JOINING HANDS FOR HEALTH

CARING AND SHARING in Summer Time
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MESSAGE FROM DR. H. MAHLER  
Director-General of the World Health Organization  
for  
WORLD HEALTH DAY, 1986  

“HEALTHY LIVING: EVERYONE A WINNER”

The theme of this year’s World Health Day, “Healthy Living: Everyone a Winner” focuses on healthy lifestyles. This reflects the growing conviction that greater emphasis should be placed on the positive actions that individuals and communities can take to protect and promote health. The Alma-Ata Declaration of 1978 clearly states “that people have the right and duty to participate individually and collectively in the planning and implementation of their health care”. As the movement for Health For All by the Year 2000 gathers momentum, it is high time to put this into practice.

The world around us has been changing rapidly, but often standard medical practices and the functioning of health services do not reflect these changes. In many places, the emphasis remains on curative measures and neglects positive steps that individuals can take to stay healthy. Partly as a result of some spectacular successes of modern medicine, an attitude has spread to many parts of the world that health is something the doctors provide for people, instead of something that a community and individuals achieve for themselves. Yet, today, it is evident that there is a growing trend which shifts the emphasis from hospital-based care to those everyday actions that promote health. This new approach, based on a positive goal of fitness, is wide enough to include all of society.

Three major elements of a healthy lifestyle deserve particular attention: exercise and sports, nutrition, and personal responsibility.

Exercise should be thought of in the broadest sense that includes walking and any other leisure pursuit. It has a direct influence on health and can act as a spur to fitness, thus improving health generally.

Active physical exercise is necessary for everyone at all stages of life. During early years it prepares the body for the tasks to be undertaken in adulthood; during adulthood it enables the body to give its utmost and to resist stress; then in later years it maintains mental alertness and physical mobility. But perhaps most important of all, keeping physically active adds to the joy of life, contributing to that sense of well-being which is the true foundation of health.

Everyone recognizes that food is the staff of life. But today, eating habits are in a state of change just as are many other ways of life. There is a menace in some new and popular ways of eating. Junk food, for example, heavy in fat or drenched in sugar, threatens the heart and the teeth. WHO is not recommending a universal diet that every people should adopt. On the contrary, every culture is able to provide the basic ingredients for a diet which promotes the growth and maintenance of a healthy body. Today there is a greater need to be aware of how diet and nutrition function, and to consciously encourage those eating habits that can help to produce excellence in sports and general well-being.

Personal responsibility covers a wide area. Individuals must be encouraged to take steps to preserve their own health and to avoid behaviour that is detrimental. This refers directly to the use of tobacco under any form and the abuse of alcohol and other drugs.

Smoking is the most important single preventable cause of ill-health and premature death, wherever it is widespread. And the smoking epidemic is one that doctors can't cure; only prevention works. What is needed are positive models of health so that youth doesn't begin to take up a lifelong and pernicious habit. Although it is the individual who has the responsibility, the choice — to smoke or not to smoke — is determined by many factors over which society has a considerable leverage. And the individual in question may be only eleven years old when called upon to make that important choice.

In the case of alcohol and other drugs, individuals should be helped to make wise choices that will ensure their own maximum capacity to use their bodies and to enjoy living.

Winners for Health

WHO and the International Olympic Committee (IOC) have signed an agreement to launch a “Winners for Health” programme, precisely in order to enlist those members of society whose example and practice can inspire others, even though they are not formal health professionals. Olympic champions and popular sportsmen are role models for millions of young people. They can help convey the message that those promoting health don’t want to take away things that are pleasurable, but rather to live their lives to the fullest and avoid damaging their health misuse of alcohol and drugs, for example.

Working with National Olympic Committees which are being encouraged to organize health fairs, runs for health, and other activities, WHO will attempt with IOC to stimulate and encourage national and international activities that underline the role of health preservation and protection as a fundamental human right for the individual and as an integral part of national development. Here again, sport furnishes an excellent example: to the extent that a nation can provide good nutrition and a healthy way of life to its citizens, it can begin to produce individuals and teams capable of competing at all levels, from the village square to the Olympic stadium, and at the same time adding to the joy of living by means of bodily and mental exercise.

Thus everybody can become a messenger for health. The message should be carried everywhere: health is the only race where everyone is a winner.
WORLD HEALTH DAY MESSAGE

DR. CARLYLE GUERRA DE MACEDO
Director of the Pan American Health Organization
Regional Office for the Americas of the World Health Organization

This year's World Health Day theme, "Healthy Living: Everyone a Winner," has a special message for every man, woman and child in the Americas. Given the proper knowledge of what is good or bad for our health and well-being, we have the responsibility to make the right kind of decisions for ourselves, our families and our communities; and — once those decisions are made — we have the added personal responsibility to take action. As a result, we all become winners in the race for health.

The choices I am talking about relate mainly to what is now commonly referred to as lifestyle. Everyday we are called upon to make choices which reflect our personal way of living and which also may have a direct effect on our mental and physical health. For the most part, we are the ones who decide to smoke or not, how much we eat, what we eat, and whether or not to use alcohol, take drugs or exercise.

Nowhere is the case more clear-cut than in deciding whether or not to smoke. The latest World Health Organization report on tobacco clearly states that smoking and the diseases it causes have reached endemic proportions in the industrialized countries and new are rapidly rising in developing countries.

The harmful effects of smoking on health are widely known...

At least one million premature deaths are estimated to occur worldwide because of the use of tobacco... As many as 10 percent of all people now alive may die prematurely of heart disease attributable to their smoking. The choice is obvious tobacco or health; yet, many people persist in smoking.

Up to now, I have been speaking about those segments of our societies that have the knowledge and the ability to make choices. But there also exist large segments which are not as privileged, victims of poverty and lack of education. These members of society are only potential winners in the race for health.

To reach these people, the Pan American Health Organization and its Member Countries have been working diligently in creating more personal responsibility among community leaders and workers in such areas as health, education and agriculture. By providing better information and education on foods, nutrition, child care, immunization of children and the need for safe water and basic sanitation, we are seeking to give everyone the knowledge to make basic choices affecting their health.

Through such initiatives, parents learn about nutrition, how to combat diseases, and how to stay well, and become better able to meet their needs and those of their families. With this basic knowledge they learn to make decisions and, by talking on their responsibilities, become winners in their own personal races for health.

I would like to emphasize that personal or family responsibility for health through healthy living does not reduce the importance of community and social responsibilities, including those of governments. Healthy personal lifestyles in many ways depend on a nurturing social environment and express a commitment to improving society. At the global level — countries, governments, peoples, and communities must be aware of the need to create social conditions which promote and facilitate healthy living for and by everyone.

As Director of the Pan American Health Organization, I urge all the people of the Americas to help us to improve the health of the hemisphere. As we observe World Health Day 1986, and in the years ahead, let us commit ourselves to taking action that will win health for all through individual self-reliance and community responsibility, and in a favorable social environment. "Healthy Living" truly makes "Everyone a Winner."
WORLD HEALTH DAY MESSAGE 1986

The Minister of Health
HON. DR. NORMAN GAY

April 7th has been designated World Health Day by the World Health Organization. Around the world, governments, agencies of the World Health Organization and other agencies of the United Nations are using this day as an occasion to promote better health for all mankind. This year, the theme “Healthy Living — Everyone a Winner” has been chosen by the WHO to emphasize the fact that, by committing ourselves to adopting healthier lifestyles, we can become healthier individuals and thus, better able to contribute to the building of an improved society.

In The Bahamas, we are surrounded by examples of the goodness of our creator, the same creator who conceived such goodness, also created us. We should and can be a healthy nation. It should not be difficult for us to appreciate that, in many instances, those flaws in our personal health, those illnesses which bother us and slow us down are not preordained.

Indeed many illnesses...have been proved to be avoidable by the adoption of a more healthy way of life.

Progress, change and development impact upon us all and we need to be more aware of the nature of the impact — of the stress and strain which follow in their wake.

No one questions development. We all enjoy the convenience it brings us. But how rejuvenating is our leisure time?

On closer scrutiny, we find that concomitant with our improved standard of living there has been a considerable rise in levels of ill health; high price it seems in terms of health, our spiritual, mental and physical well-being.

At the Ministry of Health, our responsibilities are to promote health — to implement strategies for enabling citizens to maintain and enhance their health and prevent ill health — promotive, preventative health care strategies and also to provide the means and facilities for caring for the sick — curative health care strategy.

Our traditional medical system is effective against less than 20% of the factors that determine a person’s state of health. The remaining 80% are determined by factors over which doctors have little or no control.

I am therefore taking the opportunity on World Health Day, to urge you, fellow Bahamians, to recognise the responsibility which we all hold for our own welfare. A responsibility not only to ourselves, but also to the entire society.

Consider, for example, the suffering, pain and cost to the individual and the cost to the nation, of attempting to cure someone with emphysema or lung cancer — caused by a completely avoidable tobacco smoking habit... We now note with some concern, the increased incidence of smoking among our womenfolk.

You and I have the right and duty to participate individually and collectively in the planning and implementation of our own health care. We are responsible for our own health. God has given us the right to choose. If we take appropriate steps and precautions and make informed decisions, we can avoid many maladies which slow us down both as individuals and as a nation.

This year we are emphasising three elements which will guide our approach to healthy living. Exercise and sports, proper nutrition and personal responsibility. Our goal is to develop a NATIONAL PROGRAMME OF HEALTH PROMOTION FOR ALL. The Government of The Bahamas has, for many years, demonstrated its commitment to the use of sports and exercise as tools in the development of the complete individual and a healthy, productive society. The Ministry of Youth, Sports and Community Affairs, in conjunction with sporting and civic organizations, conduct community-based programmes designed to promote fitness among our people. There is an ongoing effort to raise public consciousness in the area. I urge each one of you, young and old, to make a particular effort to participate in some exercise programme or sporting activity in response to this campaign. Regular exercise, at least three times per week for thirty minutes, is one of the best things you can do for yourself. The data on the benefits of exercise are far too impressive to be ignored.

Nutrition — You are what you eat — we may have to question, but not necessarily compromise, certain dearly loved cultural values and age-old traditions. Over the next several months, indeed for the rest of this year, the Ministry of Health will bring to you a number of ideas and suggestions, through the medium of press, radio and television, for modifying our eating habits while retaining our enjoyment and cultural identity. We shall all be better off for having done so.

Personal Responsibility — This rests with each one of us. Very little we do is done in isolation. Decisions we take affect us, our families and our co-workers in some way. The health of each one of us is an important national resource, one on which we all rely and which we cannot afford to take for granted. Different personal health decisions in regard to smoking, alcohol and drug use, exercise and proper eating habits offer a much greater hope for a healthier Bahamas than does sweeping restructuring of our medical system. MORE MEDICAL CARE DOES NOT EQUAL BETTER HEALTH. While our health care professionals and our Government have important roles, you, the individual, are responsible, by the grace of God, for the quality and length of your life. What you do for and with yourself determines your health.

In conclusion, I invite each of you...to make a commitment, starting now, to the building of a healthier and happier Bahamas. Remember: Healthy Living — Everyone a Winner.

(Edited version of the Honourable Minister of Health’s message to the nation on World Health Day, 1986.)
Mr. Charles Smith, Permanent Secretary M.Y.S.C.A. with a winner and Mr. Gus Cooper, Director of Sports presenting trophy at Xerox (Bahamas) Road Race, 1986.

The Ministry of Youth, Sports & Community Affairs has always promoted health through sporting activities.
A WHOLE NEW WORLD
SHONELE FERGUSON

My participation in track and field is well worth the effort. It is not always easy or happy but it is full of discovery, surprises and adventure. I suppose I could divide my athletic career into three parts: the early days, the college days and life after college.

The early days

I didn't win very often, I was the person who came third or second. It was a time full of doubt and trying to find a niche for myself.

As a school girl, I can remember always coming second or third in the 200 meters race. I was fastest out of the starting blocks but did not have the strength to hold my speed to the finish line. This presented a serious problem. Only two participants per school were allowed to compete in each event in the inter-school track and field meet. My chances of making the school team seemed very slim. There was no guarantee that I would be among the top two finishers. I knew that I was quick out of the blocks and also knew that I was never caught until the last 10 meters of the race. I figured that my best chance of getting to the inter-school meet therefore was via the 50 meter dash for junior girls. This was where I had my first success. I didn't simply win the junior girls' 50 meter dash, I established a new inter-school record. I thought that I had found my place in track and field. This would be my event.

It was quite a shock to me when, the very next year, this "race" was dropped from the schedule of events. I was now an athlete without an event. So, it was back to the drawing board. I experimented with the 400 meters race for several years. I attempted the high jump, ran countless relays and even threw the shot put. I didn't seem to belong in any of these events nor was I that good at any of them. One thing I did discover during this period though, was that I could long jump fairly well and that it was a lot of fun. So I became a fixture around the long jump pit.

Progress was steady and satisfying. I could set goals for myself and there was no reason why I shouldn't attain them. It was at this stage that I met Keith Perker who shared my love for long jumping. We developed a coach/athlete/friend relationship that has steadily grown over the years. It was an encouraging time and my progress was such that as a junior athlete I qualified for several senior competitions and thus began travelling around the world. It was also at this time that I came into contact with Bradley Cooper and Steven Hanna who were also aspiring athletes. They became part of my world and we helped and encouraged each other. We shared the joys of winning and the despair of losing.

The Carifta Games of 1976 were the highlight of this stage of my athletic career and they catapulted me into the second phase. I finished high school in 1975 and, despite some of my teachers' warnings that I wouldn't "do well" because of the time spent practicing and travelling, I still managed to pass the 'O' level examination with two As, three Bs and one C. It was a juggling act, but I found time for everything. I suppose that this was my first experience with time management and it was to become very important as my career progressed. I was always tired, but I was happy doing the things that I enjoyed.

The college days

Several colleges in the United States offered me athletic scholarships. I packed my bags, resigned my teaching job at Clarendon Primary School and took off for the University of Florida in Gainesville. To say that my first experience with college was unsettling is mildly. I was shocked, excited and not a little scared. No doubt my Mom was also scared because she cried for the entire period while waiting to board the aircraft that would take her back to Nassau — leaving her only daughter in the United States.

Still, it was a pretty wonderful time. I was the only foreign girl on the university's track team, but there were some guys from Jamaica, Trinidad and Tobago, Bermuda and Fletcher Lewis from Grand Bahama.

Just before classes began, the Americans on the team invited me to Disney World. There is no need to guess my answer! I had a fantastic time, and it served as a very good informal way of getting acquainted. How can you remain strangers when you are flying down Thunder Mountain at the speed of lightning and feeling any moment that you had breathed your last! One of the things that embarrasses me, even to this day, is that I couldn't keep my eyes open on the way back to the university. I slept like a log. It was a two and a half hour drive and I felt like I had been driving for ten hours. When we finally arrived at the University's campus, I had to ask where I was. I went to bed happy and bone tired. It was a good beginning and I hoped, a good omen.
Classes were informal and very interesting. But what really blew me out of the water was when I first stepped into the math class. I was certain they were preparing for a movie. There were about three hundred students seated in what looked like the Shirley Street Theatre. The instructor taught the class using an overhead projector, a movie sized screen and a microphone. It was quite an experience as i sat there trying to look as though I had been in classrooms like that all my life.

On the track, the story was different. I was a celebrity. I was the only one who had been on an Olympic team and everyone wanted to know what it was like to compete in the Olympic Games. It was an adventurous season. I travelled and competed throughout the Southern United States, with occasional trips up north to Pennsylvania and New York and out west to California. The competition was good and I didn’t feel at all intimidated. At the first competition in Knoxville, Tennessee, I was second in the long jump and second in the 200 meters. This was the Dogwood Relays and we went to other competitions with names like Becky Boone Relays in Lexington, Kentucky, Tigerbells Relays in Nashville, Tennessee. We travelled by bus for short trips, by the University’s plane for mid range trips and used the commercial airplanes for long flights.

There was always the need to win because the coaches were judged by the team’s performance and their jobs depended on it. I ran races that I never agreed to run in the scholarship. That it was a team effort and that everyone needed to help out where ever possible was constantly stressed. This was difficult because I felt that we had no right competing in events in which our competitors were below par. To have to run flat out in the 200 meter leg on a sprint medley relay then try to compete in the long jump spelt disaster. Any spring that I ever had in my legs was long gone by the time the long jump competition began. I wasn’t progressing in the long jump and other athletes were finding that they were stagnating in their specialties. At the end of the season, instead of having done well in the few events in which we were strong, our all round performance was dismal. We had a new coach for the second year. Pretty much the same thing happened but she moved to another state and avoided being fired by the Athletic Department. I started my third year of University with my third track coach. It was a crucial time because I was now completing courses in my major area of study. It was the same story, so I gave up the scholarship and joined a local track club. It was an amazing turn around. In my first meet with this track club, I jumped further than I had ever jumped in my life. The sun was shining again! School was going well and now track and field was going well again.

I finished my studies and headed south to Nassau and home.

**After college days**

Track and field took on another dimension altogether after I returned home. My first job was with the Ministry of Health working at the Sandilands Rehabilitation Centre as a trainee Executive Officer. Personally, these were good years. I accomplished my goals in track and field and after some time at the SRC, I started a new career at Xerox (Bahamas) Limited.

In 1981, The Bahamas team travelled to Santo Domingo in the Dominican Republic for the Central American and Caribbean Games. This was a good experience because I won the long jump AND set a new games record, but it was bad in that our bathroom had no door and in the shower, you were either frozen by cold water or jolted by electrical shocks. There were no towels or soap, so the BAAA bought some locally to enable our athletes to bathe. The food defies my descriptive powers. We survived on pineapples, chocolate bars and any other snacks that we could purchase. The following year we had a meet in Cuba; having learned my lesson in Santo Domingo, I packed sheets, pillow cases, toilet paper, carnation instant breakfast, chocolate bars and lysol. We had an interesting time in Cuba. It was different from any other country that I had visited before. My best description would be that Cuba got stuck in the 1960s. One got the feeling of having gone back in time. It was a drab place. The office buildings and houses did not appear to have been painted in many, many years. Wherever you saw a shop you saw a queue; we even had to stand in a long line to board the bus. The only good thing about waiting was that the ride was free. It was a graphic reminder of the phrase "being packed like sardines". All in all, it was a good trip. Our visit coincided with the carnival season, a carnival the likes of which I’d never seen before. The floats were huge and colourful, the music very good. Actually, we hadn’t gone to Cuba to have a holiday, we went to compete and we did rather well, very well in fact when you remember that the Cubans are the track and field power of this region.

1982 was by far the most exciting year. The Commonwealth Games were held in Brisbane, Australia. We were only a small team but we were able to hold our own against over 40 Commonwealth countries. We won three bronze medals, one silver and two gold — Bradley Cooper and myself — which incidentally also set records for the Games in those events. The meet was very well organised and executed — Australians know how to put on a track meet. The living quarters were comfortable and clean, the dining area was clean and the food was arranged in tasteful displays. The organizing committee seemed to have realized that there would be people from all over the Commonwealth so they arranged to have food from each geographical region so that the change in diet would not adversely affect performance. We met athletes from many African countries, Hong Kong and islands in the Pacific Ocean that we didn’t even know existed.

On completion of the Games we stayed in Australia for other competitions. During this time we took the opportunity to visit its parks and saw kangaroos, Koala bears and other forms of wild life not seen in our part of the world.

The years after 1982 have not been as successful. It is becoming increasingly difficult to keep up with world class competitors and work full time. The ultimate goal of all my hard work and persistent effort was to win an Olympic medal. That I didn’t win a medal in the 1984 Olympic Games is now history but, as I said at the beginning, the time and energy that I have put into track and field were well worth the effort.
I have competed all over the world — in Trinidad and Tobago, Jamaica, Bermuda, Puerto Rico, Mexico, Columbia, Venezuela, Martinique, Guadeloupe, all over the United States, in England, Ireland, Hungary, Germany, Italy, France, Australia, Taiwan, Cuba, Norway, Finland, to name a few countries. It has been a fantastic adventure and discovery. I have grown up with the world as my home and I hope that I am a better person for it.

Any young girl who feels that she has a talent in track and field or any other sport has my full support. Sometimes parents feel that sports are not the best activities for their young daughters and have many misgivings about letting them compete. There is a whole new world of fun, learning and finding out exactly what you are capable of. The opportunities are many and, for those who work hard, the rewards include a university education and the attainment of a goal that you have set for yourself.

My goal in track and field this year is to win the Central American Games which will be held in Santo Domingo, again and to successfully defend my Commonwealth Games title. These will be held in Scotland. I have never been to Scotland and whether I win or lose I shall know a little more of this world in which we live.

S5.

SINGLE...BY CHOICE???
Anonymous

Are women today looking up and really moving on? Are the days gone when women depend heavily on men for support and security gone? Until fairly recently women were beholden to men but this trend is gradually changing. For women over a generation or so ago, dependency resulted from their outlook on life and not on any lack of opportunity to further their education as many would have us believe.

At that time many women entered college but because the trend was to get married, after her marriage the woman was expected to stay at home and become a home maker and have children. This meant that if she entered college before getting married, she would then have to leave because it would not be necessary for her to work, the man was considered to be sole bread winner. However, this trend has changed greatly with the advent of the feminist movement. Women are now seen as being more assertive, they claim to want more "out-of-life" than just staying at home, raising children and being "housemaid" to her companion.

Considering herself his equal, she is now busy taking advantage of every opportunity to prove to him that she is just that — his equal. But does she really know what she wants out of life and/or what will satisfy her personal needs? How does she feel about "self"? What is so new about this "new found independence" that some claim to have? What does this mean? It is fair to assume that if a person knows "self" and is in "full-control" then it is unnecessary to go out of one's way to prove what you are capable of doing. Women, what then is it about the male that you strive so hard to emulate him in order to achieve something?

As a result of more women taking a greater interest in becoming and being successful it would appear that more women are opting to remain single. A short questionnaire was therefore designed to try to ascertain whether this was so and if it were, to explore some of the reasons.

A small number of women from various socio-economic groups were interviewed. What I found was that those women who opted to stay single did not in fact want to remain single, although they liked being independent and free of the responsibilities that come with a permanent relationship. The reason for their choice was that they had not yet found anyone with whom they would be able to enter a lasting relationship and they were not willing to enter a relationship merely for the sake of "having someone". It was interesting to note that although most of these women felt that a lack of companionship was one of the disadvantages of being single, only one noted that marriage would threaten her independence. For the others, the loss of job or sickness would be that threat. So, if marriage is not a threatening factor to our independence why opt to remain single? Is it true that there is a shortage of eligible men?

Lastly it was noted that the extent to which the woman looks forward to remaining single varied with her age.

Are we women in full control of our lives? Do we know what we are striving for? Could we be missing out on the best days of our lives as we strive to reach our goals?
THE CHANGING ROLE OF BAHAMIAN WOMEN
MALVERN BAIN

Over the past two decades, some of the most noticeable changes in the social and economic role of women both internationally and locally have taken place in the labour market. In The Bahamas in the last 20 years or so, thousands of women have turned their backs on the kitchen and — some eagerly, some reluctantly and some through sheer necessity — entered the world of work. In fact, according to the latest census figures, some 34,886 women worked in 1980 compared with only 16,995 women who “did some work” in 1963 (an earlier census year). Today, it is estimated that almost one out of every two jobs in this country is held by a woman.

In addition to the significant quantitative changes in the number of women who work, there have also been some qualitative changes in the type of work done by women. In 1970, the earliest year for which specific information is available, some 2885 women in The Bahamas held jobs in the professional, technical and related field. Only ten years later, as many as 4763 women were noted in this occupational group. This represents an increase of over 65 per cent.

Needless to say, most of the women who now hold these more rewarding and lucrative jobs are the younger women. Older women, lacking the specialized training for most of the better paid jobs, are relegated to the growing number of the traditional, lower-paid service sector jobs.

Actually, it has been this rapid expansion in the number of service sector jobs which has attributed mostly to the growth in the female work force in The Bahamas. Back in 1963, the service sectors employed some 15,000 females or just over 70 per cent of the total female labour force. By 1980, the service sectors had grown to provide jobs for over 30,000 women or some 88 per cent of the female work force.

Among the growing number of females in the work force in The Bahamas are the many married and single women. An increasing number of married women are finding themselves in the work force; supplementing their spouse’s income (and in many instances being the main wage earner) to ensure a certain minimum standard of living for their families. Many single women, unmarried and living alone without the benefit of income sharing with spouses or economies of scale that accrue to larger households, are also finding it necessary to go out to work. In 1980, married women accounted for 27 per cent of the female work force and single women who were never married accounted for another 39 per cent.

There are many and varied factors which have motivated the surge of women into the Bahamian work force in recent times. Space does not permit a discussion of many of these factors, however it would be a shortcoming not to mention the role played by 1) education and 2) changing family structures.

In The Bahamas today women are better educated and are becoming more persistent in their desire to use that better education. A quick glance at the most recent education statistics shows many more female high school graduates than male. This general improvement in the level of female education over the last two decades is even better illustrated by examining the two census years of 1963 and 1980. In 1963, 5.7 per cent of the females in the work force, 15 years of age and over, had no schooling. In 1980, only 1.6 per cent fell in this lowest category. In 1963, 74.2 per cent of the females had only elementary or primary level education. In 1980 this number fell to 36.7 per cent or just over one-third. In 1963, 17.7 per cent of the females had high school education. By 1980 this number had grown to 47.2 per cent, almost half of the work force. In 1963, less than 2 per cent of the females had some college or university education. By 1980 this number had grown to a significant 12.6 per cent. Expressed another way, one in every eight females in the work force in 1980 had some college or university education compared with only one in 74 in 1963.

The other major reason mentioned for women entering the labour force in increasing numbers has more to do with needs rather than desires. In recent times, the growing number of separations and divorces occurring in our society has left many women with no choice but to go to work. The vital statistics on divorce show the numbers to have more than tripled over the ten year period 1975 to 1984. The 1980 census figures present a similar picture. According to those figures, one out of every nine women in The Bahamas in 1980 was either divorced or separated.

The need for separated, divorced and other previously married women to work is further compounded by the family commitments and responsibilities with which they are burdened as a result in the breakdown in family structures. This particular situation is highlighted by household survey data generated throughout the seventies which show that close to 40 per cent of the households in The Bahamas were headed by females. With this growing tendency towards the breakdown in family life, the number of females in the work force who head households will continue to grow. Actually when all the facts are taken together, The Bahamas can expect to see a continued expansion in the female labour force, including the work force, for many more years to come.
The current “in phrase” among health professionals is “Health Promotion”. What does this mean and who will assume responsibility? Generally, this responsibility is assigned to health education, the panacea for all health problems, but, Health Education is a process...to better health, not a “quick fix.”

Health Promotion has been defined by the WHO as “the process of enabling people to increase control over, and to improve their health”.

The U.S. Surgeon General’s Report — Healthy People describes Health Promotion thus...“begins with people who are basically healthy and seeks the development of community and individual measures which can help them develop lifestyles that can maintain and enhance the state of well-being”.

Yet another definition is “a realm of health-enhancing activities which differ in focus from currently dominant curative, high technology, or acute health services”.

The common thread in all three descriptions is that of “enabling healthy people to enhance their health”. The emphasis is on the greater number who may be helped to better health, incidentally, at a fraction of the cost of curative medicine.

Caring and Sharing in the Summertime, 1985-1986 has sought to deal with some of the health problems, before they become “problems”, affecting women who comprise half the population and who are almost exclusively responsible for producing future populations. Many of their health problems are associated with their reproductive function. Knowledge of their bodies which leads to action and ultimately improvements in their quality of life is one step in that direction and an example of health promotion.

Joining Hands For Health welcomes and invites comments and contributions from its readership. You may use the Evaluation Form at the back of the magazine or write, telephone or call in person.
They spend long hours engaging in physical fitness activities. The various health spas or aerobics classes are the favourite spots. Their primary objective is physical fitness and they will do almost anything to achieve that goal.

Women have always been weight-conscious and no matter how lean they are or may appear to be, their favourite words seem to be, “I think I’m getting fat.” Understandably so, considering that the appearance competition among women is far more interesting than among men.

If one were to tour the various fitness centres on the island or visit centres where sporting activities are played it would be interesting to note the increasing number of female participants. No longer are they confined to the domestic chores at home on the weekends or after work. They are now finding time to exert their energies and their efforts to achieve physical fitness.

Sure, the competition must be keen among women involved in physical fitness. Men these days seem to be more attracted to women who are physically active, women who can play and appreciate a sport the way they would their favourite day or night-time soap opera, women who realize that men are as conscious about their physical conditioning as they are about their relationships.

Jogging is also a favourite pasttime of women these days. Along the street sides, in the parks and on the beaches, more and more women are getting in their exercise. They jog early in the morning and late in the afternoon, thinking that the frequency has much to do with the time involved in trying to change their physical image.

Bahamian men find women an ideal topic of conversation. Their conversations range from the type of women who attract them to women whom they do not find attractive and why women are unattractive.

You will normally hear Bahamians, like their fellow Caribbean and Afro-American brothers say that they find a firm solid body attractive. That is the initial appearance. But they would drool over women who are physically fit and allow their imaginations to wander.

Physically fit women are sights for sore eyes. Their bodies are well proportioned, they feel better about themselves and it enhances their physical appearance.
Preparing for first pelvic and menstrual hygiene.

Puberty and adolescence are times in life when women experience a great deal of stress due to rapid psychological and physical changes. As our bodies mature we are faced with new responsibilities for caring for our bodies and maintaining good health. Girls have the experience of menarche, or the onset of menstrual periods, usually between the ages of 10 and 15 signifying the still early physical development of the reproductive system. Many youngsters are unprepared for proper menstrual hygiene and are embarrassed, shy or afraid to talk openly with their parents, older sisters, nurse or doctor about the subject. To help these youngsters we older women need to become more comfortable ourselves and develop our ability to discuss menstruation and its effects on the body.

It is important to promote cleanliness by daily bathing (bath or shower) with soap and water. Douching is unnecessary prior to, during or after a menstrual period and may in fact lead to a vaginal infection. Douching removes the normal bacteria that live in the vagina (lacto bacillus) which tend to prevent vaginitis and thus allows other ones to flourish — such as yeast infections. Once the external perineal area has been cleansed, that is enough.

It is not wise to use feminine sprays or perfumes either since they can cause skin irritation and lead to allergic reactions. The normal menstrual odour can be kept to a minimum by simply washing with clean water and soap.

The question of using sanitary pads or tampons has become controversial in the recent past because of the toxic shock syndrome (TSS). Since TSS has occurred in non-menstruating women there has not been a definite cause and effect relationship between tampons and TSS. Most researchers now feel that there is an increased incidence of TSS in those women who used a specific extra absorbent (extra super size) tampon, which has subsequently been taken off the market. There does not seem to be any problem associated with using the regular size tampons of the brands currently available. The general feeling was that the super absorbent tampons absorbed not only menstrual blood, but normal vaginal mucosal secretions which keep the vagina moist. When drying of the vagina occurs it makes the mucosa more vulnerable to getting small abrasions from removal and insertion of the tampons, thus allowing bacteria to enter the blood stream and causing the systemic illness TSS. When the regular or junior size tampons are used this extra strong absorption does not seem to take place. The use of tampons therefore is a safe method of maintaining hygiene and absorbing menstrual flow.

Because of a general lack of understanding and knowledge of female anatomy, many girls and women are afraid to use tampons thinking they can harm one or "get lost inside". This is impossible as the vagina is a cul-de-sac — a cavity open only at one end. Tampons cause no damage, cannot get lost and with proper placement should not be felt after insertion. Tampons should be changed or removed at least every 24 hours to prevent infection. Although young girls will probably find using sanitary pads easier when they first start having their periods, many women prefer switching to tampons later on when they become more knowledgeable about and comfortable with their bodies. For the first few times of using tampons, insertion may be made easier by using a small amount of K.Y. Jelly or contraceptive cream on the tip of the tampon so that it slides in more easily. The frequency of tampon change depends on how heavy the flow is — just as with pads, but it should be changed at least every 24 hours. If one encounters a problem in removing or inserting, it is a simple matter to ask your nurse or doctor to instruct on proper use.

It should be noted that some women have frequent urinary tract infections from wearing sanitary pads. The pad create frictional pressure on the urethra resulting in a urethritis and cystitis. Women who encounter this problem should switch to tampons. Also, avoiding tight clothing and panty hose, using 100% cotton panties and using white (no color dyes) non-perfumed toilet paper — and always use toilet paper in a front to back wiping motion to avoid faecal contamination of the urethra and vagina — can help women avoid vaginal and urinary tract infections.

These are some of the technical points of menstrual hygiene. General ideas that should also be conveyed to young women is that menstruation is a normal, healthy part of growing up. There should be no fear or shame associated with it. Neither should a general feeling of "monthly sickliness" be conveyed. If young girls or women experience dysmenorrhea (cramps) with their periods, they should consult a physician and receive an examination and treatment for the problem. The normal physical activities should be continued — even swimming. Tampons of course would need to be worn rather than pads while swimming.

One fallacy which should be dispelled is that tampon use does not cause a loss of virginity.

This brings us to another subject, the first pelvic examination. Like childbirth, the pelvic 'exam' is shrouded in mystery, fear and sometimes even hysteria. This is unfortunate because it not only delays women from seeking medical examination and therefore treatment; but also hinders the prevention of many medical problems associated with the genital tract.

We need to sit and talk calmly and matter of factly to young women about female anatomy and why women should have a pelvic exam starting at age 18 or at the onset of sexual activity if this is earlier than age 18.

Pelvic exams are necessary for performing a papanicolaou (pap) smear, or cancer check of the cervix. The cervix is one of the three most common areas of cancer in women, others being breast and stomach. The pap smear can also reveal or confirm certain infections commonly found in the vagina. When cancer of the cervix is detected
early, it has a much higher cure rate or 5, 10 and 15 year survival rate than if discovered late in its course. The pelvic exam is also used to diagnose vaginal infections which sometimes have symptoms of a discharge with or without odour and sometimes itching. It should be noted that some infections eg. gonococcal infections often have no symptoms noticeable to the patient but which nonetheless have serious far reaching effects.

The pelvic exam is also used to assess the reproductive organs — uterus, tubes and ovaries. Tumors, benign and malignant, cysts and uterine/tubal infections can often be initially picked up during a pelvic exam.

Pelvics are also used to determine the size of the uterus or womb in early pregnancy. Before women start practicing contraception, they should have an exam and pap smear as part of their medical assessment as this information is used in the determination of the method most suitable to them.

The procedure itself is very simple. The woman lies on her back, with hips and legs flexed (bent) and feet placed in a metal “stirrup” or foot rest, with hips at the edge of the table. The woman should be told about, shown and reassured about (if necessary) a speculum prior to insertion. She should also be instructed on how to relax the inner thigh, buttock and perineal muscles for greatest degree of comfort and to use deep, slow breathing with a visual focal concentration point to help with relaxation. Conducting a conversation requiring the woman’s involvement also helps relieve tension. If she has been shown a pelvic model and had the process explained to her prior to exam, she is often less fearful.

As in wearing tampons, it should be stressed that a pelvic exam does not cause one to lose one’s virginity.

Helping women relax for their first pelvic exam does take more time, but proves worthwhile in the long run and leaves the patient with a more positive attitude for future pelvic exams and no frightening experience to recall as so often can happen with young, and often not so young, anxious and fearful women who are not adequately prepared for their exam.

It is also helpful to acquaint women with their own anatomy and use a mirror and adjust the lighting so they can see the inside of the vagina and know what the cervix looks like. The more they know, the less reason there is to fear their own bodies. Suggested reading material which can help women become more comfortable with their bodies, is “Our Bodies, Ourselves” a Health Book by and for women.

Simple and brief pamphlets which are helpful can be obtained from the Health Education Division, Ministry of Health.
PREGNANCY AFTER CANCER?

PAM BURNSIDE

Recently, it seems that every three years I wind up in hospital. In October 1979, I gave birth to our first child, Ebony Raine, a robust 8lb. 4oz. baby girl and left the Princess Margaret Hospital with an additional bundle of joy. In 1982 and 1983, however, my hospital stays were somewhat different in that I left parts of me behind following first, a breast biopsy then a modified radical mastectomy — surgical removal of a breast and lymph nodes — due to cancer.

It was in 1982 when my husband discovered a small growth, like a pimple, on my nipple which gradually developed into a dry scaly patch. Although I could not feel any lumps, with a family history of breast cancer, I went to the doctor when I noticed a clear discharge from the nipple. The condition was diagnosed as a blocked milk duct but after it did not respond to the prescribed creme, a second doctor's opinion and subsequent biopsy confirmed it as cancer — the early stages of Piaget's Disease of the nipple. I was advised that the breast should be removed.

It is strange how life is — we had been trying to have another child during this period and it was just as well I had not become pregnant. One of the first questions we asked the surgeon was whether I would be able to have children after the mastectomy. Of course, each case is different and although the average assessment period after breast surgery is five years, I was told not to even consider it until after two years.

During those two years, Ebony constantly told us how lonely she was and how she wanted a sister. The two years finally came to an end with regular check ups every two months. The surgeon told us that, due to my age, quick recovery and positive attitude and the fact that the cancer had been discovered early enough with no lymph node involvement, I could 'try again'.

We were overjoyed to learn I was pregnant in 1985. Ebony was with me when I got the results of the pregnancy test and she was so excited. She made a point of counting the months as they passed and telling everyone else know! People were amazed to see me pregnant after breast surgery and, as a local distributor for prostheses (artificial breasts), I came into constant contact with other mastectomees who were encouraged by my condition and surprised to learn that I was not the only mastectomee in The Bahamas to become pregnant.

The pregnancy progressed without complication and I kept myself busy as usual. On the 28th February 1986, the exact due date, Orchid Wynd was born, a healthy 6 lb. 14½ oz. baby girl!

People constantly asked us throughout the pregnancy whether we wanted a boy or a girl. Our reply was always "a healthy baby". As I write this article, I am watching Orchid smiling in her sleep after her feeding. Yes, I do breast feed, as well as supplement with formula.

There is so much to be thankful for each day. Life goes on regardless and although I may have lost a breast three years ago, I have gained so much more as a result — a greater awareness of life, more family togetherness, a sense of purpose and invaluable friendships by being able to offer encouragement and support through active participation in the Cancer Society of The Bahamas and as a distributor for prostheses.

The fact remains that there are many, many women who have had, or are going to get breast cancer and I cannot emphasize enough the following points: 1) Know your body; 2) Know the seven warning signs of cancer —

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<tr>
<th>Change in Bowel or Bladder Habit</th>
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<tr>
<td>A Sore That Does Not Heal</td>
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<tr>
<td>Unusual Bleedings or Discharge</td>
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<td>Thickening or Lump in Breast or Elsewhere</td>
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<td>Indigestion or Difficulty in Swallowing</td>
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<td>Obvious Change in Wart or Mole</td>
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<td>Nagging Cough or Hoarseness Which Persists</td>
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3) Practise monthly breast self-examination (see illustration). If you do have a lump, consult your doctor IMMEDIATELY — remember that the majority of breast lumps are NOT cancerous but ONLY YOUR DOCTOR CAN TELL FOR SURE. Remember also, EARLY DETECTION is the key to recovery and cure from cancer — it is better to be safe than sorry. The Cancer Society recently donated a mammogram machine (an x-ray machine for early detection of breast lumps) to the Princess Margaret Hospital. Ask your doctor about its use.

Should you have to lose a breast, remember that you are not alone. The Cancer Society can put you in touch with many of us who have come through the experience and are here to offer support and encouragement. It is important to maintain a positive attitude; the understanding and support from family and friends goes a long way in reinforcing this.

I would also like to urge the public to obtain proper medical insurance for themselves and their family. Cancer spares none and can strike any part of the body of man, woman or child. The stress and burden of worrying about how medical expenses will be paid, particularly if you have to go abroad for treatment, can impede treatment and recovery.

On closing, I would like to extend my thanks to all the people who have given me their support and encouragement over the years, and to pass on that positive spirit to others. CANCER CAN BE BEATEN — LET'S BEAT IT TOGETHER!!
Examine your breasts regularly at the same time each month, e.g. the day after your period ceases. If you have passed the 'change of life', the first day of the calendar month. When bathing it is an excellent time to examine the breasts, lightly soap the hands, and relax against the back of the bath.

Examine the upper part of the breast, including the armpit, then the lower and central parts of the breast.

With the right hand, examine the whole of your left breast, as shown in the diagrams, starting at the armpit. The left hand should be used if examining the right breast.

It is important to use the flat of your hand, keeping your finger tips held lightly together, making sure that the finger tips, the most sensitive part of the hand, follows the same path as the flat of your hand.

Should you find a lump in the breast, or any of the following 'warning signs', which was not present last month, go to your doctor and say "I have a lump in my breast" or "There is something wrong which I was not aware of last month".

Tell him carefully what difference you have noticed, and ask his advice. Through lack of knowledge some women only report to their doctor when a lump or swelling in the breast has been present a long time. The following points may be 'warning signs' that something could be wrong.

1. A lump or swelling in the breast.
2. Pain in the breast, not confined to the time just before a period.
3. A stained discharge from the nipple, or skin trouble around the nipple, or a 'pulling in' of the nipple.
4. An alteration in the appearance of the breast, e.g. dimpling or puckering of the skin.
5. A change in shape or size of one breast, compared with the other breast, which has occurred during the month.
UP-DATE

FELICITY AYMER

WELCOME:—

* to the staff of the Public Health Department, Dr. ERIC BROWN, from the Accident and Emergency Department of the Princess Margaret Hospital on 3rd March, 1986.

* to the Ministry of Health, Princess Margaret Hospital, Mrs. FRANCINE HORTON Financial Controller and member of the Hospital Management Committee. As Financial Controller, Mrs. Horton is responsible for the Business Office, the Accounts, Budget and Planning Sections. Mrs. Horton is well qualified and has wide experience in both the private and public sector accounting systems and on occasion has acted as Deputy Treasurer and Chief Valuation Officer. A graduate of the Government High School and the Napier College of Commerce and Technology, Edinburgh, Scotland, Mrs. Horton has the proud distinction of being the first female professional to qualify as an accountant in the civil service.

Married to Eugene Horton, the couple have three children.

Joining Hands For Health wishes you every success in this new and challenging position, Mrs. Horton.

* to the staff of the Sandilands Rehabilitation Centre:
  * Dr. BHUPATHIRAJU RAJU, Psychiatric Registrar.
  * Ms. KATHRYN JONES, Special Education Teacher.

* to the staff of the Health Inspectorate Department of Environmental Health Services on 31st March, 1986:
  * Ms. PRESCOLA BAIN, Clerical Assistant.

Joining Hands For Health welcomes the following interns to the Princess Margaret Hospital:—

Bruce AUDEN, Andrene CHUNG, Peter CRAIG, Margaret GRELL, Egbert GRINAGE, James JOHN-SON, Jerome LIGHTBOURNE, Allan LYONS, Ne-vindra MANGRU, Rosetta MARSHALL, Deborah MITCHELL, Bryan TYNES, Keith WATSON, Lauren WILLIAMS.

May you proceed and progress successfully towards completion of your course.

Congratulations to:

* Mr. PEDRO ROBERTS, popularly known Chief Pharmacist at the Princess Margaret Hospital for many years, on his “elevation” to Director, Materials Management Directorate at the same institution. One of Mr. Roberts’ duties is to facilitate and streamline the procurement of supplies for the Ministry. Good luck.

* Mrs. VIVIENNE LOCKHART, Senior Pharmacist, PMH on having assumed responsibility for the Pharmacy.

* Ms. ALVETAR BARTLETT and Ms. JANET BULLARD on having passed the final examinations in Pharmacy. The ranks of pharmacists in this department at the PMH have now been swelled and the public should benefit. These two young women deserve special commendation, they have been working and studying towards this goal for some time now. May you find your job satisfying.

* Mrs. CHRISTABEL GRIFFIN, on your promotion to Chief Clerk within the Department of Environmental Health, Health Inspectorate Section effective October, 1985.

* Mrs. BEVERLEY FORD, Principal Nursing Officer SRC on your promotion to Deputy Director of Nursing. Very best wishes Mrs. Ford, we shall miss you at Sandilands.

* Mr. LEON HANNA, Carpenter Foreman at the SRC on your promotion to Building Supervisor.

* Congratulations to the following on their promotion to Senior House Officer: Vishnu BEHARI, Earl CAMP­BELL, Kirk CHIN, Srinivas DUWAURI, Dino GRAMMA­TICO, Sandra GRANT, Arlene HAYNES, George KO­LYBUS, Donna PERSAUD, George SMITH, Paul WARD.

Congratulations to:—

* Dr. EUGENE NEWRY Consultant Neurosurgeon at the Princess Margaret Hospital on his recent election as President, succeeding Dr. Percy McNeil, of the Medical Association of The Bahamas.

* Dr. ELIZABETH DARVILLE Consultant Radiologist, PMH, on her election to the Vice Presidency of the Association. Dr. Darville attended boarding and medical schools in Jamaica, completed her internship at the PMH and post graduate work in Radiology and computerised Tomography in Canada, returning to the PMH in 1983. She was Treasurer of the Association from 1984-1986 and successfully coordinated their recent annual conference on Health and Fitness.

Congratulations Dr. Darville, may you continue to be an efficient physician and a positive role model for other women.
Continuing Education

The Hospital Management Committee (PMH) conducted a successful seminar in budgetary control at the Pilot House Hotel, East Bay Street, 16th — 18th April, 1986.

Participants included senior officers throughout the Ministry of Health although it was designed essentially for staff of the hospital. The objective of this three day seminar was to provide a better understanding of the importance of budgeting and to assist Section Heads at the Princess Margaret Hospital in the preparation of their annual budget.

Resource persons included Mr. Mohamed Shameer, Financial Consultant to our Ministry, Mr. Edgar Hall, Chief Revenue and Finance Officer, Mr. Roger Forbes, Finance Officer and Mr. Gracian Sands, Controller, Central Purchasing Unit, all of the Ministry of Finance. Co-ordinated by In-service Training Officer, Mrs. Barbara Thurston, the seminar was opened by the Honourable Minister of Health.

* Mr. RICHARD ADDERLEY, Clinical Psychologist SRC has been granted an in-service award for one month to allow him to participate in a Drug Abuse Control/Community Drug Prevention Programme.
* MR. CARLTON BODIE, Maintenance Supervisor, SRC has been awarded a two month fellowship — courtesy PAHO — at the Jackson Memorial Hospital, Florida.
* Ms. CHRISTINE GREEN and Mr. TIMOTHY MUNROE, Health Inspectors, DEHS, are pursuing a 16 week course beginning 10th April, in Meat and Other Foods at the West Indies School of Public Health, Kingston, Jamaica.
* Once again the Department of Child Health, Princess Margaret Hospital, presented a community based educational programme. This activity titled Sensitivity to the Needs of Disabled Persons, was held over the week March 10th — 13th in the Grand Salon of the Wyndham Ambassador Beach Hotel, Cable Beach. Co-sponsors were Abbott Laboratories. Displays of the work done by and services available to, this special group of persons were open to the public 10am — 4pm daily. Response to the nightly presentations was mixed. The conference was opened by the Honourable Minister of Health and featured Mr. Butch Lupkin a 24 year old tennis coach who is a victim of Thalidomide, from Georgia. This young man is independent, outgoing, healthy. He is kept very busy and was only able to visit The Bahamas for a couple of days.
* NO II GLORIA GARDINER, Blue Hill Road Clinic, and CHARLES PRATT Hawksbill Clinic, Grand Bahama are currently pursuing a course in Tropical Diseases in Dominica. The course runs from 11th April —11th July, 1986.
* A Drug Abuse Workshop was held at SRC 19th —26th February and attended by N. Os Antoinette Outten, Princess Lewis, Elizabeth Rolle, of the Ann’s Town Clinic, Gloria Gardiner, Blue Hill Road Clinic, SNs Lorna Skyrers, School Health Services and Marcelle Johnson, Coconut Grove Clinic.
* NOs Antoinette OUTFEN and Stephanie DEAN recently attended a course in Effective Writing in Government — every Wednesday, from 15th January —12th February, at the Government Training Centre, Arawak Cay.

CHANGE AND???

* Ms. EUGENIE SMITH, Executive Officer, DEHS, has been transferred to the Sandilands Rehabilitation Centre.
* Ms. ELOISE ANDERSON, Health Aide, DEHS (Director's Office) has been transferred to the Health Inspectorate Section.
* Ms. STACIA ROBERTS, Clerical Assistant has been seconded from the Director's Office to the Health Inspectorate Section.

Transfers in

* SN Henrietta Hanna from SRC to Smith's Bay, Cat Island 3rd March, 1986
* TCN Eugene CADET from PMH to Old Bight, Cat Island 3rd March, 1986.
* SN Edith Miller, Fox Hill Clinic has resigned from the service with effect from 17th February, 1986.

About the Community

* The Community Nurses’ Club — President Mrs. Willa Mae Stewart — has recently donated four text books, Community Health, to the service — one to each of the three main clinics, the other to the office in the Clarence Bain Building.
* The Community Nurses, Club has also donated a cheque for $500, proceeds of their Variety Concert, held late last year, to Mr. Andil LaRoda, President of the Commonwealth of The Bahamas Nurses’ Association, towards their Building Fund.

An Association is born

For the past three or so months, a small group of interested and very dynamic persons had been meeting every Saturday afternoon to try to form a Diabetic Association. Under the leadership of Mrs. Diana Pinder, a mother whose young daughter is a diabetic, and with the active cooperation of health professionals such as Mrs. Jannen McCartney, Dietician PMH, Dr. Cecil Bethel and more recently Mrs. Thirza Dean, Nurse in charge of District Nursing Services, an association was formed on Saturday 15th March, 1986.

The inaugural meeting was held at the St. Matthew's Church Hall, off Shirley Street in Nassau and was very well attended by members of the public as well as health professionals. Officers elected were:

Mrs. Diana Pinder — President
Mrs. Vernice Symonette — Vice President
Ms. Lesley Sands — Secretary
Ms. Vestra Forbes — Assistant Secretary
Ms. Ethel Knowles — Treasurer
Ms. Betty Francis-Toote — Assistant Treasurer
Committee members are Ms. Kathy Benjamin, Ms. Janeen McCartney and Ms. Thelma Williams.

This Association will, among other functions, provide a support group for diabetics, something which apparently is very needed at this time.

Membership is open to anyone interested in diabetes or who may be or is related to a diabetic.

Further information is available from the President, Mrs. Diana Pinder — 31200.

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Welcome back:

Senior Nursing Officer Celeste LOCKART who has been away from her desk in the Community Nursing Service, Clarence A. Bain Building, for about four weeks following a car accident in which she was extensively shaken, considerably bruised, suffered lacerations to her forehead and arm and other abrasions. Although Mrs. Lockart was not admitted to hospital, her injuries required suturing and she attended many sessions of painful physiotherapy treatment.

Her car was a complete write-off. We are so glad you survived the ordeal Celeste and are extremely pleased to have you back at work.

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Road use in Nassau is becoming increasingly hazardous to both motorists and pedestrians. Crossing intersections at traffic lights no longer guarantees a safe passage. How much carnage will be enough one wonders?

GET WELL SOON

Dr. LINELLE HADDOX, Medical Staff Coordinator of the Princess Margaret Hospital. We understand that Dr. Haddox was an inpatient for about a week and is expected to be out of office for a few weeks.

We understand that SN Dorian Clarke’s, Black Point, Exuma, father has been ill. We wish him a speedy recovery.

From GRAND BAHAMA

A Health Service Committee comprising health personnel from the Community Health Services and Rand Memorial Hospital has been formed. This should greatly facilitate health consumers on the island.

Rand gets into the Community — Physicians at this institution are now involved in their branch of the Medical Association’s weekly radio programme on a more regular basis. Some of the topics they have discussed are abdominal pain, the importance of antenatal care, immunisation, oral health and AIDS.

Consultants are now taking the opportunity to address different health topics each month at the weekly meetings held at the Community Clinics every Friday.

Paediatrician Dr. Robert McKeage RMH is now conducting weekly clinics at the Grand Bahama Children’s Home — the objective of these clinics is to monitor and
screen the children's health and reduce admissions to the hospital.

The twice weekly immunisation sessions at the Rand continue. This service continues to be popular among the population and is provided alternately by Drs. Nehru (Community) and Chombi (RMH) on Tuesday and Thursday afternoons.

Still with children, the Paediatric Fund Raising Committee established on World Health Day, 1984, continues to be actively fund raising for projects to assist in improving child health in the island.

Both Drs. Philip Thompson and Robert McKeage conduct weekly luncheon meetings for their colleagues in private and government practice. All health workers are encouraged to take advantage of this opportunity.

Vital Statistics

Births

Congratulations:

* Anthony BROWN of the Photographic Department, PMH on the birth of your second daughter, Krystle Alexis on 10th August. 1985 (weight 8lb. 3oz.). Krystle was "of course" breast fed for the first ten or so weeks of her life.

* to Mr. and Mrs. Robert CHIN, both physicians, a daughter, born in Jamaica on 28th March.

* To Dr. Andree Hanna, Consultant Pathologist PMH, a daughter. This is Dr. Hanna's second daughter.

* To Dr. Kirk Anthony and Angela CHIN, a daughter, on 11th April, 1986.

Marriage

* Wedding Bells rang out loudly and clearly for Dr. Winston McFarlene Campbell ENT Consultant at the PMH and Barbara Ann Gray on Saturday 12th April. The couple, we understand, tied the proverbial "knot" before a large group of friends. Hopefully the knot will tighten in love, understanding and togetherness. All the very best Dr. and Mrs. Campbell.

Deaths

* Condolences to: C.N. Nathalie Bonimy, Supervisor for the Ann's Town Clinic on the death of your sister.

* the relatives of TCN Althea McKenzie formerly of Coconut Grove Clinic.
One of the topics often discussed today especially by women is that of family planning or planned parenthood. More and more women are taking control of their lives and taking advantage of the family planning services available to them. Controlling one's fertility and enjoying reproductive freedom means that they are free not only to prevent pregnancy but also to have children when they so choose. This freedom has opened the way for women to achieve their full potential and equitable participation in social and economic development.

Family planning is having a responsible attitude toward the creation of human life. This attitude favourably influences the health, development and well-being of the whole family especially the mother and children. It is a basic human right for individuals to decide freely and responsibly the number and spacing of children. It does not mean merely limiting the number of their children per family but rather thoughtful planning of how many children a family can adequately support. Such a responsibility takes into account the couple's living and future children.

Given the necessary information and education and the means to practice effective family planning, couples are able to:
   i) avoid unwanted pregnancies
   ii) achieve an optimal interval between pregnancies
   iii) choose the time to have children.

Fundamental to this reproductive freedom is the understanding of one's body especially the reproductive system and a knowledge of the health care that the body requires. A family planning programme provides this knowledge and understanding. Such a programme has two components:
   i) Education, which is the basis of developing positive reproductive attitudes
   ii) The provision of easily accessible services offering family planning counselling and medical assistance to the childbearing population.

SOME FAMILY PLANNING CONSIDERATIONS

1. Closely spaced pregnancies, less than a two year interval, leave little time for a woman to replenish her nutritional reserves. A woman should have enough time between pregnancies for her body to recuperate; this improves the health status of both mother and child.

2. In large families, siblings often compete for food, attention, love; they are frequently cared for by an older sister, tend to grow more slowly and have more frequent bouts of illness than do children from smaller families.

3. Too early child bearing contributes to certain complications during pregnancy and childbirth. Postponing the first birth until the woman is mature physically, mentally and emotionally, gives the baby a healthier start in life. It also makes pregnancy and childbirth safer.

4. Studies have shown that women over the age of 35 years run a greater risk of developing complications of pregnancy than do their younger counterparts.

5. Pregnancy is contraindicated when a woman's health predicts that a new pregnancy could be life threatening.

6. Ideally, pregnancy should not occur after a couple or woman has the number of children the family can adequately support.

FAMILY PLANNING METHODS

There are many methods of family planning giving a woman many choices. It means that she has to decide what is best for her and the method with which she feels most comfortable.

Some available choices are:

1. NATURAL METHODS

   The effectiveness of these methods depends both on the motivation of the woman or the couple and how well the method is taught. They are based on the natural cycle and rhythms of the individual female body.

   a) ABSTINENCE

   This is the oldest and most effective method. It means that the couple refrains from intercourse during the time that pregnancy is unwanted.

   b) WITHDRAWAL

   In this method the male withdraws the penis from the vagina before ejaculation. The success of this method is dependent on the man knowing the right time for withdrawal. Even if the timing is correct, there is a risk of pregnancy because sperm may be present in the pre-ejaculate fluid discharged by the penis during the sex act.

   c) LACTATION

   When a woman is breast feeding, no other feeding is given, and especially before menstruation has returned, the chances of her becoming pregnant are reduced. However, lactation is not a reliable or recommended method of child spacing.

   d) MUCUS OVULATION

   This method is based on the avoidance of sexual intercourse during the fertile period of a woman's cycle. A woman can identify her fertile period by noticing the change in the consistency of the mucus that is naturally secreted in her vagina throughout her menstrual cycle. With this method, intercourse is limited and, even when practised correctly, there is the risk of pregnancy.
e) RHYTHM
Like the mucus ovulation, the rhythm method is based on the avoidance of intercourse during the fertile period of the woman’s menstrual cycle. A formula, using figures, is used to calculate the fertile days. This method helps a woman to become more aware of her body’s natural cycle. Practised correctly there is a relatively high pregnancy rate.

f) TEMPERATURE CHANGE
Slight but noticeable temperature changes occur in a woman’s body when she ovulates. The temperature is observed daily with the use of a special thermometer. A couple may have unprotected intercourse three days after the rise of the temperature. This method is not useful in determining unfertile days before menstruation.

All of the above methods, except abstinence, even if practised correctly, run the risk of pregnancy. A highly motivated woman can determine her fertile period more accurately by using a combination of mucus ovulation, rhythm and temperature change methods; making this, the natural methods of child spacing, more effective.

2. ORAL CONTRACEPTIVE “THE PILL”
Oral contraceptives are made of synthetic hormones, oestrogen and progesterone. These hormones affect the uterine lining, the fallopian tubes, the cervix, breasts and the development of eggs in the ovaries. They create conditions in the body that are similar to those of pregnancy thereby preventing ovulation.

Although most healthy young women can take the pill, they are advised to seek medical advice before starting and to have regular medical check-ups. Women who have certain medical problems e.g. hypertension may be advised to use another method of contraception. Taken as directed, the couple has almost complete protection against pregnancy. It also helps to regulate the woman’s menstrual cycle. The pill is one of the most popular and effective methods of contraception in use today.

3. INJECTABLE CONTRACEPTIVE
This is made of a long acting synthetic hormone that acts like the natural female hormone progesterone, it prevents pregnancy for extended periods of time. Different amounts of this hormone make a single injection effective for two to three months. The injection is given in the upper arm, buttock or thigh.

Again, this method of contraception is not suitable for every woman. They are therefore advised to get a medical examination before taking the injection and to visit the doctor periodically and if medical problems arise. The injection is a very reliable method.

4. INTRA UTERINE DEVICES (LOOP, COIL)
Most intrauterine devices or IUDS are small plastic devices. They are available in different shapes and sizes. An IUD, Inserted into the uterus by a specially trained practitioner, prevents pregnancy by causing a chemical reaction in the uterus and its lining. This reaction interferes with the implantation of the fertilized ovum and with the ability of the sperm to travel to the fallopian tubes. Some IUDS need only be removed and/or replaced if problems occur or when the woman wants to become pregnant. For continuing effectiveness others have to be changed after a few years. The doctor or nurse advises on the change. An IUD is an effective and excellent method of preventing pregnancy.

5. DIAPHRAGM
The diaphragm is a small, shallow, rubber cup which a woman puts into her vagina to cover the cervix. When the diaphragm is in place, semen is prevented from entering the uterus.

A diaphragm must be fitted to the size of the woman’s cervical area. It is important that diaphragms be used with contraceptive cream or jelly which help to incapacitate any sperm which may pass the diaphragm.

For this method to be effective, the device must be properly fitted and the woman highly motivated. Strict personal hygiene must be practiced. The diaphragm must be kept clean and properly stored when not in use. Use of this method gives a woman control over her reproductive function and puts her in touch with her body. Used meticulously, it is an effective method.

6. THE CONDOM
The condom, also known as the French letter or sheath, is a rubber covering for the erect penis which prevents sperm from getting into the vagina.

A condom, used properly, gives reliable protection against pregnancy, and also against venereal disease. Used with contraceptive jelly, cream or foam, it provides additional protection in case of accidents. Used with the diaphragm, protection is even greater. Condoms are inexpensive and can be bought “over the counter”.

7. CONTRACEPTIVE CREAMS, JELLIES AND FOAM
Creams, jellies and foams contain chemical substances, spermicides, which immobilise sperm. When inserted high into the vagina these substances block the entrance of the uterus and immobilise the sperm in the vagina. They are available in tubes of small cans with applicators.

Absolute reliance on them is not recommended for young fertile women. They are most effective when used in combination with a condom, or a diaphragm and as a supplement with the first cycle of oral contraceptive pills. They may also be effective for the older pre-menopausal woman with lowered fertility. These methods are relatively inexpensive and available without prescription.
8. **FOAMING TABLETS AND SUPPOSITORIES**

Foaming tablets are small tablets which "foam" when inserted into the vagina. The suppositories are small blocks of firm jelly which melt at body temperature. Except for the shape, these tablets and suppositories act to prevent pregnancy in much the same way as contraceptive foams and jellies. Again they are available without a physician's prescription and are limited in reliability as a contraceptive method.

9. **STERILIZATION**

This is the only method of contraception that is not reversible. With the other methods already mentioned, a couple can decide to stop the method at any time and have a baby.

A man can have a **VASECTOMY**
A woman can have **TUBAL LIGATION**

a) **VASECTOMY**

This is a minor operation in the male. The scrotum is cut on both sides and the vas deferens (the tubes that carry the sperm from the testes to the penis) is cut and tied. This prevents sperm from passing out of the man's body. It is a quick, simple operation. It does not interfere in any way with a man's sexual desires, his capacity or ability for sexual intercourse.

b) **TUBAL LIGATION “tying the tubes”**

In this operation the fallopian tubes (the tubes which carry eggs from the ovaries to the uterus) are cut and tied. This operation is also simple but takes a bit longer than the vasectomy.

Any couple who chooses sterilization of the man or woman, as their method of contraception must be sure that they do not want to have any more children.

By providing people with information and choices about child spacing methods individuals and couples are assisted in exercising their right to make voluntary and informed decisions and to practice responsible fertility behaviour. Family Planning information gives women alternatives to continual childbearing and contributes to enhancing their status and improving their health.

Family Planning, then, is not merely concerned with the use of contraceptives as some misguidely think, but rather, it is concerned with the quality of life of the individual, the family and ultimately the nation as a whole.
THE ROLE OF THE FEMALE PHYSICIAN IN BAHAMIAN SOCIETY

ELIZABETH DARVILLE

I have tried to find some deep and complicated answers to this rather formal sounding topic I have been asked to address and have failed, so I shall share the uncomplicated answers which come to mind.

First of all, is the female physician (as opposed to the female person) any different from the male physician? Are their roles any different? I think not. As physicians I can see no difference, but as women, we can bring certain gifts, certain qualities, to our profession, be it medicine or any other profession, that men cannot. The reverse is also true, there are qualities that men bring to their professions that women cannot. These differences are normal and healthy and as the French say 'Vive la difference!!'

The importance of the qualities we bring as women often come under fire and it is tempting to hide our femininity in order to avoid this fire, but the woman who doubts the importance of the female qualities she possesses and attempts to develop male-like qualities, is often the lady who finds herself frustrated and dissatisfied in her work and at odds with those around her; since she is being honest neither with herself nor her colleagues. On the other hand, it is a grave mistake to believe that a pretty face will make up for lack of ability.

There is no doubt that chauvinism is alive, well and living in The Bahamas. But it seems to be slightly different than in some larger countries and certainly less obvious in professional circles. Maybe it is the heat, but it is probably largely due to the Bahamian professional woman herself whose grace, poise and self confidence seem to be more developed or maybe just better carried and in a less threatening fashion than many of her 'big country' counterparts.

But, back to medicine . . . the days when women sought out a female physician because they were embarrassed to go to a male are over and it is questionable whether such a situation ever existed. People choose their physicians and surgeons on the basis of whether they believe them to be "good" doctors or not. In The Bahamas, this is often decided by what one's aunt, cousin, grandmother or Miss Janie through the corner had to say after her visit to the doctor in question. So if Miss Janie approves of you, you may be chosen by Aunt Lisa and Mr. Moss next week. Now that you have Aunt Lisa in your office, what are your gifts as a woman which you can use to enhance your gifts as a physician? As a woman, your natural attention to detail may help pick up that little clue that may make the diagnosis sooner. Your sixth sense is more developed and can help you recognise and address the problems which are not voiced. As a woman you can empathise with Aunt Janie who may be having problems with the children — problems which her mate does see as very important, but which are driving poor Aunt Janie up the wall. As a woman, you can empathise with Aunt Janie who has finally realised that those lines are wrinkles and not laughter lines, whose headaches probably stem from a worry that she is no longer attractive. And so on. I am sure all women can think of long lists of seemingly unimportant things which we all know are very important.

Responsibilities for all physicians extend beyond the office, but because medicine is a high profile profession and we are in the minority, we have the opportunity to use this position for the advancement of all professional women by the examples we set, by our involvement in our community and by the way in which we interact with other women who may wish to follow our profession or who may simply need a reminder that they (we) do count.

The joys and sorrows of being a physician are immense, but they take on a very special meaning when viewed through female eyes. The role of the female physician in any society is to reflect and to share this very special position in which she finds herself.
GET IN SHAPE
BRENDA LOCKHART

With the longer daylight hours of summer come longer periods for leisure. Webster describes leisure as "freedom provided by the cessation of activities" and as "time free from work or duties". This cessation of activities or free time can be used to produce your best summer body ever.

The waist is the most watched area of the human body and it is also the area that first shows that the body is getting out of shape.

The waistline is the arbitrary line around the body's middle. Its muscles include the rectus abdominis on the front, the internal and external obliques on the sides and the erector spinae group on the back. The joints of the waist (or the spinal column) allow us to move in various ways: curling forward (flexion), straightening upright (extension), arching beyond upright (hyperextension), bending sideward (lateral flexion) and twisting (rotation). Usually two or more of these muscle groups work together to create these movements.

1. The rectus abdominis works in conjunction with the four obliques to cause flexion, as in a sit-up.
2. Right lateral flexion takes the combined efforts of the right internal oblique, right external oblique and the right lateral fibres of the erector spinae. Left lateral flexion requires the left equivalent of these muscles as in waist bends and reverse trunk twists.
3. Extension and hyperextension happen when all the fibres of the erector spinae contract together, as in back raises.
4. Right rotation is made possible when the right internal oblique, left external oblique and the right lateral fibres of the erector spinae contract simultaneously. Left rotation occurs when the opposite combination contracts, as in back raises with a twist.

The amount of movement available to you in the waist area indicates how much you can tone and trim your waistline. Your body type further affects how well your waist moves, its contours and tones. Long-waisted persons are usually able to generate greater range of motion than short-waisted ones. This means they have more innate ability to see results from waist exercises. On the other hand the long-waisted type also tends to have more "soft" space between the lower ribs and the hipbone to tone up. Short-waisted people have the advantage of achieving a harder waistline because the area is girded directly underneath by the closely positioned rib cage and pelvis. If anything, a short-waisted type may actually tone to the point of becoming undesirably thick. If you are short-waisted, your exercise program should emphasize light or no weights, high repetitions and plenty of torso stretching to counter this tendency. If you are long-waisted and desire a waistline that is hard as well as trim, your exercise program needs to emphasize heavier weights, moderate repetitions and less stretching.

If the body you have right now isn't the one you want, start working now; beat it, shape up, maintain the routine and stay "in shape". Eat fresh, light but healthy meals, work out through body-shaping aerobic and spot exercises. Do tough exercises for tough problems. Most women have trouble shaping up buttocks, hips and upper thighs. The tough exercises such as: pelvic lift, leg lift, full circle leg lift, saddle bag solver lie and inner thigh leg lift really produce results.

Aerobic exercise is a great fat burner. It is the kind of exercise that makes full use of your respiratory and circulatory systems, is a first-rate way of burning unwanted fat and keeping fit. Pick the activity that appeals most to you. It is better to stick to one activity so that you can build proficiency.

Use your leisure time to improve your physical and social life and of course you will feel better; try it, you'll like it.

*Excerpts from WAIST WATCHER'S ANATOMY by Joy Grau, M.S.
THE WOMEN’S DESK

The years 1976-1985 were declared the international decade for women by the United Nations. This mandate was initiated to focus worldwide attention on the needs of women and to devise active strategies to meet their needs over the ten year period. The theme for the decade was “Equality, Development and Peace.”

In establishing this forum around the world, it was hoped that women’s awareness on issues of importance to them would be heightened. It was further hoped that the status of women as equal partners in development and prosperity would be strengthened.

Women in The Bahamas were well aware of the development of these initiatives and in 1981, the Women’s Desk was established within the Ministry of Youth, Sports and Community Affairs. This was in a large part, a governmental initiative, created in response to and in recognition of the United Nations’ decade for Women.

Once established, the following five objectives were identified:

1. advise on the formulation of a policy as a basis for women’s affairs at the national level;
2. establish organizational links between the Women’s Desk and other organizations, Government Ministries and Departments;
3. establish organizational linkages with regional and International Women’s Organizations;
4. encourage and support the establishment of programmes and Women’s Organizations which are in accordance with the National Policy.
5. initiate relevant programmes for women at the national level and in accordance with the national objective.

In keeping with these objectives, the Women’s Desk has been instrumental in a number of significant activities:

1. an annual Registration of Women’s Organizations in The Bahamas,
2. a national conference on “Issues Affecting Women in The Bahamas”, October 1981,
3. establishment of a mobile community education unit — addressing topical issues such as Teenage Pregnancy, Drug Abuse and Career Opportunities,
4. meeting of representatives of women’s organizations in The Bahamas and the formation of a planning committee for the end of the decade for women; this committee was responsible for the activities which marked the end of the decade.
5. the naming of an advisory council on women’s affairs listed among government boards and committees for 1985. This body has responsibility for advising the Minister on matters related to women’s affairs;
6. initiating celebrations in March 1985, which were held in The Bahamas to commemorate “International Women’s Day”; a thanksgiving service was also held in 1986 to commemorate the day.
7. conducting a National Women’s Conference, November, 1985, which addressed The Role of Women in Health, Legislative concerns of Women and Women in Non-Traditional Employment Areas. Nearly two hundred women from the Family Islands, New Providence and young women from our school system came together to discuss matters vital to their development. It is hoped that this activity will become an annual event.
8. regrettably, The Bahamas was not represented at the World Conference held in July in Nairobi, Kenya, to review and appraise the achievements of the United Nations Decade for Women. This Conference, the largest conference ever held, adopted its ‘Forward-Looking Strategies’ for the advancement of Women to the year 2000.

Activities envisaged for 1986 include:

1. Local conferences in the Family Islands from which representation will be made to the annual conference planned for New Providence. These conferences will address issues relevant to women in the particular island community,
2. Special attention will again be placed on young women in the community as we attempt to integrate them fully into national development,
3. Participation in regional and international activities sponsored by the Commonwealth and CARICOM Secretariats, the Organization of American States along with other conferences, workshops and seminars.

It is necessary to emphasise that, although the Women’s Desk will be responsible for putting on programmes to sensitize and educate the community about issues affecting women from time to time, it will only be a catalyst for the changes necessary for improving the lives and status of women.

Further information may be obtained from:
The Women’s Desk, Ministry of Labour, Youth, Sports & Community Affairs P.O. Box N-10114 Fourth Floor, Centreville House Building Telephone: 23140-4
CAN WE HELP?

SHANE BRENNEN

The term "battered woman" refers to any woman who has been beaten or physically harassed by a spouse, cohabitant or boyfriend. The parties need not be married or living together.

The two most commonly held misconceptions about battered women are: 1) they enjoy being beaten, and 2) the violence itself is related to sexual stimulation.

Because of a woman's family structure she may have come to associate violence with love. For example: a parent beats a child severely and afterwards says that he/she beats the child because he/she loves the child; after several events it is then possible for the child to associate the violence with love. When the child is older he/she may continue this association if help is not sought.

In such cases women justify the abuse by saying "he loves me because he beats me". Similarly, if a child is from a home where periodically father physically abused mother, that situation may be re-enacted in adulthood.

In the United States during the 1800's, it was considered a husband's prerogative, if not his responsibility, to beat his wife. In the early 1900's, the idea was basically the same, the husband would beat the wife to keep her in line. Or, if she was beaten, it was believed that she provoked him. The woman was always to blame.

The idea of beating a woman then is deep-rooted in American culture. It is also deeprooted in our culture.

Other common reasons why women are physically abused, that I have found are:

1) low self-esteem — the woman does not think very much of herself, she has a low opinion of self.

2) low self-confidence — she does not believe that she can do certain things for herself, she has no belief in self.

3) low self-worth — she is no good, is not worth anybody's effort.

4) Dependency — a large number of women have told me that, because they are financially and emotionally dependant on the men in their lives they have to stick with the situation.

5) lack of options — a lot of women do not see themselves as having any options.

6) male dominance — many women have been brought up in male dominant families — only male children were actively encouraged to achieve professional ca-

reers. Female children were raised to be subservient homebodies.

7) despair — women who have been physically abused for a long time tend to adopt a hopeless, helpless attitude which prevents them from doing anything about their situation.

The "battered woman" does not belong to any specific socioeconomic group. She is a woman caught in a pathological tangle. A tangle brought about by family beliefs and cultural traits. Beliefs that were imposed upon her and which she internalized because of her lack of choices. Cultural traits that bounded and stifled her, again due to a lack of choices.

Today, although the problem is still very much with us, there has been a slight decline in the number of events. Reasons? women are staying in school longer than men. More women are seeking college degrees, these women are career-minded and goal-oriented, they are no longer homebodies or subservient. What used to be a "man's world" is now "our world". Today's women see that in any situation they do have options. They view themselves as individuals, are independent and highly motivated, they possess self-worth and high self-esteem, they believe in themselves.

This group of women though, is small in number. They are the "New Women". These ladies are in more control of their lives. Presently small in number, they are growing at a slow but steady pace.

What help is available to the battered woman?

A multidisciplinary approach is taken: the social work system and the legal system. Together they provide a strategy of total intervention. This model has a task-oriented client-centered philosophy. Its objective is to provide the battered woman with a comprehensive, continuous and co-ordinated service.

- This approach has four components:

1. Intake component:

   a) assessment of the problem and gathering of the facts.

   b) education of client — she is taught basic survival skills, made aware of her legal rights, how to deal with the police, and given information on how to pursue criminal charges or civil remedies.

   c) client is allowed to ventilate — express fully her anger, fears, ambivalent feelings.

   d) intervention plan
1) the client is provided with a clear understanding of what is being done with her case.

2) she is informed of her responsibilities as a client.

3) she is assured of confidentiality — it is made clear to her what information may be shared with members of the team.

2. Social Work Component
   a) assistance with psychosocial problem(s).
   b) referral, if necessary.
   c) counselling — on a short term basis with special emphasis on problem solving, goal setting, development and experience of self confidence, assessment of strengths and limitations, and progress to date. Counselling is a goal specific and time limited activity.

   During counselling four basic issues surface:
   1. lack of self-confidence
   2. reliance on fantasies e.g. the unrealistic belief that “he'll change”
   3. guilt feelings e.g. the unrealistic belief that she has failed as a wife and/or mother
   4. the effects of violence on the children.

   A plan or intervention for the children involved is also devised. The plan is designed to develop techniques that will prevent the client from scapegoating, ignoring, over-loading or beating the children during the crisis.

   d) peer group counselling (group therapy) topics may include:— survival skills, fears, resources, problems with children, techniques used in past experiences.

3. Legal Component
   The purpose here is to provide comprehensive legal intervention. This consists of giving the client advice, providing legal representation and educating the client on her legal rights.

4. Collaboration Component
   This assures the client integrated and co-ordinated intervention. It also provides consultation between the two professions, and ensures that the battered woman in search of help is provided with continuity of a comprehensive, co-ordinated service.

   Further information may be obtained from: The Women's Crisis Centre, telephone number 56111.
GETTING TO KNOW YOU!

How many of us women are comfortable with and about our bodies? Really comfortable and know them intimately? How aware are we of the changes as and when they occur, why they occur and possibly what action to take if any, as they occur? What changes?

Cancer of the breast is the most common site for cancer among women in The Bahamas. In 1984, it was the leading cause of death in the age groups up to 49 and 60 - 74 years. This form of cancer readily lends itself to early detection and therefore effective treatment; are we women examining our breasts regularly, once every month or are we too scared and/or embarrassed to touch let alone systematically examine them? Or do we simply forget?

Apart from the anatomical position of the vagina, how many women do you think know what it looks like? How many have ever felt their cervix? Indeed, may the female reproductive organs for many females not be an area of utter darkness? Could our reluctance to use tampons and for sexually active women, the diaphragm, be associated with our reluctance to “touch ourselves”? Anatomical knowledge and understanding of our anatomy might lead to greater acceptance of and respect for our bodies as beautiful simple yet unique forms of life. Recognition of our basic similarities coupled with our inherent individuality can only demystify the female anatomy and hopefully improve our self-image and quality of life.

The life expectancy of any woman is on average three years longer than that of her male counterpart. The waiting area of the General Practice Clinic at the PMH and Doctors' waiting rooms are predominantly female. Gynaecologists’ waiting rooms regularly have standing room only. We dread the “doctor”, put off going for our “pap test” and check-up. We are anxious to become pregnant but don’t quite understand how it all ends. Somewhere we don’t/won’t realise that if the baby doesn’t get lost inside us then neither will the tampon, IUD or diaphragm; that what goes into the vagina usually exits by the same route!

Often, we are, we say, too busy trying to “make it”. We don't have time to get to know our bodies, but maybe just may be, we don't like them in the first place and so ignore and abuse them. Even a cursory glance of our nude bodies in a mirror once every so often would possibly galvanise us to action and prevent so many of us attaining those gross proportions for which we are noted, which are unhealthy, the butt of the comedian, the cause of much anguish and often times self destructive behaviour e.g. drastic weight loss programmes, eating for solace and in solitude, wearing of unflattering clothes.

The ancient masters recognised and tried to capture for all time the delights of the female image. Should we then not appreciate our images a little more? If we do indeed outlive our men folk should we not strive to enjoy and enhance the quality of our living?

Perhaps we may begin by looking, touching exploring our bodies. Try looking at your nude body in the mirror periodically and act on the feedback you receive. Age is not synonymous with shapelessness and/or discomfort. We should, like good wine, improve with age. This can only be done effectively if we are on “good” terms with ourselves. Maturation starts early, it is a gradual process. Encourage other women, young and old, to begin to know their bodies, life will be so much more enjoyable.

While the pelvic examination is no “party piece”, it is necessary and important for our well-being. We can reduce our discomfort and time spent in such a seemingly vulnerable position if we can but relax. Concentration on taking deep breaths, in and out through the mouth helps to relax our pelvic muscles and makes the examination more tolerable, a less unpleasant experience.

Encourage your female friends and patients to ask the physician to explain procedures to them in simple language. After all it is our body, we have the right to know! We health providers can begin by getting onto more intimate terms with our bodies, then we can actively and sincerely promote self care for all our female consumers.
VAGINAL AND URINARY INFECTIONS...

Excerpt from: Our Bodies Ourselves
A Health Book by and for Women

All women secrete moisture and mucus from the membranes that line the vagina. This discharge is transparent or slightly milky and may be somewhat slippery. When dry, it may be yellowish. When a woman is sexually aroused or ovulating this secretion increases. It normally causes no irritation or inflammation of the vagina or vulva.

Many bacteria grow in the vagina of a normal, healthy woman. Some of them help to keep the vagina somewhat acid and keep yeast, fungi and other harmful organisms from multiplying out of all proportion. In large amounts, the waste products secreted by these harmful organisms may irritate the vaginal walls and cause infections to develop. At such times we may experience an abnormal discharge, mild or severe itching and burning of the vulva and chafing of the thighs, and occasionally frequent urination.

Some of the reasons we get vaginal infections are: a general lowered resistance (from lack of sleep, bad diet, another infection in our body and similar factors); too much douching; pregnancy; taking birth control pills, other hormones, or antibiotics; diabetes or a pre-diabetic condition; cuts, abrasions and other irritations in the vagina (from childbirth, from intercourse without enough lubrication, or from using an instrument in the vagina medically or for masturbation).

‘Feminine hygiene sprays’ (vaginal deodorants) may also damage the delicate skin of the vulva. They are at best unnecessary, often harmful, and should be avoided. Some infections, bacterial or viral, are very contagious and can be transferred through sexual contact.

Prevention

Here are ways to prevent recurring infections:

1. Wash your vulva and bottom regularly. Pat your vulva dry after bathing and try to keep it dry. Also, don’t use other people’s towels or washcloths. Avoid irritating sprays and soaps (use special non-soap cleansers for skin very sensitive to plain soap).

2. Wear clean, cotton underpants. Avoid nylon underwear and panty hose, since they retain moisture and heat, which help harmful bacteria to grow faster.

3. Avoid trousers that are tight in the crotch and thighs.

4. Always wipe you anus from front to back (so that bacteria from the anus won’t get into the vagina or urethra).

5. Your sexual partners should also be clean. It is a good practice for a man to wash his penis daily, especially before making love. Using a condom can provide added protection.

6. Use a sterile, water-soluble jelly if lubrication is needed during intercourse (K Y Jelly or birth control jelly — NOT vaseline). Even saliva can aggravate a chronic yeast infection.

7. Avoid sexual intercourse that is painful or abrasive to your vagina.

8. Don’t put anything sharp in your vagina.

9. Don’t put anything in your vagina that you wouldn’t put in your mouth...

Diet is also important. A blood-sugar malfunction can make you more susceptible to infection. The condition can be corrected by reducing carbohydrate intake and keeping up vitamin B levels.

Cystitis

Cystitis is an inflammation and/or infection of the bladder. Sometime in her life nearly every woman gets it, and it can be hard to eradicate permanently. It usually means that intestinal bacteria, such as Escherichia coli (E. coli), useful in the digestive tract, have got into the bladder. Trich can also cause cystitis. The symptoms can be really frightening, though it is not a serious condition. If you suddenly have to urinate every few minutes and it burns like crazy even though almost nothing comes out, you probably have cystitis. There may also be blood in the urine (haematuria) and pus in the urine (pyuria). You may have pain just above your pubic bone, and sometimes there is a peculiar, heavy urine odour when you first urinate in the morning.

If these symptoms develop, you should see a doctor... Examination is important, as cystitis and herpes symptoms can be confused...

Full treatment may take 2 weeks, but the symptoms should disappear in a day or so. If they don’t, return to the doctor. Some bacteria are resistant to, and even thrive on, some of the drugs... Vaginitis, thrush and some digestive upset are common side effects of the antibiotics and sulpha drugs. Nausea may be decreased by taking the medication with meals.

Like vaginitis, cystitis is more likely to occur when your resistance is low. Damage to the urethra from nearby surgery, childbirth, or intercourse may also make you more susceptible to infection. Women who urinate infrequently and people who are catheterized for a long period or frequently, often develop cystitis. If your cystitis keeps recurring consult a urologist, as a serious abnormality may be present.
Cystitis is sometimes, though not always, sex-related. The first time you have intercourse with a particular man or have intercourse after a long period of abstinence, you may get a sudden attack of urethritis (inflammation of the urethra), often called 'honeymoon cystitis'. In some cases this can lead to true cystitis.

Prevention

If you are a chronic cystitis sufferer there are preventive measures which you can take:

— Drink enough to urinate several times a day (every hour if symptoms have started).
— Avoid tea, coffee, alcohol and spices, particularly when symptoms have started, as they irritate the bladder.
— Ensure that the hands and/or penis of your sexual partner are clean and avoid intercourse positions which stretch or damage the urethra or put excessive pressure on the bladder (such as penetration from the rear), particularly while the bladder is still tender from recent infection.
— Urinate before and after sex.
— If symptoms start, soak in a hot bath several times a day, or try a hot water bottle on your abdomen and back.

Regular urine tests should be routine for any woman who has had chronic cystitis or kidney trouble, because it is possible to have a symptomless infection which could lead to complications such as kidney infections, high blood pressure or premature births if it is untreated. All pregnant women should have routine urine analysis throughout their pregnancy . . .
CAUSES OF DEATH IN BAHAMIAN WOMEN

KEN OFOSU-BARKO

"Dust to dust, ashes to ashes", these words usually mark the end of a life, they are uttered solemnly and in an atmosphere filled with tears and grief.

Our sojourn on this earth, we are told, is to last three scores and at best three scores and ten. Some make it to that line and a few exceed it, but the vast majority "kick the bucket" before they reach the mark.

It is a fact, women tend to live longer than men and The Bahamas is no exception to this current rule. In The Bahamas, the number of years a woman is expected to live is estimated to be 71 years while her male counterpart is expected to live for only 63 years. The reasons for this difference will not be discussed. Suffice to say that, by what we eat or fail to eat, drink or fail to drink, smoke or fail to smoke, by the sexual contacts we have or fail to have, the cars we drive and how we drive them, we sign our own death warrant.

The leading causes of death in The Bahamas are (1) Cancers (2) diseases of the heart and (3) transport accidents. However, the order of these three killers varies depending on which age group one examines. I will first examine the major causes of death by age group and then take a closer look at the specific cancers that are responsible for the death of women in this country.

When does a girl become a woman? I do not intend to enter into this controversy. For the purpose of this discussion, we shall be looking at the cause of death in females 20 years and above. We shall also take as an example the causes of death in women during the year 1984.

Cancer killed more Bahamian women during 1984 than any other disease. This was followed by diseases of the heart and stroke, in that order. Although injury (accidents) was the third leading cause of death in the country, (men and women combined) it was the sixth leading cause of death among women. The fourth, fifth and seventh leading causes of death were diabetes mellitus, (Sugar disease) pneumonia and chronic liver disease (related to alcohol consumption).

If we look at the ten-year age groups from 20 years and above, the story becomes a little different. Between the ages 20-29, injury was the leading cause of death — perhaps the young women died with their boy friends in the car crashes?

Between 40-69 years, cancer was the leading cause of death, followed by diseases of the heart in each of the three ten year age groups. After 70 years, diseases of the heart became the leading cause of death. (See table 1 and figure 1).

Now a closer look at the number one public enemy of Bahamian women, Cancer. A pathologist once described the female as a "potentially cancerous creature." This is perhaps because of the frequency with which cancer attacks her reproductive organs. Breast cancer was not just the overall leading cause of cancer deaths but also the leading cause of cancer deaths in all the ten year age groups except one. In the 50-59 year age group, breast cancer was displaced from first place by cancers of the uterus (womb).

Most patients present with cancer in the advanced stages, when survival is very minimal. Survival can be prolonged if these cancers can be detected early. There is at present, a screening program for cancer of the cervix. All women are strongly urged to make sure that they avail themselves of this test at least once a year. (Pap smear).

What can be done about breast cancer? The aim should be regular Breast Self Examination. Every woman should learn how to examine her breast for any lumps once a month at the end of her period. This will help with the early detection and treatment of lumps.

Yes, we are all mortals and will die some day. However, we can prevent premature deaths and add some quality to our lives on this earth.

References
1. Major causes of death, Commonwealth of The Bahamas. Research Unit, Public Health Department Ministry of Health (unpublished)
2. Major causes of Cancer death — Research Unit, Public Health Department, Ministry of Health (unpublished)
### TABLE I

**MAJOR CAUSES OF DEATH IN FEMALES, 1984**

**20 YEARS AND ABOVE**

<table>
<thead>
<tr>
<th></th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
<th>80+</th>
<th>TOTAL</th>
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<tbody>
<tr>
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<td>1</td>
<td>2</td>
<td>18</td>
<td>23</td>
<td>20</td>
<td>18</td>
<td>10</td>
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<td>Diseases of the Heart</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>13</td>
<td>12</td>
<td>20</td>
<td>30</td>
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</tr>
<tr>
<td>Cerebrovascular Accident</td>
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<td>3</td>
<td>5</td>
<td>10</td>
<td>7</td>
<td>8</td>
<td>34</td>
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<tr>
<td>Diabetes Mellitus</td>
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<td>—</td>
<td>—</td>
<td>7</td>
<td>7</td>
<td>12</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Injury</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>27</td>
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<tr>
<td>Chronic Liver Disease and Cirrhosis</td>
<td>—</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>—</td>
<td>—</td>
<td>10</td>
</tr>
<tr>
<td>All Others</td>
<td>6</td>
<td>10</td>
<td>11</td>
<td>7</td>
<td>24</td>
<td>18</td>
<td>33</td>
<td>109</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>22</td>
<td>21</td>
<td>43</td>
<td>64</td>
<td>82</td>
<td>81</td>
<td>103</td>
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### TABLE II

**MAJOR CAUSES OF CANCER DEATHS**

**FEMALES 1984**

<table>
<thead>
<tr>
<th></th>
<th>0-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
<th>80+</th>
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<tr>
<td>Breast</td>
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<td>8</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>21</td>
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<tr>
<td>Cervix Uteri and Other Uteri</td>
<td>—</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>—</td>
<td>13</td>
</tr>
<tr>
<td>Stomach</td>
<td>—</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Trachea, Bronchus and Lung</td>
<td>1</td>
<td>—</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Leukemia, Lymphatic and Haemopietic Tissue</td>
<td>—</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Oral Cavity and Pharynx</td>
<td>1</td>
<td>—</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>—</td>
<td>5</td>
</tr>
<tr>
<td>Rectum, Rectosigmoid Junction and Anus</td>
<td>—</td>
<td>—</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Colon</td>
<td>—</td>
<td>—</td>
<td>1</td>
<td>—</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Oesophagus</td>
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<td>1</td>
<td>1</td>
<td>—</td>
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<td>2</td>
</tr>
<tr>
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<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
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<td>11</td>
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<tr>
<td>All Others</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>—</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>7</td>
<td>18</td>
<td>23</td>
<td>20</td>
<td>18</td>
<td>10</td>
<td>96</td>
</tr>
</tbody>
</table>
Look, I is make more money dan you, so I got more say in dis dan you, an' I say she gets this one!!

She fad a good point, but who cares?

UH-UH! De Bible say de man is de boss. I is de man, so I is de boss!!

I say she gets dis one!!

Long as de real boss of dis family gets what she wants dey could argue all dey want!

Now, which shall it be?... de red or de blue?

He's right, but so what?

L.C. Smith
“NURSES ASSOCIATION BAHAMAS” (NAB)

ENID RUDDOCK

“Nurses”
Of our native Land,
Out of many we are one,
No fame, ONE Aim,
Living for the joy
Of acting our calling,
Bringing peace to the
Life of suffering humans.

“Association”
With the voice
Of progress, loyalty and morality,
Liberty its grace and favour,
Here, not to emulate
But to create and perpetuate
Prosperity to our
Struggling native land.

“Bahamas”
A heavenly gift free indeed,
Greatly in need, great indeed,
Land of the beautiful sunshine,
Beaches, sun, sand, and sea,
Land of the “Goombay’s Kings,
Island of the fine arts
Land of our birth.

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Help us to make the newsletter as interesting and informative as possible.

Please complete, detach and return this short evaluation form to the Health Education Division, Public Health Department, Nassau, Bahamas.

Tick the most appropriate response.

1. How did you find the newsletter?
   a) very interesting   b) interesting   c) somewhat interesting   d) uninteresting   e) did not read

2. Was there any article of particular interest to you?
   Yes □   No □
   If yes, please give title ................................................................................................................................................

3. What changes, if any, would you like to see?
   ...............................................................................................................................................................................................

4. What topics would you like in future issues?
   ...............................................................................................................................................................................................

5. Would you like to contribute to this newsletter?
   Yes □ No □
   If yes, please give name and address.
   Name: ........................................................................................................................................................................... .
   Address: ........................................................................................................................................................................... .

   Thank you for your co-operation!
HEALTH EDUCATION DIVISION
PUBLIC HEALTH DEPARTMENT,
MINISTRY OF HEALTH

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NASSAU, BAHAMAS.
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