



*Promoting social change through  
policy-based research in women's health*

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## **BUILDING ALLIANCES TO IMPROVE WOMEN'S OCCUPATIONAL HEALTH**

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## EXECUTIVE SUMMARY

Women suffer many problems related to their work: musculoskeletal problems; stress leading to heart disease and psychological distress; sexual and sexist harassment; job demands incompatible with pregnancy, nursing and family life; cancers, skin disease and toxic effects of chemical exposures; difficult work schedules; violence from clients and co-workers; eyestrain from meticulous work and exhaustion from overwork, inadequate rest breaks and repetitive work.

Women with health problems face obstacles at two levels: recognition of their problems and ability to organise to prevent problems.

The relative lack of progress in **recognition** can be attributed to:

1. A perception, relatively impervious to evidence, that women's issues will be appropriately dealt with by gender-neutral research
2. Pressure to deal with "real" issues of mortality and defined and compensated morbidity; ignorance of women's occupational health issues
3. Lack of gender-identified data from governments and other sources
4. The multidisciplinary nature of research in women's occupational health
5. Feminists do not hold positions of power in scientific institutions

The relative lack of progress in **prevention** can be attributed to:

1. Reluctance of employers and government to widen the definitions of the purview of occupational health and safety efforts to include issues in women's jobs, with consequent pressure on those active in health and safety to concentrate on "real" problems resulting in death or visible injury
2. Relative absence of women and absence of people representing the issues in women's jobs from decision-making positions in occupational health and safety
3. Relative absence (although progress is being made) of women from positions of power in unions
4. A perception by health and safety practitioners, relatively impervious to evidence, that the interests of all workers are well served by gender-neutral interventions in health and safety
5. Invisibility of problems for women workers, leading to a belief that their jobs are safe

Women workers, resource people and scientists have been involved in change at all levels. This has happened through unions, governments and community groups, although feminist health organisations have been little involved. In order to progress to action on these problems, concerted efforts among feminist health advocates, representatives of women workers, decision-makers and researchers will be necessary. A detailed action plan, available in French and English, has been drawn up by a Canada-wide group of researchers and practitioners.

## **KEY FINDINGS**

- Working women are subject to many occupational health problems, but these may be invisible or met with skepticism from those charged with protecting occupational health and compensating for damage.
- Feminist health advocates have been little involved with occupational health.
- Women, particularly non-unionised women, making claims or asking for changes in their working conditions need support groups and help from outside the workplace.
- The scientific community has not been helpful in identifying women's occupational health problems.
- No Canadian research in occupational health (and very little elsewhere) has considered the impact of racism on women's occupational health.

## **KEY POLICY RECOMMENDATIONS**

- In order to progress to action on these problems, concerted efforts among feminist health advocates, representatives of women workers, decision-makers and researchers will be necessary.
- Data, gathered in a gender-sensitive way, should be made available on occurrence of and risks for women's occupational accidents and illnesses, at provincial and federal levels. These should include workplace factors that impinge particularly on women, such as risks for health arising from schedules incompatible with family responsibilities.
- Working conditions typical of women's work in the service sector should be included in standard-setting: prolonged standing; protection from abuse; restrictions on the variability of work schedules, etc.
- Those women and men charged with decision-making in occupational health should receive training to remove bias in treatment of reports and claims from women workers. Rehabilitation and retraining programmes should offer women a wide range of occupational options.
- Researchers in occupational health should be required to show gender-sensitivity and involve inputs from women workers at all stages of research.



## INTRODUCTION

This paper will present some problems facing women workers and how women workers have attempted to deal with them, with some indications of the important issues. However, it is very far from complete, involving only those activities of which I am aware.<sup>1</sup> I apologise for what must be many omissions.

## PROBLEMS FACING WOMEN WORKERS

Women suffer many problems related to their work: musculoskeletal problems from repetitive work, constrained work postures, overuse, and tools and work sites ill-adapted to their size and shape; stress leading to heart disease and psychological distress from multiple demands, sexual and sexist harassment, lack of job control, emotion work and job demands incompatible with pregnancy, nursing and family life; cancers, skin disease and toxic effects of chemical exposures; reproductive problems associated with exposures to chemicals, ergonomic stresses and difficult work schedules; violence from clients and co-workers; eyestrain from meticulous work, and exhaustion from overwork.<sup>2</sup>

It is our contention that these problems have not yet been fully treated by the institutions and practitioners charged with occupational health and safety. Historically, occupational health and safety intervention has concentrated, somewhat understandably, on visible, dramatic problems such as work accidents. Recently, many health and safety activists have struggled to gain recognition for subtler health effects, such as occupational cancer (Firth, Brophy & Keith 1997), heavy lifting, and effects of extreme physical conditions such as cold, heat, noise and dust. These struggles are not and have not been easy and it is still quite difficult even for workers exposed to palpable, visible dangers to obtain compensation or to

access prevention efforts (Tartaryn 1979; Lippel 1986).

These struggles are complicated in Canada by the fact that occupational health, like other labour questions, is covered by two levels of government: federal and provincial. Employees who work in certain areas (transport, communications, finance, etc.) are covered by the Canadian labour code and Canadian occupational health legislation, whereas others fall within provincial jurisdictions. Most provinces have some government board that is responsible for prevention and inspection, another for compensation, another for human rights in the workplace and another for ensuring observation of the provisions of the labour code. In addition, in some provinces, notably Québec, the public health service has some responsibilities for prevention activities. The interaction of pregnancy and working conditions is covered very differently according to jurisdiction.

In practice it is difficult for non-unionised workers to access health and safety protection, and unions have been an important force in advancing health and safety education and legislation. In addition, labour clinics have been set up in Ontario and Manitoba to provide information and treatment in occupational health. Some non-profit groups of injured workers have formed to protect workers' rights to compensation. Usually, feminist advocacy in the area of women's health would be an important tool to force the appropriate inclusion of women in occupational health research and practice. This has not happened widely, for various reasons (discussed below).

## AREAS FOR CHANGE

Women with health problems face obstacles at two levels: recognition of their problems and ability to organise to prevent problems. Women workers, resource people and scientists have been involved in change at both levels.

## AREAS FOR CHANGE INVOLVING WOMEN WORKERS AND RESOURCE PEOPLE

First, workers' organisations must include women in **union health and safety activities** and to provide **support** when women identify a problem. Women's ability to organise requires **access to unionisation**. As women work increasingly under contract, for small employers, or in the informal economy where the relation with the employer is tenuous, unionisation becomes less accessible. **Government regulations** on unionisation and on minimal labour standards must be changed.

Women's ability to organise also depends on the support they receive from other sources. The existence of **labour clinics** or a strong **public health service** is also necessary.

For non-unionised women, there are **support groups** and **injured workers' groups**.

**Government health and safety bodies** and **health care organisations** must accept women's descriptions of their problems. **Legislators and regulators** must write programmes that deal with health hazards encountered in women's jobs. Although, on paper, governmental workers' compensation boards and inspection and prevention systems are usually controlled by joint union-industry bodies, in practice industry usually has a determining voice in how the money is spent. Also, as we have mentioned, decisions made by these organisations involve systemic or direct discrimination against women. Therefore, women workers have worked through unions and NGOs in order to improve their health. The union structures involved are women's committees and health and safety committees. The latter have traditionally been composed of a majority of men and have been concentrated on the risks typical of men's jobs, but this is changing, due to the efforts of women workers.

Various union and popular organisations both nationally and internationally are becoming interested in women's occupational health. However, progress is frequently blocked. Pressure from union women's committees has helped to advance the issues but mainstreaming has not yet occurred on a large scale anywhere in the union movement.

The relative lack of progress can be attributed to:

- Reluctance of employers and government to widen the definitions of the purview of occupational health and safety efforts to include issues in women's jobs. Pressure on those active in health and safety to concentrate on "real" problems resulting in death or visible injury
- Relative absence of women and absence of people representing the issues in women's jobs from decision-making positions in occupational health and safety
- Relative absence (although progress is being made) of women from positions of power in unions
- A perception by health and safety practitioners, relatively impervious to evidence, that the interests of all workers are well served by gender-neutral interventions in health and safety
- Invisibility of problems for women workers, leading to a belief that their jobs are safe

This last area is where scientists can play an important role.

## AREAS FOR CHANGE IN SCIENCE

In order for women's occupational health problems to be recognised and compensated, scientists must be made aware of them. This requires efforts at the level of **scientific institu-**



**tions**, which must be able to access and profit from the insights and experience of women workers. Data must be collected by **governments** and others in such a way that women are visible. Researchers must be able to get support from **granting organisations** and **universities**. They must be able to **publish their results** and share them with other scientists at **scientific meetings**. They must be able to do this while **listening to workers' experience**.

Progress in identifying women's occupational health problems has been considerable, but mainstreaming has not occurred within the occupational health institutions, except possibly to some extent in the Scandinavian countries. This is due to:

- A perception, relatively impervious to evidence, that women's issues will be appropriately dealt with by gender-neutral research
- Pressure to deal with "real" issues of mortality and defined and compensated morbidity; ignorance of women's occupational health issues
- Lack of gender-identified data from governments and other sources
- The multidisciplinary nature of research in women's occupational health
- Feminists do not hold positions of power in scientific institutions

It has been proposed that a worker-scientist alliance is the best way to channel information about women's occupational health issues to decision-makers. Two such alliances are: (1) the "Gaming Workers' Health and Safety Research Project", a study of casino workers' health based on difficulties experienced by the mostly female workforce of the Winnipeg and Windsor Casinos.

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decision-makers. Two such alliances are: (1) the "Gaming Workers' Health and Safety Research Project", a study of casino workers' health based on difficulties experienced by the mostly female workforce of the Winnipeg and Windsor Casinos,<sup>3</sup> and 2) the Québec team, "l'Invisible qui fait mal", a partnership between the CINBIOSE research centre and the three unions' women's committees and their health and safety committees, supported since 1993 by the Québec Council for Social Research to identify and solve problems in women's occupational health.

## OUTSTANDING ISSUES

### DIVERSITY

Although unions include women of diverse ethnicity, sexual preference and ability, our occupational health studies have not explicitly included these aspects. The absence of data on occupational cancer of black women has been pointed out by Zahm, Pottern, Lewis, Ward, & White (1994) and differential treatment of black people in the US compensation system has been demonstrated by Herbert et al., (1999).

### LESSONS FOR CHANGING WOMEN'S WORK

In general, gains have been made under the following circumstances:

- Women are able to invoke their reproductive role. The Québec law providing adaptation of the workplace, reassignment with full benefits or paid leave to pregnant workers exposed to risks is an example. Under constant attack by employers since its inception in 1979, the programme is still used by more than a third of pregnant workers (Malenfant 1996) and has inspired some workplaces to institute changes that benefit all workers.

- Women in service-based industries are able to build support from the clientele. The pressure campaigns mounted by Québec bank tellers (Syndicat des employés-es professionnels-elles et de bureau local 434) in order to improve working conditions are an example. However, the recent defeat of the Québec telephone operators' struggle to resist their "sale" to a US-owned subcontractor is a counter-example. In the latter case, the public was solidly behind the operators' struggle to resist deterioration of their conditions and salaries, but the sale went ahead, due to the relative weakness of their union compared to Bell Canada.

Alliances between unions and scientists to show dangers, for example, in the case of the workers affected by poor air quality at the federal building at Terrasses de la Chaudière, Hull.

Alliances between health and safety and women's committees. The notion that risks and value of women's work should be treated together has inspired campaigns in Canada and Europe. The information on difficulties and dangers generated by our collaboration with unions has been used both for equal pay campaigns and for health and safety campaigns. Of course, the issue of whether risks should be paid for or eliminated is a complex issue in relation to work of both men and women.

## OBSTACLES

### PARADIGM SHIFTS ARE NOT EASY

We did a recent project with input from health and safety experts. We showed that women hospital attendants may be exposed to excess risk of musculoskeletal disorders because they do more physically demanding operations per hour than men (Messing 1999, study 5). The study was extensively commented on by work-

ers and experts and the final report incorporated their comments. One expert, a man, gave helpful comments all along and was quite instrumental in publicising the study. A few days ago, I showed him a book on women's occupational health that had just come out. His comment was (before reading it), "You know what I think, that there is really no difference between women and men in occupational health – their jobs are the same and the health effects are the same." As an example, he spontaneously cited hospital attendants! He had to be reminded that our study, with which he was very familiar, had shown the opposite.

We have experienced many other examples of how even feminist scientists and practitioners have a hard time getting their minds around the paradigm shift necessary for research in women's occupational health.

Unfortunately, this blindness is sometimes shared by feminist health advocates. I have been in feminist meetings where, impervious to the glares of participants, I introduced occupational health questions repeatedly into the discussions, only to find them absent from the final report. I find this strange, given that almost all women work at some time in their lives. I tentatively attribute the reluctance to five factors (discussed more extensively in Messing 1998, chapter 10):

Most feminist health advocates have non-unionised office jobs and do not identify their office-related health problems (stress, musculoskeletal problems, air quality problems, conditions incompatible with pregnancy) as occupational health problems. They may not be aware of the risks experienced by women with blue-collar and pink-collar jobs.

Even feminist health advocates may share the perception of others that women's working conditions are easy. A lot of propaganda (contradicted by the evidence – see Macintyre, Ford & Hunt 1999) tells women that they are

"complainers" who are prone to exaggerate. Women, even feminists, may be reluctant to appear to complain about working conditions.

Feminists are usually strongly in favour of women's equality in the workplace. They are aware that women's "complaints" about women's working conditions may be interpreted as unfitness to work. They may be reluctant to provide arguments for those who are opposed to full equality for women in the workplace.

Feminists are usually strongly opposed to theories of biological determinism. Some may feel that women do not have specific problems in occupational health.

It is not easy to forge alliances between women's health advocates and unions, probably because of social class differences and because of feminists' mistrust of male-dominated organisations.

Careful discussion of these issues between feminist health advocates and representatives of working women will be necessary in order to overcome some of these barriers.

## CONCLUSIONS

There is increasing consciousness of women's occupational health problems among researchers and working women in Canada and internationally. However, action has been slow, blocked by political, intellectual, social and economic barriers. In order to progress to action on these problems, concerted efforts among feminist health advocates, representatives of women workers, decision-makers and researchers will be necessary. Recently, a pan-Canadian group of women researchers, practitioners and union activists has produced an action plan for women's occupational health.<sup>4</sup> Women's Bureau of Health Canada has informed us that they have assigned resources to carry out priority aspects of the action plan that are within federal jurisdiction.

## REFERENCES

1. I would very much appreciate being informed of any other relevant activities, at [messing.karen@uqam.ca](mailto:messing.karen@uqam.ca).
2. A review of these questions can be found in Messing (1998).
3. The study was organised and carried out by local unions affiliated with the Canadian Auto Workers Local 444 (CAW) and the Manitoba Government Employees Union (MGEU), with technical help from the Windsor Occupational Health Information Service (WOHIS), the Occupational Health Clinics for Ontario Workers-Windsor (OHCOW-W), and the Manitoba Federation of Labour Occupational Health Centre (MFL OHC).
4. In 1992, Frieda Paltiel and Cathy Mattern of the Women's Health Bureau of Health Canada organised a round table of researchers, government officials, labour activists and company health and safety practitioners on Gender and Workplace Health (Women's Bureau 1993). A group who met at this meeting, mostly researchers, produced a book (Messing, Neis and Dumais 1995). In 1998, with the help of Women's Bureau, the researchers were joined by health and safety experts from unions to discuss priority issues in women's occupational health and produce an action plan (Tissot and Messing 1999).

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