

PART FOUR

Conclusions





Conclusions

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It is time to rethink the concepts and practices associated with healthy living and women in Canada. The evidence presented in this report suggests that there are both opportunities and challenges facing women with regard to achieving the targets established by provincial and federal healthy living policies. Many women are keenly interested in improving their health and report taking steps to do so, most commonly by increasing their physical activity – one of the most valuable actions that can be taken to prevent chronic disease and improve both physical and mental health. Yet many aspects of current healthy living initiatives do not address health and other issues in ways that are meaningful for women. The scope of issues usually considered within healthy living strategies is also not sufficient to address the root causes of health problems that arise from the physical, social and environmental conditions in which women in Canada live. Thus “healthy living” would benefit from being reframed to embrace a broader concept of health and well-being.

The 2008 report of the *Integrated Pan-Canadian Healthy Living Strategy* (1) acknowledged the importance of actions to improve the physical, social and economic conditions that foster unhealthy ways of living and constrain individuals and communities from improving their health and reducing health disparities (2). Health promotion, as put forward in the *Ottawa Charter* (3), is fundamentally about empowerment for action. The people who need to act include health researchers, health care providers and policy makers, all of whom can either sustain or redress the conditions that foster or impair health.

“Make the healthy choice the easy choice” – a key health promotion message for nearly 30 years – does not mean that healthy living is only a product of individual choices. As we have seen, women’s choices about their health and well-being are often constrained and “choice” is not equally available to all women. Some women are consistently disadvantaged, to the point that virtually all aspects of current healthy living discourse are irrelevant to their lives. These constraints point to the significant role that structural –political, social and economic – approaches to healthy living can play in improving the health of women in Canada. It also points to the imperative of working with women in ways that support their own efforts to achieve and maintain health as well as advocating for changes in the conditions in which women live, work, play and study.

Our review of several healthy living strategies suggests that they have not typically embraced women as a distinct population of interest although women are often implicitly the targets of such strategies. Exhortations for healthy eating and increased physical activity are often aimed at women in their roles as mothers and guardians of family health. They are encouraged—indeed expected—to plan, purchase and prepare nutritious meals and ensure that the members of their household are sufficiently physically active to achieve health benefits. The distinct role and responsibility that women have for the health of others is often assumed in healthy living strategies but this does not necessarily translate into adequate supports for women to fulfill



these roles, nor recognition that these responsibilities are not universally welcomed by women. On the other hand, many school-based strategies have not taken into account the different ways in which girls interact with their peers and families, the extent to which they have real opportunities to eat well or participate in sports, and how they may perceive pressure from society or media to behave in particular ways or achieve a specific body shape. Ironically, many school-based strategies encompass a role for women, as mothers, to support children's physical activity and nutrition goals, but do not address the implications of programming on girls and women themselves. This approach represents both a missed opportunity and a tendency to make assumptions about women's roles.

Moreover, from our analysis of the healthy living strategies using the SGBA framework outlined at the beginning of this report, it is clear the strategies seldom address all elements of the framework. While we occasionally see aspects of sex acknowledged, such as in the *Canada Food Guide* (4) with its sex-based caloric and nutritional guidelines, we have seen few examples of strategies that address gender considerations, such as the average lower incomes of women, women's patterns of employment, and experiences of gender-based violence, and how gender shapes women's opportunities for and experiences of healthy living. When it comes to acknowledging the diversity of women, we sometimes see age-specific suggestions, such as the importance of falls prevention for middle-aged and older women, or the value of weight-bearing activities for bone development in young women, but there is less discussion of how low-income women are to be supported to have adequate nutrition in a context of scarcity. Most often, diversity is equated with ethnicity, yet even with this understanding, we seldom see much formal consideration of culturally or linguistic-based adaptations in policies and public education or in services and programs. Thus many healthy living initiatives run the risk of exacerbating rather than reducing health inequities as they inadvertently privilege women who have the most access to the resources and opportunities for healthy living—education, income, safe working conditions, and shelter.

Healthy living for women needs to be about more than just healthy eating and physical activity. Our analyses suggest that it is vital that we adopt a broader conception of health and, in turn, of healthy living, one that encompasses mental health promotion, violence prevention, and food insecurity as core elements. While we were not able, within the scope of this report, to address all the elements of healthy living that we feel are important to women, we hope that our selection of topics for the profile illustrates the value of a fuller, richer view of the field. It will be interesting, for example, to see what results emerge from the recently piloted Canadian Sexual Health Indicators Survey (5), which does use a broader conceptualization of women's sexual behaviour than previously available. We look forward to the potential for new analyses of sex-disaggregated data from the First Nations' Longitudinal Regional Health Survey that could complement the findings of many sections of this report.

As we have illustrated in this report, all the topics addressed are a function of sex-based factors and gendered experiences. For example, we question the heavy emphasis in the healthy living discourse on body weights,



especially given the known limitations of the BMI as a measure of women's body size and the limited evidence of a causal connection between overweight and obesity, chronic conditions and poor health. When it comes to eating well, many women in Canada have adopted a diet that is high in calories but deficient in essential nutrients. Food labels and research reports give conflicting information that can make healthy eating choices bewildering. Women have no control over the salt content or the presence of other fillers in packaged foods, and to date, there has been little systematic government influence to make sure that prepared foods meet international nutrition guidelines. Structural conditions that contribute to food insecurity are also responsible for high-energy, low nutrient diets. Lone mothers, women living with low income and Aboriginal women are at greatest risk for food insecurity. The emergence of food deserts in some communities, when larger stores with fresh produce move out of some declining neighbourhoods, leaves populations that must rely on public transportation to get their groceries with few options for eating well.

Regardless of the way physical activity is measured—self-report or by accelerometry—the majority of women do not engage in enough physical activity. We suggest that this problem reflects, in part, the nature of current living arrangements which include, for many women in Canada, dependence on motorized transportation, limited time for physical activity, and built environments that are not conducive to women being safely, regularly active. Moreover, it is helpful not only to understand the reasons behind women's lack of physical activity, but also to explore sedentary behaviour, a new realm of research and programming. The evidence suggests that women engage in different sedentary behaviours than men and experience different health effects, some of which are related to differences in the reproductive systems. We need further and better information about women and sedentary behaviour and we urge governments to consider developing sex-specific guidelines for sedentary behaviour for adults. If, for example, women's tendency to engage in communications-based sedentary behaviour as opposed to playing video games (which tends to be more common among men) is not recognized in recommendations to limit time spent sitting, then messages such as “reduce screen time” may not be interpreted as relevant to women and therefore may be ignored (or put women in difficult situations as they attempt to change the behaviour of other household members to comply with the guidelines).

Some women are drinking alcohol at rates that could have serious harmful effects and it would help if research and policy adopted a “four-drinks on a single occasion” measure as the benchmark for high-risk drinking among women – as per the newest low-risk drinking guidelines in Canada (6). Drinking during pregnancy and heavy drinking are more common among some women and the stigma associated with Fetal Alcohol Spectrum Disorders (FASD) calls for health care providers and policy makers to be mindful of how this influences their expectations for women to disclose substance use if or when it might put them at risk for child apprehension. Prenatal initiatives to help women reduce or stop drinking during pregnancy should embrace some of the principles of trauma-informed practice such as ensuring a woman's safety and choice of whether or not to disclose.



While tobacco use has decreased among many women in Canada, it remains stubbornly high in particular groups and in some communities. Women-centred tobacco cessation and relapse prevention emphasizes that smoking is an addiction, that women may have particular challenges with nicotine dependence that make quitting difficult, and that smoking is often a strategy for coping. Quitting smoking should entail helping women to identify other supports for coping and policies and programs should examine the benefits of women-specific treatment, services and health promotion efforts.

Sexual behaviour among women is not well documented in this country. The focus to date has been to collect data only related to preventing teen pregnancies and reducing rates of sexually-transmitted infections. As a result, we do not have a good understanding of how sexual behaviour fits into women's perceptions of healthy living or the best ways to support women to enjoy their sexual lives, and we have no information about women's sexual behaviour beyond the reproductive years.

Our analysis of evidence related to injuries (a vast field) reveals that some women are particularly vulnerable, not only because they are primary employees in some fields – health care and “pink collar” work – but also because they have not been considered at all in other sectors, such as farm work. Societal perception of “valuable” occupations and the people who do them have skewed ideas about where injury prevention is most needed. The evidence related to falls, however, is one area where the preponderance of injuries to older women is getting some attention.

Finally, gender-based violence remains a serious health issue for women in this country and it certainly prevents healthy living. Despite having structures and laws in place to protect women, true respect and equality for women are goals that remain. A critical starting place will be to develop effective monitoring systems so that the magnitude of gender-based violence is better understood and addressed at all levels. Gendered assumptions about the ways girls and women are expected to behave may be preventing a recognition that self-injury in women is frequently associated with past abuse and discrimination as well as present circumstances that prevent women from having real control in their lives.

Recent examples of gender-sensitive interventions suggest exciting new directions for healthy living research, programs and policies. In particular, they underscore the importance of advancing women's equality and gender equity to improve health. Programs and policies in the health sector can support gender equity by refusing to exploit gender stereotypes that denigrate women as part of their messaging and by taking action to support women's safety, freedom of movement and choice about their health, their relationships and their lives. Other developments, such as the exploration of trauma-informed practice principles in physical activity programming, also suggest that new developments in this field hold the promise of enhancing the effectiveness of healthy living interventions for women in Canada.

As we noted at the outset, the initial *Integrated Pan-Canadian Healthy Living Strategy* identified mental health as an area for future action (1). The recently released mental health strategy for Canada, *Changing*



Directions, Changing Lives (7), while not formally linked to the healthy living *Strategy*, represents another milestone in discussions of the influence of sex and gender on health in Canada. What is particularly compelling is that the mental health strategy aspires to not only address mental health problems, but also to recognize the value of positive mental health—“feeling well, functioning well and being resilient in the face of life’s challenges” (7). Moreover, it stresses the importance of organizational and social conditions for mental health and argues for the creation of mentally healthy schools and workplaces and acknowledges their importance in contributing to mental health challenges and potential for supporting mental wellbeing. In addition, the mental health strategy is explicit about the implications of racialization and the particular challenges created by stigma and discrimination. Most significantly, it embraces a thoughtful understanding of gender, as reflected in discussions of the mental needs and experiences of gay, lesbian, bisexual, two-spirited, trans-gendered and trans-sexual people:

“The different ways that gender makes a person vulnerable to mental health problems and illnesses mean that the impact of gender needs to be considered in prevention and early intervention efforts” (p.92) (7).

This would also include the ways in which gendered assumptions about women and girls can limit their aspirations, opportunities and ability to satisfy their needs. Stereotypes also increase women’s vulnerability to numerous health problems, and minimize their capacity to act to improve their lives and health.

The new mental health strategy may provide a model for the approach to healthy living among women in Canada we have described in this report, one that embraces a comprehensive view of the diversity of women in Canada, recognizes the links between physical and mental health, and one that sees women in Canada as resilient not just vulnerable. However, unless there are investments and changes in, for example, the education of health care providers and the organization and delivery of services and programs, the mental health strategy will remain more vision than reality.

The recent report from the Chief Public Health Officer (8) is another valuable contribution to our understanding of the health status of women and men in Canada. It is promising to see a report of this stature embrace aspects of sex- and gender-based analysis and we hope that it represents a commitment by government to consistently report separate findings for women and men, boys and girls.

In this report, *Rethinking Women and Healthy Living in Canada*, we have offered an extended examination of healthy living among women in Canada. We have illustrated that SGBA can be applied to all aspects of a health issue—from the discourse that frames and expresses it through to the data collection and research that informs action to the programs and policies that direct change. We hope that our analysis inspires others to embrace our approach and build on our legacy to ensure that all women in Canada have access to the conditions that support them to live healthful, meaningful lives.



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