centres of excellence
for WOMEN'S HEALTH
RESEARCH BULLETIN

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NEW QUESTIONS NEW KNOWLEDGE

INSIDE

REDUCE DIFFERENCES IN HEALTH STATUS

BUILD HEALTHY PUBLIC POLICY

STRENGTHEN COMMUNITY AND PERSONAL ACTION

What makes us healthy, what makes us sick?

ONE WAY TO INVESTIGATE WHAT MAKES US HEALTHY AND WHAT MAKES US sick is to use the determinants of health approach, integral to the research that is being done at the Centres of Excellence for Women's Health. This approach offers a means to examine health in the context of everyday life by recognizing the complex interplay of social, political, environmental and economic conditions in producing health. This issue of the *Research Bulletin* highlights some recent work from the Centres on the links between women's health and their social and economic circumstances.

With the release of *A New Perspective on the Health of Canadians*[1]—the now famous Lalonde Report—in 1974, Canada became the first national government to articulate the importance of factors beyond the health care system that promote or diminish health. While the Lalonde Report named four factors as determinants of health (human biology environment, lifestyle and health care organization), today Health Canada recognizes 12 determinants: income and social status, employment, education, social environments, physical environments, healthy child development, personal health practices and coping skills, health services, social support networks, biology and genetic endowment, gender, and culture. Significantly, both sex (biology) and gender are recognized in this list as determinants of health and the emphasis on lifestyle has been reduced.[2]

The power of such a list is that it reminds us to recognize the limitations of considering health services or biophysical endowment in isolation from the rest of life. Yet any list runs the risk of omitting some aspect of women's lives. For example, the migration experience has not yet been identified as a determinant of health, though there is growing evidence of its importance to health and illness.[3] This issue of the *Research Bulletin* highlights two studies that consider this as a determinant.

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Some of the research presented in this issue may also indicate the need to constantly consider the interaction of multiple factors. Indeed, the complexity of women's health in its everyday context makes it difficult to study a single determinant. A project that examined the midlife health needs of women with disabilities, for example, suggests that a middle-aged woman with a disability may have difficulty, financially, accessing exercise programs; exercise equipment adapted to her physical needs is scarce; social contact and support is hard to find; and accurate information about the interaction of disability with menopause does not exist. All of these factors interact and may affect a woman's health at midlife.

Other articles in this issue illustrate how social isolation, economic restructuring, homophobia, geography, poverty, public health policy, and weak language skills can undermine women's well-being. In contrast, several articles suggest that collective action, personal empowerment, social relationships, strong public health policy and a health-enhancing physical environment can help maintain and foster good health. Thus the message from this issue is that even as we need to understand more about what makes women sick, we also need to ask ourselves what makes women healthy.

A strength of the determinants of health approach is that it shows that many of these factors are *changeable*—with sufficient individual and collective action. A risk that could arise from this important understanding, however, is that by demanding individual responsibility we overdo it and further burden the affected individual by blaming them for their illnesses. The health promotion strategies outlined in the *Ottawa Charter* offer some safeguards against this by suggesting how we can support *both* individual and collective action by building healthy public policy, creating supportive environments, strengthening community action and reorienting health services toward prevention.[4]

■ **A strength of the determinants of health approach is that it shows that many of the factors that make women healthy or make women sick are *changeable*—with sufficient individual and collective action.**

As we face the continuing reality of health reform—most recently apparent in the Romanow Commission on the Future of Health Care in Canada—finding answers to what makes us healthy and what makes us sick is more important than ever.[5] New evidence continues to be needed to ensure that we are making the maximum difference where it is needed. This means understanding not only acute medical conditions and how to optimally organize health services, but also what enhances and threatens health outside the hospital doors.

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REDUCE DIFFERENCES IN HEALTH STATUS

The Midlife Health Needs of Women with Disabilities

Marina Morrow, British Columbia Centre of Excellence for Women's Health

> *The social experience of living with chronic illness and disability is neither gender nor context neutral.*[1]

Disabilities, including chronic illnesses, occur in a social context. Yet, traditional science methodologies have generally studied disability as a physical phenomenon only, ignoring the impact of determinants such as gender, race and socio-economic circumstance on the development and experience of disabilities. This is evidenced in the literature's focus on conditions that mostly affect men (e.g., spinal cord injuries) and by the fact that conditions primarily affecting women (e.g., chronic fatigue syndrome and fibromyalgia) are sometimes even questioned as to their very existence.[2] That men and women might experience disability differently has not been addressed comprehensively in the literature to date.

In the past decade there has been an information explosion in the area of ageing and menopause,[3] reflecting an increasingly older population, the majority of whom are women.[4] In traditional forms of research and in the emerging body of feminist research, there remains an information gap about the health needs of women with disabilities during menopause. Speculations about why this gap exists include the tendency in the literature to de-sexualize women with disabilities and hence to ignore their reproductive health and sexuality. Women with disabilities are often reduced to their disability by health practitioners, which may mean that their other health issues are overlooked. Finally, feminist approaches to menopause that emphasize empowerment and women's choices often disregard the fact that women with disabilities may face very different challenges at midlife than their non-disabled counterparts. These challenges are often directly related to gaining or maintaining autonomy in situations where some amount of dependency on others is necessary.

A study conducted by the Pacific DisAbled Women's Network (DAWN) and the British Columbia Centre of Excellence for Women's Health set out to explore women with disabilities' experiences of menopause. The research team was comprised both of women who had a disability and those who did not, and had representation from both academics and community-based disability activists. Actively involving women with disabilities as researchers and advisors promoted a substantial dialogue with respect to the way in which disability has been traditionally defined in research, and led to a commitment to involve women with developmental disabilities. Specifically, the research was designed to explore the interconnections between physical, psychological and social determinants of health. The researchers were interested in women's physical health changes during the perimenopausal and menopausal periods, as well as the social and life changes that women generally experience during that time of their lives (e.g., children leaving home, divorce, increased poverty, the death of loved ones, increased caregiving responsibilities as parents age). Interviews were conducted with 39 women with physical disabilities and chronic illnesses. Twelve interviews were conducted with women with developmental disabilities and their caregivers.

■ **This study shows the complexity of the relationship between disability, midlife and menopause and underscores how little is known about their inter-relationship.**

The resulting data showed that the women's lives were marked by significant events during the midlife period at the same time that they struggled with their disabilities. These two themes were often linked; many women had gone through transitions in their personal and social relationships during their midlife years due to the progression of their disabilities. For other women, disabilities began either during or around the time of menopause or after a significant experience during midlife. What was most pronounced was that women in this study could not easily attribute the physical and emotional changes they were experiencing to their disability, to the process of menopause, or to other midlife changes. This finding reflects the complexity of the relationship between disability, midlife and menopause and underscores how little is known about their inter-relationship.

However, it was clear that social context was critically important to how women experienced their disability and menopause. Women spoke especially about the financial and social barriers they encountered as a result of disability. Women described themselves as struggling to make ends meet after partners left them and about how difficult it was to survive on disability pensions. In particular, financial restrictions meant that women could not avail themselves of proper nutrition, vitamins, exercise equipment and alternative therapies that might have eased the symptoms they experienced as a result of menopausal changes. Social isolation and the loss of intimate relationships were other predominant themes in the interviews. Women repeatedly indicated that they needed more social support, including caring partners and groups where they could talk to other women experiencing similar difficulties.

Often, the physical difficulties women experienced as a result of their disabilities could not be distinguished from the physical changes they experienced during menopause. This reflects a lack of information about the specific interactions between particular disabilities and menopause. Women were clearly not getting this kind of information from medical practitioners, from the popular media or from specialized women's health packages on menopause and midlife changes.

Our study highlights the methodological challenges associated with designing studies that examine the physical, psychological and social determinants of health. It also stands as an example of the rich information that is mined when using such an approach, and holds out the possibility that the utilization of similar methodologies for further studies on disability and menopause will yield a more comprehensive understanding of women's experiences and their midlife health needs.

For a copy of the full report contact:

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REDUCE DIFFERENCES IN HEALTH STATUS

The Effects of Social Isolation and Loneliness on the Health of Older Women

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Women are more vulnerable to higher levels of loneliness in part because of their average greater longevity compared to men: women often outlive spouses, friends and family who previously provided the social and emotional support important for good health and well-being. Many older women live with multiple chronic health conditions that can limit mobility and further restrict their capacity to socialize. Studies have found associations between loneliness, poor health and well-being.[1] Some, for instance, have found that older individuals who are very lonely are at an increased risk of nursing home placement.[2] What is not clear is whether loneliness results from fewer contacts with other people *due* to ill health, or if decreased contact and the possibility of loneliness *precede* ill health.

Our study of older Manitobans was conducted within the framework of population health. This perspective views social isolation and loneliness as factors that potentially influence health and well-being, access to health care and the effectiveness and outcome of the care received. The term "social isolation" is an objective measure of social interaction, while "social loneliness" is considered to be the subjective expression of dissatisfaction with a low number of social contacts.

We partnered with five community organizations to meet the following objectives: (1) to explore the gender differences related to social isolation and loneliness for older men and women in a representative population; (2) to determine the relationship among social isolation, social loneliness and the health and well-being of older women; (3) to develop recommendations for policies and programs to address situations of social isolation and social loneliness.

The first two objectives were met by analyzing data from the Aging in Manitoba Study (AIM), which contains measures of social isolation and loneliness as well as socio-demographics and health utilization for older adults. The AIM is a long-term study conducted in waves since 1971. The 1996 wave used for our study included 1,868 men and women whose minimum age was 72. Forty percent of the sample was male and sixty was female, typical of the gender distribution for this age group in Manitoba at the time. Those living in nursing homes represented 13.6% of the sample.

Fifteen items that have been found to indicate isolation were explored through bivariate analysis of the AIM data.[3] The Loneliness Index used in our study is a composite of the Loneliness Scale developed by researchers in the Netherlands and two single-item loneliness questions from the Netherlands NESTOR studies on ageing.[4]

Our research showed that women in the sample could be described as being more socially isolated than the men, as a

■ Women who were lonely or had few social contacts were more than one-and-a-half times as likely to be using home care services one year after the interview.

greater proportion of the women were widowed (3:1) and lived alone (2:1). The results of the objective 2 analyses showed that social loneliness was also more common for those women who lived alone, had few contacts with others and felt that their health was poor. These effects are additive: a widow who lives alone, sees few other people and feels her health is poor would be almost six times more likely to be lonely than a married individual who lives with a spouse, sees many people on a regular basis and is in good health. While female gender per se was not found to be a significant influence on loneliness, the implication from the analyses is that the women in the sample were more likely than the men to be lonely because more of the women lived alone and were widowed.

Using health utilization data we also found that higher levels of loneliness were more likely for women who had more admissions to hospital, longer stays in hospital, a greater number of physician visits, a higher number of pharmacare claims, and used home care services. The AIM dataset includes health utilization for the year following the interview as well as the year prior. These measures allowed us to test whether loneliness and social isolation in 1996 could predict use of services one year later. Analyses of the data showed that both social contacts and loneliness were significant predictors of home care use when adjusted for age and gender. Women in our sample who were lonely or had few social contacts were more than one-and-a-half times as likely to be using home care services one year after the interview.

The preliminary data were presented in public meetings throughout Manitoba. Participants, including professional caretakers and seniors, said that our findings concurred with their own experiences and knowledge. They also suggested that those in poor health have little enthusiasm for socializing, and that those who are socially isolated may be more likely to experience declines in health status because they may be at risk for decreased activity, poor nutrition, decreased mental stimulation and may lack awareness of their health conditions.

The Executive Summary of this report (Project Number 6, 1999) and the address to contact to receive the full report can be downloaded from www.pwhce.ca/isol.htm.

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REDUCE DIFFERENCES IN HEALTH STATUS

Immigration and Perinatal Risk

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Do immigrant mothers, who are living in new social and cultural environments and are likely to lack social support, experience increased vulnerability to health risks during the perinatal period of pregnancy? In our study of immigrant women living in Quebec, we investigated factors associated with the immigrant experience that may increase vulnerability. Interviews were conducted with 91 immigrant mothers who were considered to be low, medium and high risk for problems during pregnancy and delivery.

About one-half of the women who participated in the study had given birth in Canada, the others had given birth before they immigrated. All of the women had been living in Quebec less than six months. The participants' babies were between three and twelve months old.

■ Stress caused by war or persecution in the country of origin, loss of family members through immigration, and poverty and social isolation in Canada appear to play a role in creating strains that impact upon pregnancy.

All of the women shared some of the same difficulties, such as low income and financial difficulties, social isolation and emotional problems. To assess emotional problems, an adapted scale from the Hopkins symptom checklist was used. The 15-item scale includes loneliness, anxiety, sadness and guilt.

Immigrant women who had no health problems during pregnancy were found to share some characteristics. For example, they had planned their migration and given birth after their arrival in Canada. They had received some college or university education, were on average younger than mothers who were assessed as either medium or high risk, and could understand either French or English. As compared to these low-risk mothers, women who were found to be at medium risk for perinatal problems had received a higher level of education, had undergone a professional de-qualification in their work as a result of immigrating, and spoke some English but little French. Some of these women had experienced problems with delivery, such as premature and/or low birth-weight babies. A difficult immigration prompted by war or persecution characterized most of the high-risk immigrant mothers. These women, most of whom were refugees, were older on average than the women in the other two categories, had lower levels of education, did not speak English or French, and already had one or more children. In addition, they had often experienced a separation from their family, either from a husband or a child. All had given birth before immigrating and all had experienced problems with delivery such as premature birth, low-weight babies, hypertension, diabetes, anemia, difficult labour or bleeding.

These findings suggest that factors arising from migration make some immigrant women potentially more vulnerable to complications during the birth of their children. Stress caused by war or persecution in the country of origin, loss of family members through immigration and poverty and social isolation in Canada appear to play a role in creating strains that impact upon pregnancy.

Nineteen interviews were also conducted with health care providers. An analysis of this data showed that care providers do not have adequate tools for identifying high-risk pregnancies or high-risk perinatal factors in immigrant women. This situation further exacerbates perinatal risks to mother and child. In order to assess vulnerability in this population, we recommend that health care providers identify risk factors in four key areas: (1) the woman's experience of immigration (to discover any trauma that may have been suffered); (2) economic difficulties; (3) social isolation; and (4) adaptation to the new culture. We recommend that an assessment tool be developed that would include the following questions related to these key areas:

- *The immigration experience:* Why did the woman immigrate? Is she a refugee? Has she been separated from another child or from a husband? Did she live in a refugee camp?
- *Economic difficulties*: Has the woman gone through a professional de-qualification? What is her education level? What sources of revenue are available to her?
- *Isolation:* Does the woman have a family or social support system in place in Canada? Are there other women around to help her?
- *Adaptation to the new culture:* What adjustments have been made in the woman's household? For example, how is the woman's husband adapting to new cultural expectations of his role as father? (In his country of origin, expectations may have been limited to his role as breadwinner.) Have there been any difficulties accessing health services?

Factors arising from migration make some immigrant women and their babies vulnerable during the perinatal period. These risk factors also have relevance to non-immigrant women: the health care tools developed from this study can also help identify women in the general population who need additional support during pregnancy.

For a copy of the synthesis paper, *Rapport synthèse,* Vol. 4, No. 4, or the full report, A. Battaglini et al. "Les meres immigrantes: pareilles, pas pareilles?" (available only in French), contact:

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Public Health vs. Chemoprevention

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and the Working Group on Women and Health Protection

While medicine has done much to ease human suffering, public health has done more to prevent it. The health gains from public health measures such as better nutrition, clean drinking water and safer workplaces far outstrip the gains from medicine.[1]

Public health policy accepts small risks, such as those incurred by vaccination or seat belts in cars, for large benefits. "Chemoprevention" experiments, which test potent drugs to *prevent* disease, introduce a troubling new standard: large risks are justified by small or ambiguous benefits. Canadian women are involved in these experiments, which blur the boundary between disease prevention, where safety is paramount, and disease treatment, where risks to the sick are weighed against potential improvements in their condition. The strategy of prescribing drugs to healthy people now threatens to overtake, and even displace, the traditional public health strategy of identifying and removing or reducing the causes of disease. At the same time, Canadian safety standards for medications, medical devices and environmental contaminants are quietly eroding.

Breast Cancer and Chemoprevention

Over the past decade, breast cancer has dominated the chemoprevention debate. In April 1998, front-page headlines described a breakthrough in preventing breast cancer: "We know for the first time in history that we can

■ **Women's health groups have critiqued the breast cancer chemoprevention trials as the latest in a series of risky drugs and medical products marketed for use in women without adequate scientific rationale or testing.**

prevent cancer through pharmaceuticals," said one of the researchers in the Breast Cancer Prevention Trial (BCPT), an experiment involving 13,388 Canadian and American women.[2] Six months later, the U.S. Food and Drug Administration approved the use of tamoxifen—previously approved only to *treat* breast cancer—for women "at high risk" of developing the disease.[3] Health Canada has not approved tamoxifen (an estrogen antagonist) for breast cancer risk reduction, which means pharmaceutical companies cannot promote the drug for that purpose in Canada. However, Canadian physicians can prescribe the drug to healthy women at their own discretion, a practice known as "off-label" use.

In the BCPT, tamoxifen lowered the risk of breast cancer but raised the risks of endometrial cancer, blood clots and vision problems, prompting one physician to observe that "disease prevention" had been replaced by "disease substitution."[4] Three women in the tamoxifen arm of the trial died from blood clots in their lungs.

Healthy Canadian and American women are now being recruited to the Study of Tamoxifen Against Raloxifene (STAR), a follow-up to the BCPT that compares tamoxifen to a similar drug, raloxifene. Raloxifene also causes blood clotting. (All women in the STAR trial will be exposed to one drug or the other.) Women's health groups have critiqued the breast cancer chemoprevention trials as the latest in a series of risky drugs and medical products marketed for use in women without adequate scientific rationale or testing. Nor is breast cancer the only disease for which treatment drugs are being tested for prevention. Others include heart disease, thinning bones, prostate cancer and schizophrenia.

The Precautionary Principle vs. Risk Management

Women's health groups, public health researchers, ethicists, environmentalists and many health practitioners have stressed the need to adopt a public health approach to breast cancer prevention. They promote the Precautionary Principle, a safety-first premise that states that when there are reasonable scientific grounds for believing a process or product may not be safe, even when cause and effect relationships are not fully understood, preventive action must be taken. If Health Canada made the Precautionary Principle its standard for health protection in regulating food, drugs and medical devices, and in protecting the environment, the prevention of disease would be maximized without recourse to drugs. This would also protect the public from the testing and marketing of chemoprevention drugs that introduce new threats to health. However, in the revised Canadian Environmental Protection Act (1999), the government diluted the initially strong statement of the Precautionary Principle after industry interventions led to last-minute amendments.[5] Further, the government's discussion paper on health protection, *Health Protection for the 21st Century: Renewing the Federal Health Protection Legislation* (1998), embraced an antithetical approach through a "modern risk management framework."[6]

The Reagan administration introduced risk management to American health and environment agencies in 1983, writes science historian Robert Proctor in his book, *Cancer Wars*. Risk management defines risk as an *unavoidable* fact of life. No longer is pollution viewed as a problem to be remedied; rather, toxins in the environment are negotiable evils. Risk assessors (scientists) determine the magnitude of a given risk, while risk managers (policy makers) determine whether that risk is acceptable. "The net effect was almost invariably to stymie health and environmental regulations," says Proctor.[7]

Thus, financial risks and benefits are factored into the same equation as health risks and benefits. Risk management invokes the ALARA Principle: human exposures to risks are kept As Low As Reasonably Achievable, "social and economic factors being taken into account."[8] A risk management framework will favour chemoprevention over public health strategies for disease prevention, precisely because most drugs for the worried well have significantly larger potential markets than drugs for the sick. This tactic also shifts the cost from society, through government-funded prevention measures, to the individual who will pay for the drug.

Health Canada assembled a working group to examine how the ALARA Principle was applied to radiation and chemical exposures. Members found that levels of acceptable risk associated with established guidelines varied "up to a million-fold."[9] They concluded nonetheless that risk management strategies to regulate both radiation and chemicals "provide a high degree of health protection based on the *absence of observable health effects using epidemiological methodology*" [italics added].[10] Thus, measurable levels of radiation, genotoxic chemicals and endocrine-disrupting substances are assumed to be safe because epidemiological studies do not yet show observable health effects. This reasoning commits what Peter Saunders of the Institute of Science in Society calls "the mathematical fallacy that absence of evidence is the same as evidence of absence."[11] In the short term, reducing and eliminating the causes of disease would lower industry profits by requiring clean-up of toxic substances, changes to polluting technologies and workplace measures to prevent accidents or exposure to agents that cause disease. In the long term, however, such steps promote sustainable development and may save industry money. They have finite costs, provide long-term health benefits to entire populations, and usually alleviate a range of illnesses rather than just one.

Combatting the Drift to Chemoprevention

For a decade the chemoprevention debate has incited FDA hearings in the United States, media coverage and meetings of community groups. Although hundreds of Canadian women have been recruited to the BCPT and STAR trials, Canada's health protection agency has yet to provide a policy forum to which women could bring their concerns. The renewal of Canada's health protection system, now under way, must address the public health implications of chemoprevention. Policy changes are needed at the highest level to affirm the Precautionary Principle as the basis for health protection and to confine chemoprevention to situations where it can be used ethically, safely and economically. To achieve this goal, the Working Group on Women and Health Protection recommends that:

1. The regulation of drugs, food, radiation equipment and the Canadian environment should all occur through a system that is independent from industry.
2. The Canadian government provide venues for public input at all stages of chemoprevention drug testing and approvals, and post transcripts of these meetings on the internet to ensure public access to the information.
3. A regulatory office be created to oversee clinical trials in

■ **Women's health groups, public health researchers, ethicists, environmentalists and many health practitioners have stressed the need to adopt a public health approach to breast cancer prevention.**

Canada, including chemoprevention trials, in consultation with relevant professionals and public interest health groups.

4. Health Canada be mandated to intervene at regulatory hearings in the United States and other countries carrying out clinical trials that involve Canadian participants to demand that the safety of Canadian participants be protected.

The Working Group on Women and Health Protection is financially supported by the Centres of Excellence for Women's Health. To obtain a copy of the paper, "Preventing Disease: Public health versus chemoprevention," see the Working Group on Women and Health Protection website at www.web.net/~desact. *The views expressed in this article do not necessarily represent the official policy of Health Canada.*

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BUILD HEALTHY PUBLIC POLICY

Restructuring and Women's Health: The Fisheries Crisis in Newfoundland

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Canadian society is experiencing the effects of extensive restructuring, yet little research has been done to examine the health impacts of restructuring processes. Overharvesting, reduced biodiversity and pollution are examples of environmental restructuring. Industrial restructuring includes work reorganization (de-skilling and re-skilling) and downsizing, and political restructuring processes involve changes to public services and social programs.

In Newfoundland, restructuring followed the northern cod moratorium of 1992. The moratorium terminated all fishing activity related to the northern cod stock along the east coast of the province. Closures and quota reductions for many other groundfish species were applied to other fishing areas, too. As a result employment in the fishing industry declined drastically. Since the moratorium, growth in the shellfish sector has provided jobs for some fisheries workers. In recent years the government of Newfoundland and Labrador has been looking at nickel mining and smelting as another possible means to create employment. As is common in restructuring, this industry, if developed, will bring with it new occupational health risks. Currently there are no mechanisms in place to ensure that these risks are anticipated and minimized at the construction phase.

From Fishplant to Nickel Smelter: Health Determinants and the Health of Newfoundland's Women Fish and Shellfish Processors in an Environment of Restructuring (April 2001) is a case study of the relationship between restructuring and women's health in a fisheries-dependent region of Newfoundland in the wake of the groundfish crisis. In-depth interviews were conducted with 22 women shellfish-processing workers and 15 women fish-processing workers who retrained in an attempt to change sectors. These interview data were contextualized using key informant interviews with health professionals, an analysis of Workplace Health Safety and Compensation Commission (WHSCC) claims data for fish-processing workers, an analysis of data on training programs introduced in response to the fisheries crisis, and key informant interviews with educational administrators.

Retraining of workers is one response to restructuring and it was a significant focus of this study. While education is often credited with improving people's health through improving social supports and participation, the greatest impact of education on health results from the ways it mediates access to meaningful employment experiences.[1] The potential health benefits of education and training may be jeopardized by limited access to career counseling and preferred training options, shortcomings in the training experience and employment outcomes. This jeopardy is perhaps particularly relevant to working class women, such as those in this study, for whom training is a response to involuntary displacement and a requirement for income support and for whom the point of education and training is to find paid work.

As the traditional fishing industry restructures and fewer opportunities for work are available, women and men from rural Newfoundland communities will seek employment in new industries. To identify the potential health risks associated with the development of the Voisey's Bay Nickel mining and smelting project proposed for Labrador and Newfoundland, we also analysed Ontario Workplace Safety Insurance Board data on the health risks for women and men associated with that industry in Ontario.

Our study found that environmental restructuring, along with government and industry efforts to downsize the fishing industry, shifts from groundfish to crab and shrimp processing, and changes to Employment Insurance (EI) regulations, have resulted in fewer jobs, less certain work, and reduced incomes for fish-processing workers. WHSCC claims during the period of restructuring showed reductions in the frequency and incidence of claims for men and women processing workers between 1985 and 1998. Lost-time accidents also became less common relative to medical aid and report-only claims. These trends are partly the result of reduced numbers of workers and reduced hours of exposure caused by plant closures and downsizing. However, interviews with study participants also suggest that seasonality and employment uncertainty may discourage workers from making WHSCC claims, particularly lost-time claims. EI regulations also appear to discourage reporting of workplace injuries and occupational diseases by excluding time off work on WHSCC benefits from the time that counts towards EI eligibility. The shift from groundfish to crab and shrimp processing has also changed occupational health risks. The risk of Occupational Asthma from snow crab, for example, has become relatively more significant while effective mechanisms for preventing, diagnosing and compensating this illness are not yet in place.

Women who attempted to leave fish processing in the 1990s encountered inadequacies with the retraining options and services provided under the federal Atlantic Groundfish Strategy (TAGS). Career counseling was largely unavailable, access to training was limited to a narrow range of options, and some women encountered negative stereotypes among TAGS administrators concerning their capabilities. As one woman said, "The message went out that all fishery workers were illiterate." Women who accessed TAGS training seats were under-represented relative to men and the average duration of their programs was shorter. Of the 15 women in this study who took skills training, some described shortcomings with the actual training, a majority were unemployed at the time of the interview and none had found stable employment after training. Many said they would not be doing any further training. One woman, only 37 years old, went back to work in fish processing after completing a technology program. Unable to find employment related to her retraining, she commented, "My personal expectations have gone down a lot. I feel like I am stuck in a job that I despise … It's too depressing."

■ "What I wanted after the moratorium was called was a reason to get up every morning. The fishplant was everything."

The word "devastated" was often used to describe the impact of the moratorium on the families and communities of the women we interviewed. Twenty-one of thirty-six respondents said they found their lives very or somewhat stressful, and twenty-two reported stress levels were higher than they had been six years earlier, around the time of the announcement of the moratorium. For women displaced from fish processing, apart from loss of income, the greatest impacts were: persistent work insecurity, disappointment because they did not get work after training, loneliness because close friends/family members had moved away and depression due to the severing of close ties with former co-workers at the fishplants. "What I wanted after the moratorium was called was a reason to get up every morning," one woman reported. "The fishplant was everything: all my siblings worked there and I've had to watch them one-by-one move away."

As the fisheries downsize and restructure, displaced workers and young people who would have sought work in fisheries have begun seeking work in other industries. Women from fishery-dependent communities want and need jobs, including the better paying ones in nontraditional areas such as trades and technology. Over the past decade, employment has expanded in the oil and gas sector. Previous research on this sector pointed to serious health risks for women at Hibernia associated with an inadequate transition into trades work. Recently the government of Newfoundland and Labrador has been trying to negotiate an agreement with Voisey's Bay Nickel for a nickel mine and mill in Labrador and a smelter in Newfoundland. It is important to anticipate and take steps to minimize the health risks this industry could bring for women and men employees. Ontario Workplace Safety Inspection Board claims data and three cancer studies were reviewed to examine jobs and the occupational health risks associated with them for women and men in these industries.

The number of women working in nickel production and mining jobs in Ontario is still small but the data and cancer studies show that both women and men are getting injured and sick as a result of nickel mining and smelting. Some of the health issues are: relatively high rates of accidents and injuries—especially for men; workers experiencing difficulty gaining compensation for respiratory cancers; a significantly higher incidence rate of trachea/bronchus cancers in the general population around Sudbury as compared to the rest of Ontario; the exclusion of women workers from cancer studies done on the industry; and safety risks to women in male-dominated work environments. The Newfoundland and Labrador government and the Workplace Health and Safety Compensation Commission should take steps to minimize these health risks for women and men when they lay the groundwork for nickel mining and smelting in the province.

The collapse of the groundfisheries jeopardized women's health through its impact on their employment and incomes and by changing the primary occupational health risks in the industry. Training programs failed to offset the risks to these women's health. This study suggests that a more in-depth, gender-based analysis and a social-ecological approach to health should be incorporated into planning and negotiations related to all resource-sector initiatives, whether in periods of downsizing or growth. In addition, governments at all levels should take a more proactive role in job creation and in guiding the makeup of the Canadian labour force in an equitable manner.

For a copy of the full report, *From Fishplant to Nickel Smelter: Health Determinants and the Health of Newfoundland's Women Fish and Shellfish Processors in an Environment of Restructuring*, contact:

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STRENGTHEN COMMUNITY AND PERSONAL ACTION

Out in the Cold: Lesbian Health in Northern British Columbia

Lynda Anderson, Theresa Healy, Barbara Herringer, Barbara Isaac and Ty Perry, British Columbia Centre of Excellence for Women's Health and the Northern Secretariat[1]

Out in the Cold, a study involving forty lesbians living in northern communities, reveals that place, sexual orientation, personal safety and community values interact and have impact upon health. In northern British Columbia where this study took place, anti-homosexual rhetoric is expressed in everyday encounters and through local media. Health services are also influenced by these biases. In focus groups and interviews, participants described the abiding dilemma of having to decide whether to reveal or conceal their sexual identity in the community and in health care. This study flags this dilemma and the condition of personal threat it denotes as a determinant of lesbian health and wellness. The interaction of place and sexual identity/personal safety, however, gives rise to a reality that is more complex and contradictory than would initially seem to be the case.

The lesbians who participated in the study ranged in age from eighteen to "too-old-to-want-to-talk-about-it," women who had identified as lesbians for decades and "baby dykes" newly claiming their sexuality. Most women had lived in the north from five to fifteen years. The objectives of the study included an investigation of lesbians' experiences in northern health care services and the barriers they encounter. An analysis of their narratives reveals three major groups of findings.

1. The northern context has a critical impact on the health and wellness of lesbians living there.

Criticism and hatred allowed in the media and homophobia within the educational system and in publicly distributed religious propaganda inflicted an overwhelming fear in some women. "Because I have had to really hide who I am for such a long time, I'm finding I'm a lot more stressed," one participant said. "There's the fear of, the risk of, losing my job if I'm out." "I realized I hadn't built a support system,“ another woman recounted. "The most detrimental thing to my overall well-being is the isolation, the feeling of not belonging, of not being included." Rural respondents who were not "out" assumed that neighbours, co-workers and health care providers knew they were lesbians. These women relied on people's good will to "not say the words" that might result in rejection, threat or lack of care.

Although many lesbians described a day-to-day oppressiveness, others cited the benefits of living outside of cities and close to wilderness. Some expressed this in spiritual terms. Others emphasized the satisfactions of self-reliance, self-determination and privacy. "I'm free to grow a lot of what I eat. Just being able to stand out in my backyard and breathe in fresh air and hold my partner's hand if I want to."

2. Formal health care services are permeated by the homophobia and heterosexism of northern society.

"A heterosexual woman doesn't go in afraid to say, 'This is my partner.' She will not have to think about whether or not this doctor in an emergency will hate her if she discloses that she is in this relationship, or if he will treat her differently," one woman told us. Another participant laughed ruefully as she recounted how a receptionist yelled across a full waiting room, "'Your medical card says your husband's name is Sally… How can that be?'" Other women, who stated they had not experienced biases and barriers, later revealed that they had not come out.

Although some participants described positive encounters, most used formal health care services minimally. Sometimes this withdrawal was described in terms of a rejection of a western medical model that focuses on disease rather than wellness. However, most often rejection of health care services was related to demeaning experiences of homophobic responses by health care providers. "[The doctor] was very attentive and real talkative before I told him that I was a lesbian," one woman said. "And then the room became silent. His whole attitude changed, you could tell. And he stared at me. Like *stared* at me, you know."

Many participants were also very aware of the history in medicine of pathologizing homosexuality. "To be labeled is a fear. Labeled as sick because you are a lesbian, labeled as depressed because you are a lesbian." For lesbian women who took their children to health services, the dilemma of disclosure was exacerbated by fear of reprisal against their children from other institutions such as school.

3. Many participants perceived the biases and barriers they encountered in health services as unremarkable. Generally, participants emphasized their own strengths and coping abilities.

Many women did not access formal health care except in the case of a critical incident, yet few women used the word "barrier" to define their negative experiences. Instead they emphasized the increased health, wellness and self-esteem gained from their autonomous health care practices. Although several participants did consider their disengagement to be involuntary, they shared the belief that disengagement had enhanced their health.

Some women remarked on the painful irony that while they were "proactive" and doing "all the right things" in their self-care approach, they might also be risking stress-related and undiagnosed illnesses by disengaging from health care services.

In the final report of this study we recommend changes at the community level to support the inclusion and personal safety of lesbians in the North; in health care services to educate providers and create equitable, welcoming protocols; and within the lesbian community to enhance social contact and support.

Social belonging and personal security—key components of health and wellness—are largely unavailable to lesbians who live in northern cities and towns. This study shows that considerations of personal freedom, safety and health are complexly and uniquely intertwined, suggesting new understandings about the determinants of lesbian health and wellness in the context of place.

For a copy of the full report contact:

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1. The Northern Secretariat has become Northern FIRE, an independent, community-based, women's health research institute that is particularly concerned with the health of women living in northern, rural and remote contexts. It can be contacted at the University of Northern BC, 3333 University Way, Prince George BC, V2N 3L9. Phone: 250-960-5602 Fax: 250-960-5644.

STRENGTHEN COMMUNITY AND PERSONAL ACTION

Empowerment in the Context of Poverty: Low-income Mothers in Saskatoon

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Power or control over the factors that shape one's life is increasingly recognized as a fundamental determinant of health. In fact, health promotion is commonly defined as "the process of enabling people to increase control over the determinants of health and thereby improve their health."[1] However, health promotion programs for low-income mothers tend to focus on skill development in areas such as parenting and cooking. While important, these programs do not address the more fundamental determinants of health that are found in the social, economic and physical environment, nor do they address the determinant of power or control.

Developing skills to not only cope with one's environment, but also work collectively to change it, is an essential aspect of women's empowerment. In addition, research has shown that support from others—practical and moral, as well as mentoring—is critical in expanding empowerment.[2] Participation in activities, groups or social actions are key processes. A project that brought together low-income mothers of preschool children in Saskatoon facilitated a process to support women who urgently wanted to move beyond coping with the conditions that affected their families' health to changing those conditions. In May 2000, two groups of low-income mothers who had previously taken part in skill-building programs began meeting with two facilitators. The participants ranged in age from the early twenties to the late thirties. Most had two or three children. About two-thirds of the women were single parents; about half were members of First Nations.

In weekly meetings the women talked about their communities and the changes they would like to see to make the community and its members healthier. In describing these changes, women spoke of having more control over their communities, including greater safety, adequate incomes and affordable housing. In order to express their vision of health, they took photos of their communities and created two large murals depicting community influences on health that they presented to invited guests. Onsite childcare and transportation were provided at each meeting and were critical to enabling participation.

One participant said, "Everything we did in the group was beneficial; it was a stress-reliever to have someone hear my concerns, to feel understood." Another woman said, "When I first started, I didn't really know what we were going to accomplish but I knew I needed the support."

> ■ "We did it together, from different walks of life, different ancestries or background. We can all pull together and accomplish things."

After creating the murals, the women decided to focus on poverty as a key determinant of the problems they were experiencing in their own lives and in their communities. In September 2000 when the women resumed meeting as a single group, they examined information about the prevalence and causes of poverty and shared their own stories about living in poverty. They found that the path that led to poverty usually, but not always, began with the woman's own upbringing. The effects of poverty that the women described included physical and mental health consequences: an inadequate diet for themselves and their children, having few opportunities for respite as parents, and poor self-esteem.

The social action that resulted from this examination was the creation of a book about poverty. The introduction to *Telling It Like It Is: Realities of Parenting in Poverty* states that, “Most Canadians agree it is a disgrace for one in five children to live in poverty. Something that may be overlooked is the fact that children are poor because their parents are poor. To end *child* poverty, we must address the bigger problem of *parents* in poverty.”[3] The book goes on to tell the stories of the women and provides facts about the causes and effects of poverty and parenting in poverty. Women said that they felt proud of the book, a tangible accomplishment, “something I can hold in my hand,” as one woman put it. Another woman commented, “We did it together, from different walks of life, different ancestries or backgrounds…We can all pull together and accomplish things.”

One of the purposes of *Telling It Like It Is* is to dispel some of the myths and negative stereotypes about low-income mothers. The story about Tracy, for example, describes a stay-at-home mother of two children whose husband works full-time for minimum wage. “We do not live from paycheck to paycheck: we live from payday to three days after payday, at best,” Tracy says. “Before we had children, my husband and I decided that when the time came, one of us would stay at home, at least until the children reached school age…I still believe we made the right decision, but it comes with a price … My husband has partial medical and dental benefits. My children are included in this plan, but I am not…I constantly worry about how I’m going to pay the bills, or what I am going to do if one of our kids gets sick and the prescription isn’t covered.” A statistic from *The Canadian Fact Book on Poverty* that concludes this story states: “In Saskatchewan, over one-third (39%) of poor families are working poor.”[4]

While all of the participants in this project wanted to take more direct action—beyond the creation of the book—to help move their communities toward the vision of health they had created, they found this to be a challenge. Lack of awareness of opportunities, time, and skills was identified as a reason, as well as more complex psychological factors, including self-confidence, believing one has the right to ask for better treatment and that change is possible, and having a stable enough life to free up energy for social action.

This study shows that opportunities should be provided for low-income mothers to develop not only personal coping skills, but also those required for social action. However, this should not preclude government’s obligation to raise minimum wage and social assistance rates to a liveable standard, or to help provide affordable, safe housing for all families. Nor should the onus to develop healthy communities be solely on those who are most disadvantaged. Individuals and groups with more resources and greater capacity for social action share this responsibility.

For a copy of the full report, “’We Did It Together:’ Low-Income Mothers Working Toward a Healthier Community” and for information about the book, contact:

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STRENGTHEN COMMUNITY AND PERSONAL ACTION

Affirming Immigrant Women's Health Practices in Prince Edward Island

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In Prince Edward Island, approximately 150 immigrants arrive annually. Today a total of 4,380 immigrants, about half of whom are women, live on the island. Immigrants to PEI face problems similar to those of other immigrants to Canada. However, the province's physical isolation and economic challenges contribute to greater cultural isolation, and fewer cultural supports and services are available.

Immigrant women have not been involved in studies about, and have not been recognized as resources for, their own health care.[1] The PEI Immigrant Women's Health Project addressed this gap in current research and explored what health means to immigrant women. In interviews we asked 22 women from 15 countries what they did before they immigrated to maintain their health and whether they were able to continue these practices in their new home. We also asked them about their experiences using health services in PEI. Our study found that immigrant women have similar health needs and subscribe to similar health maintenance practices as those born in Canada,[2] but their resources are significantly less.

The women expressed well-defined beliefs about health as a resource for daily living. They were very aware of the importance of practices such as eating well, getting adequate rest, and engaging in exercise, hobbies and other stress-reduction activities. They shared beliefs that physical, mental and spiritual health are closely related, that health in one area affects health in other areas, and that their health affected their ability to take care of themselves and their families, to relate to other people in positive ways and to financially support themselves or go to school.

However, the women said they did not have the time or resources to manifest their health maintenance beliefs or continue their health care practices. For example, their traditional foods were not available in PEI, nor were the herbs that they had learned to use as medicines for minor ailments in their home countries. Another critical factor identified by all of the women was the lack of social support (e.g., the ability to visit family, to have a good family environment and support from family, and the ability to visit friends). One woman said, "Family. Miss them a lot and when I think too much about them, I get depressed. [That] affects my health … I can live without my country but without my family is more difficult." A feeling of not being accepted in their communities was identified by many of the women as a related impediment to personal health care. Many of the women said that for psychological distress, depression or other emotional illness, they would talk to friends or family or distract themselves with work or other activities rather than, or before, going to a doctor. Without social connection and a feeling of belonging, these options

■ Policies and programs need to recognize immigrant women as a resource for their own health, provide supports to help them maintain their health care practices, and bring down barriers to health services.

for self-care are greatly reduced. In fact, for this group of women, everything that offered the comfort of the familiar seemed unavailable to them.

Loss of social support is believed to predispose the individual to feelings of vulnerability and to eventual illness. Some researchers have reported that social support is a major variable providing protection from mental and physical illness, especially during stressful life events such as chosen or forced immigration.[3] The lack of support experienced by the immigrant women who participated in this study, therefore, is a critical finding. One remedy, among the many that are needed, would be to make food and nutrition classes available to immigrant women. This would serve the dual purpose of teaching them how to adapt their traditional cooking styles to the foods available in Canada and, at the same time, provide them with an opportunity to build a social network. A related intervention would be for Health Canada to develop an alternative Food Guide that would take into consideration the food and cooking preferences of other cultures.

Language—the ability to express oneself in English—was another factor the women said profoundly affected their health and that of their families, creating unemployment, disadvantages in employment and obstacles in health care services. Although health care in PEI is "free," these women still face the complexities of learning how to access health care services and how to communicate and be understood. All of the women who were asked about language as a barrier said that professional health care interpreters were needed. Obtaining the kind of health care they value—holistic assessments and thorough examinations by a physician — was also perceived as an impediment.

Despite strong beliefs about health and how to sustain it, immigrant women find it difficult to maintain their health practices in PEI. Their health needs are related to several determinants of health and, consequently, strategies for supporting their health care practices are needed in several areas. Specifically, higher levels of English language classes are critical to enable immigrant women to continue health-maintenance practices and gain sufficient skills to compete in the job market. All of the women in this study felt that it was essential to have information about the Canadian health care system upon arrival, rather than three to four years later when they became Canadian citizens. Professional health care interpreters are also needed. Community outreach programs to facilitate the women's participation in their communities and improve access to social and leisure activities are another common-sense strategy.

Perhaps the first step toward affirming immigrant women's health and achieving inclusive health policy is for politicians, health care providers and communities to begin to value these women. Putting policies and programs in place to support them in their efforts to build a new life would also be "cost effective" because, as they themselves report, when they are healthy they are better able to take care of their families and themselves.

For a copy of the full report, "Affirming Immigrant Women's Health: Building Inclusive Health Policy," contact:

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