

PART ONE

Overview





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Introduction

Ann Pederson, Anna Liwander, Barbara Clow and Margaret Haworth-Brockman

A discourse of “healthy living” has become dominant in health policies and practices as well as in health promotion strategies in many parts of the world (1, 2). Several countries, including Canada, Australia, the United Kingdom and the United States, have created guidelines and benchmarks for “healthy living” as a response to rising rates of chronic health conditions, such as cardiovascular diseases and type 2 diabetes, and escalating health care costs associated with the diagnosis and treatment of these conditions (3). The emphasis of these healthy living strategies has often been on diet and exercise because of the association between obesity and chronic diseases. The World Health Organization (WHO) (4) has, for example, designed a global strategy for improving diet, physical activity and health explicitly for the prevention and control of non-communicable diseases.

In 2005, Canada’s Federal, Provincial and Territorial governments released the *Integrated Pan-Canadian Healthy Living Strategy (Strategy)* (5). The aim of the *Strategy* is to demonstrate and affirm a consensus among all governments on the need for action on common chronic disease “risk factors and the underlying conditions in society that contribute to them” (5). As with the WHO report, this accord emerged largely because of concerns over reported increases in rates of overweight and obesity among the Canadian population and their link to chronic disease.

The *Strategy* was intended to improve overall health outcomes and to reduce health disparities among Canadians that were evident in the population by sex, race (Aboriginal identity), geographic location and socio-economic factors. A conceptual framework identifies goals, strategic directions, areas of emphasis for action and targets. It was agreed that the first areas of emphasis would be healthy eating, physical activity and their relationship to healthy weights—with mental health and injury prevention identified as areas for potential future action. Following the endorsement of the *Strategy*, governments established benchmarks within the three areas, explicitly aimed at increasing the proportion of Canadian adults who engage in regular physical activity and report eating fruits and vegetables five or more times per day (6).

Targets in the Integrated Pan-Canadian Healthy Living Strategy for 2015 are to increase by 20% the proportion of Canadians that:

- Make healthy food choices;*
 - Participate in regular physical activity;*
 - Are at “normal” body weight.*
-



Although all jurisdictions in the country, with the exception of Quebec, signed on to the *Strategy*, no single approach to addressing the goals was adopted and jurisdictions have responded differently to the challenge of meeting these benchmarks. The 2007 and 2008 annual reports of progress on the *Strategy* suggest that there has been slight, if any, improvement in the target behaviours (6, 7). The 2008 report, published in 2010, observes, for example, “the severity of the challenge for the Strategy’s partners to address physical activity, healthy eating and healthy weights” (7). After noting that there had been little change in the key indicators related to the *Strategy*, the 2008 report noted that important social determinants are associated with health disparities, including “socio-economic status (SES), Aboriginal identity, gender and geographic location” and that “reductions in health disparities will come from addressing all of the determinants of health—the factors that greatly influence why some people and some populations are healthy and others are not” (7). Thus the implicit explanation for the limited progress on the targets established by the *Strategy* was that there needed to be attention to the causes of the causes—the conditions that create health disparities in Canada. For example, the report notes that some households in Canada lack access to sufficient, safe and nutritious food and that food insecurity is more prevalent in some households, especially those with children led by a lone mother.

The Centres of Excellence have a federal mandate to investigate aspects of women’s health and healthy living, and to advise on policy and programming, on all levels, that can lead to improvements in the health of women and girls. We have been following the developments of the healthy living discourse and related strategies, and have been interested to see if the desired goals are being met. The *2008 Strategy* report noted that 20.8% of women were classified as active based on the Canadian Community Health Survey, while 54.5% were classified as inactive. Slightly more than 50 percent (50.4%) of women reported eating fruits and vegetables five or more times a day, while 27.4% of women were classified as overweight and 16.1% as obese based on self-reported data (7).

These numbers provide only the briefest of glimpses into the lives of women in Canada in relation to healthy living. They tell us some things about patterns of diet, exercise and body weight for women in Canada overall, but not why these patterns exist or what implications they may have for health and well-being, broadly defined. Many other dimensions that can support health living are not captured by these indicators. Given what we already know about the greater social, economic and political disadvantages experienced by women and girls, it is important to gain a better appreciation of what healthy living looks like for them. As we approach 2015, the first target date for the *Strategy*, it is time to take seriously the value of applying a sex- and gender-based analysis (SGBA) to healthy living.

Framing the Analysis of Healthy Living with Women in Mind

The conceptual framework for this discussion of healthy living is sex- and gender-based analysis (SGBA) (8, 9). The *Health Portfolio Sex and Gender-based Analysis Policy*, released in 2009 (10) requires the member organizations to “develop, implement and evaluate the Health Portfolio’s¹ research, programs and policies to address the different needs of men and women, boys and girls” (10). The goals of the policy include “a comprehensive understanding of variations in health status, experiences of health and illness, health service use and interaction with the health system” (10). The policy applies to any population of interest. With our collective experience in women’s health research and policy and in SGBA, the Centres of Excellence for Women’s Health are well-positioned to demonstrate how SGBA can generate new knowledge that can inform programs and policies and lead to women’s improved healthy living.

SGBA rests on the understanding that both biology (sex) and the social experience of being a man or a woman (11) affect people’s lives and their health. *Sex* refers to the biological characteristics that distinguish males and females in any species. In humans, sex differences begin with the chromosomal patterns that distinguish males and females – with males usually having one X and one Y chromosome and females having two X chromosomes. From these fundamental genetic differences, other sex differences in humans arise, such as different reproductive organs, hormones, and proportions of fat to muscle. There are also differences between female and male bodies, such as body hair, that are referred to as secondary sex characteristics. Sex has typically been viewed as having only two distinct categories, male and female, which are mutually exclusive. While this is a common way of thinking about sex, it does not adequately capture the range and variety of human biology and self-perception. The majority of people readily identify themselves as female or male, but the distinction may not always be clear or fixed. This is perhaps most obvious with people who identify as “trans”², but there are also important variations among people who identify as male or female. Consequently, a more accurate model for sex is a continuum, in which biological and physiological characteristics may be associated more with females or males, but individuals may combine these characteristics to varying degrees. Paying attention to sex is important because our biology influences every aspect of our lives, including how our bodies work, how we see ourselves, how we appear to others, what keeps us healthy or makes us sick and what kinds of care we need.

¹ Member agencies of the Health Portfolio are Assisted Human Reproduction Canada, Canadian Institutes of Health Research, the Hazardous Materials Information Review Commission, the Patented Medicine Prices Review Board and the Public Health Agency of Canada.

² The TransPULSE project defines “trans” as follows: “We see “trans” as being a term that includes both those who are transsexual in other words those who take physical and social steps to live as a gender different from the one assigned at birth as well as those who are transgender, gender queer, and others with similarly gender-variant lived experiences. While we certainly understand that some people have “trans” identities, we also recognize that many “trans” people may not identify as such. They may have transitioned at some point in their life and identify as “women or men of trans experience” or, even more simply, as “women” and “men” (12).



At the same time, *gender*, the roles and expectations attached to being male or female also affect our well-being. Like sex, gender has typically been viewed as having two distinct categories – maleness (or masculinity) and femaleness (or femininity) — which are mutually exclusive. But again, like sex, this approach does not adequately capture the range of human experiences or expressions of self and identity that gender encompasses. Few – if any – of us fulfill the ideals of masculinity and femininity and most of us do not aspire to achieve one ideal to the exclusion of the other. Gender both describes and prescribes what it means to be female or male at a given time, in a given society. It profoundly influences our chances of completing school, having an adequate income, experiencing violence and providing care, being expected to provide care for others as well as every other aspect of our lives.

Addressing the influence of sex and gender on health requires challenging assumptions and historic practices. These assumptions about sex, gender and health influence perceptions of risk as well as individual and collective approaches to healthy living....(15)

SGBA also recognizes that while there are commonalities among women and men, there is also a great deal of variation. The concept of *diversity* includes sex and gender, but it also involves thinking about how other factors affect how we see ourselves and how others see us, where we live, what we do and how easy it is for us to get and stay healthy. Often the word “diversity” is associated with race/ethnicity and culture and recognizing this kind of diversity is crucial in research, policy and planning because culture and ethnicity affect our values, beliefs and behaviours, including how we live as women, men, both or neither. Acknowledging and valuing cultural and ethnic diversity is also vital to the fight against prejudice and discrimination. It is also important to pay attention to other kinds of variations between and among women and men, such as income, education, age, sexual orientation, ability, place of residence, etc. The factors, often referred to as the “social determinants of health”, exert enormous influence on the health and well-being of individuals, communities and populations. Emerging theory and practice in SGBA emphasize the importance of paying attention to the intersection of multiple aspects of identity and experience when it comes to explaining health, illness and care.

Finally, SGBA helps to support and promote an understanding of *equity* in health. Equity is defined as the quality of being fair, unbiased, and just (8, 9). In other words, equity involves ensuring that everyone has access to the resources, opportunities, power and responsibilities they need to reach their full, healthy potential. It also involves working to change policies, programs and conditions so that unfair differences may be understood and addressed.

Healthy living strategies at all levels of government could be more effective if they took sex and gender as their starting point rather than limiting sex and gender to the margins of research, policy-making and program development. It is time to re-think the concept of healthy living using sex, gender, diversity and equity -- to reflect upon what we know about healthy living when it comes to diverse populations of girls and women, and to consider new approaches to supporting girls and women to lead healthy lives.

Background to this Report

This project was inspired by a decade and a half of work on women's health that has been conducted by our three Centres of Excellence for Women's Health. During these years we saw relatively little critical discussion of women's health built upon a comprehensive sex- and gender-based analysis, despite mounting evidence of the value of SGBA. In response, we have championed the theory and practice of SGBA and developed resources, learning tools and myriad analyses of health topics and issues to illustrate its value. This particular report is another element of that legacy of research for action and change.

This report builds on two previous national-level analyses of women's health status in Canada. In 2003, the Canadian Institute for Health Information released the *Women's Health Surveillance Report* (WHSR) (13), the first comprehensive report on women's health in Canada. Using data from large Canadian surveys and administrative databases, the WHSR provided a portrait of many topics relevant to women's healthy living, including analyses of personal health practices, body weight and body image, physical activity and obesity, as well as tobacco and other substance use. Depression, violence against women, and various aspects of sexual health were also discussed. Major sources of data used to generate the findings included the 1994-95 and 1998-99 National Population Health Surveys, the 1999 General Social Survey, and 2000-2001 Canadian Community Health Survey (13).

Health Canada commissioned a *Profile of Women's Health Indicators in Canada* (14) which was also released in 2003. The authors stressed the importance of assessing health behaviours by sex and gender, because men and women differ both in their health practices and in the social and economic context of those practices. In contrast to the WHSR, the *Profile* focused on five key health practices: dietary practices; alcohol consumption; smoking prevalence; age of smoking initiation; and physical activity. Both the WHSR and the *Profile* identified important variations among women in Canada with respect to health practices based on age, geographic location, income and Aboriginal status, as well as significant differences between women and men. Among the relevant findings were observations that women reported being largely physically inactive, displayed different patterns of smoking and substance use depending upon income, education, age and geography, and were not meeting daily recommended intake of fruits and vegetables.

The 2012 report of the Chief Public Health Officer (CPHO), *Influencing Health – The Importance of Sex and Gender* (15) provides a useful complement to the Health Canada report. By presenting sex-disaggregated



data on a selection of topics, including some discussed in detail here, the CPHO report illustrates the value of adopting a sex- and gender-based analysis while also illustrating some of the limits of what is currently known about some key health issues. However, the CPHO report does not fully develop the material on healthy living and our report expands the framework of what should be considered as aspects of healthy living.

Unlike these earlier reports, we extend our SGBA to consideration of the discourse of healthy living itself as well as to the programs and policies associated with the field. In so doing, we illuminate the gender-blindness of current approaches to healthy living in Canada and introduce the possibility of gender-responsive programming and policies to enhance initiatives designed to improve women's health in this country.

Organization of the Report

This report consists of four parts. Part One provides background to the overall study, including a brief description of the status of women in Canada and a critical analysis of the discourse of healthy living through the lens of SGBA.

The status of women in Canada includes an overview of international measures of gender equality that provide some of the context about women in Canada, with particular attention to social, economic and political progress. While women in Canada appear to fare well against some international measures, we know that not all women in Canada share equally in the progress toward gender equity, nor do we have comprehensive details about women in Canada at a sub-national level to track against the progress of these indicators. In our demographic profile of women in Canada we illustrate the diversity of the population and explore various aspects of women's lives including their engagement in the political and economic spheres, both of which are important to understanding women's ability to participate fully in society.

The discourse analysis includes a brief overview of the history of healthy living and themes that have evolved within this concept. We touch on issues related to individual responsibility and individual solutions, blaming and victimization as well as the evidence base for healthy living. Our analysis suggests how the healthy living discourse and the practices associated with it may be particularly challenging for girls and women given their respective access to resources and positioning as responsible not only for their own health but the health of others. By examining the contemporary healthy living discourse from the perspective of gender, we want to encourage reflection on how healthy living is understood, what the status of girls and women is in various areas of healthy living, and what value there might be in re-thinking the overall approach to interventions to support improvements in women's health and wellbeing.

In Part Two we provide snapshots of women’s healthy living in Canada in ten topic areas. Three of these were identified in the *Integrated Pan-Canadian Healthy Living Strategy*—body weights, eating well and physical activity—and seven additional topics are discussed here as they are important to a fuller understanding of women’s health. These latter topics include food insecurity, sedentary behaviour, alcohol use, tobacco use, sexual behaviour, injuries, and gender-based violence. Mental health, an area in which we have worked and which is significantly identified in the *Strategy* as needing to be addressed (in 2012 the federal *Mental Health Strategy* was released) is a theme woven throughout these ten topic areas. Aspects of mental health and wellbeing arise, for example, in the discussion of body weights, which addresses overweight and obesity but also underweight and body satisfaction—both of which are particular concerns for women—and in the analysis of violence and self-harm, both of which are entwined with mental health. Indeed, it is our contention that there is no health for women without mental health, a theme echoed in the federal *Mental Health Strategy* (16), and our analyses of substance use explicitly recognize the ways that smoking and drinking alcohol can be behaviours that arise as women try to cope with histories and experiences of violence, trauma and abuse.

Topics included in the report are body weights, eating well, food insecurity, physical activity, sedentary behaviour, alcohol use, tobacco use, sexual behaviour, injuries and gender-based violence.

Drawing on national survey data, key reports and published literature, we present the current evidence about women in Canada for each of the topics. Because it is so important to examine where there are disparities, we present the numerical and other data by age, income, geography and where possible by education and Aboriginal identity—key stratifiers for understanding variation among women with respect to health issues and practices. Our analyses move “between different levels of analysis and diverse sources and types of evidence, moving both horizontally (from situation to situation) and vertically (from particular to general, micro to macro-structural)” (17). This makes it possible to look at the overall picture of women’s healthy living in Canada as well as to relate the stories women in different parts of the country have shared about what supports or prevents them from living in good health.

The third Part of the report examines select healthy living strategies and practices in Canada from the perspective of sex, gender, diversity and equity. Specifically, we explore how the federal *Strategy* and strategies from Prince Edward Island, Ontario, Manitoba and British Columbia have addressed healthy living in a variety of policy and planning documents. We provide a summary of activities within each jurisdiction based upon published documents and public websites, paying particular attention to any evidence of decision makers taking sex, gender, diversity and equity into consideration in the articulation or evaluation of policies and programs. While many of the strategies note the importance of factoring in the determinants of health – which include sex and gender – most do not make provisions to address sex and gender as determinants of health, in the measurement of and reporting on progress, or in the formulation of policies and programs.



In Part Three we also explore the concept of gender-sensitive healthy living interventions and present a few suggestions for promising policies, practices and research directions related to some of the topic areas included in the report. These interventions, such as trauma-informed physical activity, have either proven to be successful for women or have great potential to improve women’s healthy living in Canada. We hope that the examples featured in this section will add value to the *Integrated Pan-Canadian Healthy Living Strategy* by deepening understanding of sex and gender in measuring and intervening to promote girls’ and women’s health in Canada.

Our report concludes in Part Four with recommendations for future directions in research, policy development, program design and delivery for women in Canada. Our aim is to increase the capacity of policy makers and program developers to design responses to the health challenges facing diverse populations of girls and women in Canada, to enhance both gender and health equity. We also wish to see greater attention to interventions and policies that work to improve the conditions of women’s lives so that the disparities arising from low socio-economic status, living in rural communities, having a history of experiencing violence or other factors are less able to undermine women’s health and wellbeing.

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The Status of Women in Canada

Anna Liwander, Margaret Haworth-Brockman and Ann Pederson

Understanding women’s health requires an understanding of women’s status. Although Canada is a rich and diverse country with many women able to participate fully in their households and communities, in the economy and politically, not all women are equally placed. Across the country there are considerable differences in women’s income, educational attainment, and access to resources and opportunities to engage in healthy living. As we noted in earlier work, “*Gender has significant implications for both socioeconomic status and for health. For example, women in Canada have lower average incomes than men and earn, on average, less than their male counterparts performing the same jobs. Women’s domestic responsibilities, including caring for children and other dependants, frequently lead to interruptions in earnings that affect their income immediately as well as when they are older*” (1)(p.3) .

Understanding the role of women in Canadian society and how it has changed over time is dependent on having information that can begin to shed light on the diverse circumstances and experiences of women.” (10).

There are legal provisions to enshrine women’s rights in Canada, including Section 15 of the *Charter of Rights and Freedoms* (1982) which protects from discrimination by sex. Canada has also signed a number of international agreements to uphold women’s rights and reduce gender inequity. In terms of health care, Canada’s social safety net includes single-payer, universal health care, which is intended to be equally accessible to all citizens. Across the country, however, there are considerable differences in women’s access to health care and the prerequisites for health; though not the focus of this report, it is important to bear these challenges in mind. As Anderson noted, “many controversial issues affecting the status of women ...remain unsolved” (2) such as equality of pay, employment insurance benefits, access to abortion, gender-based violence and the rights of Aboriginal women under the *Indian Act* (3).

To contextualize the challenges that women may experience with regard to healthy living, we begin this chapter with a description of women’s status in Canada in relation to international measures of gender equality. These measures demonstrate that while women in Canada may appear to have gained full equality to men, women in some other countries still fare better than women here. We then provide a demographic profile of women in Canada and explore various aspects of women’s lives including their engagement in the political and economic spheres – both of which are understood to be indicators of women’s ability to participate fully in society and ideally reach their full potential for health.



International Measures of Gender Equality

International measures of gender equality help to provide some of the context about women in Canada, particularly in terms of social, economic and political progress. That is, they document the extent to which women have equality³ in their rights and opportunities in comparison to men in a given country. Three such measures are the World Economic Forum's *Global Gender Gap Index*, the United Nations Development Programme (UNDP) *Gender Inequality Index*, and the newer *Women's Economic Opportunity Index*, created by the Economist Intelligence Unit.

Many controversial issues affecting the status of women remain unsolved such as equality of pay, employment insurance benefits, access to abortion, gender-based violence and the rights of Aboriginal women under The Indian Act.

The Global Gender Gap Index (GGI) was introduced in 2006 by the World Economic Forum as a “framework for capturing the magnitude and scope of gender-based disparities and tracking their progress” (4). The annual *Global Gender Gap Report* documents the results of the GGI and, “benchmarks national gender gaps on economic, political education – and health based criteria” (4), as well as an assessment of how well resources are divided between men and women in different countries. Canada has had a ranking of 18-31 out of 115-135 countries over the past 5 years, and in the 2012 report, Canada ranked 21st when compared to 134 other countries. This is a lower rating than the previous year when Canada ranked 18th. This lower rating was attributed to “a small decrease in the secondary education ratio and in the percentage of women in ministerial positions” (5) (p. 24). In 2012, Canada ranked 12th for economic participation and opportunity, but lower for education attainment (rank 70), health and survival (rank 52), and political empowerment (rank 38).

The *Gender Inequality Index* (GII) was introduced by the UNDP in 2010. This index is a composite measure reflecting inequality in achievements between women and men, looking specifically at dimensions of reproductive health, empowerment and labour markets in 146 countries (6). Indicators include maternal mortality, adolescent fertility rate, level of education, women and men in parliamentary seats and labour force participation rates. The GII can help us understand the magnitude of gaps between women and men, but as with any global composite index, it is constrained by the need for international comparability; the

³ This attention to *equality* addresses where there are still gaps between women and men, in what they have achieved, or in their opportunities to fully participate in their societies. It is based on a recognition that in many countries women have historically been (or currently are) oppressed in a variety of spheres – political, economic and household, for example. The measures discussed in this section do not necessarily address *equity* which, ideally, assures that all women and all men start with the same resources, can live without fear of discrimination, and are not impeded from being fully included in all aspects of society.

national-level data on Canada (or any other nation) typically mask the heterogeneity of our population. In 2011, the UNDP ranked Canada 20th on the GII (6).

The *Women's Economic Opportunity Index* (WEO) was developed by the Economist Intelligence Unit and aims “to look beyond gender disparities to the underlying factors affecting women’s access to economic opportunities” (7). The index provides an “assessment of the enabling environment for women’s economic participation” including the laws, regulations, practices and attitudes that affect women as workers and entrepreneurs (7) (p. 5). It uses 26 indicators categorized in five areas (labour policy and practice, access to finance; education and training; women’s legal and social status; and general business environment) to evaluate every aspect of the economic and social value chain for women, from fertility to retirement. The indicators range from maternity and paternity leave and years of schooling, to prevalence of contraceptive use and political participation. In 2012, Canada ranked 9th overall on the WEO, but first in the Americas. Canada had high rankings for education and training, as well as for labour policy, but lower scores for indicators related to access to financing (7).

Each of these index ranks suggest that women in Canada fare reasonably well by international comparison, but there is still room for improvement, as there are gaps between women and men on key economic and social indicators, and as this report will demonstrate, there can be considerable variability among women across the country. As international data and ranks of gender equality have not been adapted to generate information about women in different parts of Canada, or from different cultural and ethnic groups, aggregate indices such as these obscure the disparities within the country. However, technically, each of these indices could be adapted for use by Canada at territorial/provincial, or sub-provincial levels, and thus provide useful internal comparisons.

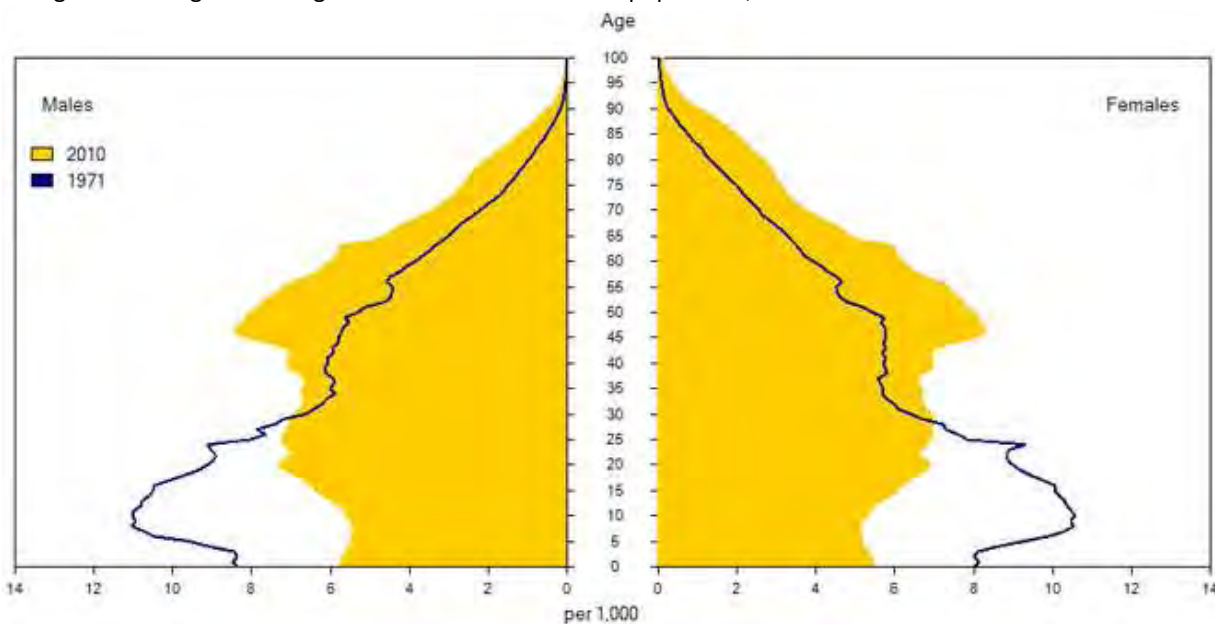
Recently a Canadian composite index, the *Canadian Index of Well-being*, was launched to “collect data at the national level to help refocus dialogue on broad societal issues” (8). As the index includes areas such as living standards, community vitality, education and democratic engagement, it could be a valuable resource, where the information is provided about women. The index also includes measures of healthy populations, including percentage of smokers, life expectancy, self-reported diabetes and self-rated health. Notably, with respect to health, the authors of the report for that domain call for improved access to information stratified by sex, income and education and note that these are the “almost universal predictors of health” (9) (p.xii).



Demographic Profile

Girls and women account for just over half of the Canadian population (50.4% in 2010) (10) (11) and females are expected to remain in the majority for the next 50 years (10). Until 2010, the proportion of girls in the population had always been greater than the proportion of senior women but this trend is starting to change (Figure 1). As in many other high income countries, Canada has an aging population which has led to a decrease in the proportion of girls compared to senior women. Today, women represent the majority of the senior population (56%), and the largest proportion of women can be found in the age group 45 to 54 years (10).

Figure 1. Changes in the age structure of the Canadian population, 1971 and 2010..



SOURCE: Statistics Canada <http://www.statcan.gc.ca/pub/91-215-x/2010000/i003-eng.htm>

In 2006, almost 4% of Canadian girls and women identified themselves as Aboriginal (Figure 2). Most Aboriginal girls and women reside in metropolitan areas but one in four Aboriginal women lives on reserves and one in five lives in remote and rural areas. Among Aboriginal females, 60% identified as First Nations, 33% as Métis and 4% identified as Inuit. Although the largest proportion of Aboriginal females lives in the three Territories, the Prairie Provinces (Alberta, Saskatchewan and Manitoba) have the greatest proportions of Aboriginal females in their populations south of the territories; the greatest number of Aboriginal women and girls lives in Ontario. The Aboriginal female population is younger than the national average, a result of lower life expectancy and higher fertility rates compared to the average of all women in the country (10).

Canada is also home to many new immigrant women and the proportion of immigrant women (defined as a person who is or has ever been a landed immigrant)⁴ has steadily increased since the mid-1980s (Figure 3). Today, approximately one in five women are considered immigrants but the proportion of immigrant women is much higher in certain areas, including Toronto, where immigrant women represent 47% of the female population.

Further, 16% of women and girls in Canada belong to a visible minority group (non-white and not Aboriginal⁵) (10) (Figure 4). As in the Aboriginal female population, the female visible minority population has a younger age structure than the Canadian average, whilst the immigrant female population has an older age structure (10). Aboriginal, immigrant and women of visible minority represent sub-populations of women that may face particular challenges related to educational attainment, employment and income.

Women represent 51.5% of the total population in Nova Scotia which is the province with the highest proportion of women in the country. The Northwest Territories, Nunavut, Yukon and Alberta

Figure 2. Percentage of Canadian Women

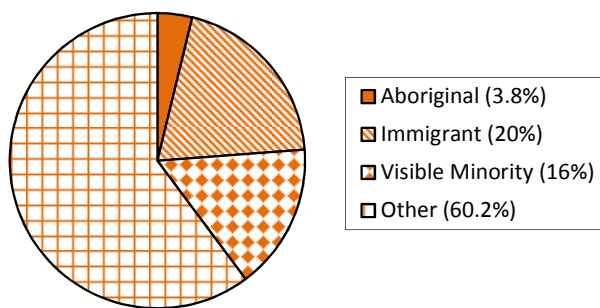


Figure 3. Percentage of Aboriginal Women in Canada

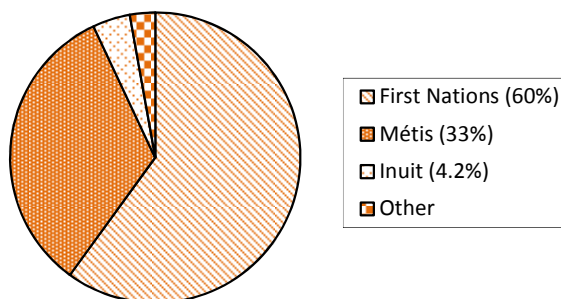
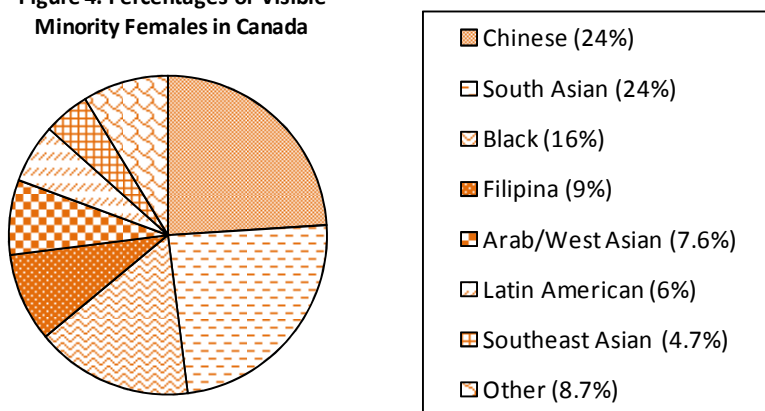


Figure 4. Percentages of Visible Minority Females in Canada



SOURCE: Ferraro and Williams, 2012

⁴ "Immigrant population refers to a person who is or has ever been a landed immigrant. A landed immigrant or permanent resident is a person who has been granted the right to live in Canada permanently by immigration authorities. Immigrants are either Canadian citizens by naturalization (the citizenship process) or permanent residents (landed immigrants) under Canadian legislation. Some immigrants have resided in Canada for a number of years, while others have arrived recently. Most immigrants are born outside Canada, but a small number are born in Canada." (10)

⁵ "The Employment Equity Act defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour." Using this definition, regulations specify the following groups within the visible minority population: South Asian, Chinese, Black, Arab, West Asian, Filipino, Southeast Asian, Latin American, Japanese and Korean." (10)



have lower shares of females ranging from 48.3% to 49% of the total population. Similar to the Canadian population as a whole, the majority of women reside in metropolitan areas with an estimated 69% of women living in census metropolitan areas. Cities such as Saint John, Victoria, Halifax, Peterborough, and Trois-Rivières have the highest percentage of females whilst Calgary and Edmonton have the lowest share, which is likely a reflection of the age structures in the different cities (10).

These statistics tell us how diverse women are in their heritage and where they reside. Women's personal life experiences are also highly varied. Descriptive statistics must be complemented by additional information about women's social and cultural roles, and where they have opportunities to reach their full potential and where they are hindered. In the remaining sections of this chapter we provide a gendered look at some of the determinants of women's healthy living – household composition and living arrangements, education, paid and unpaid work, income and political representation. We then briefly describe some key measures of women's health status in Canada.

Household Composition and Living Arrangements

Family structures and living arrangements are significant in women's lives. Marriage rates have been decreasing in Canada, however more women live as common-law partners. An estimated 57% of women aged 15 years and over lived as part of a couple⁶, with 47% living with a married spouse and 10% in common-law unions. Quebec has the highest proportion of women living in common-law unions in the country. Few women reported living in same-sex unions (married or common-law), representing only 0.6% of all women in couples (10).

More than 80% of all lone parent families in Canada were headed by females in 2006, representing 20% of all families with children. In younger age groups (25-54 years), women born in Canada and immigrant women were equally likely to be lone parents (12-13%). However, in older age groups (55 years and over), greater differences were noted, with an estimated 8% of Canadian-born women being lone parents and 11% of immigrant women. More Aboriginal women (aged 15 years and older), were lone parents (18%) than non-Aboriginal women (8%) (10). Lone mothers often experience a lack of financial and social support, higher levels of time stress, food insecurity and poor health outcomes (12,13).

Lone mothers often experience a lack of financial and social support, higher levels of time stress, food insecurity and poor health outcomes.

⁶ Note that no limitation is placed on who the two adults in a couple are.



Education

Higher educational attainment has been associated with increased likelihood of securing employment and income and is also associated with several positive health effects. Education levels have increased in Canada overall and, as a result of more women completing high school and continuing to higher education, the gender gap in formal education has narrowed.

In 2006, more than 75% of Canadian women received a high school certificate or continued to higher education (14). One in three women aged 25-34 years and 25% of women aged 35-44 years had a university degree (15). In 2008, 60% of all degrees, diplomas and certificates that were awarded by Canadian universities were received by women, including 55% of all master's degrees and 44% of all doctorates (11). However, differences in educational attainment can be seen when comparing subpopulations of women. Only 7% of Aboriginal women had a university degree at bachelor's level or above in 2006, as compared with 23% of immigrant women and 26% of the female visible minority population (aged 15 years and older). Canada's immigration policy, emphasizing educational and occupational qualifications, is believed to be one of the main reasons for the highly educated immigrant population (10).

Women who are more likely to drop out of high school include Aboriginal women (10), young mothers, and youth from lone-parent households (1,16). Whilst approximately one in five non-Aboriginal women (aged 25 years and older) did not graduate from high school, more than one in three Aboriginal women dropped out (10) but a number of these women return to school later. Recent news stories⁷ and a federal report (17) have renewed attention to the fact that schools on reserves are drastically underfunded, which is considered a large part of the reason First Nations children do not receive the education they need.

Paid and Unpaid Work

Many women manage multiple roles, combining employment with household work and child caring responsibilities as well as volunteer activities—sometimes referred to as paid and unpaid work. Women's unpaid work is often hidden in the household and as community volunteering, with the result that it is rarely included in discussions on labour force participation. But paid and unpaid work are intimately entwined in their effects on women's health and well-being. Family caregiving responsibilities, for example, are among the main reasons for women's lower employment rates compared to men. Even as employment rates have increased for women, women spend on average 13.8 hours a week on unpaid work (10). In other words, many women are doing “double duty” and this heavy workload can be detrimental to women's mental and physical health.

⁷ See for example: <http://www.cbc.ca/news/canada/story/2012/03/29/first-nations-schools-budget.html>



In 2010, women represented 47% of the Canadian labour force⁸ (15 years and older), with approximately 62% of all women in paid employment (11). The employment rate among Aboriginal women was lower, with 51% being employed in 2005, the majority being Métis women, followed by First Nations and Inuit women (10). In 2006, the employment rate among immigrant women was just over 50% compared to almost 60% among Canadian-born women. Similar to immigrant women, women who belong to a visible minority also had a slightly lower employment rate than non-visible minority women (10).

In the past three decades, an increase in employment rates among women with children has been noted but the rates are still much lower than among women without children. In 2009, 80% of women under 55 years without children at home were employed, compared to 64% of women with children under the age of 3 years. Women in two-parent families were more likely to be employed than female lone parents (10), perhaps reflecting the limited opportunities mothers have for continued education and employment with sufficient wages to support a family, as well as the lack of affordable, good quality child care available in many parts of the country (18).

Family care giving responsibilities are also among the main reasons why women represent the large majority of part-time workers (16). In 2010, 67% of the part-time workforce were women and more than 27% of women with a paid job worked part-time (11). Young women (aged 15-24) were most likely to work part-time (55% of those employed) and approximately 20% of employed women in the age groups 25-44 and 45-54 years worked part-time (19). Both immigrant women and visible minority women were more likely to work part-time than Canadian-born and non-visible minority women. Women in part-time employment often have lower job security, lower hourly wages and may also be less eligible for benefits such as extended health care and pension plans.

Women are less likely than men to hold management positions and jobs with authority which can restrict their employment benefits as well as their incomes. The main sectors in which most women work, whether Canadian-born, immigrant, non-visible minority or visible minority, include sales and services, followed by the business, financial and administrative sectors (10). The health care sector is also largely female-dominated, but women often earn less than their male counterparts and provide more unpaid care than men even when they perform the same paid roles (20).

As we have noted in earlier research, “There is a gender divide in employment, apparent at every level of education” and as women’s unpaid work can remain invisible, “their time stress from added roles may be considerably under-represented” (1). Thus an examination of women’s “choices” in healthy living must

⁸ Labour force refers to those persons who are employed or unemployed (that is, seeking work). It does not include those persons who have removed themselves from the paid workforce (such as retirees, unpaid stay-at-home parents or students who do not also have employment).

include an understanding of whether women can take time to “lose weight, eat well and get more exercise”, as well as their employment status.

Income

There is a persistent gender wage gap between women and men in Canada, as there is in much of the world. In 2008 for example, the average income of all female workers in Canada was \$30,100, representing 64% of men’s average income (10). Female lone parents represent one of the groups with the lowest income. In 2008, 21% of lone mothers were considered low-income using Statistics Canada’s low-income after-tax cut-off (LICO). This was significantly higher than the rate among couples with children where 6% were considered low-income (10). Aboriginal women, visible minority women, and young immigrant women, as well as senior women (10) and women with disabilities (21) are also at greater risk of low income. When comparing median incomes, Ferrao and Williams noted that Aboriginal women on average have a lower median income than non-Aboriginal women. Aboriginal women with a university degree, however, have a higher median income than non-Aboriginal Canadian women with the same level of education (10).

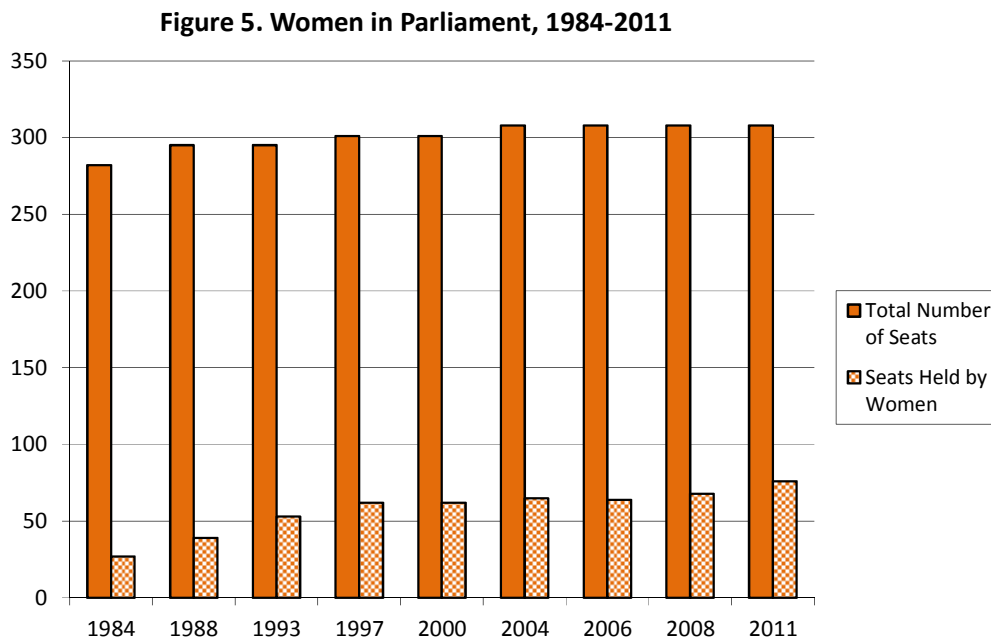
Women’s lower income level is partially a reflection of their tendency to work part-time and in non-management positions. Armstrong et al. however, also note that fee structures might reward men. For example, in the field of medicine, there is greater remuneration for specialties, surgeries, and disease treatment, areas that have typically been male-dominated, as opposed to prevention-based services and primary care where the majority of women practice (20). Investigations by Drolet (22) and Colman (23) found that gender discrimination persists in many occupations. As Lahey noted, “women’s low incomes flow from a variety of interlinked phenomena: gender barriers to paid work, occupational segregation, low wages, work-family conflict, difficulty in escaping part-time, seasonal or intermittent work, declining access to full-time work, the smaller value of women’s employment benefits... and barriers to obtaining venture capital financing for women-owned businesses” (24) (p. 4).

Income levels can also be measured at the household level. It should be noted, however, that income is not necessarily equally distributed within the household and women might have less control over these resources. In fact, it has been argued that women’s increased contributions of income to marital partnership have not brought proportionate gains in women’s control over money, decision making, or the division of domestic labour (25).



Women in Elected Positions

Notably, each of the international indices described earlier in this chapter considers women’s political engagement as a marker of their social status. Despite the results of recent elections in Alberta and Ontario, and the fact that there are currently six sitting female premiers in Canada (one is the premier of Nunavut), women nevertheless still make up a minority of elected officials; although as Figure 5 illustrates, the proportion of women in elected positions has been growing in the past 25 years.



SOURCE: Catalyst.org

In 2011, only 21.1% of all elected officials in provincial, territorial and the federal governments were women, which is significantly short of the international goal of 30% representation by women in governments (26). The 2011 federal election saw a record 76 female MPs elected to the House of Commons, but this represents just 24.6% of all seats held. Canada’s Senate shows a slightly higher proportion of women, with 36 women appointed, or 37% of the 98 Senators in 2011 (11). At this time, only one woman leads a federal political party.

Political representation by women is higher in some provinces and territories (Table 1). Only British Columbia had more than 30% women in the legislature in 2011, and only Quebec had greater than 30% of women in the government caucus in 2011. British Columbia, Quebec, Manitoba and New Brunswick had more than 30% women in Cabinet positions. In 2013, five provinces and one territory had female premiers: British Columbia, Alberta, Ontario, Quebec, Nunavut and Newfoundland and Labrador.

Table 1. Women’s representation in elected positions in Canada, 2011.

Rank	Province	% Women in Cabinet	% Women in Government Caucus	% Women in Legislature
1	British Columbia	44.4%	22.9%	31.0%
2	Quebec	40.7%	31.3%	28.8%
3	Manitoba	38.9%	28.6%	28.1%
4	New Brunswick	31.3%	19.1%	14.6%
5	Nova Scotia	28.6%	25.8%	23.0%
6	Ontario	27.3%	28.3%	28.0%
7	Newfoundland & Labrador	25.0%	13.5%	16.8%
8	Prince Edward island	18.2%	22.7%	22.2%
9	Saskatchewan	16.7%	18.5%	22.4%
10	Alberta	14.3%	16.2%	20.5%

SOURCE: Catalyst.org

Structural features of society may reinforce gender inequality and inequity and legitimize who holds power. While an indicator of women in elected positions can be a convenient test for women’s power and decision-making, other areas such as women’s freedom from violence or women’s opportunities for expression in the media or art could be others. Thus women’s equality of power must also be examined in relationships, families, households and communities as well as political office.

Health Status

As noted earlier in this chapter, women’s health is a reflection, in part, of women’s status. Political participation, household arrangements, access to education and income are all important factors that have a direct bearing on health, and although Canada ranks fairly highly when compared with many other countries, there are considerable differences across the country in women’s socio-economic status as well as in their health. Rates of non-communicable diseases, for example, differ considerably among women, depending on other factors in their lives (27).

This report analyzes several examples of women and healthy living, but before considering these, we briefly touch on two commonly-used population health measures—life expectancy and maternal mortality—and briefly present the current health status of women in Canada with regard to chronic conditions. As previously noted, much of the contemporary policy discussion of healthy living has arisen in the context of a concern with rising health care costs, some of which has been attributed to observed increases in the rates of chronic conditions.



Life Expectancy

In 2006-2008, the estimated life expectancy for newborn girls in Canada was 83.1 years, although there are significant differences in life expectancy across groups of women. For example, in the three territories life expectancy at birth for girls was much lower (78.5 years) (28), and this is also true among Aboriginal women, whose life expectancy was 76.8 years compared to 82 years among non-Aboriginal women in 2001 (10). Projections from Statistics Canada estimate that the gap in life expectancy between Aboriginal people and the total Canadian population will decrease by 2017 (29,10) but the differences will still be significant. Tjepkema et al. for example, found that, “Compared with non-Aboriginal members, life expectancy at age 25 was 3.3 and 5.5 years shorter for Métis men and women, respectively, and 4.4 and 6.3 years shorter for Registered Indians.” (30) (p. 1)

Life expectancy at age 65 is used as a population health measure of quality of life, social and economic conditions for seniors, and may point to inequalities between sub-populations. In 2007 the average life expectancy at age 65 for women in Canada was 21.0 years (10), an increase from 18.9 years in 1980. Living longer, however, is not the same as living with good health. Health Adjusted Life Expectancy (HALE) was developed to measure expected years of good health and functional status, making it a measure of quality of life, not just quantity (years). HALE is measured at age 65, and according to the most recent estimates (2001), women in Canada could expect 70.8 years in good health (10). This figure is higher than for males but it is worth pointing out that although women may live longer than men, they can acquire a number of conditions (such as circulatory and respiratory diseases, cancers and other chronic conditions) that limit their enjoyment of life as well as their mobility (10).

Maternal Mortality and Morbidity

Maternal mortality is another standard benchmark of the health of nations, as well as a broad measure of attention to women’s health. In Canada, maternal mortality is very low compared to many other parts of the world, at 7.8 maternal deaths per 100,000 deliveries in 2008/09-2009/10 (31). However, this figure is not consistent across the country. Table 2 shows differences across the provinces and territories up to 2010, and Table 3 shows how maternal mortality varied by the mothers’ ages.

Because maternal mortality is very low in Canada, it is worthwhile to consider maternal morbidity, a proxy measure for the care women receive in labour and delivery (16). In 2009/2010, the rate of severe maternal morbidity in Canada was 14.5 (95% CI: 14.1-15.0) per 1,000 deliveries. The overall rates of severe maternal morbidity remained stable between 2003/2004 and 2009/2010 (31).

Table 2. Maternal mortality rates by province and territory (excl. Quebec) 1996/1997-2009/2010

Province/Territory	N	Rate per 100,000 deliveries	95% CI
Newfoundland and Labrador	11	16.4	8.2-29.3
Prince Edward Island	*	20.3	5.5-51.9
Nova Scotia	7	5.6	2.2-11.4
New Brunswick	6	5.8	2.1-12.6
Ontario	186	9.8	8.4-11.2
Manitoba	5	5.5	1.8-12.9
Saskatchewan	11	6.3	3.1-11.2
Alberta	46	8.0	5.9-10.7
British Columbia	53	9.2	6.8-12.0
Yukon	*	20.1	0.5-112.1
Northwest Territories	0		
Nunavut	0		
Canada	330	9.0	8.1-10.1

SOURCE: Canadian Institute for Health Information, Discharge Abstract Database. Note: Manitoba data which were incomplete for earlier years were included from 2004/2005. * suppressed due to cell size less than 5

Table 3. Maternal mortality rates by age (excl. Quebec). 1996/1997-2009/2010

Age	N	Rate per 100,000 deliveries	95% CI
15-19	17	8.9	5.2-14.3
20-24	41	6.6	4.7-8.9
25-29	94	8.6	7.0-10.6
30-34	84	7.5	6.0-9.2
35-39	70	13.2	10.3-16.7
≥40	24	24.4	15.6-36.2
Total	330	9.0	8.1-10.0

SOURCE: Canadian Institute for Health Information, Discharge Abstract Database. Note: Manitoba data which were incomplete for earlier years were included from 2004/2005



Maternal mortality and morbidity rates among Aboriginal women tell a different story as they are considered disproportionately and alarmingly high. However, data records remain uneven and a search of the literature revealed that there are very few papers about maternal mortality in Aboriginal women. A study of infant mortality rates by Janet Smylie and her colleagues (32) demonstrated that data collection varies across the country, and this is likely also the case for the health of mothers.

Chronic Conditions

Many women in Canada live long lives in good health. In fact, in 2010, 60.5% of females aged 12 years and over reported very good or excellent health (33,34). However, as women age they are at increased risk of developing chronic conditions and few women (30%) aged 75 years and older report very good or excellent health. Although women tend to live longer than men, women are more likely to experience some chronic conditions, including arthritis, some cancers and high blood pressure (10). In 2010, 24.4% of women (aged 12 years and older) reported high blood pressure, 19.7% arthritis, 19.6% back problems, 9.8% asthma and 8.2% mood disorders (33,34).

Some conditions, including cardiovascular disease, may be significant health problems for both men and women, but prevalence, rate of case identification and treatment, and responses to care may differ. For example, French data suggest that although the overall rate of cardiovascular mortality among patients with ST-segment elevation myocardial infarction (STEMI) has declined, there has been an increase in both the proportion and number of younger women (younger than 60) with STEMI (35). The authors suggest that these “observations suggest that future reductions in the incidence and mortality related to AMI will need specific targeting of preventive measures toward younger women and possibly younger men” (35) (p. 1003). Canadian data show similar trends in this country and suggest that hypertension, diabetes, and obesity are key risk factors; smoking, however, remains a significant problem (36). Together, these studies point to the value of primary prevention strategies to reduce the risk factors for cardiovascular disease themselves for women, not simply to help manage heart disease once it is established (36) (35).

Circulatory diseases—including ischaemic heart disease, cerebrovascular and hypertensive diseases—represent the most common cause of death among women in Canada (30% of female deaths), followed by cancer and respiratory diseases. Death due to injuries and poisoning are less common among women compared to men, but the female proportion of deaths due to Alzheimer’s disease and other dementia was substantially higher among women (33,34).

Rising rates of these chronic conditions and the associated health care costs have led to increased focus on healthy living; eating well, being physically active, avoiding smoking and cutting back on alcohol consumption may reduce the risk of developing chronic conditions, although changes to improve women’s

health in these ways are not solely dependent on women's own behaviour. These healthy living topics are among those further explored in Part Two in this report.

Summary

Understanding women's health requires an understanding of women's status. In this chapter we have looked at three international measures of gender equality - the *Global Gender Gap Index*, the *Gender Inequality Index*, and *Women's Economic Opportunity Index* - to provide some of the context about women in Canada, particularly in terms of social, economic and political progress. We also presented a demographic profile of women in Canada, including their ages, as well as economic, social and political standing – all of which are important factors that have a direct bearing on health. As a result, women experience different health outcomes and are more likely to report some chronic conditions such as arthritis, high blood pressure and some cancers. We consider these important factors when looking at healthy living for two reasons. First, women are not all the same. Broad, international measures which give a summary impression of the status of women must be complemented by more in-depth descriptions of women's circumstances, including their varying education levels, personal income, ability to get health care and other services, and opportunities for employment, social supports and decision-making at many levels. Furthermore, it is critical to examine where and why women are prevented from participating fully in society. Second, national and sub-national measures provide essential context for the meaning that healthy living has to women and the relevance of healthy living strategies, programs and interventions at a given time in their lives. Where possible, we therefore provide data in this report that is broken down by region or urban/rural status.



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The Meaning of the Healthy Living Discourse

Barbara Clow

The healthy living discourse has its roots in health promotion, a relatively new discipline that emerged in the 1970s and gradually became codified as a distinct field of research and policy as well as professional education and practice. Canada played a key leadership role in the founding and evolution of health promotion theory and practice: the federal government released a report, *A New Perspective on the Health of Canadians*, in 1974, that laid the groundwork for a new approach to public health; a second federal government document, *Achieving Health for All: A Framework for Health Promotion*, was published in 1986, contributing to discussions that broadened and clarified the parameters of health promotion, and; Canada hosted the first International Conference on Health Promotion in Ottawa in 1986, which led to an enduring international accord, the *Ottawa Charter for Health Promotion* (1).

According to Minkler, health promotion was first defined as “the art and science of helping people change their lifestyle to move toward a state of optimal health” (O’Donnell quoted in (2)). This approach, she contends, was based on “two interrelated assumptions that (1) the individual has a great deal of influence over his or her personal decisions and actions regarding diet, exercise, and other lifestyle behaviours and that (2) changes in these personal behaviours can in turn significantly effect [sic] health outcomes” (2). By the early 1980s, the emphasis on individual behaviour in health promotion was joined by a growing awareness of the importance of the social determinants of health. In 1986 the World Health Organization published a report on the concepts and principles of health promotion, arguing that health is a collective responsibility involving legislation, fiscal measures, organizational change and community development as well as lifestyle education and intervention (3). These principles were echoed in Canada’s 1986 report on health promotion and enshrined in the *Ottawa Charter*.

While many in the field of health promotion enthusiastically embraced the social determinants of health and advocated for collective action to address the systemic causes of health disparities and inequities, the emphasis on the individual did not disappear from health promotion policy or practice (4-9). By the late 1980s, the phrase ‘healthy living’ was increasingly being equated with personal responsibility for health as well as with policies and programs aimed at improving health by fostering changes in individual ‘lifestyles’ (10). A decade later, the discourse of healthy living had become dominant in health promotion policies and practices in many parts of the world (11-14).



On the surface, attention to healthy living would seem to be, unquestionably, a good idea. Who among us would not want to enjoy a long life, free of illness and infirmity, particularly if this outcome is easily within our grasp? All that is needed, according to the healthy living discourse, is for individuals to modify their health behaviours and choices, specifically reducing “nefarious lifestyle habits such as smoking, poor diet, lack of exercise, and risky sexual behaviour” (15). While this seemingly simple solution is attractive, before we embrace the discourse of healthy living, we need to ask some serious questions: What does it mean to live a healthy life and who decides? Are policies, programs and interventions based on the healthy living discourse representative of or sensitive to differences across time and place as well as between and among diverse populations? Is the prescription for health outlined in the healthy living discourse likely to improve or even address health disparities? What does the discourse of healthy living mean for women in Canada?

On the surface, attention to healthy living would seem to be, unquestionably, a good idea. Who among us would not want to enjoy a long life, free of illness and infirmity, particularly if this outcome is easily within our grasp?

In this chapter, we analyze the content and gaps in contemporary healthy living discourse using sex- and gender-based analysis (SGBA). Our goal in undertaking this exploration is to identify the strengths and limitations of this approach to health and care for women. The analysis suggests that the healthy living discourse may not only fail to lead to improvements in health for women, it may also contribute to poorer health outcomes for some women.

Overview

This analysis draws on published and grey literature to: 1) describe the key features of the healthy living discourse; 2) provide an overview of its emergence in Canada, and; 3) examine the extent to which the healthy living discourse can or does address the needs and experiences of diverse populations of women. Using the four core concepts of SGBA (16, 17) – sex, gender, diversity and equity – allows us to consider if and how the healthy living discourse applies to women and girls and the consequences for women and girls of embracing the main tenets of the discourse. In the third section, we will look at examples related to the specific behaviours addressed in the healthy living discourse: body weight, diet and exercise. A fuller analysis of these topics appears in later chapters along with analyses of topics that are not typically – but should be – included in discussions of healthy living.

The Shape of Healthy Living

In some jurisdictions, the term “healthy living” encompasses any individual behaviour that has the potential to affect health – diet, exercise, smoking, substance use, sexual activity, screen time, risk-taking behaviour, etc. As Lindsay has remarked about the Australian context, “Healthy living guidelines appear to be proliferating in recent decades and prescriptions for healthy living are covering more and more everyday activities” (13). Some of these behaviours, specifically tobacco smoking, alcohol use, and sexual behaviours in specific populations have received considerable research, policy and program attention in the past. Other aspects of healthy living, such as mental health, are emerging or, in the case of injury prevention, are slated for future policy discussions and action (12, 18). But in many parts of the world, including Canada, the main emphasis of the healthy living discourse today is body weight and related behaviours, specifically healthy eating and active living. Whether healthy living policies and programs focus on one set of behaviours and conditions or a broad array, however, the discourse itself is characterized by several key themes.

First, the healthy living discourse is rooted in the conviction that many chronic diseases – and rising health care costs – are the result of individual ‘lifestyle’ choices, including eating poorly, getting insufficient exercise and rest, indulging in risky behaviours related to sex, alcohol and substance use, among others. Individuals, rather than society as a whole, are held responsible for illness as well as for health. In the case of obesity, for example, healthy living policies and programs revolve around the “energy in-energy out” equation, arguing that if individuals simply ate less or better and exercised more, they would be able to avoid overweight and obesity and the diseases associated with unhealthy weights. In the process of emphasizing individual behaviour and choices, the healthy living discourse ignores or neglects the systemic causes of illness (19). For instance, active living and healthy eating become much more challenging if communities lack parks and affordable sports facilities or if neighbourhoods lack shops that stock nutritious, high quality and affordable foods. As Henwood et al. have observed “knowledge about healthy living is framed in a way that ignores factors beyond individual control and presents the achievement of health goals as matters of individual choice, ‘good behaviour,’ and self-care” (20).

The second theme of the healthy living discourse, blame, is directly related to the emphasis on personal responsibility. Because healthy living casts individuals as responsible for health, the failure to achieve or maintain health is ultimately laid at the doorstep of individuals. Those who fall ill, particularly with chronic diseases that have been associated with overweight and obesity or risk-taking behaviours, may be seen and portrayed as undisciplined, imprudent and negligent. As Low remarks, the healthy living discourse, in ignoring systemic influences on health, is “effectively blaming the victim of ill health for what are socially produced health problems” (19). Blame is frequently subtle and implicit in the healthy living discourse, but the focus on individual responsibility can lead to stigma and even, in rare cases, support for sanctions. In a recent study in the United Kingdom, for example, 54% of doctors surveyed maintained that the National



Health Service “should have the right to withhold non-emergency treatment from patients who do not lose weight or stop smoking” (21). The blaming phenomenon appears to affect women disproportionately because they are not only held responsible for their own health, but also for the health of their families, especially their children (22). As we will see in a later chapter, *Eating Well*, there is an overwhelming and bewildering amount of public information and corporate marketing about nutrition and healthy eating, much of it aimed at women as the gatekeepers for their families’ diets. Implicit in these promotional and public education materials is the message that women are failing their loved ones if they don’t make sure their families eat the right foods.

The third theme relates to the nature of contemporary discussions of risk, which also contribute to a culture of blame. The concept of risk has historically been understood as the statistical probability that an adverse event, such as an illness or a bad reaction to a medication, would occur in a given population. For example, insurance companies use statistical analyses to calculate the likely number of accident claims that would have to be paid in a population of young male or female drivers and set premiums accordingly. But in the healthy living discourse, this probability of disease in a population is transformed into certain danger for the individual. In the case of obesity, for instance, “the impression is created that as individuals get fatter, they increase their chances of becoming sick from a variety of diseases” (23). Indeed, in a later chapter on body weight, we will see that even healthy or “normal” weight is associated with some measure of risk. Moreover, risk is presented as something that women and men can control by virtue of making healthier choices.

The healthy living approach seems to be rooted in the assumption that if individuals ‘know better’ they will ‘do better’. But often the circumstances of people’s lives make it impossible to act differently even if they know that specific behaviours may be detrimental to their health,

Fourth, because the healthy living discourse focuses on individual behaviours as the cause of ill health, policies and programs framed by this discourse tend to revolve around helping or exhorting individuals to change these behaviours (24). This approach seems to be rooted in the assumption that if individuals ‘know better’ they will ‘do better’ (20, 25). But often the circumstances of women’s and men’s lives make it impossible to act differently even if they know that specific behaviours may be detrimental to their health. As we will see in a subsequent chapter on food insecurity, advice to increase the intake of fruits and vegetables is frequently proffered without an understanding that these foods are generally expensive and therefore inaccessible to those living in poverty, more of whom are women. The healthy living discourse not only ignores collective responsibility for health, but also the potential for systemic solutions for chronic diseases and other ailments. For instance, many health promotion policies and programs focus on personal or family food purchasing or leisure patterns rather than on regulating the food industry to ensure greater access to healthful, affordable and nutritious foods or safe and accessible places for recreation (25).

Fifth, although the healthy living discourse emphasizes individual behaviour and personal responsibility as the causes of ill health, it ironically offers a single prescription for good health that rests on weight management, healthy eating, and physical activity. With a few notable exceptions, such as pregnant women, nursing mothers and young children, the same healthy living guidelines are recommended for large segments of the population. Variations in individual bodies and individual circumstances are treated as irrelevant or are rendered invisible.

Sixth, to a considerable extent the healthy living discourse focuses on physical health rather than mental health and social well-being. For example, Lindsay's research in Australia suggests that when women and men drink more than is recommended in healthy living guidelines, they are not necessarily ignoring their physical health but rather are making informed choices about other dimensions of their health. "Consumption", she argues, "remains central to social relationships – drinking and eating together expresses friendship and intimacy and refusing to take part can threaten relationships" (13). Mental health and social well-being may also be adversely affected by the emphasis on physical health in the healthy living discourse.

Already in this discussion of the key themes of the healthy living discourse, we can begin to appreciate how they might apply to and affect women in particular ways. Before we look at these issues in greater detail, however, it is important to understand the emergence of the healthy living discourse in relation to the needs and experiences of women. Many factors contributed to the rise and persistence of the healthy living discourse, but few of them acknowledged gender or considered the diverse societal and structural aspects of women's and girls' lives.

Healthy Living Takes Shape

According to Robertson,

Discourses on health come into and go out of fashion, but not arbitrarily. Rather, they emerge and gain widespread acceptance primarily because they are more or less congruent with the prevailing social, political and economic context within which they are produced, maintained and reproduced (9).

The healthy living discourse is no exception. While many of the themes and messages contained within this discourse are far older than the phrase itself, interest in them began to coalesce and gather momentum in Canada during the 1970s in response to the social, economic and political climate of the time (24, 26). Enthusiasm for the healthy living discourse was fuelled by changing patterns of morbidity and mortality, evolving ideas about disease causation, growing concern about rising health care costs, and shifting convictions about the balance between social and personal responsibility for health and care. Each of these



contextual elements contributed to the entrenchment of the healthy living discourse, but almost none of them attended to the needs and experiences of women and girls.

During the early years of the 20th century, the leading causes of death in the developed world began to change. Prior to this time, contagious diseases and infection in general had represented the most significant threat to health and life. Diseases such as cholera, influenza, tuberculosis and measles claimed millions of lives and medical care offered few effective remedies for infectious diseases or post-surgical and post-trauma infection. After the 1920s, however, the tide began to turn. Effective sanitation systems became more common and, together with the development of new vaccines, helped to curb the spread of infectious diseases. The discovery of antibiotics also provided

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doctors with powerful treatments. As a result, instead of succumbing to infectious diseases, women and men began to live longer, ironically long enough to develop chronic and non-infectious ailments, such as arthritis, diabetes, and high blood pressure. Non-communicable diseases – cardiovascular diseases and cancers in particular – soon eclipsed infectious diseases as the main causes of death in Canada and elsewhere. Because many of these conditions were blamed on overweight and obesity, the emphasis on diet and exercise in the healthy living discourse was both attractive and compelling. As Lindsay has observed, “the development of healthy living guidelines began in the 1970s, as diet-related illnesses became a major cause of death in industrialized countries” (13). Similarly, in Canada, concerns about rising rates of cardiovascular diseases led to the creation of ParticipACTION, a health education program designed to “motivate all Canadians to be more active, and to improve general levels of fitness over the long term” (27). Women were seldom mentioned explicitly in discussions of changing disease patterns, except in relation to sex-specific conditions such as breast cancer. This was a curious omission given that women were over-represented among those experiencing chronic health conditions because, among other reasons, they live longer. Similarly, interventions to address the rise of chronic non-communicable diseases did not acknowledge or address the needs and experiences of women.

Evolving ideas about disease causation also created fertile ground for the healthy living discourse. Prior to the mid-19th century, illness was understood as constitutional and contextual – “a product of the long-time interaction between a biologically unique individual and a particular environment” (28). At the end of the 19th century, the development of the germ theory consolidated a dramatic shift in the ways that illness was understood. Disease was no longer defined primarily as a product of personal choices and circumstances, but rather was seen as a specific entity with discrete, external causes and clear-cut symptoms and outcomes. While this new view of disease captured the etiology of infectious diseases, it could not as easily explain many chronic conditions and non-communicable diseases, such as cancer or cardiovascular diseases, which do not have a single identifiable cause or a consistent presentation. As Rosenberg notes, “our general

conceptions of disease have become increasingly specific while – as individuals – we have become increasingly likely to suffer from vague, multi-causal and overlapping ailments” (28). Even as it became clearer that the “specific-entity” model could not adequately explain non-communicable diseases, there was a growing tendency to apply the model to health conditions that were deemed to be contributing factors in or the precursors of many chronic illnesses. Health conditions such as hypertension, high cholesterol, low bone density, and overweight were transformed into “proto” or “incipient” diseases that could be understood as treatable entities (15,28). Indeed, the increasing propensity to think of and talk about an “epidemic” of obesity exemplifies this trend (23). The healthy living discourse gained support because it could be focused on these proto-diseases and offered seemingly simple solutions for some of the most widespread and intractable chronic health conditions. Eliminating obesity and reducing rates of hypertension, for example, appeared more feasible than curing cancer or cardiovascular diseases. Some of these proto-diseases, such as osteoporosis and hypertension, are more common among women than men. Others, such as overweight and obesity, present in different and changing patterns between and among groups of females (and males), as described in the chapter on Healthy Body Weight. But the interest in proto-diseases that helped to fuel the healthy living discourse ignored such differences.

Another key driver of interest in and enthusiasm for the healthy living discourse was the economic context of the 1970s. Canada, like many other countries, had experienced an unprecedented era of economic growth in the thirty years following the Second World War. This economic boom allowed for the expansion of Canada’s social welfare system, including the introduction of publicly-funded physician and hospital care. But post-war prosperity came to an abrupt halt in the 1970s as a result of the oil crises and other global economic developments (26, 29). According to O’Neill and his colleagues,

The ‘glorious thirties’ were followed by 20 gloomy years of economic stagnation or minimal growth within the Western economies, which deprived governments of taxation revenues and forced them to borrow heavily to maintain the level of public services they had committed to provide to their populations (26).

While the economic downturn created enormous challenges for governments trying to fund any social services, the task of managing publicly-funded health care became particularly pressing because the costs of health care services were rising sharply even as tax and other revenues fell. Women were implicated in rising health care costs because they tended to use the health care system more than men, for themselves as well as on behalf of their children and families. But governments needed to find ways to contain health care budgets. One approach to managing health care costs was the decision not to expand publicly-funded health care to include services other than hospitals and physicians, such as dental and eye care and medications, which had been part of the original plan (30). Another approach was to shift responsibility for health away from the government and away from the increasingly costly health care system. The healthy living discourse garnered



attention and support because it provided a rationale for this latter approach, but it also meant that those most likely to use the health care system, women, were also implicitly targeted by this shift.

A pivotal moment in the evolution of the healthy living discourse was the release, in 1974, of the federal government report entitled *A New Perspective on the Health of Canadians*. This document, authored by Marc Lalonde, then Minister of National Health and Welfare, proposed a radically new way of thinking about health and care (19). Rather than focusing on the medical model of disease and treatment alone, Lalonde drew attention to other factors – individual lifestyle, human biology, and social and physical environments – that could affect health. He maintained that “access to health care was not the only – and, perhaps, not even the most important – determinant of health” (9). This perspective on the health of Canadians led Lalonde to recommend that governments should “stop investing solely in providing more acute care services and instead seriously consider addressing the three other sets of factors” (26). Improved environments and lifestyles, he argued, would contribute to better health, thereby reducing both health care needs and costs. This broader view of health was taken up enthusiastically by many working in health care and health education. Indeed, some have credited Lalonde with founding the field of health promotion, both in Canada and internationally, as well as with creating the first social determinants of health framework (8, 19, 26, 31). But while Lalonde was proposing a broader, more holistic understanding of health and care, his work also gave a boost to the healthy living discourse by naming and describing the role of personal habits and choices – ‘lifestyle’ – in health. He did not privilege lifestyle factors over the influence of biology or environment, but many others did because, as Low and Theriault note, “it is infinitely easier to focus on the individual than to write policy that addresses structural change” (19). It is also, from the perspective of government, less expensive. It is important to note that even when the Canadian government subsequently championed the social determinants of health, sex and gender were not included in this framework until nearly 30 years after the release of the Lalonde report.

The dominance of the healthy living discourse was also advanced by the rise of neo-liberalism in Canada during the 1980s and 1990s. Neo-liberalism is a philosophy of economic and social relations that defines a limited role for government in market-based capitalism as well as in the lives of citizens (4, 8, 19, 29). Economic growth and competition, rather than government intervention, is seen as the key to societal advancements, including improvements in health (5, 9, 20). Furthermore, neo-liberalism stresses individualism over communalism – personal over shared responsibility for the social, economic, and political conditions that affect health and well-being (29). There are clear affinities between the healthy living discourse and the main tenets of neo-liberalism. The focus on individual behaviours and personal choices in the healthy living discourse echoes the emphasis on individual responsibility in neo-liberalism. The healthy living discourse also has also provided a rationale for reduced government intervention in the social and economic realms, which is a key feature of neo-liberalism. As Low and Theriault have argued, “it is expedient for government to reduce population health problems to the individual as it turns attention away from the social production of health [and] ... enables government to use the lifestyle rhetoric of health

promotion as an ideological justification for their failure to address the social determinants of health” (19). The alignment between neo-liberalism and the healthy living discourse has taken shape without explicit reference to the needs and experiences of women and girls, but the impact of these approaches on the health and well-being of women and girls has been well-documented (23, 32-34). The case of women’s unpaid caregiving is an excellent example of the affinity between the healthy living discourse and neo-liberalism and the deleterious effects of both for women. The emphasis on individual versus social responsibility and the emphasis on personal rather than structural interventions have meant that women provide the greater share of unpaid care for others, often to the detriment of their own health and well-being (35).

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Even the growth of feminism, particularly the emergence of the women’s health movement during the 1960s and 1970s, contributed to support for and interest in the healthy living discourse. In the early years of the women’s liberation movement, many feminists focused their efforts on exposing the social and economic inequalities experienced by women and advocating for equal opportunities for women in the labour market and education. They formulated a compelling critique of gendered power relations, describing the ways in which social institutions, such as law, government, education, and religion, served to privilege men and subordinate women. The women’s health movement was an integral component of second-wave feminism, providing a similar critique of the power that medicine and health care professionals exerted over women and their bodies. It began with an emphasis on sexual and reproductive health issues, with activists arguing and advocating for women’s rights to have access to contraception and abortion (34). At the same time, the women’s health movement sought to empower women to reassert control over their sexual and reproductive health by learning more about their bodies (36). In 1969, at a women’s liberation conference in Boston, a small group of women launched a summer project to develop a course on women’s health “by and for women” (37). This project led to the ground-breaking women’s health guide, *Our Bodies, Ourselves*, which was published in 1973, just one year before the release of the Lalonde report in Canada (37). While this approach to empowerment was highly effective – as evidenced by the popularity of the book and other victories of the women’s health movement – it also unwittingly reinforced one of the key themes of the healthy living discourse, the importance of personal over social responsibility for health. As Ehrenreich observed, “The Women’s Health Movement ... legitimized self-help” (38).

As we have seen, the healthy living discourse was shaped by the social, economic and political context of the 1970s and 1980s. It persists today, in part, because many of the factors that originally fuelled interest are still at work, particularly the on-going commitment to neo-liberal values, the state of the economy, escalating health care costs, and climbing rates of chronic diseases. While women have often been ignored or neglected



in the rise and evolution of the healthy living discourse, it nonetheless has profound implications for the health and well-being of women and girls in Canada and elsewhere.

Sex- and Gender-based Analysis of the Healthy Living Discourse

By applying the core concepts of SGBA – sex, gender, diversity and equity – we gain a better appreciation of the ways in which and the extent to which the healthy living discourse may affect the health of women and girls. We will consider each of these concepts in turn, drawing on examples related to the main topics addressed by the healthy living discourse, namely body weight, diet and exercise.

Sex

Although the healthy living discourse has, historically, paid scant attention to the influence of sex on health, efforts to track patterns of weight, diet and exercise for women and men have become common in many parts of the world. For example, the *Integrated Pan-Canadian Healthy Living Strategy*, launched in 2005, and subsequent progress reports in 2007 and 2008, included some sex-disaggregated data on healthy living targets (12, 39,40). Healthy living guidelines are also sometimes different for males and females, with levels of alcohol consumption and caloric intake typically set at lower levels for females than for males (13). Nonetheless, the subject of sex rarely figures in the healthy living discourse. For example, discussions about healthy weight continue to ignore, in large measure, how physiological differences between and among women and men affect weight loss and gain as well as the ability to achieve and maintain a healthy weight. Similarly, *Canada's Food Guide* recommendations vary more by age than they do by sex and *Canada's Physical Activity and Sedentary Behaviour Guidelines* do not even acknowledge sex differences across the lifespan (41, 42). The preoccupation with overweight and obesity in the healthy living discourse also means that limited attention is paid to the phenomenon of underweight, which is much more common among females than males.

The healthy living discourse typically refers only to females and males, treating them as rigid and distinct categories and ignoring the considerable variation that exists among and between males and females

At the same time, when the healthy living discourse does include a consideration of sex, it typically refers only to females and males, treating them as rigid and distinct categories and ignoring the considerable variation that exists among and between males and females. Body Mass Index (BMI), the most common measure of healthy body weight, is a case in point. The BMI ranges for females and males are, with a few notable exceptions, applied to all women and all men regardless of other factors affecting their size, shape, fitness levels and, indeed, their health. Furthermore, because BMI treats male and female as mutually exclusive categories, it may not be accurate or relevant for sexual minority populations, specifically those

who identify as transgender (43). It is not clear, for instance, if a transwoman or her health care providers would use the male or the female BMI range, but the choice could have implications for this woman's own sense of health and attractiveness as well as for how the health care system sees and treats her. In other words, the failure of the healthy living discourse to address sex in a complex and comprehensive fashion creates the potential for policies, programs and practices that are not necessarily appropriate across the sex continuum.

Gender

Probably the most sophisticated analysis of gender and health promotion has emerged in relation to smoking tobacco. A considerable body of research and theory, as well as an array of programs and interventions have been developed purposefully to address the different reasons women and men have for starting and continuing to smoke as well as the different barriers they face to quitting smoking (44, 45). This work demonstrates conclusively that it is not only possible, but also imperative to address the gendered dimensions of healthy living. Yet gender is seldom mentioned in the healthy living discourse, despite the fact that it is tacitly – and ominously – present because of the current emphasis on weight, diet and exercise. Both in the past and present, women have faced enormous social and cultural pressures to achieve particular ideals of body shape and size (46). While these ideals have changed over time and may differ between cultures and places, in Western societies there has been an increasing emphasis on thinness, which the healthy living discourse has encouraged, rationalized and reinforced (23, 33). Indeed, according to Gard and Wright, the slender ideal has been further transformed by the healthy discourse into the “‘worked-on’ slender body” (23). In other words, it is no longer enough for women to be thin, they must also be toned or ‘ripped’ in the common parlance. The expectation that men will also be thin and toned is growing, but there is much greater tolerance for a “big” man than a “big” woman in Western society. Women who fail to achieve the ideal body are much more likely than men to suffer negative consequences, including poor self-esteem, depression, social exclusion, stigma and discrimination (47). Women are also more likely than men to engage in injurious patterns of diet and exercise in order to achieve the thin, toned ideal and the social and economic benefits associated with it.

Women's gendered roles also place them at greater risk of blame in the healthy living discourse. Because women often are – or are expected to be – caregivers, they are more likely than men to be held responsible not only for their own weight, diet, exercise levels, but also for those of their families – children, partners, etc. A great deal has been written in recent years about the phenomenon of blaming mothers – rather than fathers – for a perceived rise in childhood obesity (48). Women's responsibility is compounded – as is the tendency to blame them – by their role in food planning, purchasing and preparation. The negative messages about gender that are embedded in the healthy living discourse have the potential to adversely affect the health and well-being of women and girls, contributing to unhealthy patterns of diet and exercise, poorer mental health and economic and social disadvantages.



Diversity

The healthy living discourse not only neglects the importance of sex and gender, it also does not consistently address the needs and experiences of diverse populations of women and girls. An obvious example is the limited attention paid to the cultural and social dimensions of diet. Lawton et al., in a study with British Pakistanis and Indians with type 2 diabetes, found that patients often tried to “manage their identity and diabetes simultaneously by reducing the quantity they ate” and going hungry (49). Given that women often play a key role in food planning and preparation, they may be disproportionately affected by the limited attention given to the social and cultural dimensions of food in the healthy living discourse. As Caplan contends, “food is never just ‘food’ and its significance can never be purely nutritional ... it is intimately bound with social relations, including those of power, inclusions and exclusions as well as with cultural ideas about ... the human body and the meaning of health” (50).

Similarly, the approach to physical activity that is embedded in the healthy living discourse is not sensitive to differences of ability, climate, culture, or socio-economic status. Women and men living in rural settings or having limited access to affordable recreation facilities will find it much harder to meet the prescribed targets for physical activity. Exercise is also a challenge for women and men living with different kinds of disabilities, but these challenges are neither acknowledged nor addressed in the healthy living discourse.

Sexual orientation is another form of diversity ignored in the healthy living discourse. Some research suggests that rates of obesity are higher among lesbians than women of any other sexual orientation (51). According to some studies, lesbians are also less preoccupied with achieving an ideal body weight and, in some studies, report higher rates of body image satisfaction as well as higher rates of physical fitness (43). Similarly, Brand et al. found that men, regardless of their sexual orientation, are more likely to focus on weight as a measure of sexual attractiveness, suggesting that those most likely to be intimate with men – heterosexual and bisexual women as well as gay and bisexual men – were most likely to be adversely affected by overweight and obesity (52). These kinds of nuances about body weight are not reflected in the healthy living discourse, with the result that interventions based on the healthy living strategy may not be effective or appropriate for members of the LGBTQ communities.

Equity

Of the four core concepts in SGBA, equity is the one that surfaces most frequently in the healthy living discourse. Undoubtedly this is related to the wealth of research that has established an undeniable link between poverty and illness. As a result, health promotion theory and practice generally acknowledges and often seeks to address health disparities rooted in economic disadvantage (53, 54). Yet it is still not uncommon to see the poor stigmatized – in the media, in research and in policy – for uninformed and unhealthy ‘choices’, particularly in relation to overweight obesity and diet. As Townsend has noted, “the convergence of moralized discourses around poverty and illness is represented most visibly and powerfully

in the issue of obesity” (55). Moreover, discussions of poverty and healthy living often ignore the intersection of gender and socio-economic status. Women are vastly overrepresented among the poor – in Canada and around the world – and some groups of women are more vulnerable than others. By ignoring these salient differences between women and men as well as among women, the healthy discourse runs the risk of deepening inequity and causing harm to women and girls.

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At the same time, other social determinants of health are typically not addressed in the healthy living discourse. Even when statistical differences between diverse populations are reported, most healthy living policies and programs fail to address the impact of sexism, homophobia, racism and other forms of stigma and discrimination. For instance, a number of studies have demonstrated that overweight and obese women are more likely than overweight and obese men to experience weight bias, including the loss of job opportunities such as increased wages and promotion (47). Puhl et al. have also reported that women experience weight discrimination at much lower BMI levels than men – 27 versus 35. This means that women suffer weight stigma when they are only slightly overweight according to BMI levels while men are not at serious risk of discrimination until their BMI levels reach a classification of severely obese (56). But the healthy living discourse remains silent on this critical dimension of health and equity.

As noted earlier, the individual focus of the healthy living discourse means that social responsibility for health and the potential for collective action to address health disparities are ignored. While this approach puts everyone at risk, women from diverse populations are more likely to be negatively affected because they are more likely to be at social and economic disadvantage compared to men. For example, the overwhelming majority of lone parent households in Canada are led by women and these households are highly vulnerable to food insecurity and poor health. Structural solutions, such as adequate income supports, affordable childcare and accessible housing, are required to improve the health of lone mothers and their children as well as other vulnerable populations. Focusing on individual behaviour and a ‘one-size-fits-all’ approach to healthy living not only fails to advance health equity, but may also contribute to deepening health disparities and inequities.

Conclusion

The relationship between the specific discourse of healthy living and the general field of health promotion was and remains both complex and contested. Some authors seem to equate healthy living with health promotion and use the terms almost interchangeably. Others seem to treat healthy living as merely a sub-set of health promotion theory and practice, a specific example of a broader philosophy. Still others seem to



regard the healthy living discourse as incompatible with the main tenets of health promotion, as it is or should be practiced (4, 8, 9, 24, 29, 57-59). As O’Neill, et al. have observed, even in the early years of health promotion in Canada, the community developed its “own internal critique” (26). Despite these differences of opinion, the discourse of healthy living has become the dominant approach to health promotion policy and practice in Canada and elsewhere in the world.

In critiquing the healthy living discourse, we are not suggesting that it is *never* useful to provide education and interventions to help individuals make healthy choices. Many people can and do benefit from nutrition and cooking classes, exercise programs in schools and communities, instructions on how to read nutrition labels, etc. Rather the point is that the individual should not be the sole or even the primary focus of healthy living policies and programs. Equipping

individuals with the knowledge to make healthy choices is only effective if structural and systemic barriers are also addressed. For example, understanding nutrition labeling is important, but so is government policy that regulates the food industry and the sodium content in packaged and processed foods. Similarly, encouraging individuals to exercise is a constructive intervention, but only if affordable, safe places for recreation are available and if the built environment facilitates active transportation.

Assessing the healthy living discourse using SGBA also underscores the importance of attending to the continuum of sex and gender as well as the breadth of diversity. Failure to do so can not only lead to interventions that are inappropriate and ineffective, but also to policies and programs that deepen health disparities and inequities. For example, the ways in which and the extent to which women’s bodies are subject to scrutiny and regulation, particularly with respect to weight, underscores the limitations and dangers of the healthy living discourse. Similarly, understanding the health needs and experiences of different groups of women and men is critical, but the healthy living discourse typically only addresses a narrow range of diversity, if, indeed, diversity is addressed at all. The result is a single prescription for healthy living – eat better, exercise more, achieve a healthy weight – that may not be feasible or suitable for all women and girls.

In the introduction to this chapter, we noted that healthy living is often presented as a simple and inexpensive solution for rising rates of obesity, chronic diseases and poor health. But it turns out that the healthy living discourse is neither simple nor, ultimately, a solution. As we have seen, it poses considerable risk to health and well-being, particularly for some populations of women and girls.

Assessing the healthy living discourse using SGBA also underscores the importance of attending to the continuum of sex and gender as well as the breadth of diversity

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