centres of excellence for WOMEN'S HEALTH
RESEARCH BULLETIN

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NEW QUESTIONS NEW KNOWLEDGE

INSIDE

Envisioning Healthy Living for Women

THE WOMEN'S HEALTH MOVEMENT and three decades of health promotion research and practice have demonstrated that women's health is inextricably linked to the context of women's lives. When it comes to thinking about healthy living for women, it is therefore important to recognize and respond to the social, economic and environmental contexts that shape and constrain individual and community action for health. Women's substance use, physical activity and eating—the focus of renewed attention in light of rising rates of chronic disease—are not merely individual lifestyle choices but patterns of living arising in particular environments, shaped by personal relationships, social norms, economic circumstances and public policies.

This issue of the *Research Bulletin* challenges readers to consider what is required for women to lead healthful lives. The issue begins by observing that for most women, caring activities are a central feature of their lives. A woman's caring responsibilities determine how she spends her day, potentially limiting her time for other pursuits, including leisure, education, community involvement, socializing and paid employment. Caring activities effectively determine the nature of women's economic well-being.

Caring responsibilities mean that women have to balance their paid and unpaid labour. They make choices about how to raise children, care for ill family members, support aging adults and provide physical, emotional and practical support to partners. These choices are affected by the particular household configuration and intimate relations in a woman's life and by the location and nature of a woman's paid work, such as whether she is employed in a small workplace or an industry that is undergoing restructuring. A woman's economic well-being is also affected by other aspects of social security, such as the current level of social assistance benefits, the existence of state-supported child and respite care, and access to social housing.

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The authors collectively demonstrate the need for action on the determinants of health that lie beyond the health care system in order to support women's health and women's lives.

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Clearly, opportunities for healthful living vary among women according to their particular circumstances. In this vein, several authors in this issue reflect upon what could support healthful living for Aboriginal women. They suggest that it is critical to understand the health disparities confronting Aboriginal peoples in Canada and that part of the solution lies in respect for cultural identity and the appreciation that health entails integration of physical, mental, emotional and spiritual aspects. They call for policies that are meaningful, appropriate and responsive to ameliorate the social and economic conditions that are damaging the health of Aboriginal people. For women, this also means situating their roles as caregivers and health guardians in appropriate cultural and practical contexts when proposing or implementing policies and programs.

Some of the solutions proposed in this issue lie in optimizing the health-enhancing role of the social determinants of health, including housing, social welfare policy and working conditions. Tools like gender-inclusive health planning can be used to tailor policies and programs to the particular realities of girls' and women's lives. Research and program evaluation can support the development of priorities for action, direct program implementation and track the effectiveness of policies and programs over time.

Learning from experience is an important method of supporting women to have healthier lives. A better practices review, for example, suggests that smoking during pregnancy could be reduced through tailoring interventions to particular groups of pregnant smokers and by addressing the stigma that is now associated with smoking. Similarly, supporting women's participation in physical activity requires both individual and community action. Research in British Columbia suggests that action to support recreation for women on low income is more likely to occur when the women themselves participate in a shared partnership with community decision makers.

The vision of healthy living for women described in this issue includes reducing smoking and improving exercise and nutrition, but calls for action on these problems to be appropriately tailored and sensitive to context. Moreover, the authors collectively demonstrate the need for action on the determinants of health that lie beyond the health care system in order to support women's health and women's lives. It is clearly a call to "develop polices and services which are accessible, appropriate, and enhance the ability of women to resist the health-eroding pressures of their daily lives."[1]

NOTES

1. Daykin N, Naidoo J. Feminist Critiques of Health Promotion. In Bunton R, Nettleton S, Burrows R (Eds.). *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. London and New York: Routledge, 1995;59-69.

OPPORTUNITIES AND CHALLENGES FOR HEALTHY LIVING

A Healthy Balance: Women's Paid and Unpaid Work in Nova Scotia

Jacqueline Gahagan, Charlotte Loppie, Laurene Rehman, Dalhousie University, Katherine Side, Mount. St. Vincent University, Marlene MacLellan, Nova Scotia Community College, Atlantic Centre of Excellence for Women's Health and the Nova Scotia Advisory Council on the Status of Women

"Caregiving" is defined as unpaid caring work throughout the life course, including the provision of care to children, teenagers and adults of all ages. Traditionally, research has explored the growth, nature, and economic aspects of caregiving. Consequently, there is a dearth of literature focusing on the psychosocial needs of caregivers and the significance of the age, gender, race/ethnicity, marital status, income and employment status of both the caregiver and the recipient.[1]

Caregiver Resilience and the Quest for Balance

A Healthy Balance: A Community Alliance for Health Research on Women's Unpaid Caregiving was established in 2001. It is funded by CIHR and co-sponsored by the Atlantic Centre of Excellence for Women's Health and the Nova Scotia Advisory Council on the Status of Women. This research project was part of the *Healthy Balance Research Program*. One component was to conduct focus group discussions with caregivers from different communities and caregiving situations across Nova Scotia. The research team conducted 18 focus groups and spoke with 98 women and 9 men aged 17 to 85. Participants also represented a variety of ethnocultural groups, including First Nations peoples (n=15), African Canadians (n=16), whites (n=49), new Canadians (n=13) and other groups (n=14). The average number of years which participants had spent caregiving was ten. The discussion guide for the focus group was developed to gain a better understanding of the relationship between unpaid caregiving, empowerment and health status, to further explicate "best practices" in caregiver policies, programs, and supports, and to gain additional insights into new or innovative approaches to caregiving and health promotion.

The data collected from the focus groups identified both the differences and similarities between various caregiving situations and provided important information about the impact of caregiving on work, family, health and well-being.

The report examines several important aspects of caregiving, including:

- **Who are the Caregivers?** The backgrounds of caregivers, their skills and qualities, gender and race, and the family dynamics within which they provide support.
- **The Additional Work of Unpaid Caregiving:** How participants balance their multiple roles and responsibilities, including advocacy as an important component of caregiving.
- **Who Cares for the Caregiver?** The social implications of accessing caregiver resources within specific family, personal, and social domains.
- **Caring for the Caregiver—Personal and Community Networks:** How caregivers care for themselves, request and receive the support of family, friends, and their communities.
- **Organizational Resources:** The resources available to caregivers, their difficulties in accessing them, and gaps in service.
- **Caregiving Experiences in Equity Reference Group Communities:** The caregiving experiences of Aboriginal women, African Canadian women, immigrants, and women with disabilities.

The Health Impacts and the Rewards of Caregiving

The following section describes the findings of the study regarding two important facets of caregiving: the effect on health and the rewards of caregiving.

Social, mental, physical, and nutritional health-related concerns were identified by many of the caregivers. Participants' social lives underwent profound changes due to the tremendous additional workload of providing care.

Their social lives were affected as their inability to maintain social networks increased and friendships declined. As one participant said, "What social life?" Overall, the participants concluded that focusing on the care recipient and providing care for them meant that the needs of the caregiver took second place. "The care recipient comes first. You're always trying to protect them, you almost never think of yourself."

The caregivers also experienced a number of emotional, mental or cognitive impacts on their health. Some of these were related to the stress associated with caring and its resultant physical impact upon the body. The majority of the participants experienced work overload in relation to their paid and unpaid work that resulted in stress. Caregiving also affected the physical health of the participants. They frequently identified exhaustion and loss of stamina and strength related to the provision of care. This resulted from both the actual tasks associated with caregiving, such as lifting, household labour, emotional caring, cleaning, and cooking, as well as its repeated ongoing demands. One participant commented, "You might find yourself refusing invitations to things as a result of being too tired."

Part of the health impacts caregivers experienced may have been influenced by their nutrition and diet. Many felt they were eating poorly both in quality and quantity due to time constraints resulting from the multitude of caring responsibilities. As the following caregiver for a person with a disability explained, proper nutrition was not a priority for her. "Sometimes when you finish taking care of everybody else, all you want to do is lay down somewhere and food is way down there at number 23 or something, not a priority." Many of the caregivers felt that they often did not have the time or energy to prepare appropriate or adequate food.

Despite the large number of challenges they faced, participants talked about the rewards of caregiving. It was often the rewards that helped the caregiver negotiate the challenges. Participants described one reward as simply feeling good about themselves, because caregiving enabled caregivers to feel they had contributed something worthwhile. They also felt that providing care brought a sense of accomplishment. Particularly for the caregivers of children, recognizing the influence they had on their children and the knowledge and skills they were able to instil provided a sense of achievement.

The other predominant reward associated with caring was the education the caregiver obtained, both about the health care system and caregiving and their own emotions. Learning how to access resources within the health care system as well as many of the nursing skills associated with providing care for a person were obtained through daily routines. Participants also described a number of traits such as compassion, patience and understanding that they had developed through their work as caregivers. "It teaches you patience, self-confidence and self-assurance. There's no other way you could get it. Those are the little words for what it is I'm trying to describe. I think probably it has more to do with spirituality, the spiritual side of self-confidence and self-assurance."

This study provides an extensive overview of the diversity of caregiving with its multiple meanings and expressions. As part of a larger program of research that encompasses a survey, secondary data analysis and caregiver portraits, this qualitative study allows for a more comprehensive understanding of the dimensions of caregiving. As a result, health service delivery will reflect new insights into the values and expectations brought to caregiving and paid work.

For a copy of the full report, *Caregiver Resilience and the Quest for Balance: Final Report of the Qualitative (Focus Group) Team*, contact:

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NOTES

1. Hoffman MK. Self-Awareness in Family Caregiving. National Family Caregiving Association Report, 2002.

OPPORTUNITIES AND CHALLENGES FOR HEALTHY LIVING

Living Well: Aboriginal Women, Cultural Identity and Wellness

Alex Wilson, Prairie Women's Health Centre of Excellence

Traditional understandings of health and wellness in Manitoba's Aboriginal communities are distinctly different from understandings that have conventionally prevailed in most Canadian health care institutions. "Aboriginal concepts of health and healing start from the position that all elements of life and living are interdependent. By extension, well-being flows from balance and harmony among all elements of personal and collective life."[1] Fortunately, an ever-increasing proportion of research, analysis and policy work on Aboriginal health in Manitoba is aware of the inseparability of cultural identity and health and wellness and is attempting to use a more traditional holistic understanding of health and wellness.

This research project, undertaken by the Aboriginal Women's Health Research Committee with support from the Prairie Women's Health Centre of Excellence (PWHCE), seeks to extend our understanding of the positive impact of cultural identity on the wellness of Aboriginal women in Manitoba and the ways in which Aboriginal women have retained and drawn upon cultural values, teachings and knowledge in their efforts to heal themselves, their families, and their communities.

What contributes to the health and well-being of Aboriginal women in Manitoba? And, what has influenced the identity of Aboriginal women? To answer these questions, this study used focus group discussions and interviews to explore cultural identity and wellness in the everyday life experiences and personal understandings of Aboriginal women. The study methodology was guided by principles that reflect the values and beliefs of local Aboriginal communities, including communality of knowledge and reciprocity, the acknowledgement of spiritual connections, relational accountability and holism. The focus group discussions and interviews were conducted in four Manitoba communities: a large urban centre, a First Nations community in Northern Manitoba, a small southern city, and a community relatively close to several First Nations in Northern Manitoba. The discussions examined several thematic areas, including (a) how women maintained their personal well-being, (b) how they maintained the wellness of their community and (c) how changes to the relationship between wellness and their community could occur. Women were asked: How do you practice well-being in your daily life? What are some ways that you try to be healthy? How is wellness a part of your community? What are some ways that you take care of the wellness of your community? What could your community do to strengthen Aboriginal women? What can we do as Aboriginal women to strengthen our communities?

Identity and Wellness

The Aboriginal women who participated in this research project took care of their health and wellness by attending to and maintaining balance between all aspects —physical, mental, emotional and spiritual —of their being. They envisioned their own identities and wellness in holistic terms. Women revealed identities that were inseparable from their connections to family, history, community, place and spirituality and were understood in the context of their whole lives. The sense of community identity was strong, rooted in their families, embracing friends, neighbours, peers, colleagues and people with shared experiences and interests, and extending to their individual First Nations groups. The importance of cultural identity was present throughout the focus group discussions and was a part of women's understandings of individual and community wellness.

The Practice of Personal Well-being

"Wellness is balance in your life, physical, mental, emotional, spiritual. You always try to balance those things in your life. For example, physically, I'm always putting things into my body that I shouldn't be. I would be certainly out of balance in those other areas also. Or if emotionally or mentally or something wasn't right, I'd be out of balance. For me, I try to balance all the areas. If I'm eating right and getting enough sleep, stuff like that,

physically. Spiritually, whether or not you go to church or say your prayers, whatever. And talking to people. To me, wellness starts with yourself, in your interactions or relationships with either your family or your community or nation."

The women in this study found many ways to take care of their physical, mental, emotional and spiritual wellness. Most of the participants described the ways they took care of their physical bodies, such as eating healthily, adhering to a vegetarian diet or avoiding junk food. Most of the women exercised regularly, taking walks, jogging, swimming or rollerblading. However, taking care of one's physical body required more than careful eating or exercise regimes. One participant stated, "What I've found in my life is that everything is in our bodies. All the pain, all the sorrow and stress is in our physical bodies."

The women who participated in the research had rich spiritual lives. The women emphasized the importance of spirituality, manifested in daily practices such as prayer, smudging or simply an ongoing commitment to extend honour and respect to others. Taking the time to feel their spiritual connection enables the women to refocus, gather confidence, anchor themselves and recollect their identities. For many of the women, the combination of practical and careful attention to all aspects of their being and wellness seemed to have made them unusually able to face challenges and take risks in their lives.

Contributing to Community Wellness

"I really feel and see the need for our community to be well, and I think that really begins with each of us. I try to practice that in my own daily life, and I try to emphasize that in the community, too, especially through my work. If I'm able to be with a group of people where I can carry a message, to encourage them to be well and to take care of each other in the workplace and encourage them to do that at home—I do that. I take advantage of each of these opportunities. And I share that with people."

Participants were asked to describe some of the ways that they take care of the wellness and healing of their communities. For many of the women, responsibility for the well-being of the community started in the home, in their relationships with family and friends. Several of the women felt that one of their most significant contributions to the wellness of their community is to raise their children to be whole and healthy people, to be "independent people who do not rely on others," "to become stronger people, to understand the power of being themselves, to do whatever they want to do and to know that they don't have to stay in relationships that are unhealthy." Some of the women were also very actively involved with their grandchildren or assisting community members to become whole and healthy people.

The women expressed a tremendous willingness to take responsibility for their own well-being and that of their communities, as well as the hope and expectation that others will be willing to do the same. The women expressed a real awareness of the impact of their own behaviour on the well-being of their community. As one woman said, "If we're not well ourselves, how can we help others? By starting with each of us, I think that's how we can help each other and other people."

Strengthening Aboriginal Women in their Communities

"Our traditional roles have been given away or taken —doesn't matter how it happened —but we're not as strong in our communities anymore. Once we were both the life-givers and the decision-makers in our communities—culturally, traditionally, we have to take back that role."

Participants felt that to strengthen Aboriginal women, individuals and their communities must reclaim and acknowledge the importance of women in traditional cultures. The women emphasized the importance of reclaiming tradition and returning honour and respect to women for the roles they perform in their families and communities. One participant stated that, "If Aboriginal women are going to make an impact or be empowered by their communities, we have to go back to our roots, the basis of our cultures. That will lead us to respect and honour women … When honour and respect flow in our community, we won't have problems—it will empower everyone."

Participants called for greater representation of women in management and leadership positions. One woman spoke with frustration of how, although effectively her whole community is run by women —with women filling the majority of staff positions, from worker to department head—the top jobs in the community are filled by men. They spoke of the need to encourage women to actively support each other. The women also recognized the need to create more supports

for men, many of whom are now struggling to maintain or recover a sense of their own strength and value; for children, who need and deserve care, protection and guidance; and for elders, who offer wisdom and knowledge derived from their lengthy life experience. With an appreciation that their own well-being is closely linked to that of their communities, the women understood that as their communities assume more control and ownership of their own cultures, both communities and women become stronger and healthier.

Conclusion

"Living well" for the women in this study required a balance between the physical, emotional, mental and spiritual aspects of a person and community. Women emphasized wellness over illness and described their health and well-being as being tightly linked to their cultural identities and a range of health determinants. These understandings affirm the importance of moving beyond a scientific approach to health and healing to integrate holistic understandings of and approaches to health into health care practices and policies.

A copy of the full report, *Living Well: Aboriginal Women, Cultural Identity, and Wellness*, can be downloaded at: www.pwhce.ca/research.htm, or contact:

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NOTES

1. Royal Commission on Aboriginal Peoples. Highlights from the Report of the Royal Commission on Aboriginal Peoples. Ottawa: Ministry of Supply and Services, 1996.

OPPORTUNITIES AND CHALLENGES FOR HEALTHY LIVING

Minobimadziwin: The Good Life for Aboriginal Women

Kim Anderson, Aboriginal Women's Health and Healing Research Group

It has long been established that, on the whole, Aboriginal women in Canada do not enjoy good health. The *Aboriginal Women's Health Research Synthesis Project* of 2001 reported that Aboriginal women are characterized by a health profile one would normally associate with the developing world, citing lower life expectancy rates than the mainstream population, along with higher rates of suicide, substance abuse, spousal violence, incarceration, sexually transmitted diseases, disability and chronic illness.[1] This is the legacy of colonization, lived out through the day-to-day lives of contemporary Aboriginal women. In our efforts to find a way out of this crisis, we need to call upon a broad based understanding of healthy living as our ancestors knew it, and we need to reclaim our identities as Aboriginal women.

Mainstream strategies typically focus on the physical elements of well-being, but as Aboriginal people, we know that this is not enough. Our elders remind us that good health encompasses not only the physical, but also the mental, emotional and spiritual elements of our being. The Anishnaabe talk about good health, or "the good life" as "minobimadziwin." This state of being is achieved through maintaining a harmony and balance of the mind, body and spirit of the individual, and in being in harmony with all of creation around us.

Few of us can boast that we have achieved this state of well-being; it is a lifelong journey to find such balance. Yet this understanding offers an important framework for our individual struggles towards well-being, as well as in our collective work towards the recovery of our peoples.

The contemporary state of disease among Aboriginal people is grounded in our experiences of oppression and dispossession. Aboriginal women suffer the ill effects of material poverty, but

they also suffer from a poverty that happened when our traditional knowledge, cultures and identities were stripped away from us through aggressive policies of assimilation and cultural genocide. This erasure is a direct cause for all of the appalling statistics about the state of Aboriginal people. The good news is that our experiences have forced us to develop some of the most creative and cutting edge work today in the area of health, healing and recovery.

Most of the healing work we have done has incorporated the genius of our ancestors. This makes sense, for if we have become sick from dispossession, then the only way we are going to get better is to reclaim the cultural, intellectual and spiritual ways that were taken from us. In order to have good health and a good life as Aboriginal people, we have to become secure again with our Aboriginal cultures and selves. If we are alienated from who we are and where we have come from, we experience an intellectual, emotional and spiritual rupture that can make us sick.

I often do community based research and consultation on social and health programming and have learned that the most successful programs are those which are culture based. Whether dealing with diabetes, fetal alcohol syndrome or quitting smoking, clients are most responsive to programs that offer traditional teachings, knowledge and approaches. For example, if we are doing diabetes prevention, we can talk about traditional foods, and how Aboriginal people understood and practiced healthy eating in the past. Children with fetal alcohol syndrome can benefit greatly from traditional medicines and re-establishing their relationship with the land. Quitting smoking can involve traditional teachings about the appropriate use of tobacco.

My personal contribution to the betterment of Aboriginal women's health has been to write and teach about Aboriginal female identity. This work started when I was a Master's student, doing research that documented the generally dire conditions of Native women. After listening to the stories of women who had suffered untold abuses, I needed to find some sense of hope. I needed a vision of a healthy Aboriginal female population, and of women who were well situated in their communities and the Canadian society at large.

When it came time to write my Master's thesis, I decided to map out the path to a positive Aboriginal female identity and experience by interviewing Aboriginal women across Canada. I sought out leaders, educators, artists, activists and community workers and asked them how they had come to a positive sense of themselves *as Aboriginal women*, in spite of all the obstacles they had surely encountered. I eventually wrote a book out of this thesis,[2] demonstrating that Aboriginal women arrive at a place of health and balance by engaging in a process of resistance, cultural reclamation and reconstruction of our traditional ways to fit a modern existence.This identity building process also includes a stage in which women bring their strength and power to use by acting on a sense of responsibility to community. The process of resist, reclaim, construct and act thus allows us to fulfill our responsibilities to ourselves, our families, communities, nations and all of creation, for we know that the good health of others and of our mother earth is connected to our individual states of well-being, and vice-versa. This is truly healthy living.

Over the years, there have been many Aboriginal women who have taught me invaluable lessons about the journey towards well-being, the good life, or minobimadziwin. I see it as my responsibility to share this knowledge with others. I am hopeful that one day, we will see health statistics on Aboriginal women that demonstrate the power of our commitment to healing and wellness, and the truth of our vision. Hai hai!

Kim Anderson (Cree/Métis) is a planning committee member of the Aboriginal Women's Health and Healing Research Group, a body that is committed to research, policy development and action on Aboriginal women's health and healing through the establishment of a Centre of Excellence for Aboriginal Women's Health and Healing. Kim is the author of A Recognition of Being: Reconstructing Native Womanhood *and the co-editor (with Bonita Lawrence) of* Strong Women Stories: Native Vision and Community Survival.

NOTES

1. Dion Stout M, Kipling GD, Stout R. Aboriginal Women's Health Research Synthesis Project, Final Report. Winnipeg: Centres of Excellence for Women's Health, 2001.

2. Anderson K. *A Recognition of Being: Reconstructing Native Womanhood.* Toronto: Sumach Press, 2000.

OPPORTUNITIES AND CHALLENGES FOR HEALTHY LIVING

The Health Benefits of Physical Activity for Girls and Women

Colleen Reid, Lesley Dyck, Heather McKay and Wendy Frisby, British Columbia Centre of Excellence for Women's Health

Research has clearly demonstrated many positive health benefits of regular physical activity. However, research in this area has tended to emphasize the importance of physical activity from a sport, exercise and recreation perspective and has not fully explored the implications of physical activity for disease prevention, management and rehabilitation. These gaps are particularly relevant in understanding girls' and women's physical activity.

In an attempt to integrate what is known about the health benefits of physical activity for girls and women, a multi-disciplinary team of 12 researchers and an advisory committee with representation from government and non-governmental health and advocacy organizations worked together with the British Columbia Centre of Excellence for Women's Health to gather relevant information regarding the health benefits and risks of physical activity for girls and women. This report tackled the complex relationship between health and physical activity in the context of girls' and women's lives through a multi-disciplinary and holistic approach and addressed the following areas:

- psychosocial health and well-being
- body image and self-esteem
- eating disorders
- smoking cessation and drug rehabilitation
- cardiovascular disease and hypertension
- osteoporosis
- estrogen-related cancers
- menopausal symptoms
- fibromyalgia and chronic fatigue syndrome

The Health Benefits of Physical Activity for Girls and Women: Literature Review and Recommendations for Future Research and Policy is a multi-disciplinary portrayal of what is known about the benefits and risks of physical activity and inactivity for the health status of girls and women. By making linkages between some of the most prevalent health issues facing girls and women today, the study demonstrates the possibilities and potential for inter-disciplinary research. For example, research has demonstrated ten times more women than men experience eating disorders and almost three times as many women than men use smoking as a way to control their weight. If a girl or woman maintains an unhealthy body weight through restricted caloric intake or by suppressing her appetite by smoking, she is at far greater risk for poor bone mineral density and osteoporosis. As well, coronary heart disease, a leading cause of death for older women, has been indisputably linked to smoking tobacco. This multi-disciplinary analysis demonstrates that osteoporosis and heart disease are linked to body image and self-esteem and suggests the need to address body image issues as a way of preventing these diseases.

In each of the health issues examined, the findings emphasize the importance of considering the relationship between the various types and contexts of physical activity and health status, and its relationship to girls and women's diversity. The report also identifies future research strategies and policy implications to support and improve the health and well-being of girls and women.

A copy of the full report, *The Health Benefits of Physical Activity for Girls and Women: Literature Review and Recommendations for Future Research and Policy*, can be downloaded at: www.bccewh.bc.ca/Pages/pubspdflist4.htm, or contact:

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THE CONTEXT OF HEALTHY LIVING

Women Working in Small Workplaces

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One-third of Canadians are employed in workplaces with fewer than 20 employees. A 1996 report found that over 90% of businesses in Atlantic Canada were small workplaces.[1] With the encouragement of the provincial and local governments, small businesses are growing in the region and an increasing number of women are working in small workplaces. Most research on women's occupational health in Newfoundland has focused on women in the fisheries industry and we know very little about women's experiences in small workplaces or their work conditions. As well, when compared to larger companies, small workplaces have higher rates of injury and ill-health and often offer low pay, few benefits and job instability.[2]

This study was undertaken to explore women's experiences in small workplaces in Newfoundland. In addition to examining how working in a small workplace affects women's health and well-being, we also wanted to explore women's perceptions of how the economic climate in Newfoundland affected the quality of their work life. We held nine focus groups in five communities across Newfoundland with a total of 60 women. In the focus groups, women were asked to describe their experiences in small workplaces in Newfoundland over the past 10 years. Women described the factors they perceived to influence their health, how their health and the health of their family connected to their paid work, and discussed different elements of their small workplace experiences (e.g., work load, policies and rules and physical environment). The participants ranged in age from 19 to 59 and had different levels of formal education. Twenty-four women were childless and 36 women had at least one child.

The participants highlighted many factors related to their work and the workplace that affected health and well-being. Four broad areas of discussion emerged from women's descriptions of their experiences in small workplaces: the social organization of small workplaces, physical work environment, work relationships and the economic climate.

The Social Organization of Small Workplaces

Workplace organization affects hours of work, schedules, places of work and the kinds of tasks employees do. Women in this study described how the organization of small workplaces often created instability and insecurity and how most small workplaces had many commonalities in terms of unstable schedules, lack of job security, and lack of control over type and amount of work. A major concern for women was the instability of their work schedule. Many employers only gave a few hours notice when a schedule was changed. In some cases, employees did not have a schedule and women were called in when it was busy or sent home when it was not.

Employees in small workplaces often work alone and several women in this study described their experiences of loneliness and isolation and concerns regarding their safety. Women described how working alone often meant they did not have the opportunity to take a break or use the washroom.

Participants also described the challenges of taking time off in small workplaces. The women often did not have paid sick days and were reluctant to take time off for illness as it meant they would have extra work when they returned. In some situations, women felt pressure from their employer to work extra hours, while in other cases, women worked long hours in order to make ends meet on their low salaries. Women described how unpredictable schedules negatively affected family life and created problems with child care. Shift work, long hours or irregular hours resulted in sleep disturbances and insomnia for several of the women.

Generally, women in this study found that they did not have the opportunity to give input into the type of work they did or their working conditions. However, women identified non-profit organizations or community-based organizations as an exception to this pattern. Women working in these organizations found their work to be rewarding and found that these jobs tended to be more flexible. They also experienced different challenges, especially when an organization was

suffering financially. They described how they often felt compelled to work, as there was a clear need for the work to be done in the community, or felt pressured to take on extra responsibilities outside of their job description.

Physical Work Environment

The physical environment that women worked in depended greatly on the type of work that women did. Women described a range of challenges and hazards they had experienced in their workplaces. They described a lack of control over heat, cold and air quality. Many women were exposed to second-hand smoke or experienced watery eyes, dry skin, headaches and coughing as a result of their work environment. Women also reported ergonomic stressors in their work environment that resulted in temporary discomfort or, in some cases, in lasting muscular damage requiring a brace or physiotherapy. Injuries resulting from inappropriately sized equipment or workstations, standing in one place for long periods of time without appropriate breaks and repetitive strain injuries were common in women's stories.

Women in the study described a range of factors they felt contributed to their poor physical surroundings, including not enough financial resources, lack of concern about safety, lack of awareness of the problems and a lack of managerial skills to address acknowledged problems. Many of the women felt that working in a small workplace entailed working in hazardous conditions. One woman commented, "When you work with a non-profit organization [as compared] to working with a big company who has got bucks deluxe, you can totally see the difference in your physical workplace."

Work Relationships

Co-worker relationships were mentioned in all of the groups as an important factor in their workplace environment. Several participants found that the small workplace environment allowed positive, close-knit relationships with employees to develop and this alleviated stress. However, conflict between co-workers was described as being "magnified" in small workplaces. "When there is an interpersonal problem, if you're in a small workplace, it's magnified; where, in a bigger workplace, it's sometimes even a non-issue or you have other people to discuss the problem with. When there's only two or three of you there and if the supervisor is being unreasonable…it's very difficult to deal with the issue and it's always right in your face —always." Interacting with co-workers was unavoidable in a small environment and a lack of physical space often intensified the conflict. In these cases, co-workers became a major source of stress.

In the focus groups, several women reported not being aware of their rights as employees. In some cases when employees knew their rights were being violated, women experienced difficulties in "speaking up" against unfair practices. Women in this study reported fears of losing their job and felt their employers reminded them of how easily replaceable they were.

Economic Climate

Many women made links between the socio-economic environment in their communities and the quality of their work. Job insecurity was a major concern for the women, especially for women living outside of St. John's. The women described the challenges of finding work in the community where they lived. Women in communities outside of St. John's reported driving long distances to get to work and all of the women in the study would have preferred to work closer to home.

Small businesses often went through frequent economic shifts depending on the time of year and these changes influenced the number of employees hired, the number of shifts employees had, how often employees worked and their earnings. Several women described how high unemployment rates in Newfoundland affected their job stability. "…Because of the unemployment rate in Newfoundland, I've noticed the last few years…that nobody will speak up because there's so many [people] out of work… There have been cases where your employer has said, 'We got 300 applications for your job. You're kind of lucky to get it.'"

Discussion

The quality of women's work environment is strongly related to the employer and type of workplace. However, this study raised several areas of concern around working in small workplaces, including the inadequacy of the physical workplace and a lack of workplace structure and job stability. This study contributes to our understanding of the relationship between the work environment and women's mental and physical well-being. Although women in this study did raise concerns specific to women working in small workplaces (e.g., lack of recognition for unpaid work, safety, different employer expectations for men versus women and descriptions of working in highly sexualized environments such as bars and

restaurants), resource limitations prevented us from fully exploring these areas and should be the focus of future research. While the women identified the influence of the economic climate on their ability to find quality employment, women also identified numerous challenges to speaking out about their concerns or initiating changes in the workplace. The findings of this study have policy implications, especially in the areas of labour standards development, adherence to the Occupational Health and Safety Act and EI regulations.

A copy of the full report, *Trying to Work It Out: Newfoundland Women's Experiences in Small Workplaces*, can be downloaded at: www.yorku.ca/nnewh/netPubs_reports.htm, or contact:

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THE CONTEXT OF HEALTHY LIVING

Health Care Restructuring, Agricultural Reform, and Rural Women's Experiences of Paid and Unpaid Work

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With the majority of Canadian women in the labour force, paid work is a fundamental feature of women's lives. Most employed women also perform unpaid work in the form of caring for family members and performing household tasks. In rural communities, many women also perform unpaid farm work. This study examined women's experiences of paid and unpaid work in the context of restructuring within two key economic sectors in rural Alberta: agriculture and health care.

Global economic changes, international competition, government debt, cutbacks, downsizing and outsourcing are features of restructuring in both the public and private sectors. Whereas farming and rural communities have been profoundly changed by specialization, mechanization, grain prices, biotechnology and changes in marketing and transport,[1] they have also experienced the effects of health care restructuring, particularly regionalization and the resultant changes in the organization and management of health care services.[2]

This descriptive study explored women's accounts of their lives after restructuring in the health care and agricultural sectors. The researchers conducted semi-structured interviews (n=34) with farm women, public health nurses, and home care nurses in four southern, central and northern Alberta health regions. Eighteen women worked in both farming *and* nursing or other health-related work such as physiotherapy or continuing care. The other 16 women worked in either farming or nursing. Seven focus groups with 56 women were conducted in a second stage of the study with women in similar occupational groupings. Thematic analysis of all the data led to the identification of three themes in the accounts of these rural women: being strong, maintaining values, and struggling for control and balance.

"Being strong" captured women's experiences of living with uncertainty, working endlessly, dealing with loss and drawing on personal resources. "Maintaining values" referred to women's sense of being a "good" woman, valuing rural life and community, making a contribution and wanting recognition for that contribution. Finally, "struggling for control and balance" described women's efforts to maintain their health in the face of multiple demands. Few women described themselves as achieving such balance, most felt that they had to "just cope and go on."

It was clear in this study that both farming and health care were importance contributors to the local economy in these regions. Restructuring, in both agriculture and health care over the last ten years, was reported by the women as having a range of impacts that affected their decision-making abilities, the organization of paid and unpaid work and their feelings about their quality of life. The following sections describe some of women's experiences with restructuring.

The Impact of Health Care Restructuring

In 1994, Alberta's health care system underwent a process of regionalization that placed health decision-making in seventeen health regions. This radically altered the way health care services were managed. Restructuring brought closure of many rural hospitals, downsizing, reduced accessibility to health care services, and increased care burdens for family members. Many health care professionals left the profession or the province in search of employment in other areas, leaving behind overworked and stressed colleagues to deliver services.[3]

As a result of the changes in the structuring of health care, the nurses in this study felt they were challenged to provide the desired care with reduced and altered resources. Both public health nurses and home care nurses in this study were concerned about having less time and staff to deliver quality care. Budget cuts meant doing more with less. They were also concerned about the lack of focus on health promotion and prevention. "We've regionalized but they haven't really put money into the things that they talk about, like health promotion and prevention." The nurses lamented the loss of "holistic practice," the constant change and the "add-ons."

Moreover, the nurses in this study described rural life for nurses. One public health nurse commented that nurses in rural communities "go into their evenings, they miss their breaks, they miss their lunches because their clients are their priority… they live in the community, these are the people they live with, these are their neighbours….it creates a whole different feeling about your job." In rural life, personal and professional boundaries are blurred. In rural communities, residents do not hesitate to call a nurse at home in the evening and on weekends nor do they hesitate to request advice when a nurse in the community is attending community functions or shopping for her family. As a rural public health nurse or home care nurse, "You're always on." Although the demands on some of the nurses were great, they valued their connection to their communities, and the trust that community members placed in them.

However, the nurses in this study commented on how taking care of their own health was complicated by reduced accessibility to health services. This occurred when the retention of physicians became an issue, when they had to seek attention from a colleague-physician, or when they needed to seek help for themselves with the risk that others in the community would know. As well, the challenges of everyday work affected their health. One public health nurse commented, "Sometimes the stresses every day change the wellness model that I have in my head."

The Impact of Agricultural Restructuring

Farming and rural communities in Alberta and elsewhere in Canada have been profoundly affected by specialization, biotechnology and major change in marketing and transportation. Global economic changes, international competition, government debt, cutbacks, downsizing and outsourcing have all played a role in the restructuring of public and private sectors. These external forces have placed decision-making power beyond the boundaries of geographic and cultural communities.[4]

Women in the study described this uncertainty in their lives. "The only thing we can be sure of is that nothing will stay the same" and "sometimes change seems to happen for no good reason." The women described financial, meteorological and organizational uncertainty. For some, financial uncertainty referred to reduced income on farms. Women described how costs had increased, product prices had fallen, and government regulations had increased taxes and charges for freight. When grain elevators were closed, it meant having to drive further to

deliver grain, which increased fuel costs. "Without my wages, we would be on welfare, I know that," said one woman. Another study participant stated, "Self-confidence and worth get chipped away seeing friends having to sell farms and wondering, when is it my turn?"

The women described many losses in their lives as a result of changes in their communities. Losses included losing all or part of a farm, contact with nurse colleagues, neighbours or community, and access to experts and services. Other reported losses were reductions in income, and the disbandment of women's organizations. "The day of the auction sale, I hid in the house…I didn't want to be outside seeing all the stuff we had gathered…be sold and basically given away ….I didn't realize how much of my identity was tied up in farming."

Some women had very little information about the reasons for restructuring and about the process of decision-making. Participants thought that more information would increase their input and ability to cope with change, yet the daily demands of managing their paid and unpaid work left them with little time to seek information. As well, many women felt distanced from policy makers and government.

Double Impact?

Women in this study experienced restructuring in different ways, some positive and some negative. One of the unique features of this study was the inclusion of both the providers and recipients of health care. As a result, the research was able to capture more comprehensive reports of the impact of restructuring on work and health in rural life. In this study, it became apparent that the boundaries between home, community, and work blurred considerably for rural women. For example, work income was used to pay farm bills or buy essentials for the home; while attending community events, nurses were expected to provide care or would be approached for advice about health problems.

This study captured the voices of rural Alberta women and their experiences of sectoral changes related to farming and health care. However, the double impact of restructuring on rural women needs to be further explored to better understand how restructuring directly affects women's work and health and how it indirectly affects women through their families and communities. This study also documents changing networks in rural communities and highlights the need for the development of mechanisms to allow for meaningful dialogue between policy makers and rural women.

A copy of the full report, *Reflections of Rural Alberta Women: Work, Health, and Restructuring*, can be downloaded at: www.yorku.ca/nnewh/netPubs_reports.htm, or contact:

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THE CONTEXT OF HEALTHY LIVING

Creating Homes for Healthy Living: A Comparison of Housing Models for Women

Molly McCracken, Prairie Women's Health Centre of Excellence, and Gail Watson, Women's Health Clinic

Mounting evidence shows that women with low incomes have acute housing needs, are at greater risk of living in unsafe and unhealthy environments and require specific supports to achieve stable and affordable housing. Over the past several years, researchers at the Prairie Women's Centre of Excellence have been investigating the effects of changing housing policies on the health of women. One of the key findings from this research is the importance of developing housing models in consultation with women living in poverty.

In a report entitled *Women Need Safe, Stable, and Affordable Housing: a study of social, private and co-op housing in Winnipeg*, researchers from the Prairie Women's Centre of Excellence and the Women's Health Clinic explore women's experiences with social, private and co-op housing in Winnipeg. Through a series of focus groups with low-income women, this study explores women's experiences with different housing models. The study identified safety, affordability and suitability as important elements of housing for women and the need for housing policy that reflects these priorities.

The report investigates the intersections among housing, poverty and health and describes how inadequate housing prevents women from addressing their other health concerns. In addition to describing the findings of the research study, the report also provides an overview of housing policies in Canada and presents policy recommendations for creating housing models that reflect the needs of women living in poverty. In particular, the study describes cooperative housing as a model that may provide promise for assisting women with low incomes to gain skills and to improve their health and economic status.

A copy of the full report, *Women Need Safe, Stable, Affordable Housing: a study of social, private, and co-op housing in Winnipeg,* can be downloaded at: www.pwhce.ca/research.htm, or contact:

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PROMOTING HEALTHY LIVING

Healthy Living and Aboriginal Women: The Tension between Hard Evidence and Soft Logic

Madeleine Dion Stout, Aboriginal Women's Health and Healing Research Group

Two narratives define Aboriginal women and healthy living: hard evidence documents our poor health status while soft logic passes us off as primary health guardians. Understanding this tension requires an insight into the health and social disparities we experience and a description of the linkages between these realities and healthy living policies. Key demographics, biological indicators, lifestyle behavioural issues and social conditions that aggravate Aboriginal women's health have to be weighed against the totality of our environments and our desire and potential to contribute as health guardians. Ultimately, "healthy living" for Aboriginal women depends, to a great extent, on meaningful, appropriate and responsive policies.

Hard Evidence: Aboriginal Women's Health Status

In 1996, there were about 408,100 Aboriginal women in Canada out of a total Aboriginal population of 799,000. Roughly 66% of these women self-identified as North

American Indian, 25% as Métis, 5% as Inuit and 3% as belonging to more than one group. In absolute terms, Ontario and British Colombia had the largest populations of Aboriginal women (73,725 and 71,455 respectively). Meanwhile, Aboriginal women made up the greatest share of the general female population in three territories and two provinces: Nunavut (86%), Northwest Territories (50%), Yukon (22%), Manitoba (12%), and Saskatchewan (12%). The number of Aboriginal people over 65 years is growing three times faster than any other age group. It is also important to point out that in 1996, Aboriginal women aged 65 and over made up 54% of all Aboriginal seniors even though proportionally to youth, fewer Aboriginal women were seniors.[1]

Recent data from Canadian Population Health Initiative (CPHI) demonstrate that Aboriginal Peoples are the unhealthiest group in Canada.[2] Aboriginal women, however, are experiencing a disproportionate burden of ill-health compared to Aboriginal men and other Canadian women. For example, diabetes among First Nations and Inuit men is reported to be 3 times the rate for all Canadian men; for First Nations and Inuit women, however, the diabetes rate is 5 times the rate for all Canadian women.[3] Compared to about 4% in the general population, 40% of First Nations women have gestational diabetes.[4] One study revealed that rates of gestational diabetes increased with maternal age such that there was a 46.9% prevalence rate in women who were over 35 years old.[5]

On the eve of International Women's Day this year, the Canadian Aboriginal AIDS Network issued a press release with bleak statistics on Aboriginal women and HIV and AIDS:

> In Canada, Aboriginal people are significantly over-represented for both HIV/AIDS, seeing an estimated 91% increase (1,430 to 2,740) during a 3 year period between 1996-1999 alone for HIV infections. AIDS cases among Aboriginal women are almost 3 times higher than non-Aboriginal women (23.1% versus 8.2%). Various social, economic and behavioral issues are believed to be influencing this health concern. In addition, Aboriginal women can experience a triple layer of marginalization, based on gender, race and HIV status. With injection drug use accounting for two-thirds of the new HIV infections among Aboriginal populations, Aboriginal women face further challenges. AIDS figures reveal that injection drug use as a risk factor is 6 times more common among Aboriginal women than their counterparts (35.9% versus 6.3%).[6]

As for reproductive patterns, 55% of Aboriginal mothers are under 25 years of age and 9% are under 18 years of age. Among non-Aboriginal mothers, roughly 28% are less than 25 years old and only 1% are under 18 years of age.[7] Given the relative youthfulness of Aboriginal women, they have a higher fertility rate than non-Aboriginal women and larger families.[8] The Canadian Population Health Initiative reports "…chlamydia rates are higher in Nunavut than for First Nations on-reserve and the prevalence among these two populations is 6 times higher than the prevalence in the all-Canadian population." As well, more Aboriginal women are dying from cervical cancer than non-Aboriginal women with the mortality rate of First Nations women in British Columbia being six times that of non-First Nations women.[9] Likewise, Inuit women in Nunavik have three times the rate of cervical cancer than the general population.[10]

The root causes of obesity, physical inactivity and poor nutrition among Aboriginal women transcend policies and action that are often fractured and exclusive to health.

Clearly, Aboriginal women have serious sexual and reproductive health problems. In addition, our health challenges are particularly relevant to the discussions in the Integrated Pan-Canadian Healthy Living Strategy.

For example, Aboriginal women face a high risk of obesity. In 1999, a study in Northern Ontario deemed 60% of adult First Nations women obese. Research on adult Cree and Ojibwa Indians living in Northern Canada found a high proportion of overweight in all age and sex groups, with almost 90% of women ages 45-54 having a body mass index (BMI) of at least 26. According to Health Canada, BMI levels between 25 and 27 may lead to health problems in some people. First Nations and Labrador Inuit women are more likely to report chronic diseases like arthritis, hypertension and heart problems. First Nations women are more likely to die from ischemic heart disease and stroke, at a rate which is much higher than that of non-Aboriginal Canadian women. [11] From all accounts, most Aboriginal women have experienced domestic violence.[12] Inuit women are particularly hard hit by environmental hazards according to the CPHI:

> In 2003 Inuit mothers had levels of oxychlordane and trans-nonachlor pesticides that were 6-12 times higher than those in Caucasians, Dene (First Nations) and Métis or other ethnicities. Inuit mothers have markedly higher levels of mercury in their blood than other ethnic groups. Inuit mothers have higher levels of polychlorinated biphenyls than Caucasian, Dene (First Nations) and Métis mothers.[13]

Injuries, poisonings and suicides exact a heavy toll in Aboriginal communities. The Report of the Advisory Group on Suicide Prevention[14] revealed that youth suicide rates in First Nations differ by gender, with young men committing suicide more often than young women, but that native young women are eight times more likely to commit suicide than their non-Aboriginal cohort.

A review of our social circumstances brings into sharper relief the multiple health burdens of Aboriginal women. Naomi Adelson, in a report from an International Think Tank on Reducing Health Disparities and Promoting Equity for Vulnerable Populations held in September 2003, observed that Aboriginal women are at a particular disadvantage as:

> the colonial legacy of subordination of Aboriginal people has resulted in a multiple jeopardy for Aboriginal women who face individual and institutional discrimination, and disadvantages on the basis of race, gender and class. [15]

In 1996, while Aboriginal women fared poorly in educational attainment compared to non-Aboriginal women, we were slightly more likely to have a university degree than Aboriginal men, 3% of whom have completed university. Also Aboriginal women were less likely to be employed, let alone full time, than Aboriginal men. Notably, we were twice as likely to be employed in low-paying occupations than Aboriginal men and almost twice as likely as Aboriginal men to be employed as professionals: 22% versus 12%.[16] Statistics Canada reported that Aboriginal women are less likely than

Aboriginal women are critical players in the health development of our communities whether we are taking care of families, maintaining cultures, conducting research or assuming leadership roles—all this in spite of our poor health prospects.

non-Aboriginal women to be living in husband-wife families, are twice as likely to be living in common-law relationships and are more likely to be lone parents. In 1996 only 3% of Aboriginal men were lone parents.

Violence is a particular problem for Aboriginal women. For example, an initiative concerning Missing Women, the Sisters in Spirit Campaign, was launched in March 22, 2004

> "to draw attention to the tragedy of 500 missing Aboriginal women in Canada and to the travesty that there is so little awareness of this. Here in BC, 32 women have gone missing from the Highway of Tears between Prince Rupert and Prince George. Over the past 20 years, approximately 500 Aboriginal women have gone missing in communities across Canada. Yet government, the media, and Canadian society continue to remain silent. In Vancouver, more than 50 women went missing in that city's Downtown Eastside. Sixty per cent were Aboriginal, and most were young. These were poor women involved in the sex trade. They struggled with drugs and alcohol. Some suffered from the effects of Fetal Alcohol Syndrome and many were victims of childhood sexual abuse. Every one of them grew up in a foster home. In other words, their lives bore all of the markings of the violence of colonization."[17]

Aboriginal women are reacting angrily about the politics of justice in Canada or more fittingly, the lack of justice in politics. Similarly, a recent publication from the National Aboriginal Health Organization (NAHO) criticises current policies that focus on changing individual lifestyle behaviours rather than dealing with historically determined power relations that have adversely affected the health of Aboriginal peoples. Myriad studies show that obesity, smoking and physical inactivity have a lesser impact on health status than income and education.[18]

Soft Logic: Aboriginal Women as Health Guardians

Aboriginal women are critical players in the health development of our communities whether we are taking care of families, maintaining cultures, conducting research or assuming leadership roles—all this in spite of our poor health prospects. Aboriginal women view health holistically and view social and cultural conditions as integral to the health of our communities. For example, childbirth in the North and midwifery in Inuit communities go hand-in-hand and are the heart of women working to keep culture alive and well.

As was suggested earlier, there is a link between the poor health of Aboriginal women and the health stewardship roles we play in the health of Aboriginal communities, yet only soft logic tries to locate this link and the immediate and intermediate health outcomes that arise from it. It is important to press hard evidence into service here for the following reasons. First, it recognizes a different context for healthy living policies where Aboriginal women are concerned, given poor health and often deadly health determinants that impact on them. Second, it re-orients healthy living policies towards an emphasis on the positive realities of Aboriginal women's struggle for health development. Increasingly, we are identifying our human agency, pragmatism and resilience as key strengths in this process. We also want to repair our efforts with Aboriginal men for the sake of our families and communities. Finally, it brings about a policy focus on Aboriginal women as nurturers of families, keepers of cultures, researchers and leaders and it recognizes the fluid and complex factors that affect our health and determine our capacity to take up and keep up the mantle of improving community health along with maintaining traditional roles.

The Women's Health Bureau of Health Canada stated, "while Aboriginal women play an essential role in community health, often under difficult social and economic conditions, their own health status is poorer than that of women in the general Canadian population."[19] Therefore, as a strategy, Healthy Living has to consider the following in order to be meaningful, appropriate and responsive to Aboriginal women: the root causes of obesity, physical inactivity and poor nutrition among Aboriginal women transcend policies and action that are often fractured and exclusive to health. While healing and wellness programs have their place in the short term, it is economic and social reforms that will bring lasting change. Above all,

healthy living has to be inclusiv e of mental, emotional, physical and spiritual aspects, must be based on cultur e and tradition and be flexible to meet community needs and priorities. It needs both a gender analysis and an A boriginal analysis. In addition, a healthy living strategy must consider the net effects of colonization and discrimination if it is to be meaning ful to A boriginal women. F inally, "healthy living" must be consider ed in light of the context of Aboriginal women's lives and their cultural, socio-economic and political aspirations.

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PROMOTING HEALTHY LIVING

Taking Action: Mobilizing Communities to Provide Recreation for Women on Low Incomes

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Contextualizing Poverty, Health and Physical Activity for Women

A recent study reported that less than 25 per cent of the female population in Canada par ticipates in sufficient physical activity to deriv e health benefits. [1] Yet, r esearch has clearly demonstrated that the risks associated with a number of serious health pr oblems, including car diovascular disease, obesity, diabetes, cancer and osteopor osis, can be r educed through r egular physical activity . I t is also w ell-known that women living belo w the po verty line ar e mor e likely to experience poor health [2] and ar e less likely to be inv olved in physical activity and community r ecreation as a means of offsetting some of the health pr oblems they encounter .[3] Women living in po verty face a staggering number of challenges, such as poor housing, inadequate childcar e, and insufficient financial r esources for food and clothing, and access to community recreation is rarely considered a priority. Not only is poor women's access to community recreation not seen as a priority , but women on lo w income encounter multiple societal, community and personal barriers to participation in community recreation.

Evidence suggests that the health and quality of life of women on low income and their families could be impr oved and that substantial savings to the health car e system could be accr ued if community r ecreation was seen as a pr eventative health promotion strategy for marginaliz ed populations. Unfortunately, little has been done in the ar eas of policy development, pr ogram design or r esearch to addr ess the interconnected social pr oblems of women 's po verty, poor health and lack of inv olvement in and access to community recreation. I t has been suggested that one r eason for this omission is that health and spor t policy ar e largely designed with little or no input fr om those who ar e encountering structural barriers to participation.

Background on the Kamloops Women's Action Project (KWAP)

The Kamloops Women's Action Project (KWAP), funded by the BC Health Research Foundation and completed in 1996, was a feminist action r esearch pr oject designed to addr ess health issues of women living belo w the po verty line b y encouraging incr eased inv olvement in community recreation. Women on low income in Kamloops identified a lack of access to community r ecreation as a major factor inhibiting the dev elopment of healthy lifestyles for themselves and their families. Women on lo w income, community par tners and r esearchers collaborativ ely identified the r esearch questions, collected data and developed actions, including the implementation of ne w recreation pr ograms. M ulti-level outcomes w ere achiev ed, including impr ovements in self-r eported dimensions of physical and mental health for the women, changes in community recreation policy, program delivery and resource allocation and the formation of ne w community partnerships. A final outcome included a Leisur e A ccess workbook written b y the r esearchers to facilitate the identification of access issues for marginalized groups and the implementation of this kind of community planning for other communities.

Taking Action: Study Purpose and Methodology

Building on the kno wledge and experiences gained in the Kamloops pr oject, a second pr oject was dev eloped to shar e the kno wledge gained. This pr oject inv olved thr ee communities in British Columbia and examined the factors that influenced whether action was taken in these communities to increase poor women's access to community recreation. The o verall goal was to pr ovide some tentativ e "lessons learned " for other individuals, organizations and communities interested in launching similar initiatives.

The methodology in the second study consisted of a full-day workshop intervention at each site by original members of the KWAP team using the Leisure Access workbook,[4] two return visits to each site and 30 follow-up telephone interviews with workshop attendees over a 12-month time frame. In all three sites, women on low income, municipal recreation staff and representatives from a variety of community groups (i.e., public health units, family services, women's centres) attended the workshops and were subsequently asked questions during return visits or follow-up telephone interviews about the factors that enhanced or inhibited action being taken in their communities. Attendance at the workshops varied from 12 to 85 participants.

Findings

The response to the workshop interventions varied considerably in the three communities. In Community #1, initial plans were developed but were not subsequently implemented. In Community #2, women on low income assumed a major leadership role and initiated action plans outside of the existing municipal recreation system because the policies and practices of that department were not community-development oriented and presented a number of obstacles. In Community #3, partnerships emerged between a larger and more diverse group of women on low income, community representatives and municipal recreation staff, and more extensive action plans, both within and outside the municipal recreation systems, were developed and implemented.

The tracking of the three communities over time revealed a number of factors that influenced whether action was taken and the direction it took. The factors that enhanced or inhibited action were either internal to the working partnerships that were created to tackle the social problems identified (e.g., practitioners adopting a facilitator rather than "expert" role) or were external or more structural in nature (e.g., the daily experiences of living in poverty, restrictive policies of the local government).

Internal and external factors that enhanced the likelihood that action would be taken included: (1) the use of a community development approach that actively involved women on low income in leadership roles and decision-making, (2) the diversity of representation, (3) the use of a community development approach accompanied by a social justice discourse, (4) the shared responsibility for action, and (5) the acknowledgement of the structural dimensions of poverty. Factors that inhibited the likelihood that action would be taken included: (1) power imbalances among collaborators, (2) fragmented community services, (3) reliance on one "idea champion," and (4) the adoption of the traditional direct model of service delivery.

Discussion

This study demonstrates that the dissemination of successful local health promotion initiatives involving community recreation is more likely to occur when the experiences and resources of women on low income are pooled with intersectoral community partners around a shared vision of social justice. Canadian health policies and programs are frequently based on the assumption that individuals should be responsible for their own health, yet provide little or no opportunities for input from the growing number of women who live below the poverty line who are also the most likely to experience poor health. A community development approach helps to ensure that marginalized voices are heard and acted upon in ways that are relevant to them. At the same time, including community leaders and researchers in the process broadens the responsibility for social change. The guidelines for health promotion dissemination developed from this study are meant to serve as a starting point for discussions about the types of principles that should guide community involvement in health promotion for women, while pointing out some of the obstacles that may be encountered along the way. These findings may be useful to other women on low income, community groups, the public sector, and researchers embarking on similar initiatives across Canada.

A copy of the full report, *Taking Action: Mobilizing Communities to Provide Recreation for Women on Low Incomes*, can be downloaded at:
www.bccewh.bc.ca/Pages/pubspdflist4.htm, or contact:

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PROMOTING HEALTHY LIVING

Better Practices: Promising Approaches to Tobacco Cessation During Pregnancy

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Maternal smoking during pregnancy remains a serious public health problem. Despite concerted efforts by researchers and health care professionals, approximately 20-30% of pregnant women use tobacco during pregnancy.[1] Many of these women do quit smoking during pregnancy, while others manage to reduce their tobacco use. However, cessation is often temporary, with the majority of women returning to cigarette use either during pregnancy or soon after the baby is born. Tobacco cessation during pregnancy has considerable positive health ramifications for both women and fetuses, and reduces health problems for children born to mothers who smoke. However, facilitating successful and sustained tobacco cessation during pregnancy is an ongoing public health challenge.

A thorough review of smoking cessation interventions and programs for pregnant and postpartum women and girls was conducted to determine the most effective strategies to facilitate smoking cessation during pregnancy and into the postpartum period. Over 65 published and unpublished smoking cessation programs and interventions were reviewed. Using a Better Practices model, interventions were evaluated on the strength of their methodology and the evidence of their effectiveness. Based on this process, six interventions were recommended for use with pregnant smokers and four teen interventions were deemed to be "showing promise." Final Better Practice recommendations were generated based on this analysis of existing literature, along with an examination of theoretical work and broader literature in the field, and the incorporation of expert opinion.

Recommendations for Better Practice

The Better Practice recommendations generated from this review span practice, research, and structural issues. They include increased emphasis on women's health as a motivation for cessation, increased tailoring of interventions, and incorporation of harm reduction, stigma reduction, and woman-centred approaches into clinical practice. The approaches or perspectives derived from these recommendations, outlined in further detail below, may be applied directly to tobacco cessation interventions for pregnant smokers or integrated into future cessation research.

1. Tailoring

The reasons underlying women's smoking patterns are varied and complex, reflecting social, cultural, economic, and biological influences. The need for tailored interventions, reflecting the specific social and economic contexts of sub-populations of pregnant smokers, became increasingly clear during the course of this review. In particular, effective tailored interventions for certain sub-populations of pregnant smokers, such as teenage girls, Aboriginal women, and heavy smokers, are entirely absent. Similar to intervention trends with smokers in general, tailored approaches to cessation will allow for more precise and effective matches between interventions, components, and pregnant smokers' circumstances.

2. Woman-centred Approach

Historically, smoking cessation interventions for pregnant women have used fetal health as a motivator to encourage quitting. Although this approach has achieved some success, the cessation is generally not sustained. A focus on fetal health fails to provide long-term motivation for abstaining from tobacco use and fails to acknowledge the value of the woman's own health. Adopting a woman-centred approach to smoking cessation during pregnancy shifts the emphasis from pregnancy-related reasons for cessation to motivations that are more universal and long-lasting. In addition, this approach places importance on the woman's health before and during pregnancy, as well as beyond the postpartum period.

Woman-centred cessation interventions are also cognizant of a woman's social, psychological, and economic context. Issues such as financial circumstances, experience of violence, and whether or not a pregnancy was planned, should all be explored. A woman-centred approach views the pregnancy period as a time of hope and a key opportunity for change.

3. Stigma Reduction and Harm Reduction

Increasingly restrictive smoking policies and the move towards denormalization of tobacco use have created an atmosphere where smokers, particularly pregnant smokers, are increasingly condemned and stigmatized. Clinical interventions with pregnant smokers should address the effects of increased public pressures. For example, an intervention using the "Five A's" (Ask, Advise, Assess, Assist, Arrange follow-up) could also integrate "Awareness of stigma." Increased public awareness is also needed about tobacco use as a reflection of social and economic circumstances rather than a "lifestyle choice."

Although the principles of harm reduction have been widely used in developing drug and alcohol use interventions, they have never been fully applied to tobacco use. A broad-based harm reduction approach means that *all* measures possible are undertaken to reduce the harmful effects of smoking to women and their fetuses. Pregnant smokers should be encouraged to decrease the number of cigarettes they smoke, and to cease smoking even at later stages of pregnancy. Interventions using a harm reduction approach could include nutritional improvements to offset the effects of smoking, better integration of nicotine replacement therapies, the promotion of stress reduction techniques, and potentially, supplementation of folate to pregnant smokers.

4. Relapse Prevention

Relapse is a significant problem for pregnant smokers who quit. Relapse rates vary, but are reported as approximately 25% before delivery, 50% within four months postpartum, and 70-90% by one year postpartum.[2] Relapse prevention did not emerge as a key component of interventions in this review. It is particularly important to create specific interventions for women who quit spontaneously during pregnancy and postpartum. After giving birth, many women return to smoking as a way of coping with the range of stresses experienced during the postpartum period. Women need additional support when their child is born and fetal health is no longer a daily motivation. Since relapse is delayed when women are breastfeeding, support for breastfeeding may be useful in extending women's experiences of non-smoking post-pregnancy.

5. Partner Support and Social Issues Integration

There are a range of social factors affecting the processes of maintenance, cessation, and relapse, including socio-economic status, education, ethnicity and maternal age. These factors, in addition to physiological changes in pregnancy, and exposure to health education and wider social messages about pregnancy and smoking, affect the rates of spontaneous and temporary quitting in pregnancy. However, few interventions appeared to focus on women's social environment. Both cessation and relapse are affected by the presence of smokers

in close proximity to the pregnant woman, so there is a need to develop and test interventions for partners of pregnant smokers. Interventions that acknowledge the presence of smokers in the lives of pregnant smokers and appreciate the dynamics of these relationships are promising.

Most pregnant smokers are experiencing multiple social and economic pressures. Issues such as unemployment, violence and poverty blur or bury the importance of tobacco cessation and other health behaviours while pregnant. Cessation interventions need to consider the entire context of social and economic factors and offer a wide range of solutions in order to be successful.

While there has been no shortage of attempts, effective smoking cessation programs and interventions for pregnant and postpartum girls and women are scarce. As well as highlighting important sub-populations that require targeted interventions, this review identified the most promising intervention components and approaches to tobacco cessation during pregnancy. These Better Practices will provide a strong foundation for future interventions and help create the conditions necessary for successful tobacco cessation during pregnancy.

For a copy of the full report, *Expecting to Quit: A Best Practices Review of Smoking Cessation Interventions for Pregnant and Postpartum Girls and Women*, contact:

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PROMOTING HEALTHY LIVING

Don't We Count as People? Saskatchewan Social Welfare Policy and Women's Health

Mildred Kerr, Debbie Frost, Diane Bignell, Equal Justice for All

For the past several years, the Prairie Women's Health Centre of Excellence has conducted and sponsored research examining social assistance policies in Manitoba and Saskatchewan and their impact on women's health. In 2002, the provincial government in Saskatchewan began the first of several phases to redesign social services.

In 2003, Equal Justice for All, with the support of the Prairie Women's Health Centre of Excellence, conducted a research project to explore how women's health is affected by the policies governing the benefits under the *Saskatchewan Assistance Act*. This project also examined whether women on social assistance have knowledge of their legal entitlements, if they are treated with dignity, and if they have access to advocates to help them appeal decisions. These three rights are part of the legislation intended to protect women from the causes and effects of poverty.

The participatory research project described in this article was conducted in April 2003 by a team of advocates from Equal Justice for All, a grassroots anti-poverty organization located in

Saskatoon. Seven focus groups were held with 43 women living on social assistance in five of the 11 administrative regions of Saskatchewan in April 2003. The participants included single women, married women, mothers and grandmothers providing care to children at home, women whose children were in care, women with disabilities and chronic health problems, and women recovering from addictions. The women were of various ages and backgrounds and lived in rural and urban communities. The participants were either on social assistance at the time of the study or had been on social assistance in the past. In addition to the 43 women, the focus groups included eight advocates who themselves had been on welfare at the time of the study or in the past and four social workers who were not on welfare.

The Impact of Social Assistance Policies on Women's Health

In focus group discussions, the women described the daily reality of their lives and the impact of social assistance policies on their physical and emotional health. The women described how the low level of welfare benefits prevented them from meeting their fundamental needs, including food, housing, health care and transportation.

The participants in this study described the effects of inadequate benefits on their access to nutritious food, which was the basis for their own health and the health of their children. Many people turned to food banks, but food banks were not available in all areas and were not always accessible when needed. Money diverted from food budgets to cover rental costs caused women and their families to go hungry. Women in the focus groups described always worrying about food for their families and themselves.

The women reported difficulties in finding safe, adequate and affordable housing. Some people reported problems with mice and rat infestations and the associated risk of Hanta virus infection as well as poor quality housing with broken steps, unsafe windows and poor insulation. Evictions were also experienced by the participants in this study due to unpaid portions of rent at month's end and the added impossibility of covering the owed portion of the damage deposit within two months. The women in this study confirmed that when they were forced to move, school attendance was disrupted and children fell behind in school.

Women reported health problems that were made worse by inadequate nourishment, cold and damp suites, and the many stresses of living in poverty. Women described difficulties in getting coverage for medications, special diets and medical needs, even when these were prescribed by health professionals. Repeated requests for medical forms verifying lifelong disabilities were experienced as harassing and embarrassing. Some felt that the forms were unnecessary if no change was likely in long-term disabilities. Some women reported that they could not afford to cover the dispensing fees for prescription drugs, the cost of over-the-counter medications or payments when doctors charged them over the department fee to complete a medical report. Women reported that it was almost impossible to get adequate special diet coverage despite doctor verification of need; this made their recovery harder and depression worse.

Several women reported difficulties in accessing medical help because they had no bus fare or no money to hire rides to get to the doctor. Medical travel is covered, but funds are not provided until after travel to appointments has been proven. Some serious health issues were related to the specific circumstances in particular locations. In one community, people became sick when the local water supply was contaminated with *Cryptosporidium*, yet income assistance workers refused extra money for Pampers for babies with severe diarrhea. They also refused to pay for over-the-counter medications prescribed to replace electrolytes for

Money diverted from food budgets to cover rental costs caused women and their families to go hungry.

family members who became ill. In one reserve community, the administration refused extra moneys for safe water purchases despite contamination and discoloration of the local water supply that caused sore throats and damaged clothing.

Women raised concerns for themselves and their teenage daughters that the personal hygiene allowance of $15/person is totally inadequate to cover the extra costs of personal hygiene supplies needed during menstruation. Mothers of infants described that the cost of disposable diapers took their entire clothing allowance.

Women in this study faced additional hardships when their welfare benefits were reduced by the recovery of overpayments or advances. Since benefit levels are already far below the poverty line, any reductions in benefits can cause serious hardships. "Overpayments" occurred when women were able to find small jobs where the pay exceeded their earnings exemption, or they had received some income tax rebate or inheritance that others in society are able to keep. Overpayments occurred when a child was taken into custody and entitlement to the Child Benefit was immediately cancelled. Monthly cheques were also routinely reduced to recover advances that had been requested to buy essential household furniture or seasonal clothing that was urgently needed. In addition, women described overpayments caused by departmental errors as the worst experience —losing precious benefits from subsequent cheques because of circumstances beyond their control.

Redesigning Social Assistance

Legislation governing social assistance mandates the province to grant eligible recipients basic needs, health care needs and rehabilitation needs. Although the federal government provides some funding for social services through the Canada Health and Social Transfer, there are no longer any mandatory terms and conditions governing the distribution of these funds, since the elimination of the Canada Assistance Plan in 1996. Provincial legislation and Saskatchewan Assistance Plan Regulations govern the funding and distribution of benefits for the social assistance program.

Phases I and II of Social Services Redesign took place in Saskatchewan in 2002 and 2003. With Phase II of the Redesign, which took place while this study was being conducted, every individual, including persons with disabilities and elder caregivers, was required to have a case plan to aid him/her towards independence and participation in his or her community through training, work or volunteering. The women in this study viewed this change sceptically and felt that it was unlikely to work without a significant change in the level of income benefits and changes in the workers' treatment of people on welfare. Some women saw this policy as further "blaming the victim" and pushing people away who really need the help.

The women in this study also commented on the need to access information about the full range of benefits to which they may be entitled. While some described positive and helpful interactions with social assistance workers, others described situations where they had difficulty reaching their workers, where their legitimate needs were not acknowledged, where they were not given adequate information about their eligibility for benefits, and where their requests for assistance were denied. The lack of information about available benefits and the lack of explanation for money withheld from monthly cheques led to frustration and feelings of disempowerment.

As well as documenting women's experiences, this study proposes changes to improve income assistance in Saskatchewan. The redesign and implementation of policy can be a collective and collaborative effort, inclusive of the people who have experience with the daily realities of these policies. This research project is intended to contribute to the dialogue regarding policies to improve the quality of life for all and to ensure women's access to justice as recipients of social assistance.

A full copy of the report, *Don't We Count as People? Saskatchewan Social Welfare Policy and Women's Health*, can be downloaded at: www.pwhce.ca/research.htm, or contact:

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PROMOTING HEALTHY LIVING

Including Gender in Health Planning

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The Prairie Women's Health Centre of Excellence and Manitoba Health, as part of the Women's Health Strategy endorsed by the Minister of Health and Minister Responsible for the Status of Women in 2000, have jointly developed a guide to gender-based analysis for health programmers and planners in Regional Health Authorities. The guide is designed to assist individuals to incorporate gender into the processes of analyzing data, planning programs and assessing the health of the community.

Gender-based Analysis (GBA) is a tool to help understand how the experiences of women and men, boys and girls, are different, and how they are the same. In the case of health, GBA illuminates the differences in health status, health care utilization and health needs of men and women. It helps to identify and give priority to those areas where different programs or treatments may be necessary to improve the health of women and men and boys and girls.

The guide provides some background and history on gender-based analysis and presents two case studies, one on diabetes and another on depression, self-inflicted injuries and suicide, as examples of GBA in action. Both are based on information from Manitoba Health about health services utilization among Manitobans. In each case study, the importance of examining health data by sex, age, culture and other factors becomes clear.

Sex refers to the biological differences between females and males while gender refers to the array of socially constructed roles and relationships, behaviours, characteristics and relative power between the two sexes. The following example considers both sex and gender. Over 5% of Manitobans in 1999 were living with diabetes; of these, 29,850 were women and 27,541 were men. When data on adult diabetes are examined by sex, it is possible to see that while new cases of diabetes have increased for both men and women since 1994, there have been more new cases reported annually among men. When age and Aboriginal ancestry are considered, other important pieces of the picture are revealed. Women are more likely than men to be diagnosed with diabetes from ages 15 to 39, while men are more likely to be diagnosed from ages 40 and up. In every age group, First Nations women have the highest rate of diabetes, compared to First Nations men and other Canadian women and men. As well, men are at much greater risk of developing complications of diabetes than women. A gender-based analysis of diabetes data strongly suggests the need for gender-sensitive diabetes prevention and treatment programs.

Gender-based Analysis can enrich the health planning process by providing better information about the health status and health needs of the population. This guide includes a checklist and series of questions designed to increase the capacity of planners to use GBA in the entire health planning process. By highlighting gender differences, planners can identify and give priority to those areas where gender-sensitive interventions will make a difference.

A full copy of the report, *Including Gender in Health Planning: A Guide for Regional Health Authorities*, can be downloaded at: www.pwhce.ca/gba.htm, or contact:

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