HEALTHMATTERS

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SMOKING AND WOMEN — Not Really a Choice

FACT: Lung cancer now equals and will soon surpass breast cancer as the leading cause of cancer deaths in U.S. women.
FACT: Smoking causes about 85% of lung cancer in women.
FACT: besides the well-known links with lung cancer, cardiovascular disease and emphysema, smoking is linked with other cancers and lung diseases, recurring ulcers, hearing loss, problem pregnancies, harm to unborn babies, optical damage, menopausal problems and osteoporosis among others.
FACT: The U.S. tobacco industry spends over $1 billion annually on advertizing and promotions and withdraws ads from magazines which run critical articles on smoking and health.
FACT: Now that many North Americans are quitting smoking, the tobacco multinationals are engaging in massive advertizing campaigns in Third World countries while more and more of their agricultural land is being turned over to tobacco.
FACT: In the twentieth century, tobacco has killed more people than war.

If cigarettes were drugs and the tobacco companies were drug companies, feminists would surely have made smoking a political issue long ago. There are parallels between cigarettes and for example, the birth control pill; many well documented health risks, a well financed advertizing campaign, production by corporations with powerful government lobbies and huge profits from their sale. Why, then, do many feminists who have been outraged for years by the cynical approach to women's health by the drug industry see smoking as a serious health issue

drug industry see smoking not as a serious health issue or as a political issue, but as a matter of "personal choice".

The "right to choose" is so basic a feminist tenet that it seems hard to argue with, and control over one's body may indeed include the right to harm it in any way one chooses. That right, however, ends when it infringes on the rights of others who choose not to smoke and their right to breathe clean air.

Besides being annoying to a non-smoker sidestream smoke (the smoke that goes directly into the air from a burning cigarette) presents a very real health hazard to the non-smoker. The problem is worse in buildings with poor ventilation, but a worker in a sealed building has no control over the air flow in that building. One Canadian study of non-smokers in a working environment demonstrated that passive smoking (the inhalation by non-smokers of tobacco-polluted air) was equivalent to smoking ten cigarettes a day. Sidestream smoke contains twice as much tar and nicotine, five times as much carbon monoxide, and fifty times as much ammonia as inhaled smoke. One of the most potent carcinogens known, N-nitrosodimethylamine, is present in sidestream smoke in concentrations 50 times greater than exhaled smoke. A fourteen year Japanese study reported a twofold increase in lung cancer in non-smoking women living with smokers. So where is the "choice" of the non-smoker? Leave her job? Not go to bars? Leave home? Isn't it ironic that we can call the police to stop a neighbour making noise after 11pm but we cannot do anything about a co-worker who forces us to breathe sidestream smoke (unless the individual office has a no smoking policy)

And what about the "rights" of children who cannot "choose" where to live? A recent study from Boston showed that children who live in households where people smoke are at a significant health disadvantage, including irritated eyes and nasal passages and increased respiratory infections. A study from McMaster University in Ontario pronounced smoking at home a greater risk to children's health than industrial air pollution. Smokers' children have more asthma, wheezing, coughing and colds.

If smoking were a rational choice for women, based on health or political concerns, there would be no smokers. Why then were 33% of Canadian women smoking in 1981? Why are more men than women giving up smoking? Have women, usually so aware of the manipulations of the advertizing industry, really bought the smoker-as-liberated-woman-Virginia-Slims image? Why does the issue of smoking produce all kinds of defensive rationalizations in women who would otherwise be the first to condemn industries whose products maim and kill women? Why do women smokers need to smoke?

The easy answer is that nicotine is physically addictive, but nicotine does not fill all the criteria for a drug which creates physical dependence. The phenomena of 'tolerance' and 'withdrawal syndrome' do not apply as clearly as to other addictive drugs. Smokers do not usually keep increasing their daily number of cigarettes past 10-25 a day, whereas someone dependent on a narcotic becomes more 'tolerant' and needs more and more of a drug to achieve the

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desired effect. Some smokers experience unpleasant 'withdrawal' symptoms when they try to stop, but many don't.

It seems that smoking is much more than a physical addiction and may have more to do with social and psycological factors. Peer pressure and the identification of smoking with being "cool" and sophisticated has no doubt led many, particularly teenage and younger women, to smoking. Smoking has been sold to us as something the confident and independent woman, the woman who knows she is equal to men, does. It is probably no coincidence that the number of women smokers rose during the beginnings of the second wave of feminism in the sixties and seventies. Tobacco companies were quick to respond by gearing some of their advertizing specifically at women. Once again the industries of a sexist society found a way to exploit women's vulnerabilities.

More basic though than complying with a certain image of the modern woman is the way in which smoking can give women the illusion of coping with stressful lives. The Addiction Research Unit in London, England has concluded that women tend to use smoking as a sedative, whereas men tend to use it as a stimulant. More men than women report smoking for pleasure. Women may in fact need smoking more than men do. In a society where women are socialized not to express their feelings, especially anger, and where feeling "out of control" emotionally is a frightening experience for most women, smoking is a way to control feelings, especially anger and aggression. Smoking becomes a safety valve, the alternative to letting off steam. Feelings can be pushed down by inhaling smoke or released as puffs of smoke. The real feelings, which might have serious consequences if released, are not recognized or experienced.

As a woman quoted in The Ladykillers said, "Our husbands can explode when they come home but we can't. We are supposed to absorb the frustration of everyone else in the family and still maintain the image of super-wife and mother. I don't want to scream or yell at the family, so I smoke".

From a feminist perspective, it becomes evident that the need of many women to smoke is grounded in their situation in society. This doesn't mean that non-smokers necessarily have more access to their feelings - there are other ways to suppress emotions -- but smoking has provided a socially sanctioned way to swallow emotions and not to have to deal with them.

Perhaps if women saw why they smoked in this light, it would be easier for them to stop. Many women try to stop smoking and start again because they cannot deal with the feelings that come to the surface. If a woman can somehow create a situation in which it is safe for her to experience her feelings and change her way of dealing with them, then she will be on her way to not needing to smoke.

The self-help group model is well suited to a woman trying to give up smoking. Here she can find other women in a similar situation and develop an understanding of why she needs to smoke. Quitting smoking isn't easy, but it would be easier in an atmosphere of support from other women. The benefits are obvious.

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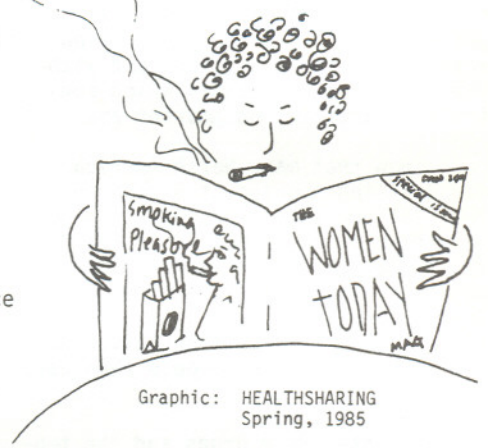
Another version of this article appeared in the June '85 issue of Kinesis.



Graphic: HEALTHSHARING
Spring, 1985

CHLAMYDIA AND ABNORMAL PAPS

A sexually transmitted disease, Chlamydia, which most people have never heard of, is now receiving widespread publicity as the most common sexually transmitted disease.

Chlamydia (pronounced "kluh-mid-ee-uh") or Chlamydia trachomatis is a bacteria. But it is unlike most other bacteria which attack cells. It is much smaller and lives inside cells like a virus. It can remain in cells for many years without necessarily provoking any symptoms. This is more common in women than in men, but can happen in anyone. Because of this characteristic many people say that Chlamydia is a bacteria which "acts like a virus." As a bacteria, it is usually easily treated with antibiotics when diagnosed early.

Women who may have Chlamydia without symptoms, may only recognize the infection when there are painful and serious consequences. Both heterosexual and lesbian women are at risk.

In women the most common manifestation of Chlamydia is an infection of the cervix or an erosion (a red, raw area) on the cervix or the presence of a yellowish vaginal or cervical discharge. Women can also have an infection of the urethra and experience a burning sensation during urination and a feeling of needing to urinate frequently. If there are symptoms, they usually appear gradually 10 - 20 days after contact with an infected person.

A number of studies have shown that Chlamydia can be found on the cervixes of a high percentage of women with abnormal Pap smear results.

Chlamydia infection in the eyes has been associated with cellular changes similar to mild dysplasia (abnormal cell development.) It is therefore not surprising that Chlamydia can have a similar effect on cells of the cervix. In the studies of abnormal Pap smear results due to Chlamydia, many women who are treated for Chlamydia experience normal Pap smear results when the infection has been cleared.

Some clinics and practitioners regularly test women with abnormal Pap smear results for Chlamydia. Women with abnormal Pap test results which range from mild dysplasia to carcinoma in situ should consider getting a Chlamydia test done, particularly if there seems to be no other explanation for the abnormal result.

MYSTERIOUS LANGUAGE — What is Your Doctor Talking About?

Do you ever wish you could understand what your doctor was talking about? Maybe you wish you could read something in simple language so that you could ask your doctor questions about your health concerns. At the Vancouver Women's Health Collective we strive to make health information accessible and understandable to women. However, one barrier we must all cope with is medical terminology, in which words not in everyday language are used to describe parts of the body, symptoms and illnesses. It is one of the many mysterious aspects of Western medicine which keeps people uninformed. Medical professionals do not have to use all this jargon to understand each other or to explain diseases or conditions to patients. It is a way for them to communicate which keeps other people ignorant and alienated because it seems so intimidating. The terminology enables the profession to claim high status in our society because they appear to hold a special body of knowledge.

Doctors can often be rushed and may not have time to explain what is important for people to know. Those who do take the time may not use everyday language in order to be well understood. Some doctors think that their patients cannot cope with all that health information, let alone understand it. Since it is our health and our bodies which are being discussed, we have a right to know and understand what is being said.

For example, endometriosis can be broken down: endo means inner or inside, metro (as well as hystero) means uterus, and osis means condition. Endometriosis is a condition where the inside or inner lining of the uterus grows in different parts of the body. Another example is osteoporosis: osteo means bone, poro means porous, and osis means condition. Osteoporosis is a condition where the bones are porous or brittle and break easily.

Medical libraries, public libraries, and health resource centers are places where some information may be found. One can use medical dictionaries and reference material as well. Once you get the hang of it, this is not so difficult.

Medical terminology has a logic to it. The words are built from Greek and Latin prefixes, suffixes, word roots, and combining forms. People often learn rhymes to remember how to spell difficult words. By learning some of the building elements, one can begin to figure out and understand what medical words mean.

An extremely useful guide and workbook is Medical Terminology, 3rd edition, by Genevieve Love Smith and Phyllis E. Davis. The format is a series of question frames explaining the anatomy of medical words, a section of self tests, and a list of medical abbreviations. Taber's Medical Dictionary is also a useful resource for brief descriptions.

Conditioning in our society has led people to believe that they cannot understand what doctors are saying. Doctors, in fact, have been taught only some of the answers. People also have answers based on their personal experiences. We are capable of learning some medical terminology, basic anatomy and physiology (the study of bodily functions) and of finding information related to our health concerns. If a doctor uses a word you don't understand, get them to write it down or spell it for you so you can look it up. We must learn to become more informed so we can, in fact, make informed decisions about our own health. For further information contact the Vancouver Women's Health Collective at 888 Burrard St. (phone: 682-1633)

GLOBAL VIEW OF DISABILITY

While the developed countries of the West can take pride in pioneering measures to make the disabled person's way of life a little more useful and a little more comfortable, the developing countries can at best only dream of special projects to meet the needs of persons with problems such as sight and hearing impairments, neurological problems and birth defects.

80% of the world's disabled people live in developing countries. The potent combination of the low status of women and the level of poverty in some countries is being acknowledged as a major cause of disability. In some societies women are considered to make little economic contribution. Thus, they may be the last to eat after husband and children in a situation where there may already be a scarcity of food. It is an established fact that one of the major causes of disability is the inadequate nutrition of mothers and children, especially daughters. Some estimate that there are 100 million people disabled because of malnutrition.

Graphic: ISIS

Problems caused by malnutrition include birth defects. Bones do not grow properly. Limb problems may occur, or women's pelvic bones may not develop properly and cause problems when they attempt to give birth. Malnutrition in pregnancy apparently makes women more susceptible to such diseases as polio and leprosy which would mean disability as mothers. There are also numerous reports of birth defects traced to pesticides. In developing countries there are fewer laws regarding environmental protection and many pesticides are used without precautions.

Problems of women with disabilities in developing countries are:

(1) Lack of mobility. Women's mobility outside the home is restricted. It is not possible for them to go out alone. There is little or no access to wheelchairs. This especially applies to rural areas where 70-75% of the population lives.

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PREMENSTRUAL SYNDROME — Latest Information

THE PMS SOLUTION
Premenstrual Syndrome: The Nutritional Approach
by Dr. Ann Nazzaro and Dr. Donald Lombard with Dr. David Horrobin
Eden Press, Montreal, 1985

"I'm like a different person."
"I get angry at small things that wouldn't normally bother me at all."
"I'm really terrible. I don't know how my family can stand me."

These are the kinds of statements one hears frequently from women experiencing PMS. PMS is a cluster of symptoms that appear two to fourteen days before the onset of a menstrual period. The symptoms are both physical and psychological. They vary from woman to woman although the pattern remains similar for an individual woman over a number of cycles. The most common physical symptoms are bloating, breast tenderness, lower back pain, headaches, fatigue, and food and alcohol cravings. The common psychological or emotional symptoms are depression, crying spells, anxiety, mood swings, irritability, increased or decreased sex drive, uncontrollable outbursts of anger/hostility, suicidal impulses, memory lapses, confusion and feelings of insecurity.

There are a number of new books on PMS. "The PMS Solution" is one of these recent new publications. The authors suggest that the underlying cause of PMS is a biochemical imbalance, an abnormality of the essential fatty acid metabolism of the body. Their approach is a nutritional one. They outline nutritional means to correct the imbalances in the biochemistry of the body. They suggest that current research indicates there is no evidence that the levels of progesterone or estrogen (hormones from the ovary) or prolactin or endorphins (hormones from the brain) are significantly different in women with or without PMS. These have been the basis for the other major physically based theories of PMS, to date.

The origins of this book go back to clinical work and research that Nazzaro and Lombard did on the basis of Horrobin's research into the metabolism of nutrition and chronic health problems. Nazzaro and Lombard began using a nutritional approach for depression with patients. They found their treatment to be impressive in women and men. The startling discovery, though, was that women who followed their program began to experience a marked diminution of premenstrual symptoms.

Graphic: ISIS

Prostaglandins, which are regulating substances controlling the behaviour of all the body's organs, are made from substances called essential fatty acids. Cis-linoleic acid which we get from certain vegetable oils such as safflower and sunflower oil goes through a series of conversions in the body to gamma-linolenic acid, dihomogamma-linolenic acid, and finally prostaglandin E-1 (PGE-1). This series of conversions requires co-factors or nutrients along the way. These are vitamins B6, B3, C, zinc and magnesium. The conversions can also be blocked by a diet rich in saturated fats and/or refined sugar, stress, the aging process, viral infections, radiation and cancer. Gammalinolenic acid, a precursor to prostaglandin E-1, is available in only two known sources apart from the body's own production. These sources are human breast milk and evening primrose seed oil. Nazzaro and Lombard's clinical research experience has shown them that when there is an increase in PGE-1 through the use of evening primrose oil and the other necessary co-factors, there is a significant reduction in PMS problems. They have found a 70% success rate through this nutritional approach for PMS symptoms; when there are underlying allergy and/or candida albicans (yeast) overgrowth problems which seem to affect PMS and these are treated too, their success rate has been about 85%.

The book includes an extensive "personal health and menstruation history" questionnaire, qualities to look for in choosing a doctor, and the kind of tests you should request in relation to PMS. The tests are for thyroid malfunction which can look like PMS, hidden infection, anemia and vitamin deficiencies. It also includes a detailed description of their nutritional program.

One of the strengths of this book is the clarity with which the authors' biochemical approach and nutrient program is presented. The authors are critical of how psychiatry has been a common treatment for PMS including tranquillizers, antidepressants, diuretics and mood elevators. They are committed to helping women, and see PMS as another instance in the history of medicine where an illness thought to have psychological causes is discovered to have organic causes. They see PMS as a "medical" problem and as having only a "medical" solution.

What is missing within their analysis is how the emotional or psychological component of PMS fits in with conditioning of women generally in this society. This is not to deny the biochemical reality or the obvious change that can be brought about through their nutrient program. The social aspect, though, has not been addressed. I think that the biochemical changes women experience premenstrually exaggerate and intensify feelings we have already. We come into more direct conflict with our conditioning and our ideas of who we are as women at that time. For example, to feel frustration, intense anger, or being out of control are not feelings we learned were acceptable to experience as women in this society. The resulting guilt and self-blame contribute to the physiological stress of PMS. We also come up against our conditioning in other ways. Premenstrually we may feel the need to have more time alone, but if our self-concept has to do with being able to provide for others (as many women have been taught), and demands continue to be put on us by children and/or partners, and we are not able to assert our need and right to some time alone, we may feel angry and explosive, and then guilty for those feelings. Because of this kind of situation I think it is important that women's experience of PMS is placed within a social context and that the interaction of social experience with the biochemical reality of PMS is examined.

BETH TROTTER

AIDS GOES STRAIGHT

Most media discussions of AIDS present it as an exclusively "gay disease." Approximately 70% of those who have AIDS in North America are gay or bisexual males. The other 30% are intravenous drug users, hemophiliacs or sexual partners of someone who carries the AIDS virus. Women account for about 7% of AIDS cases in North America.

In mid-April scientists gathered in Atlanta, Georgia for a world meeting about AIDS. Some of the facts from that meeting were grim. The acknowledged modes of transmission for the AIDS virus remain as they have for four years: blood or blood products, or semen, or in rare cases other fluids (urine, saliva) that contain minute amounts of blood-borne lymphocytes or white blood cells, the immune defense troops that the virus likes to single out as its targets. James Curran of the Center for Disease Control in Atlanta

Graphic: ISIS

stated that "The disease can be readily transmitted heterosexually as well as homosexually." The proportion of heterosexuals at risk is expected to remain lower than for homosexuals. But the disease is progressing among heterosexuals in the same geometric proportions as it is occuring among gays. This means that the number of reported cases has been doubling every year since first being reported. In the U.S. there are approximately 10,000 cases tallied so far. Scientists expect that number to double by next year.

In Canada the total number of women reported with AIDS is 11. Only one is still alive. In the U.S. over 530 women have contracted AIDS. In the U.S. over 12 percent of the women appear to have contracted it from sexual contact with a man. The AIDS virus may have been transmitted from semen entering the mouth, vagina or rectum. Women who are partners of bisexual men may want to take some safe-sex precautions. Do not allow blood, semen, urine or feces to enter your body through the mouth, vagina or rectum or through open cuts or sores. A condom should be used during intercourse.

AIDS is mainly a blood-borne disease. You don't have to be a gay or bisexual man, a sharer of needles, a hemophiliac or a resident of Haiti to get AIDS. (Note that Haitians were taken off the high risk list by the Canadian Laboratory for Disease Control.) Wherever you live, if you are having sex with an infected person, you stand a high chance of being infected. If you live in Zaire, in central Africa, where 30 million people may be infected, your chances of getting the virus rise sharply. The number of cases studied in central Africa indicate that as many women as men are coming down with AIDS through heterosexual transmission. Researchers point out that the circumstances are different in a developing country because people live in crowded quarters and sanitation is poor because of lack of access to clean water.

There have been media reports suggesting that prostitutes are possible carriers and transmitters of AIDS. The San Francisco Health Department has been on red alert since three prostitutes turned up with AIDS last November. Recent media reports seem to be exaggerating the role of prostitutes in passing AIDS. Prostitutes have historically been blamed for the transmission of sexually transmitted disease when, in fact, transmission is widespread. It appears that it is more difficult for a woman to pass the virus to a man than it is to pass it from a man to a woman since semen is a prime carrier of the virus. There are still no reported cases of AIDS transmission between lesbians or bisexual women.

(Sources: Village Voice: "AIDS Goes Straight" by Nathan Fain, May 14, 1985, and "Women and AIDS" by the AIDS Committee of Toronto)

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GLOBAL VIEW OF DISABILITY

(2) Lack of education. Disabled women and girls are not considered fit for education. Generally, the literacy rate among women is extremely low.

(3) Marriage is a serious problem, especially in rural areas. Severe prejudices and negative attitudes exist about the disabled person's ability to lead a normal life with responsibilities. Without marriage a woman can be deprived of her only measure of status in her family and community.

(4) Lack of opportunity for employment and any income. Disabled women are entirely the responsiblity of their family and are totally dependent on them. There are a few institutions for their education, training or orientation, but most of them are substandard.

Thus, disabled women in the developing countries often lead lives in isolation and poverty.

Sources include: Women, Development and Disability packet by the Coalition of Provincial Organizations of the Handicapped.

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