*, 30 Ellis St.,Room 501, San California, Calif., U.S.A. 94102.

## Crime Statistics

In December 1985, the Solicitor General of Canada released a report, *Female Victims of Crime*. It was the fourth in a series analysing the findings of the *Canadian Urban Victimization Survey* undertaken by the Ministry. The report provides an analysis of the characteristics of crimes of sexual assault and domestic violence, and the impact of these crimes on women.

For a copy of the report, write to the Statistics Division, Programs Branch, 340 Laurier Ave. W., Ottawa, Ont. K1A 0P8 or contact Holly Johnson (613) 991- 2954.