# EXPLORING THE INTERSECTIONS BETWEEN WOMEN'S HEALTH AND POVERTY

**A Policy Paper for**
**Prairie Women's Health Centre of Excellence**
**prepared by**
**Josephine Savarese, B.A. (Hons.), LL.B., LL.M.**

**August 2003**

centres of excellence *for* WOMEN'S HEALTH
centres d'excellence *pour* LA SANTÉ DES FEMMES

**Project #60 of the Prairie Women's Health Centre of Excellence**

PRAIRIE WOMEN'S HEALTH
CENTRE OF EXCELLENCE
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**Administrative Centre:**

Prairie Women's Health Centre
of Excellence
56 The Promenade
Winnipeg, MB R3B 3H9
Telephone: (204) 982-6630
Fax: (204) 982-6637
E-mail: pwhce@uwinnipeg.ca

**Regina Site:**

Prairie Women's Health Centre
of Excellence
University of Regina Extension
Regina, SK S4S 0A2
Telephone: (306) 585-5727
Fax: (306) 585-5825
E-mail: pwhce@uregina.ca

**Saskatoon Site:**

Prairie Women's Health Centre
of Excellence
University of Saskatchewan
Saskatoon, SK S7N 5E5
Telephone: (306) 966-8658
Fax: (306) 966-7920
E-mail: pwhce@usask.ca

**WEBSITE: www.pwhce.ca**

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# Exploring The Intersections Between Women's Health And Poverty:

A Policy Paper for the Prairie Women's Health Centre of Excellence

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**Josephine Savarese**
**Regina, Saskatchewan**
**May 2003**

# EXPLORING THE INTERSECTIONS BETWEEN WOMEN'S HEALTH AND POVERTY:
# A Policy Paper for the Prairie Women's Health Centre of Excellence

## Executive Summary

### Introduction

The population health model encourages health analysts to consider both bio-medical and socio-economic determinants of health in the implementation of policies and practices. Over the last few decades, studies have connected socio-economic factors and health inequalities. New research also acknowledges that women's health is a by-product of gender-based differences resulting from social and economic inequities as well as biologically based sex differences.

Regrettably, in much of the literature, the connections between women's health and women's poverty are often overlooked. Poverty is often addressed as a gender-neutral problem. The failure to connect income inequality, health and gender is problematic due to the pervasiveness and depth of poverty among women in Canada. Overlooking this factor at the research stage makes certain that the gendered nature of poverty remains unaccounted for in policies and programs. According to Beaudry and Reichert:

> *If we are to define poverty as more than simply the lack of income, but a systemic deprivation of healthy human development as part of the human community, then poverty can be an extension of all the life experiences… As well, women, who have endured these histories have accepted (not willingly) the transfer of their own decision making to the state…*

The Prairie Women's Health Centre of Excellence (PWHCE) has addressed the paucity of information on the health issues faced by poor women by supporting a number of research studies. This paper is a review of research papers supported by the PWHCE and is a synthesis of the policy recommendations arising from the research. These are combined with the results and recommendations from two other,

external papers written at the same time, one in Saskatchewan and one in Manitoba.

The documents emphasize that multi-faceted, comprehensive strategies are required to address the health issues women face, arising from living in poverty. The narratives emerging from the research provide valuable insights into women's experiences with parenting, working and living in poverty. Donner et al's paper provides important quantitative data to broaden the understandings of the full scope of the problems. The recommendations for action are based on the voices and observations of the women themselves.

## Summaries of Reports

The five recent reports reviewed from the PWHCE and the two external reports delineate the scope of women's poverty and the ways that low incomes impede well-being.

***Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project*** by Connie Deiter and Linda Otway traces the history of health policies for First Nations people in Canada. The chronic disempowerment experienced by many Aboriginal people suggests that the adoption of health practices will only be realized through long-term healing and the gradual re-acquisition of basic life skills. The report goes on to summarize 98 interviews with Aboriginal women from Saskatchewan and Manitoba, including five Elders. The women interviewed connected their health status with governing policies and procedures. Poverty is identified as a major contributor to the health issues of Aboriginal women. Among its many recommendations, the report calls upon governments to recognize and accept Aboriginal concepts of health and healing.

***Sexual Violence and Dislocation as Social Risk Factors Involved in the Acquisition of HIV Among Women in Manitoba*** by Iris McKeown, M.D., Sharon Reid, Shelly Turner and Pam Orr explores factors leading to the over-representation of Aboriginal women in the incidence and prevalence of HIV infections in Canada. The researchers investigate women's movement and dislocation from rural and remote communities to urban centres. In a study designed by the participants themselves, the women reveal that health decisions for low-income women usually involve giving up one detrimental behaviour for another that affords moderately enhanced well-being. Thus health promotion models that promote individual choice making and responsibility must be cautiously applied when women in fact have profoundly limited "choices" to make.

***"We Did it Together": Low-Income Mothers Working Toward a Healthier Community*** by Kathryn Green emphasizes the limitations of health policies that encourage skill and knowledge development without addressing the social context of poor women's lives. The project brought together low-income mothers to discuss ways to make their communities and social environments safer for women and children. The women call for adequate financial support in a number of ways to enable all families to meet their basic needs. Other recommendations request the

implementation of policies that promote parenting as important and essential and providing parents with further supports such as respite care and further financial aid.

***Left in the Cold: Women's Health and the Demise of Social Housing Policies*** by Darlene Rude and Kathleen Thompson is a comprehensive overview of the diminishing availability of adequate housing for low-income Canadians due to federal and provincial withdrawal of funding and responsibilities. The report includes a literature review and review of policy trends in Canada over the last decade, including an analysis of housing and health policies in Regina, Saskatchewan and Winnipeg, Manitoba. The authors interviewed thirteen women who provided first-hand accounts of their housing difficulties. The report calls for the development of a gender-sensitive housing strategy that can address the shortage of adequate and affordable housing for women, particularly women raising young children, and women with disabilities or other health problems.

***Mothers' Health and Access to Recreation Activities for Children in Low Income Families*** by Shirley Forsyth explores the intersections between children's ability to participate in recreation activities and their mother's health. Forsyth found that increases in recreation fees present challenges for low-income families who cannot cover the costs of children's involvement in activities. In Winnipeg, Manitoba families were affected disproportionately by recent increases in community and municipal fee hikes. The study verifies the cost-savings that result from even minor investments in population health related strategies.

The other two key reports are summarized briefly and the findings and implications from the work are interwoven through the policy analysis.

***Women, Income and Health in Manitoba: An Overview and Ideas for Action*** by Lissa Donner et al. provides statistics on poverty among women in Manitoba and the connections that are made to women's health status. One of the paper's particular strengths is the attention it pays to poverty among Aboriginal women and the resulting health concerns. Donner et al. identify strategies aimed at improving women's incomes, and consequently, their health. The paper makes a persuasive argument that policy initiatives on population health must consistently include women.

***Women, Health and Poverty: Review and Looking Forward*** by Jayne Melville Whyte evaluates the success of initiatives aimed at addressing women's poverty and their well-being. Whyte also visited seven communities that sponsored projects on women's poverty with funding form Health Canada. The women Whyte interviewed provide key insights into the experience of poverty. One of Whyte's most troubling conclusions is that women's poverty is almost invisible to policy makers and program designers: "Poverty has not been seen as a women's issue – not by government and sometimes, not by women's groups, not even by anti-poverty groups".

## Key Themes

From this Policy Analysis five key themes emerge:

1. **The continued importance of gender-based analysis.**

The research confirms that health policies and programs continue to downplay the importance of socio-economic factors in women's health. The research documents the problems that low-income women face in parenting, in "choosing" healthy behaviours and in accessing services that incorporate their multiple roles as survivors, mothers and caregivers. Health promotion strategies are ineffective if they are based on the assumption that "all women are engaging in risk behaviours by choice".

2. **The importance of defining and implementing population health approaches.**

All of the studies point to the need to define and put into operation the population health approach in ways that would more adequately address the parameters of women's poverty. In the case of social housing, for instance, governments endorse population health ideals while implementing policies that undermine its ideals. In *Sharing Our Stories*, one woman points out, "It makes me mad when I see hospitals closing, and doctors leaving, yet, they can build onto the casino."

3. **The need for further research clearly linking health and poverty.**

Researchers' attempts to link well-being to economics are compromised by the interplay between a number of factors that are individually capable of affecting health. Poverty can be difficult to isolate from issues of race, social isolation, low self-esteem. The studies do connect poverty with health conditions, particularly stress and mental health concerns. Largely, however, the causal relationships between women's poverty and all types of illness and disease remain invisible and unexplored. Women's health researchers must also work to provide the epidemiological data policy makers demand.

4. **The importance of women's stories of their lives and their health.**

Notwithstanding the above, the voices of the women in the reports provide real evidence of the challenges that low-income women confront. Their voices are descriptive and evocative. Policy models that promote personal responsibility for health without reflecting on the barriers that some individuals and communities face are inadequate. The women who were part of *Sexual Violence and Dislocation*, for instance, shared their past histories which led to their crucial choices in dismal circumstances. This points to the difficulties in developing effective health policies without extensive and careful consultation with women at risk.

5. **The need to promote positive images of poor women, children and families.**

Living in poverty presents numerous challenges and risks, particularly for those women who are also mothers. *Figuring out how to get enough food for the month when you're using grocery money to pay the rent, you have mall kids and no care; keeping your kids happy and out of trouble when you live in a dangerous neighbourhood and can't*

*pay for recreation; moving a couple of times a year in the hope of finding somewhere decent to live – challenges like these fill the days of parents in poverty.* One way to end "poor bashing" is to provide women in poverty with opportunities to celebrate their strengths and resourcefulness, while at the same time working towards equity and equality. Society must examine the ways that consumerism shapes values and behaviour.

## Consolidated Recommendations

To create a coherent message for future work addressing poverty as a determinant of women's health, the recommendations from the studies cited in this report were analyzed and a set of twelve consolidated recommendations were formed.

1. Expand thinking and commit to further action on the determinants of health.
2. Develop comprehensive strategies for women's equality.
3. Support the creation of healthy communities.
4. Treat women's poverty seriously. Address children's poverty as a common outcome of women's poverty.
5. Commit to developing and implementing a plan to reduce and eliminate poverty.
6. Develop research agendas, policies and programs on women's health and women's poverty in partnership with poor women.
7. Foster and develop supportive networks for poor women.
8. Ensure safe and affordable housing is available for poor women and their families.
9. Commit to improving the health and well-being of Aboriginal women.
10. Develop education programs for women at risk.
11. Require appropriate training for service providers.
12. Recognize non-mainstream professionals, particularly Aboriginal Elders and traditional healers.

## Conclusion

The successful implementation of the population health approach depends upon the adoption of a gender lens. The links between poverty and health, coupled with the fact that women comprise the majority of Canada poor, confirm that addressing women's poverty within the context of women's health will enhance the likelihood that reform strategies will exert a positive influence on health status.

# EXPLORER LES CROISEMENTS ENTRE LA SANTÉ ET LA PAUVRETÉ DES FEMMES: Un document d'orientation pour le Centre d'excellence des Prairies pour la santé des femmes

## Résumé


### Introduction

Le modèle de santé de la population encourage les analystes de santé à tenir compte des déterminants biomédicaux et socio-économiques dans la mise en vigueur des pratiques et politiques. Au cours des dernières décennies, des études ont relié les facteurs socio-économiques aux inégalités de santé. Selon de nouvelles recherches, la santé des femmes serait un sous-produit des différences de genre résultant des inégalités sociales et économiques ainsi que des différences sexuelles à base biologique.

Malheureusement, dans la plupart des documents, les liens entre la santé et la pauvreté des femmes sont souvent négligés. La pauvreté est souvent traitée comme un problème sans distinction de sexe. À cause de l'omniprésence et de la profondeur de la pauvreté chez les femmes au Canada, toute déconnexion entre l'inégalité du revenu, la santé et le sexe est critique. Négliger ce facteur à l'étape de la recherche garantit le fait que l'aspect de la pauvreté spécifique au sexe demeure occulté dans les politiques et programmes. Selon Beaudry et Reichert:

> *Si la pauvreté doit être définie comme étant bien plus qu'un manque de revenu mais plutôt comme une privation systémique du développement sain de la personne dans la communauté humaine, alors la pauvreté peut être un prolongement de toutes les expériences de vie..... De plus, toutes les femmes qui ont enduré ces histoires ont accepté (de force) que leur pouvoir décisionnel soit transféré à l'État*.

Le Centre d'excellence des Prairies pour la santé des femmes (CEPSF) s'est attaqué au manque d'information sur les

problèmes de santé subis par les femmes pauvres en appuyant plusieurs études de recherche. Ce document offre un examen des documents de recherche parrainés par le CEPSF et une synthèse des recommandations politiques émanant de la recherche, combinées aux résultats et recommandations découlant de deux documents externes publiés en même temps, l'un en Saskatchewan et l'autre au Manitoba.

Ces documents soulignent l'importance de stratégies globales et à multiples facettes pour régler les questions de santé qu'affrontent les femmes vivant dans la pauvreté. Les récits tirés des recherches éclairent de façon inestimable les expériences des femmes en matière de parentalité, d'emploi et de vie dans la pauvreté. Le document de Donner et al comporte d'importantes données quantitatives qui accentuent la compréhension de l'étendue des problèmes. Les recommandations d'action sont basées sur les commentaires et les observations formulés par les femmes elles-mêmes.

## Résumé des rapports

Les cinq rapports du CEPSF et les deux rapports externes décrivent l'ampleur de la pauvreté chez les femmes et les diverses entraves des faibles revenus sur le bien-être.

***Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project***, par Connie Deiter et Linda Otway. Ce rapport retrace l'histoire des politiques de santé pour les peuples des Premières Nations au Canada. Étant donné la dés-habilitation chronique de nombreux autochtones, l'adoption de pratique de santé ne se réalisera que par le biais du rétablissement à long terme et de la ré-acquisition graduelle des aptitudes fondamentales à la vie quotidienne. Le rapport résume ensuite 98 entrevues avec des femmes autochtones de la Saskatchewan et du Manitoba, y compris cinq Aînées. Les femmes interviewées ont relié leur condition de santé aux politiques et procédures en vigueur. La pauvreté est identifiée comme un vecteur important des problèmes de santé des femmes autochtones. Parmi leurs nombreuses recommandations, les auteures du rapport demandent aux gouvernements de reconnaître et d'accepter les concepts de santé et de guérison des autochtones.

***Sexual Violence and Dislocation as Social Risk Factors Involved in the Acquisition of HIV Among Women in Manitoba*****,** par Iris McKeown, M.D., Sharon Reid, Shelly Turner et Pam Orr.. Ce rapport explore les facteurs engendrant la sur-représentation des femmes autochtones dans l'incidence et la prévalence des infections VIH au Canada. Les recherchistes ont examiné le mouvement des femmes et leur migration des communautés rurales et éloignées vers les centres urbains. Dans une étude conçue par les participantes elles-mêmes, les femmes ont révélé que les décisions de santé pour les femmes à faible revenu impliquent en général l'abandon d'un comportement préjudiciable pour un autre favorisant un bien-être relativement amélioré. Par conséquent, la promotion de la santé encourageant la responsabilité et la prise de décision individuelles doit être prudemment exercée lorsque les femmes ont des "choix" très limités à faire.

***"We Did it Together": Low-Income Mothers Working Towards a Healthier Community*,** par Kathryn Green. Ce rapport met l'accent sur les limitations des politiques de santé favorisant le perfectionnement des compétences et des connaissances sans tenir compte du contexte social de la vie des femmes pauvres. Au titre de ce projet, des mères à faible revenu ont été réunies afin de discuter des moyens à prendre pour rendre leurs communautés et leurs environnements sociaux plus sécuritaires pour les femmes et les enfants. Les femmes ont réclamé de l'aide financière adéquate et diversifiée afin de combler les besoins fondamentaux des familles. D'autres recommandations ont été formulées, notamment la mise en vigueur de politiques encourageant la parentalité comme importante et essentielle et fournissant d'autres soutiens aux parents comme des soins de relève et de l'aide financière supplémentaire.

***Left in the Cold: Women's Health and the Demise of Social Policies*** par Darlene Rude et Kathleen Thompson. Ce rapport est un bilan complet de l'érosion de la disponibilité des logements adéquats pour les Canadiens à faible revenu, érosion due au désengagement des gouvernements fédéral et provinciaux en matière de financement et de responsabilités. Ce rapport inclut une revue de la documentation et un examen des tendances politiques au Canada depuis la dernière décennie, notamment une analyse des politiques de logement et de santé à Regina, Saskatchewan et à Winnipeg, Manitoba. Les auteures ont interviewé treize femmes qui ont donné des exemples concrets de leurs difficultés de logement. Dans ce rapport, les auteures réclament l'élaboration d'une stratégie de logement spécifique au genre susceptible de régler la pénurie de logements adéquats et abordables pour les femmes, notamment pour celles qui élèvent de jeunes enfants et pour les femmes avec des déficiences ou autres problèmes de santé.

***Mothers' Health and Access to Recreation Activities for Children in Low Income Families***, par Shirley Forsyth. Ce rapport explore les croisements entre la capacité des enfants de participer à des activités récréatives et la santé de leur mère. Selon Forsyth, les augmentations des frais d'activités récréatives constituent des défis pour les familles à faible revenu qui ne peuvent défrayer les coûts de participation des enfants. À Winnipeg, Manitoba, les familles étaient touchées de façon disproportionnée par les récentes hausses des frais communautaires et municipaux. L'étude vérifie les économies résultant d'investissements même mineurs dans des stratégies liées à la santé de la population.

Les deux autres rapports clés sont brièvement résumés; les résultats et les implications du travail s'entrelacent tout au long de l'analyse politique.

***Women, Income and Health in Manitoba: An Overview and Ideas for Action*** par Lissa Donner et al. Ce rapport offre des statistiques sur la pauvreté chez les femmes au Manitoba et les rapports établis avec la condition de santé des femmes. L'attention accordée à la pauvreté chez les femmes autochtones t les problèmes de santé résultants constitue l'une des forces particulières de cette étude. Donner et al. identifient des stratégies visant à améliorer les revenus des femmes et, par

conséquent, leur santé. Ce rapport contient un argument persuasif, à savoir que les femmes soient systématiquement inclues dans les initiatives politiques en matière de santé publique.

***Women, Health and Poverty: Review and Looking Forward***, par Jayne Melville Whyte. L'auteure évalue le succès des politiques visant à régler la pauvreté des femmes et leur bien-être. Mme Whyte a également visité sept communautés ayant parrainé des projets sur la pauvreté des femmes grâce au financement de Santé Canada. Les femmes interviewées par Mme Whyte ont donné des exemples concrets de leur expérience avec la pauvreté. L'une des conclusions les plus troublantes de l'auteure est que la pauvreté des femmes est pratiquement invisible pour les décideurs politiques et les concepteurs de programmes: "La pauvreté n'a pas été perçue comme un problème de femme - ni par les gouvernements et ni par les groupes de femmes quelquefois et ni même par les groupes anti-pauvreté".

## Thèmes principaux

Cinq thèmes principaux émanent de cette analyse politique:

1. **L'importance soutenue de l'analyse basée sur le genre**
   La recherche confirme que les politiques et programmes de santé continuent à minimiser l'importance des facteurs socio-économiques dans la santé des femmes. La recherche documente les problèmes qu'affrontent les femmes à faible revenu en matière de parentalité, lorsqu'elles "choisissent" des comportements sains et accèdent à des services incorporant leurs rôles multiples de survivantes, mères et aidants naturels. Les stratégies de promotion de la santé sont inefficaces si elles sont basées sur la prémisse selon laquelle "toutes les femmes s'engagent par choix dans des comportements à risques".

2. **L'importance de définir des approches de santé publique et de les mettre en vigueur**
   Toutes les études concordent sur le besoin de définir et de mettre en vigueur des approches de santé publique susceptibles de traiter plus adéquatement les paramètres de la pauvreté des femmes. Dans le cas du logement social par exemple, les gouvernements endossent les idéaux de santé de la population tout en implantant des politiques sapant leurs idéaux. Dans *Sharing Our Stories*, une femme a déclaré " Je suis malade quand je vois des hôpitaux fermer, des médecins partir et pourtant, on agrandit des casinos".

3. **Le besoin de recherches supplémentaire liant nettement la santé et la pauvreté**
   L'action réciproque de plusieurs facteurs individuellement capables d'affecter la santé compromet les tentatives des recherchistes visant à lier le bien-être à l'économique. Il peut s'avérer difficile d'isoler la pauvreté des questions de race, d'isolement social, de faible estime personnelle. Les études relient la pauvreté aux conditions de santé, notamment les problèmes de stress et de santé mentale. Mais les relations causales entre la pauvreté des femmes et tous les types de maladie demeurent largement invisibles et inexplorées. Les recherchistes en

santé féminine doivent également fournir les données épidémiologiques demandées par les décideurs politiques.

4. **L'importance des histoires de vie et de santé des femmes**
   Nonobstant ce qui précède, les femmes énoncent dans les rapports la preuve réelle des défis auxquels font face les femmes à faible revenu. Leurs récits sont descriptifs et évocateurs. Les modèles politiques encourageant la responsabilité personnelle en matière de santé, sans tenir compte des obstacles qu'affrontent certaines personnes et communautés, sont inadéquats. Les femmes ayant participé à l'étude *Sexual Violence and Dislocation* , par exemple, ont partagé leurs histoires qui les ont amenées à faire des choix cruciaux dans de lugubres circonstances. Ce qui montre les difficultés d'élaborer des politiques de santé efficaces sans avoir intensément et soigneusement consulté les femmes à risques.

5. **Le besoin de promouvoir des images positives des femmes, enfants et familles pauvres**
   Vivre dans la pauvreté présente de nombreux défis et risques, notamment pour les femmes qui sont également mères. *Imaginer comment obtenir suffisamment de nourriture pour le mois quand l'argent de l'épicerie sert à payer le loyer et que vous avez de petits enfants et aucune aide; garder vos enfants heureux et hors des problèmes quand vous vivez dans un voisinage dangereux et que vous ne pouvez payer des activités récréatives; déménager quelquefois dans l'année avec l'espoir de trouver un lieu décent pour vivre - que de défis qui comblent les jours de parents vivant dans la pauvreté*. Pour mettre fin à "ce dénigrement", il suffirait de fournir aux femmes vivant dans la pauvreté des possibilités de célébrer leurs forces et leur ingéniosité tout en oeuvrant simultanément pour l'équité et l'égalité. La société doit examiner la manière dont le consommateurisme façonne les valeurs et les comportements.

## Recommandations consolidées

En vue de créer un message cohérent pour les futurs travaux traitant la pauvreté comme un déterminant de santé des femmes, nous avons analysé les recommandations des études citées dans ce rapport et nous les avons consolidées en un ensemble de douze recommandations.

1. Élargir le raisonnement et s'engager envers de futures actions sur les déterminants de santé.

2. Élaborer des stratégies complètes pour l'égalité des femmes

3. Appuyer la création de communautés saines

4. Traiter sérieusement la pauvreté chez les femmes. Traiter la pauvreté des enfants comme un résultat commun de la pauvreté des femmes.

5. S'engager à élaborer et à implanter un plan visant à réduire et éliminer la pauvreté.

6. Élaborer des programmes de recherche ainsi que des politiques et programmes sur la santé des femmes et la pauvreté des femmes, en partenariat avec des femmes pauvres.

7. Encourager et établir des réseaux de soutien pour les femmes pauvres.

8. S'assurer que des logements sécuritaires et abordables soient disponibles pour les femmes pauvres et leurs familles.

9. S'engager à améliorer la santé et le bien-être des femmes autochtones.

10. Élaborer des programmes d'éducation pour les femmes à risques.

11. Réclamer de la formation appropriée pour les fournisseurs de services.

12. Reconnaître les professionnels non conventionnels, notamment les Aînés autochtones et les guérisseurs traditionnels.

**Conclusion**

L'adoption d'une optique spécifique au sexe est le principal facteur de succès de la mise en vigueur d'une approche de santé de la population. Parallèlement au fait que les femmes constituent la majorité des Canadiens pauvres, les liens entre la pauvreté et la santé confirment que le règlement de la pauvreté des femmes dans le contexte de la santé accroîtra vraisemblablement l'incidence positive qu'exerceront les réformes et stratégies sur la situation de la santé.

# EXPLORER LES CROISEMENTS ENTRE LA SANTÉ ET LA PAUVRETÉ DES FEMMES:
# Un document d'orientation pour le Centre d'excellence des Prairies pour la santé des femmes

## Résumé


### Introduction

Le modèle de santé de la population encourage les analystes de santé à tenir compte des déterminants biomédicaux et socio-économiques dans la mise en vigueur des pratiques et politiques. Au cours des dernières décennies, des études ont relié les facteurs socio-économiques aux inégalités de santé. Selon de nouvelles recherches, la santé des femmes serait un sous-produit des différences de genre résultant des inégalités sociales et économiques ainsi que des différences sexuelles à base biologique.

Malheureusement, dans la plupart des documents, les liens entre la santé et la pauvreté des femmes sont souvent négligés. La pauvreté est souvent traitée comme un problème sans distinction de sexe. À cause de l'omniprésence et de la profondeur de la pauvreté chez les femmes au Canada, toute déconnexion entre l'inégalité du revenu, la santé et le sexe est critique. Négliger ce facteur à l'étape de la recherche garantit le fait que l'aspect de la pauvreté spécifique au sexe demeure occulté dans les politiques et programmes. Selon Beaudry et Reichert:

> *Si la pauvreté doit être définie comme étant bien plus qu'un manque de revenu mais plutôt comme une privation systémique du développement sain de la personne dans la communauté humaine, alors la pauvreté peut être un prolongement de toutes les expériences de vie..... De plus, toutes les femmes qui ont enduré ces histoires ont accepté (de force) que leur pouvoir décisionnel soit transféré à l'État*.

Le Centre d'excellence des Prairies pour la santé des femmes (CEPSF) s'est

attaqué au manque d'information sur les problèmes de santé subis par les femmes pauvres en appuyant plusieurs études de recherche. Ce document offre un examen des documents de recherche parrainés par le CEPSF et une synthèse des recommandations politiques émanant de la recherche, combinées aux résultats et recommandations découlant de deux documents externes publiés en même temps, l'un en Saskatchewan et l'autre au Manitoba.

Ces documents soulignent l'importance de stratégies globales et à multiples facettes pour régler les questions de santé qu'affrontent les femmes vivant dans la pauvreté. Les récits tirés des recherches éclairent de façon inestimable les expériences des femmes en matière de parentalité, d'emploi et de vie dans la pauvreté. Le document de Donner et al comporte d'importantes données quantitatives qui accentuent la compréhension de l'étendue des problèmes. Les recommandations d'action sont basées sur les commentaires et les observations formulés par les femmes elles-mêmes.

## Résumé des rapports

Les cinq rapports du CEPSF et les deux rapports externes décrivent l'ampleur de la pauvreté chez les femmes et les diverses entraves des faibles revenus sur le bien-être.

***Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project***, par Connie Deiter et Linda Otway. Ce rapport retrace l'histoire des politiques de santé pour les peuples des Premières Nations au Canada. Étant donné la dés-habilitation chronique de nombreux autochtones, l'adoption de pratique de santé ne se réalisera que par le biais du rétablissement à long terme et de la ré-acquisition graduelle des aptitudes fondamentales à la vie quotidienne. Le rapport résume ensuite 98 entrevues avec des femmes autochtones de la Saskatchewan et du Manitoba, y compris cinq Aînées. Les femmes interviewées ont relié leur condition de santé aux politiques et procédures en vigueur. La pauvreté est identifiée comme un vecteur important des problèmes de santé des femmes autochtones. Parmi leurs nombreuses recommandations, les auteures du rapport demandent aux gouvernements de reconnaître et d'accepter les concepts de santé et de guérison des autochtones.

***Sexual Violence and Dislocation as Social Risk Factors Involved in the Acquisition of HIV Among Women in Manitoba*****,** par Iris McKeown, M.D., Sharon Reid, Shelly Turner et Pam Orr.. Ce rapport explore les facteurs engendrant la sur-représentation des femmes autochtones dans l'incidence et la prévalence des infections VIH au Canada. Les recherchistes ont examiné le mouvement des femmes et leur migration des communautés rurales et éloignées vers les centres urbains. Dans une étude conçue par les participantes elles-mêmes, les femmes ont révélé que les décisions de santé pour les femmes à faible revenu impliquent en général l'abandon d'un comportement préjudiciable pour un autre favorisant un

bien-être relativement amélioré. Par conséquent, la promotion de la santé encourageant la responsabilité et la prise de décision individuelles doit être prudemment exercée lorsque les femmes ont des "choix" très limités à faire.

***"We Did it Together": Low-Income Mothers Working Towards a Healthier Community*,** par Kathryn Green. Ce rapport met l'accent sur les limitations des politiques de santé favorisant le perfectionnement des compétences et des connaissances sans tenir compte du contexte social de la vie des femmes pauvres. Au titre de ce projet, des mères à faible revenu ont été réunies afin de discuter des moyens à prendre pour rendre leurs communautés et leurs environnements sociaux plus sécuritaires pour les femmes et les enfants. Les femmes ont réclamé de l'aide financière adéquate et diversifiée afin de combler les besoins fondamentaux des familles. D'autres recommandations ont été formulées, notamment la mise en vigueur de politiques encourageant la parentalité comme importante et essentielle et fournissant d'autres soutiens aux parents comme des soins de relève et de l'aide financière supplémentaire.

***Left in the Cold: Women's Health and the Demise of Social Policies*** par Darlene Rude et Kathleen Thompson. Ce rapport est un bilan complet de l'érosion de la disponibilité des logements adéquats pour les Canadiens à faible revenu, érosion due au désengagement des gouvernements fédéral et provinciaux en matière de financement et de responsabilités. Ce rapport inclut une revue de la documentation et un examen des tendances politiques au Canada depuis la dernière décennie, notamment une analyse des politiques de logement et de santé à Regina, Saskatchewan et à Winnipeg, Manitoba. Les auteures ont interviewé treize femmes qui ont donné des exemples concrets de leurs difficultés de logement. Dans ce rapport, les auteures réclament l'élaboration d'une stratégie de logement spécifique au genre susceptible de régler la pénurie de logements adéquats et abordables pour les femmes, notamment pour celles qui élèvent de jeunes enfants et pour les femmes avec des déficiences ou autres problèmes de santé.

***Mothers' Health and Access to Recreation Activities for Children in Low Income Families***, par Shirley Forsyth. Ce rapport explore les croisements entre la capacité des enfants de participer à des activités récréatives et la santé de leur mère. Selon Forsyth, les augmentations des frais d'activités récréatives constituent des défis pour les familles à faible revenu qui ne peuvent défrayer les coûts de participation des enfants. À Winnipeg, Manitoba, les familles étaient touchées de façon disproportionnée par les récentes hausses des frais communautaires et municipaux. L'étude vérifie les économies résultant d'investissements même mineurs dans des stratégies liées à la santé de la population.

Les deux autres rapports clés sont brièvement résumés; les résultats et les implications du travail s'entrelacent tout au long de l'analyse politique.

***Women, Income and Health in Manitoba: An Overview and Ideas for Action*** par Lissa Donner et al. Ce rapport offre des statistiques sur la pauvreté chez les femmes au Manitoba et les rapports établis avec la condition de santé des femmes. L'attention accordée à la pauvreté chez les femmes autochtones t les problèmes de santé résultants constitue l'une des forces particulières de cette étude. Donner et al. identifient des stratégies visant à améliorer les revenus des femmes et, par conséquent, leur santé. Ce rapport contient un argument persuasif, à savoir que les femmes soient systématiquement inclues dans les initiatives politiques en matière de santé publique.

***Women, Health and Poverty: Review and Looking Forward***, par Jayne Melville Whyte. L'auteure évalue le succès des politiques visant à régler la pauvreté des femmes et leur bien-être. Mme Whyte a également visité sept communautés ayant parrainé des projets sur la pauvreté des femmes grâce au financement de Santé Canada. Les femmes interviewées par Mme Whyte ont donné des exemples concrets de leur expérience avec la pauvreté. L'une des conclusions les plus troublantes de l'auteure est que la pauvreté des femmes est pratiquement invisible pour les décideurs politiques et les concepteurs de programmes: "La pauvreté n'a pas été perçue comme un problème de femme - ni par les gouvernements et ni par les groupes de femmes quelquefois et ni même par les groupes anti-pauvreté".

## Thèmes principaux

Cinq thèmes principaux émanent de cette analyse politique:

1. **L'importance soutenue de l'analyse basée sur le genre**
   La recherche confirme que les politiques et programmes de santé continuent à minimiser l'importance des facteurs socio-économiques dans la santé des femmes. La recherche documente les problèmes qu'affrontent les femmes à faible revenu en matière de parentalité, lorsqu'elles "choisissent" des comportements sains et accèdent à des services incorporant leurs rôles multiples de survivantes, mères et aidants naturels. Les stratégies de promotion de la santé sont inefficaces si elles sont basées sur la prémisse selon laquelle "toutes les femmes s'engagent par choix dans des comportements à risques".

2. **L'importance de définir des approches de santé publique et de les mettre en vigueur**
   Toutes les études concordent sur le besoin de définir et de mettre en vigueur des approches de santé publique susceptibles de traiter plus adéquatement les paramètres de la pauvreté des femmes. Dans le cas du logement social par exemple, les gouvernements endossent les idéaux de santé de la population tout en implantant des politiques sapant leurs idéaux. Dans *Sharing Our Stories*, une femme a déclaré " Je suis malade quand je vois des

hôpitaux fermer, des médecins partir et pourtant, on agrandit des casinos".

3. **Le besoin de recherches supplémentaire liant nettement la santé et la pauvreté**
   L'action réciproque de plusieurs facteurs individuellement capables d'affecter la santé compromet les tentatives des recherchistes visant à lier le bien-être à l'économique. Il peut s'avérer difficile d'isoler la pauvreté des questions de race, d'isolement social, de faible estime personnelle. Les études relient la pauvreté aux conditions de santé, notamment les problèmes de stress et de santé mentale. Mais les relations causales entre la pauvreté des femmes et tous les types de maladie demeurent largement invisibles et inexplorées. Les recherchistes en santé féminine doivent également fournir les données épidémiologiques demandées par les décideurs politiques.

4. **L'importance des histoires de vie et de santé des femmes**
   Nonobstant ce qui précède, les femmes énoncent dans les rapports la preuve réelle des défis auxquels font face les femmes à faible revenu. Leurs récits sont descriptifs et évocateurs. Les modèles politiques encourageant la responsabilité personnelle en matière de santé, sans tenir compte des obstacles qu'affrontent certaines personnes et communautés, sont inadéquats. Les femmes ayant participé à l'étude *Sexual Violence and Dislocation* , par exemple, ont partagé leurs histoires qui les ont amenées à faire des choix cruciaux dans de lugubres circonstances. Ce qui montre les difficultés d'élaborer des politiques de santé efficaces sans avoir intensément et soigneusement consulté les femmes à risques.

5. **Le besoin de promouvoir des images positives des femmes, enfants et familles pauvres**
   Vivre dans la pauvreté présente de nombreux défis et risques, notamment pour les femmes qui sont également mères. *Imaginer comment obtenir suffisamment de nourriture pour le mois quand l'argent de l'épicerie sert à payer le loyer et que vous avez de petits enfants et aucune aide; garder vos enfants heureux et hors des problèmes quand vous vivez dans un voisinage dangereux et que vous ne pouvez payer des activités récréatives; déménager quelquefois dans l'année avec l'espoir de trouver un lieu décent pour vivre - que de défis qui comblent les jours de parents vivant dans la pauvreté*. Pour mettre fin à "ce dénigrement", il suffirait de fournir aux femmes vivant dans la pauvreté des possibilités de célébrer leurs forces et leur ingéniosité tout en oeuvrant simultanément pour l'équité et l'égalité. La société doit examiner la manière dont le consommateurisme façonne les valeurs et les comportements.

## Recommandations consolidées

En vue de créer un message cohérent pour les futurs travaux traitant la pauvreté comme un déterminant de santé des femmes, nous avons analysé les recommandations des études citées dans ce rapport et nous les avons consolidées en un ensemble de douze recommandations.

**1.** Élargir le raisonnement et s'engager envers de futures actions sur les déterminants de santé.

**2.** Élaborer des stratégies complètes pour l'égalité des femmes

**3.** Appuyer la création de communautés saines

**4.** Traiter sérieusement la pauvreté chez les femmes. Traiter la pauvreté des enfants comme un résultat commun de la pauvreté des femmes.

**5.** S'engager à élaborer et à implanter un plan visant à réduire et éliminer la pauvreté.

**6.** Élaborer des programmes de recherche ainsi que des politiques et programmes sur la santé des femmes et la pauvreté des femmes, en partenariat avec des femmes pauvres.

**7.** Encourager et établir des réseaux de soutien pour les femmes pauvres.

**8.** S'assurer que des logements sécuritaires et abordables soient disponibles pour les femmes pauvres et leurs familles.

**9.** S'engager à améliorer la santé et le bien-être des femmes autochtones.

**10.** Élaborer des programmes d'éducation pour les femmes à risques.

**11.** Réclamer de la formation appropriée pour les fournisseurs de services.

**12.** Reconnaître les professionnels non conventionnels, notamment les Aînés autochtones et les guérisseurs traditionnels.

## Conclusion

L'adoption d'une optique spécifique au sexe est le principal facteur de succès de la mise en vigueur d'une approche de santé de la population. Parallèlement au fait que les femmes constituent la majorité des Canadiens pauvres, les liens entre la pauvreté et la santé confirment que le règlement de la pauvreté des femmes dans le contexte de la santé accroîtra vraisemblablement l'incidence positive qu'exerceront les réformes et stratégies sur la situation de la santé.

# EXPLORING THE INTERSECTIONS BETWEEN WOMEN'S HEALTH AND POVERTY

### A Policy Paper for Prairie Women's Health Centre of Excellence

## PART 1. INTRODUCTION

Over the last decades, studies have proliferated that connect socio-economic factors and health inequalities. They reflect the understanding that "health" is more than biological factors. Linking health to social and political factors led to the development of more comprehensive health concepts and policies.

The increase in literature on women's health is a further positive outcome of expanded health definitions. The research acknowledges that women's health is a by-product of biologically based sex differences as well as gender-based differences that result from social and economic inequalities.

Regrettably, the connections between women's health and women's poverty are often overlooked. Health researchers habitually address poverty as a gender-neutral problem.[1] The failure to connect income inequality, health and gender is problematic due to the pervasiveness and depth of poverty among women.[2] Studies on gender inequality report that women comprise the majority of Canada's poor.[3] Overlooking this factor at the research stage makes certain that the gendered nature of poverty remains unaccounted for in policies and programs.

Prairie Women's Health Centre of Excellence has supported gender-specific research on the social determinants of health in Manitoba and Saskatchewan since 1997. Research teams of academics and women's organizations have explored and reported on a wide range of topics. Recommendations concerning specific health care issues, and government policies and programs affecting the determinants of health are contained in the PWHCE reports available through the Centre or on the Centre's website, www.pwhce.ca.

The Prairie Women's Health Centre of Excellence (PWHCE) addressed the paucity of information on the health issues faced by poor women by supporting a number of research studies. This paper is a review of research papers supported by the PWHCE and is a synthesis of the policy recommendations arising from the research. These are combined with the results and recommendations from two other papers written at the same time, one in Saskatchewan and one in Manitoba.

## Defining Health

In 1948, the World Health Organization issued a definition of health "as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[4] Over the years, concepts of health further expanded to acknowledge a correlation between socio-economic factors and health inequalities.[5] New frameworks related unemployment, poor housing, educational status, child poverty and problems in early childhood development to poorer health status.[6] Links were also made between health and gender. The literature associates women's health status with biological factors and gender-based differences that often result from social and economic inequalities.[7]

## Defining Poverty

In Canada, governments have not adopted an official definition of poverty. The complex dimensions of poverty pose difficulties in determining its parameters. According to the Canadian Council on Social Development, achieving universal guidelines is challenging because what comprises poverty varies from location to location, across time periods and family units.[8] Debates on the appropriate measure of poverty centre around two elements: definitions of income and determinations of "legitimate necessary expenditures."[9] Differing viewpoints have led to the development of several working definitions of poverty. These vary from Statistics Canada's Low Income Cut-off lines and Low Income Measure to the Fraser Institute's poverty lines and the Social Planning Council of Metropolitan Toronto budget guidelines.[10] Some of the guidelines are national in scope while others are provincial, even local. [11]

## Women-Centred Definitions of Poverty

Poverty is connected to health status because it encroaches on many aspects of life**.** It is argued that the real definition of poverty lies in the experiences of people who regularly confront this situation. In the study, *Taking Control: A Wellness Program for Women Building Healthier Communities,* Beaudry and Reichert describe how poverty affects women's lives and their health. They describe poverty in broad terms that reflect the social and political implications for women. They state:

> *If we are to define poverty as more than simply the lack of income, but a systemic deprivation of healthy human development as part of the human community, then poverty can be an extension of all the life experiences [of abuse, school dropout, substance abuse, and victimizations.] As well, women who have endured these histories have accepted (not willingly) the transfer of their own decision making to the state...*[12]

Donner highlights the extent of women's poverty, stating:

> *The link between income and health has a special importance for women. In Manitoba (as in the rest of Canada), poverty discriminates, striking women substantially more frequently and more severely than men.*[13]

She underscores the need for concentrated action on poverty to improve women's health.[14]

Regardless of the measurement used, it is confirmed that women constitute the majority of Canada's poor. [15] *Women, Income and Health in Manitoba: An Overview and Ideas for Action* adopts Statistics Canada Low-Income Cut-off lines as the measurement of poverty. The research demonstrates high levels of poverty among women in Canada.[16] In Manitoba, it was determined that sixty per cent of all poor adults were women.[17] Poverty is particularly persistent and problematic among Aboriginal women, women with disabilities, visible minority women and women who are separated and divorced.[18] According to the Saskatchewan Women's Secretariat, in 1999 30% of lone parent families headed by women had after-tax income below the LICO compared to 5% of two parent families with children[19]. Manitoba rates second among the provinces on child poverty as 23.7 % of the province's children live in economic deprivation. Children residing with single-parent mothers experienced the second highest rates of poverty in Canada at 70.7%.[20]

One of the most troubling aspects of women's poverty is its persistence in the face of labour market involvement.[21] Unions play an important role in advocating for their members and in ensuring equitable wages for women.[22] Women's over-representation in insecure, poorly paid jobs accounts for their high profile among the working poor.

## The Connections between Health and Poverty

The Canadian health community has endorsed a population health approach that stresses intersectoral action on health. Both the Governments of Saskatchewan and Manitoba have acknowledged this finding in public documents, including *A Population Health Framework for Saskatchewan Health Districts*, the *Manitoba Sustainable Development Initiative* [23] and *The Action Plan for Saskatchewan Health Care* (published in 2002).[24] The primary goals of population health are maintaining and improving the health of the entire population and reducing inequalities in health.[25] This model is premised on the belief that health status is influenced by an array of factors, known as the determinants of health. These include: income and social status, social support networks, education, employment and working conditions, physical environments, social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture.[26]

The 1996 *Report on the Health of Canadians* is an example of a Canadian document that analyzes the health affects of poverty.[27] It states that health inequalities continue to exist even after several decades of Medicare. High income is a predictor of longevity and is a factor that influences almost every category of death and illness.[28] According to the report, improvements to health will result from multi-sectoral strategies. Cooperative action by federal and provincial ministries, ranging from health, finance, education, and social services to housing, labour, justice, Aboriginal affairs, and economic development should become the norm.[29]

A limitation of the population health approach is the relative absence of gender-based analysis on the determinants of health. Health programs directed towards the achievement of health continue to be conceptualized and implemented without reference to gender. Donner's review of the literature led to this conclusion:

> *While Health Canada recognizes gender as one of twelve determinants of health, much of the research in population health makes no reference, or limited reference, to the health of women, and the few references that are included deal mostly with women as mothers.*[30]

Canada's national and international commitments to women's equality give emphasis to the call for renewed policy attention to women's health.[31]

## The Connections Between Health and Low Income for Women

According to the Canadian Research Institute for the Advancement of Women's (CRIAW) Women and Poverty fact sheet, there are numerous health problems that relate to women's poverty.[32] These include acute and chronic ill health, susceptibility to infectious and other diseases, increased risk of heart disease, arthritis, stomach ulcers, migraines, clinical depression, stress, breakdown, vulnerability to mental illness and self-destructive coping behaviours.

Low-income women report that financial limitations, stress and isolation wear them down emotionally and physically. Poverty undermines self-confidence, making it more difficult to be healthy and to provide a positive environment for children. The challenges of living in poverty are manifold. They include finding work, locating better paid jobs, and finding adequate housing and subsidized child care to facilitate work or school involvement. With limited resources, women must meet the nutritional, clothing and other needs of children and themselves, and get emotional support from others. Many are trapped in a cycle that opens few avenues. Low-income women struggle to meet minimal living standards, leaving them with limited resources for change.

## Poverty and Health Status Among Aboriginal Women

It is reported that Aboriginal people are the "most disadvantaged of all citizens" with the lowest health status.[33] Aboriginal women experience widespread poverty and significant health challenges.[34] According to *Women, Income and Health in Manitoba: An Overview and Ideas for Action*, health problems among Aboriginal women range from heart problems and chronic conditions developed at younger ages to hypertension, diabetes, arthritis and rheumatism. Violent deaths and suicides occur more regularly among Aboriginal women. Their health compares negatively to that of Aboriginal men and other Canadian women.

Aboriginal women in Saskatchewan face similar challenges. *A Profile of Aboriginal Women in Saskatchewan* reports that the well being of Aboriginal women is severely compromised by unrelenting poverty and persistent discrimination.[35] They have shorter lives, more hospitalizations, and higher rates of disability. Researchers hypothesize that post traumatic stress disorder may be high among Aboriginal women.[36] Drug, alcohol and nicotine addiction is more common as is the contraction of HIV.[37] Family violence is identified as a concern for eight out of ten

Aboriginal women. Poor housing conditions, unemployment, violence and instability are among the factors that work to the detriment of Aboriginal women.

A factor relating to the lower health status of Aboriginal women is that they often parent alone. Studies from Regina and Saskatoon indicate that approximately half of Aboriginal children reside with a single parent.[38] Aboriginal children comprise thirty per cent of the children in lone parent families in these cities. As single parent families experience high rates of poverty, the majority of these families likely live in low-income situations.[39] The problems associated with poverty are particularly acute for Aboriginal women. The *Sharing Our Stories* report, highlighted later, states:

> "*the loss of traditional values, poverty, alcohol and drug abuse, overcrowded housing and low self-esteem play out in the lives of Aboriginal women."*[40]

# PART 2: KEY REPORTS ON WOMEN HEALTH AND POVERTY IN MANITOBA AND SASKATCHEWAN

Recent reports from the Prairie Women's Health Centre of Excellence, the Women's Health Clinic and by Jane Whyte, with the Women, Health and Poverty Advisory Committee, delineate the scope of women's poverty and the ways that low income impedes well-being. The documents emphasize that multifaceted, comprehensive strategies are required. The recommendations for action are based on the voices and observations of women. These narratives provide valuable insights into women's experiences with parenting, working and living in poverty.

Five PWHCE research studies are summarized in this document.

*Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project* by Connie Deiter and Linda Otway

*Sexual Violence and Dislocation as Social Risk Factors Involved in the Acquisition of HIV Among Women in Manitoba* by Dr. Iris McKeown, Sharon Reid, Shelley Turner and Pam Orr

*"We Did It Together": Low - Income Mothers Working Toward a Healthier Community* by Kathryn Green

*Left in the Cold: Women, Health and the Demise of Social Housing Policies* by Darlene Rude and Kathleen Thompson

*Mothers' Health and Access to Recreation Activities for Children in Low Income Families* by Shirley Forsyth

## A. Two Key Reports from Saskatchewan and Manitoba

Findings from the following studies are distributed throughout this document to illustrate points and to provide clarification on central points.

### 1. Women, Income and Health in Manitoba: An Overview and Ideas for Action

by Lissa Donner, with contributions by Angela Busch and Nahanni Fontaine

One of the key contributions of Donner's study is the statistics provided on poverty among women in Manitoba and the connections that are made to women's health status.

Donner's study describes the incidence of poverty among women in Manitoba. It summarizes and expands on the literature linking income to health, with a focus on women's utilization of health services. The paper outlines exemplary models of service for low-income women, and it proposes public policy interventions for improving the health of Manitoba women living in poverty. A further strength of the paper is the attention paid to poverty among Aboriginal women and the resulting health concerns.

Donner identifies strategies aimed at improving women's incomes, and, consequently, their health. In addition to providing extensive documentation on the breadth of women's poverty in Manitoba,

the paper makes a persuasive argument that policy initiatives on population health must be consistently expanded to include women.

## 2. Women, Health and Poverty: Review and Looking Forward [41]

by Jayne Melville Whyte

The report *Women, Health and Poverty: Review and Looking Forward* evaluated the success of earlier initiatives aimed at addressing women's poverty and their well-being. The study was guided by the following vision, stated on page 3:

> *To work together to empower all stakeholders in the women, health and poverty agenda through a research and community development process.*

The document includes an overview of the various projects that were implemented throughout Saskatchewan. To complete her study, Whyte visited seven communities that sponsored projects on women's poverty with funding from Health Canada. In each of the communities, she met with women's organizations, policy makers and researchers, and women in poverty to explore the value of the project to the community and to participants and to explore the next steps that were needed to further the anti-poverty agenda. Whyte incorporates quotes from the women she interviewed. Their observations provide key insights into the experience of poverty.

Based on these consultations, Whyte prepared an extensive action plan on improving the lives of poor women. Her recommendations relate to strengthening community action, building healthy public policy, creating supportive environments, reorienting health services and the provision of adequate funding for the range of health and community services that women require.

One of Whyte's most troubling conclusions is that women's poverty is almost invisible to policy makers and program designers. She states:" Poverty has not been seen as a women's issue – not by government and sometimes, not by women's groups, not even by anti-poverty groups." Planning committees and decision-making bodies rarely include women who live with poverty among their members. Women who live in poverty have limited access to "service clubs, recreation and culture groups, and other associations that bring women together to work on issues." The social isolation that poor women experience limits their claims to full citizenship. In her recommendation, Whyte encourages government and community decision makers to enhance their efforts to increase women's participation in policy development.

Both Donner and Whyte cite Canada's national and international commitments to women's equality as the basis for their call for renewed policy attention to women's health. Nationally, the Canadian Public Health Association has publicly committed itself to eliminating social and economic inequalities and to working in partnerships with organizations to share this goal (Whyte, 2001:11-12).

## B. Prairie Women's Health Centre of Excellence Reports

### 1. Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project

by Connie Deiter and Linda Otway

**Summary of Findings**

*Sharing Our Stories* "presents and honours the perspectives and stories of Aboriginal women in describing what good health and healing means to them and their communities."[42] The views and experiences of the 98 women interviewed were combined with theoretical analysis to formulate recommendations "for improvements to the health and well-being of Aboriginal women."[43] The most effective health promotion strategies are holistic, drawing on traditional practices and the wisdom of the Elders.

The report summarizes 98 interviews with Aboriginal women from Manitoba and Saskatchewan, including 5 Elders. The women interviewed connected their health status with governing policies and procedures. The report documents the health consequences that result from the social and political realities that the women confront and negotiate, individually and with their communities. Poverty is identified as a major contributor to the health issues of Aboriginal women.

*Sharing Our Stories* traces the history of health policies for First Nations people. The devastation of Canadian Aboriginal populations due to unfamiliar germs and diseases exemplifies the negative consequences of early European approaches. Subsequent policies were equally damaging, from the *Indian Act* of 1876 that destabilized traditional societies to modern practices of separation and under-funding.

The chronic disempowerment experienced by many Aboriginal people suggests that the adoption of healthy practices will only be realized through long-term healing and the gradual re-acquisition of basic life skills. Contemporary health promotion policies may assume levels of individual agency and self-reliance that some Aboriginal people lack due to historic and current institutionalization. One Elder interviewed states: "The meaning of health for me is healing. Fortunately, I'm still healing, because you never get healed. It's a lifetime process."[44] The creation of the Aboriginal Healing Foundation, an Aboriginal-run, non-profit corporation, showcases the federal government's growing commitment to correcting historic injustices and to rejuvenating Aboriginal communities.[45]

**Summary of Recommendations**

The report calls upon governments to recognize and accept Aboriginal concepts of health and healing. Working towards wellness through holistic health approaches is also cited as important.

The recommendations state the need for the increased use of community based health services developed in accordance with Aboriginal values. The use of Aboriginal healers was cited as important. The recommendations highlight the need for increased resources dedicated towards mental health issues, stress reduction and empowerment. The reduction and elimination of family violence in Aboriginal communities and families was highlighted as central. Violence against Aboriginal

women must be addressed on an urgent basis. The recommendations state that Aboriginal, federal, provincial and other agencies must jointly increase the funding for uninsured benefits for Aboriginal women including funding for glasses, dentures, prescription care and mental health practitioners. Aboriginal women need increased opportunities to advance their economic and social equality. One way of achieving this is by supporting their increased involvement in health care decision-making.

## 2. Sexual Violence and Dislocation as Social Risk Factors Involved in the Acquisition of HIV Among Women in Manitoba

by Dr. Iris McKeown, Sharon Reid, Shelley Turner and Pam Orr

**Summary of Findings**

The study was prompted by the recognition that Aboriginal women were over-represented in the incidence of prevalent and new HIV infections in Canada. It was thought that movement between urban centres and isolated, rural communities contributed to the spread of HIV among Aboriginal women. The researchers explored women's movement patterns, as a possible factor in the contraction of HIV. The study was designed to obtain greater understanding of the social and environmental factors that influence HIV risk behaviours among Aboriginal women. A further goal was obtaining greater information into the service needs of Aboriginal women.

Twenty women were interviewed over a period of seven months. The majority of the women were aboriginal. From the interviews, information was obtained on the women's ages, income sources, education, participation in behaviours that might make them vulnerable to acquisition of the virus, ethnicity and residence. The women were questioned on past experiences with violence and on the impact of these behaviours on their ability to negotiate positive outcomes.[46]

The women reported limited connections to the labour market, which may have resulted from their low educational attainment - the mean education level was Grade 9 with a range of Grade 5-12. Many had worked in the formal labour market yet were concentrated in low paying entry-level jobs.[47] Most of the women supported themselves through Social Assistance and had sufficient income for basic necessities. Housing was a factor in their drug use and subsequent HIV development.[48] Affordable housing is located in the inner city where drug distribution and use are common. Most women reported past involvement with prostitution and past incarceration, both as adults and as young adults. The life experiences of the women with HIV underscore that improvements to Aboriginal women's health must be directed towards education, employment, housing, day care and family supports. The study reveals that health decisions for low income women usually involve giving up one detrimental behaviour for another that affords moderately enhanced well-being. One study participant reported escaping an abusive relationship by going to jail. On their work as prostitutes, the participants indicated that they had the "ability and power to insist on the use of a condom if they wanted."[49] Only one, however, always used a condom with client. The remainder used condoms sporadically, depending on the situation. Notably, the men paid higher amounts for

sexual services when condoms were not used.

These findings imply that women's control over their lives is more limited than they perceive. The differences suggest that women's freedom is curtailed more severely than they acknowledge. Men's supremacy in sex related purchases, derived from their higher economic status, exposes the limits of some women's power to insist on healthy sexual practices. A central theme of the report is that health promotion models that promote individual choice making and responsibility must be cautiously applied to Aboriginal and poor women because these women make choices within a profoundly limited context.

**Summary of Recommendations**

The report emphasized the need for early intervention strategies for children at social risk. Reducing family violence and providing childhood sexual abuse education in schools were highlighted as important strategies. Parents, educators and communities need enhanced resources and supports to guide children through the early years. Training and resources must be allocated to the development of culturally appropriate parenting models.

Youth need assistance developing healthy living strategies that would facilitate educational achievement and employment. Agencies should be empowered to transfer these skills, with particular attention and resources for First Nation communities. Teenagers at risk for sex trade involvement need to be able to access appropriate education and training to develop employable skills.

Additional resources should be dedicated to housing, health, education and employment training for girls and women. Transition housing, affordable secondary housing, "safe houses", support groups and drop-in centres must be made available to facilitate women and girl's integration into the urban milieu. Women at risk for the acquisition of HIV and service providers should be educated on the social risk factors for Manitoban women and how these factors influence women's risk-taking behaviour.

Finally, it was acknowledged that stable and sustained resources were needed for AIDS service organizations to develop and implement women-centred and culturally appropriate outreach programs that address the socio-economic needs of HIV positive women. In particular, the report calls for enhanced resources dedicated towards facilitating women's employment, with particular supports given to those women moving to urban environments from rural and remote areas.

Because the women studied resided in Manitoba, the policy recommendations in the report are directed to governments and agencies in that province. Due to geographic proximity and the parallels between the populations, the study's findings have application in Saskatchewan. The recommendations, therefore, should be implemented in both provinces, with cooperation from all levels of government.

## 3. "We Did It Together" Low Income Mothers Working Toward a Healthier Community"

by Kathryn Green

**Summary of Findings**

*"We Did It Together"* began from the recognition that "parenting in poverty" demanded significant resources from mothers.[50] The study emphasized the limitations of health polices that encourage skill and knowledge development without addressing the social context of poor women's lives. It recognized that the women were the best source of information about the prerequisites to personal and community health. Consequently, the major findings of the report derive from the meetings and consultations held with the women who participated in the project.

The participants were under 40 and approximately half were First Nations. The majority were single parents with two or three children. Social assistance was the primary source of income but some women were employed part-time or were supported by a partner. Accommodation varied from owned homes to rented apartments and homes. Most of the women lived in the inner city. Others who moved to higher income areas for safety reasons reported discrimination and isolation. Some past involvement with abusive partners was reported.

The project sought to bring low-income women together to discuss ways to make their communities and social environments safer for women and children. With a facilitator, the women discussed their communities and identified needed changes. They documented their lives in murals, supplemented by photographs they took with a camera purchased from project funds.

The group prepared a companion document titled *Telling It Like it Is: Realities of Parenting in Poverty*.[51] In that document, the women relay their stories about their lives in poverty. In meetings, they discovered that poverty was a common factor between them. They also shared the goal of communicating their experiences with a wider audience, to foster appreciation of their lives. The second book resulted from the desire to inform the public on the challenges and joys they experienced.

**Summary of Recommendations**

The central recommendation was providing adequate financial support (whether through social assistance, wages, or a combination) to enable all families to meet their basic needs. Adequate community resources including childcare and safe and affordable housing were also cited as necessary. Programs aimed at preventing and treating addictions in low-income communities were identified as particularly required.

Other recommendations requested the implementation of policies that promote parenting as important and essential and providing parents with further supports such as respite care and further financial aid. The report highlights the need for the development of a network of accessible, responsible services. The report stressed the need to eliminate the stigma associated with being poor and to ensure that programs are informed by positive images of poor women and that the programs seek to increase poor women's control. Finally, low-income mothers need opportunities to develop skills to engage in social action.

## 4. Left in the Cold: Women, Health and the Demise of Social Housing Policies

by Darlene Rude and Kathleen Thompson

**Summary of Findings**

The population health model has promoted recognition of the connections between appropriate housing and well-being. In fact, the availability of adequate housing for low income Canadians has become more limited due to federal and provincial funding decreases and the withdrawal of the federal government from social housing obligations. Some level of government funds one third of Canada's housing. According to the report: "Very few new public housing initiatives have been built since the late 1970s; those that have been developed have been specifically for seniors and special needs groups."[52] The "privatization" of housing means that ability to pay is the central determinant of housing quality. Because women are over-represented in lower income brackets, they have felt the adverse effects of these policies on their health.

The report is a comprehensive overview of low-income women's attempts to access adequate housing. It includes a literature review and delineates policy trends in Canada over the last decade. In addition, the report analyzes housing and health policies, with a specific focus on the cities of Regina, Saskatchewan and Winnipeg, Manitoba. The authors interviewed thirteen women who provided first-hand accounts of their housing difficulties. Eight professionals working in housing policy and social planning for government (provincially or municipally) or provide front-line services through a government-funded agency (such as the Health District) were also interviewed.

The report outlines the implications of housing policies on women's health. Common among the women interviewed were reports of long standing housing struggles and multiple displacements, with deleterious psychological effects. Living in sub-standard and unsafe housing was described as very stressful. Conditions included plumbing and heating problems, infestations of rodents and insects, air-quality problems, and various safety issues which participants felt affected their health and the health of their children. Women with disabilities, a major illness or other pre-existing health problem, report that substandard housing worsened their health. Sexual harassment and mistreatment by landlords was common yet it was determined that there are not adequate processes and mechanisms for women to report harassment or abuse by landlords.

**Summary of Recommendations**

The report calls for the development of a gender sensitive housing strategy that would address the shortage of adequate and affordable housing for women, particularly women raising young children and women with disabilities or other health problems. The strategy should be developed using a grass roots approach that would include extensive consultation with women. Training in gender-based analysis to housing professionals and policy makers is necessary to ensure policies and practices are gender sensitive.

Enhanced housing options are urgently needed and must reflect concern for basic health and safety rules and regulations. This requirement is particularly acute for rental housing, especially in the private housing market. Houses that are insulated and heating systems that are maintained are essential to proper housing. Women must

be educated in basic home maintenance skills to do routine home repairs. This is particularly important for women who are in a home–ownership program and who are often responsible for maintaining a home without adequate skills, tools or finances for household repairs. In addition, women need support in developing communication strategies to deal with landlords. A non-governmental organization could provide this training. An organization at arms-length from the government could also provide advocacy in more extreme and complex situations.

### 5. Mothers' Health and Access to Recreation Activities for Children in Low Income Families

by Shirley Forsyth

**Summary of Findings**

The study explored the intersections between children's participation in recreation activities and their mother's health. The study was modeled after an earlier one by Brown (1998) that demonstrated positive links between children's involvement in recreation and decreased behavioral disorders in the children. Notably, the parents of the children decreased their reliance on social and health services. All of those studied by Browne were social assistance recipients and the majority were women.

Forsyth found that increases in recreation fees present challenges for low-income families who cannot cover the costs of children's involvement in activities. Her study suggested that "when mothers are living in financially stressed situations, and they perceive recreation programs for children to be out of reach, their health is adversely affected." [53] Mothers buffer their children's disappointment when they are left out of activities. The consequences are to their own health.

The study verifies the cost savings that result from even minor investments in population health related strategies. It demonstrates the positive benefits that occur when steps are taken to alleviate poverty. As Forsyth notes:

> *The results of this study . . . indicate that the lack of an 'access' program adversely affects the health of low-income women, and costs the health care system more money than would a program to assist low-income families to access recreation opportunities.* [54]

**Summary of Recommendations**

The report recommends that that the province provide comprehensive health benefits to low-income families and for the working poor. Parents should have access to subsidized programs or to transportation funds to keep their children involved in recreational activities. All three levels of government need to develop policies that would promote accessibility in relation to recreational facilities. Additional free or low-cost days / time-slots at recreation or cultural institutions should be made available to persons reliant on public funding.

It recommends that the City of Winnipeg develop a long-term strategic plan for enhanced recreational opportunities. The planning process should involve all levels of government and should incorporate citizen input. Government agencies should work cooperatively on the plan and should renew their commitment to recreation activities as a determinant of health and as a factor in

health policy development. Children with behavioural problems should be targeted for focused attention and inclusion at the policy and program level.

Documents and policy directives by the City of Winnipeg should be further developed with a more detailed vision outlined on recreation and culture. It is recommended that there be further investigation into the health implications of the finding by Statistics Canada's National Longitudinal Survey of Children and Youth (NLSCY) that Manitoba's children are involved in unorganized recreation activities less often than children in other parts of Canada.

To ensure that quality recreation programs are offered to low income people, further research is needed. The topics that Forsyth believe need attention are: the relationship between individuals on social assistance and their psychological and behavioural characteristics and a long-term study connecting reliance on social transfer payments like social assistance with health system usage.

# PART 3. CONSOLIDATION OF THE STUDIES

The next sections of this overview report summarize the key themes and the central recommendations of the reports. The words of Hilary Graham guide the policy advice provided in this section. She states:

> *Interventions are required which open up pathways out of poverty by returning to a policy of uprating benefits in line with average earnings, for example, and through improving access to public housing, to education and training, to day care and to employment. Such measures not only tackle poverty directly, but can also provide parents and children with the material and psycho-social resources to make positive lifestyle changes.*[55]

The need for empowerment to be central to poverty reduction strategies was a common emphasis among the women who participated in the research reports outlined in this paper. Each of the reports outlined in this document was unique in presenting and addressing a particular women's health issue. Many commonalties were discovered in the reports, pointing to the shared aims for concerted action on several fronts.

**Key Themes:**

1. The Importance of Gender Based Analysis
2. The Importance of Defining & Implementing Population Health Approaches
3. The Need for Research Linking Health and Poverty
4. The Importance of Women's Stories of Their Lives and Their Health.
5. Promote Positive Images of Poor Women, Children & Families.

## A. Key Themes

### 1. The Continued Importance of Gender Based Analysis

The studies confirm the continued importance of applying a gender lens to health issues and to health policy development. The research also confirms that health policies and programs continue to downplay the importance that socio-economic factors have on women's health.[56]

This point is illustrated in *Sexual Violence and Dislocation*. The researchers state that the high incidence of HIV/AIDS among men meant the attention was not focused on women. This pattern is changing.

Consequently:

> *Correction of the gender gap in HIV prevention is required in order to understand the barriers to individual risk reduction, and to plan for prevention strategies, program and policy development among women as well as men.*[57]

Paying more attention to socio-economic disparities and violence towards women would foster better understanding on the spread of HIV/AIDS.

The studies call for more equitable policies that would lead to the delivery of services suitable to women's needs. They document the problems that low-income women face in parenting, in "choosing" healthy behaviour and in accessing services that incorporate their multiple roles as survivors, mothers, and caregivers. Health promotion strategies are ineffective if they are based on the assumption that "all women are engaging in risk behaviours by choice."[58]

## 2. The Importance of Defining and Fully Implementing Population Health Approaches

All of the studies point to the need to define and put into operation the population health approach in ways that would more adequately address the parameters of women's poverty. While governments are officially committed to this approach, policy makers appear reluctant to fully embrace the population health concept. [59] Arguably, greater political will is necessary to fully address the health determinants.[60]

In 1996, the federal government implemented the Canada Health and Social Transfer (CHST) as a replacement for the Canada Assistance Plan (CAP). The CHST decreased funding for health, education and social services and it abolished the standards in CAP which assured supports for people in need. CAP funding was directed to a variety of services including: social assistance programs, shelters for abused women, group homes for people with disabilities, and a wide range of services for people in need, as well as social assistance income. With the elimination of CAP, "the federal government has abandoned most of its responsibility for the national problem of poverty in Canada."[61] Under the CHST, transfers to the provinces do not specifically allocate funds for social assistance or poverty reduction.

*Left in the Cold: Women, Health and the Demise of Social Housing Polices* illustrates the contradictions that occur when governments endorse population health approaches while implementing policies that undermine its ideals. Rude and Thompson report little activity on the social housing front in the past decade. They state:

> *In the early 1990's, federal and provincial-debt reduction strategies resulted in decreases in social program expenditures, and the federal government began systematically withdrawing from its previous responsibilities for social housing. For many Canadians it has become increasingly difficult over the last decade to secure and sustain affordable, adequate and suitable housing.* [62]

According to the report authors, the negative consequences of social housing policy revisions have been significant, particularly for women. *Left in the Cold* is particularly effective in illustrating that while population health models encourage gender sensitivity, health and economic policy often directs limited attention to this factor and may work to the detriment of population health goals.[63]

Aboriginal women also commented on the competing goals of provincial policy. Alma, a Metis mother in her fifties who relied on a wheelchair, commented in *Sharing Our Stories*: "It makes me mad when I see hospitals closing, and doctors leaving, yet, they can build onto the casino." [64]

### 3. Conduct Further Research Clearly Linking Health and Poverty

Researchers' attempts to link well-being to economics are compromised by the interplay between a number of factors that are individually capable of affecting health. Poverty is difficult to isolate from issues of race, social isolation, low self-esteem. Because the women's problems are compounded, linking their health concerns to one central factor is difficult and even impossible. Visually, this statement is supported by the charts provided in the McKeown et al. study at page 18 and in the Green study at page 29.

Women with HIV, for example, cite injection drug use as the cause of their health condition. Their injection drug use is related to the emotional pain of sexual, physical abuse and isolated child and adult hoods. The women often supported addictions through prostitution. In addition to HIV, the women report mental health issues, such as depression, multiple personality disorder, panic attacks, post traumatic stress disorder and schizophrenia. [65]

The researchers in *Sexual Violence and Dislocation* did pinpoint two major links between economic inequality and HIV exposure. [66] Women with limited education and work skills look to the sex trade for income. Women surmount the deleterious affects of the sex trade through intravenous drug use. These two behaviours position them for HIV contraction. [67] The report also highlights the influence that inadequate housing has on sickliness and ill health for low-income women.

In *Left in the Cold*, women reported struggling with psychological distress, due to their adverse living conditions. They related their edginess and discomfort to the insecurity they experienced living in homes that weren't secure from intrusion by the weather, rodents or people. The nearby street life also posed a problem.

The studies do connect poverty with health conditions, particularly stress and mental health related concerns. Largely, however, the causal relationships between women's poverty and all types of illness and disease remain invisible and unexplored. More work is needed to clearly expose the relationships between these factors. Most of the studies were conducted from a social science perspective. While rich in information and thorough in realizing its objectives, there is no epidemiological information in the studies. Women's health researchers must work to provide the "hard" scientific data that policy makers demand. Without this information, it is difficult to translate the research findings into health system recommendations.

### 4. Listen to Women's Stories About Their Lives and their Health

The projects demonstrate the value and strength of participatory action research. The voices of the women in the reports provide real evidence of the challenges that low income women confront, particularly when they are mothers. Their voices are descriptive and evocative. Beaudry and Reichert encourage health experts to develop policies and programs that reflect women's complex histories in their design.

They state:

> *Generally, programs and services . . . have provided information to them, assuming that the simple transfer of information is enough to make a*

> *difference in their lives. The problem is that too few of these programs are interested in the histories of the women involved and so do not deal with the painful issues that have hindered their ability in the first place*.[68]

Models that promote personal responsibility for health without reflecting on the barriers that some individuals and communities face are inadequate. The HIV positive women studied in *Sexual Violence and Dislocation* report histories of sexual and physical abuse that began in childhood and continued into adulthood. The women disclosed past and present involvement in relationships where their independence and decision making was restricted for they were not allowed to travel, use the phone, talk with family or friends without restriction or choose their own clothing. The women made crucial choices in dismal circumstances - as runaways or as injection drug users "choosing" to use substances to escape emotional pain.

This points to the difficulties in developing effective health policies without extensive and careful consultation with women at risk. McKeown et. al. state: "Utilizing the experience and knowledge of HIV positive women themselves in new and beneficial ways will go a long way in developing appropriate action plans. A concerted effort to include HIV positive women in the design, implementation and communication strategies in a meaningful way is paramount." [69] The women interviewed strongly requested an opportunity to share their life experiences with young women to promote healthier safe practices. [70] They also reported feelings of betrayal towards professionals they encountered as children, indicating that human services agencies involved with the lives of poor women and children need to be extremely vigilant in their efforts to assist, not re-traumatize, their clients.

## 5. Promote Positive Images of Poor Women, Children and Families

Living in poverty presents numerous challenges and risks, particularly for those women who are also mothers. The report *Telling It Like It Is: Realities of Parenting* dispels myths that surround the lifestyles of low-income women. A common misconception is that social assistance recipients are lazy. In contrast, the research team confirms that poor mothers are productive rather than slothful. They state:

> *The ordinary daily activities involved in running a household and raising children become much more complicated and time-consuming when you don't have money or your own vehicle. Figuring out how to get enough food for the month when you're using grocery money to pay the rent, you have small kids and no car; keeping your kids happy and out of trouble when you live in a dangerous neighbourhood and can't pay for recreation; moving a couple of times a year in the hope of finding somewhere decent to live - challenges like these fill the days of parents in poverty*.[71]

The stigma associated with poverty is persistent and reveals no signs of relenting. A need to "keep up appearances" further curtails women's ability to make choices that generate health. One woman in *We Did It Together* reported spending money on a glass of wine to give the appearance that she could afford "a few extras."[72] Another reported that she refused to take subsidies for her children's recreation activities because she wanted her child to know that they could afford the programs and because

she did not want to be "stigmatized as poor."[73]

According to Jean Swanson, author of *Poor-Bashing: The Politics of Exclusion*, a key step to eliminating poverty is ending the tendency to classify people under headings like "the poor" or "those on welfare". She argues that these labels justify bad treatment and hold the poor responsible for their circumstances. She argues that by refusing to blame the poor or other oppressed people for poverty, it is possible to expose "the policies, laws, and economic system that force millions of people to compete against each other, driving down wages and creating more poverty."[74]

One way to end "poor bashing" is to provide women in poverty with opportunities to celebrate their strengths and resourcefulness. To counteract the negative effects of poverty, organizers of the Women and Wellness conference hosted a ceremony honouring "women who survived poverty, violence, cultural oppression . . ." The women were invited to join a line where others greeted them and "acknowledged the strength and courage required to name, face and survive the problems." Rather than experiencing blame or ostracism, the women in the procession were honoured and supported.[75]

Another theme that emerged from the research was the need for society to examine the ways that "consumerism" shapes values and behaviour. It was thought important to adopt belief systems that value individuals, families and communities and that measure success apart from material wealth. In *Telling it Like it is: Realities of Parenting in Poverty*, the women expressed a desire for: "An end to poor-bashing, recognizing that people's worth is not equal to their income, education of the kind of clothes they wear, and that poverty is caused by many things beyond a person's control."[76]

## B. Consolidation of the Recommendations

To create a coherent message for future work addressing poverty as a determinant of women's health, the recommendations from the studies cited in this report were analyzed and a set of twelve consolidated recommendations was formed.

### 1. Expand Thinking and Commit to Further Action on the Determinants of Health

The reports identify gaps in policies and practices that highlight the need for expanded thinking, further action and new models on the determinants of health. It is clear from the research that the lives of poor women continue to be under-resourced, isolated and stressful. While commitment to population health approaches is evident in official pronouncements, the studies highlight the need for expanded thinking and further action. [77] They call for finely-tuned population health models that address the determinants as both causes and effects of ill-health. Collaborative effort by "individuals, families, communities, organizations, agencies and society, including all levels of government" is necessary to improve the lives and health status of women and families.[78]

Rude and Thompson argue that the research exploring the connections between housing and heath status is limited and has not provided concrete advice on practical solutions.[79] It is noted that: "The complex web of social, economic and biological factors in the lives of human beings makes it difficult to establish a clear cause-and-effect relationship."[80] Housing, like the other determinants of health, may cause ill health or it may be a consequence of ill health. It may be one of a number of factors that diminish well-being.[81] While the exact consequences of poor housing are difficult to isolate, the report provides strong arguments for enhanced housing policies as a means of promoting women's health.

**Consolidated Recommendations:**

1. Expand thinking and commit to further action on the determinants of health.
2. Develop comprehensive strategies for women's equality.
3. Support the creation of healthy communities.
4. Treat women's poverty seriously. Address children's poverty as a common outcome of women's poverty.
5. Commit to developing and implementing a plan to reduce and eliminate poverty.
6. Develop research agendas, policies and programs on women's health and women's poverty in partnership with poor women.
7. Foster and develop supportive networks for poor women.
8. Ensure safe and affordable housing is available for poor women and their families.
9. Commit to improving the health and well-being of Aboriginal women.
10. Develop educational programs for women at risk.
11. Require appropriate training for service providers.
12. Recognize non-mainstream professionals, particularly Aboriginal Elders and traditional healers.

## 2. Develop Comprehensive Strategies to Improve Women's Equality

Reducing women's poverty requires dedication and innovation. While the recommendations outlined could be implemented incrementally, the development of comprehensive, short and long-term strategies directed towards women's social and economic equality is essential. According to CRIAW:

> *Equality between women and men, which honours and respects women's perspectives, paid and unpaid work, and values/priorities, is key to eliminating the feminization of poverty. Equality cannot be achieved by a one-off initiative or any one of the solutions listed here in isolation. The poverty of women is a part of systemic, structural inequality and it requires a systemic response that deals with poverty and gender inequality at its roots.*[82]

## 3. Support the Creation of Healthy Communities

Participants in *We Did It Together* emphasized the importance of healthy communities where people lived and worked cooperatively. They articulated a wish for respectful and courteous treatment for all, including children and elders, the absence of violence and discrimination, cohesiveness, shared responsibility and a climate for healing. Adequate income for all persons was seen as crucial to viable neighbourhoods. The women stated that supports were particularly needed to ensure that women did not become parents under conditions of low income. The factors required to avoid this fate were: school supports for pregnant and parenting students, access to childcare, and increased social assistance to parents of young children without paid employment.

Women in Whyte's study issued a similar call for further supports for directed activity on community building. Their vision focused on the formation of a community centre that would provide a range of services and supports. They formed the following vision:

> *A dream: to create a facility that would be a unified, integrated location for a wide variety of needs and activities including child care, nutrition, cooking, parenting, drama, quilting and sewing.*[83]

The centre would service multiple functions, from serving as a base for cooperative housing, counselling, self-help and support groups to community policing, victim services, 24-hour crisis response, and other health and social services. Furthermore, the centre could offer services and act as a haven for children and youth at risk (of health problems, prostitution, addictions, crime), particularly if recreation facilities were included. Another facet would involve providing information and advocacy for people who have problems with poverty, racism, social services, housing, and disability and health issues.[84]

While strong communities are often identified as a positive feature of Aboriginal life, some of the Aboriginal women in the study voiced concern about inadequate social supports. One stated: "having no social or emotional support affects my parenting and school marks." [85] Many women felt that they did not live in healthy communities, mostly due to violence, substance abuse and involvement in illegal activities. One stated that her home was healthy but her reserve was not.[86]

In a study that preceded *Sharing Our Stories*, Deiter discovered a need for community development initiatives that are reflective of the life experiences of Aboriginal people. In *From Our Mothers' Arms*, she outlined the damaging consequences of residential schools. Deiter states:

> *Some survivors and their communities have lost the skills needed to be healthy individuals. The loss of nurturing parents; loss of parenting skills; loss of identity; low self-esteem; the inability to think independently; the lack of unity within families and communities; the loss of language, culture and respect for self; and finally, the loss of spiritual values have left communities in chaos.* [87]

Further recommendations for the creation of healthy communities in the studies were:

1. Provide treatment facilities and support groups to address addictions and mental health issues.
2. Commit to creating safe, attractive physical environments – including parks, playgrounds, streets and buildings.
3. Provide opportunities for women to learn advocacy and leadership skills that they could apply towards community development initiatives.

### 4. Treat Women's Poverty Seriously. Address Children's Poverty as a Common Outcome of Women's Poverty.

The findings of *Mothers' Health and Access to Recreation Activities for Children in Low-Income Families* are unique in linking women's well-being to their children, demonstrating solid interconnectedness between the two. Contemporary programs often attempt to separate children and their parents, highlighting the former as a focal point for policy development. The Child Tax Benefit is an example. The use of the word child suggests that it is only children who require and are deserving of benefits. This conceptualization misses the fact that the fates of children are tied to that of their parents, or parent, usually a low-income mother. *"We Did It Together"* discussed the intergenerational links between the poverty that children experience and their subsequent poverty as adults. The mothers described the effect of the stressful conditions related to raising children while poor. The housing consequences that children experience, described in *Left In The Cold* are clearly linked to their mother's inability to afford more appropriate accommodation.

Forsyth's study reinforces the importance that population health strategies have for women and children, together. Regrettably, the mothers in *"We Did It Together"* reported little recognition for their parenting work; in contrast, they were subjected to frequent criticism, stigmatization, and devaluation.[88] While children are seen as deserving subjects of social programs, their mothers are rigidly scrutinized and condemned for parental "failings". Sometimes, social policies attempt to disconnect children from their mothers. At other times, mothers are seen as inseparable from their children and are considered responsible for their children's poor behaviour. As one woman interviewed in *Women, Health and Poverty: Review and Looking Forward* stated:

> *The focus on children in poverty seems to ignore the fact that children live in families. Many of the children in*

> *poverty live in single mother households. The reasoning seems to be that children should not be blamed for poverty. But neither should most adults!*[89]

The studies demonstrate the ways in which social policies can promote healthy lifestyles and increased health status, benefiting both mothers and children.

## 5. Commit to Developing and Implementing a Plan to Reduce and Eliminate Poverty

All the research reports identify one central strategy that is crucial to reducing women's poverty - raising social assistance rates to provide women living in poverty with an adequate income. Having their basic needs met would allow women to direct their resources to other aspects of their lives, from work skills to further education. The reports call for interdisciplinary comprehensive poverty reduction strategies. A detailed strategy is outlined later in this paper.

Many of the reports emphasize the importance of increasing women's economic resources as well as their social supports. *"We Did It Together" Low-Income Mothers Working Towards a Healthier Community* recommends, for example:

> *That social assistance rates and the minimum wage be raised to levels sufficient to enable all families in Saskatchewan to meet their basic needs (i.e., live above the poverty line.)*[90]

*Sharing Our Stories* calls for supports for Aboriginal women on higher education, better paying employment, adequate housing, affordable day-care and family support services.[91] The McKeown study on social risk factor and HIV acquisition highlights the importance of these strategies for young women who are vulnerable to street prostitution and disease contraction due to the absence of viable economic strategies.[92]

Improvements are required in the form of increased government transfer payments and in expanded health benefits, particularly for the working poor[93] and Aboriginal women.[94] In *Sharing Our Stories*, an Elder questioned "why we're treated so differently when we live off the reserve. Many poor elders do not live on the reserve."[95] Comprehensive health coverage for low-income Aboriginal women was recommended in the report.

The Canadian Research Institute for the Advancement of Women has developed a detailed plan of action to address women's poverty. It calls for the establishment of a minimum wage that accurately reflects actual living costs. CRIAW urges governments to incorporate "reality-based welfare rates that reflect a "basket" of necessary goods and services, based on actual market rates". Donner's recommendations for action include: increasing the minimum wage, increasing social assistance rates, broadening eligibility for Employment Insurance, expanding subsidized childcare, reducing the costs of telephone service, providing free recreation for low income persons, and funding an expand set of necessary health benefits to persons living in poverty.[96]

Higher social assistance payments could be accomplished by altering the threshold for income tax payment. Currently, payment demands begin at income levels under the poverty line, meaning the low income individuals and families are paying a portion

of their "wages" to taxes. Low-income women must pay for essentials and taxes "while high income people get a tax break that allows them to take an extra vacation overseas."[97]

Without the necessary services and support, women navigate poverty through individual resourcefulness and resiliency. They are courageous in negotiating the "rocks" and "hard places" of their lives. Without additional resources, however, they are often forced to trade one possible health producing behavior for another slightly more advantageous one. Many women, for example, stated that they gave up food in order to purchase other goods, such as recreational activities.

The recommendations in *"We Did It Together"* focus on structural solutions that address poverty as a social condition. While poverty affects individuals and families, it does not result from personal inadequacies. By highlighting the broader context for poverty, the report encourages action on fronts that would help women move out of poverty. The researchers note:

> *The recommendations . . . call for action by those who have influence over policies and programs, as well as the general public, whose attitudes towards the poor and social policies play an important role in determining how we as a society deal with poverty.*[98]

Essential elements of the poverty reduction plan, compiled from the various reports include:

1. The provision of publicly funded childcare and respite services.
2. Adequate social assistance.
3. Additional services and resources.
4. Enhanced supports for low income working families.
5. The development of bridging programs that would facilitate women's involvement in the paid labour force.
6. Pay and employment equity programs that would ensure a fair wage for women in all occupations.
7. Subsidized recreational programs and transportation funds to allow children from low-income families to participate in recreational activities.
8. Additional free or low-cost periods at recreation or cultural institutions.
9. Enhanced maternity and parental leave that would ensure that these programs are fully accessible to the working poor.

### 6. Develop Research Agendas, Policies and Programs on Women's Health and Women's Poverty in Partnership with Poor Women.

The Royal Commission on Aboriginal Peoples stated the importance of going directly to women for input into health problems and health policy.[99] The Commission found:

> *Aboriginal women lag behind men and well behind Canadian women as a whole on many social and economic [and health] indicators, but statistics do not reveal why. Women themselves provide a deeper understanding of the barriers that have been placed on their path, barriers that must be recognized, acknowledged and removed before real progress can be made.*[100]

These comments are relevant to women living in poverty in general. Low-income women offer valuable insights into the lived reality of poverty, when they serve as

research partners and participants. The stories they shared are a rich resource for future health policies.

Three approaches were identified to encourage poor women's participation in public forums and health care debates.

### 6.1 Eliminate barriers to poor women's involvement in policy and program development

*"We Did It Together"* provides important insights into the barriers that poor women face in attending meetings and in discussing their lives. The original intention of the project was to have the women gather regularly to review their lives, share with the group, and, most importantly, to develop ideas for creating healthy communities. The women (understandably) brought their "worries, fears, anger, and sadness to the meetings." [101] This inward focus resulted from the obvious challenges of "parenting in poverty" yet it limited the women's ability to look outward to the community and to strategize on social policies. Often the women arrived looking harassed and frazzled. Seeing their distress, the researchers hesitated to involve them in discussions about the stressful conditions of their lives. Sometimes they were offered tea or a place to lie down, and soothing music. Consequently, "the unpredictable nature of their lives" presented a significant barrier to the activities envisioned in the project.

The project team worked to surmount these problems by acknowledging their existence and by providing extra support to the women. Future efforts to obtain the input of poor women are likely to be successful if they demonstrate the awareness and sensitivity shown in *"We Did It Together."*

### 6.2 Use non-traditional approaches to obtaining women's input.

*"We Did it Together"* demonstrated the viability and suitability of innovative strategies to obtain women's input into building healthy communities. Research methods included creative activities, such as mural making and photography. These approaches, particularly the mural making, provided the women with a means of viewing and re-creating their lives. Creating a visual symbol of the woman's life prompted reflection on its positive and negative aspects. Moving from the unhealthy to the positive, through the mural, was inspiring and energizing. The conversation became lighter and more hopeful. The murals and the action around the murals represented the change that the women desired in themselves and their environments.[102]

Furthermore, these approaches provided a way for the women to share their lives with persons in authority and with policy makers. The women discussed their work with additional members of the Community/Research Team and a guest from the Saskatoon District Health. Importantly, some of the women, with two researchers, met with a receptive audience made up of three senior administrators from Saskatchewan Department of Social Services.[103]

The success of these initiatives reinforces that the "town hall" meeting, that is the typical approach to health related consultations, may be an inadequate mechanism to obtain the input of poor women. The report documents the persistence stigmatization of low-income women. The perception that personal inadequacies cause women's poverty makes

it difficult for them to discuss their lives, knowing that the input may be met with scepticism.

### 6.3 Ensure that Aboriginal women are included in health related consultations.

The findings in *Sharing Out Stories* point to the need for further consultation with Aboriginal communities on policies that relate to and impact on health. On the issue of community involvement in health decisions, responses from the Aboriginal women in *Sharing Our Stories* were inconclusive due to a divided response.[104] Participants did observe that community members were expected to attend consultations yet the reverse was not true - consultants did not travel to the communities. It was also stated that when efforts were made to consult communities, "no one wants to get involved."[105]

These findings suggest that bureaucratic consultations are not meaningful in Aboriginal communities. The "town hall" method where meetings are held in large rooms with technical supports, like microphones, a formal agenda and a specific time frame appear to be less appropriate for Aboriginal people. Given the emphasis placed on involving the public in discussion on health system reform, it is recommended that more effort be made to sufficiently engage Aboriginal people in the debates and to ensure that policy changes adequately reflect their views.

## 7. Foster and Develop Supportive Networks for Poor Women

Creating further social support networks was identified in the reports as essential to improving women's health status. The work of the women in *"We Did It Together"* demonstrates what can be achieved when low-income women are provided with support, encouragement and resources. The insightful recommendations generated illustrate the thoughtfulness and initiative that women in poverty bring to their lives. The women cited the project's value for their lives. One stated:

> *We did it together, from different walks of life, different ancestries and backgrounds. A lot of groups fall apart because of different lifestyles, so I'm glad this one stayed together. I feel we're close . . . What is colour? We can all pull together and accomplish things.*[106]

Importantly, it fostered relationships between mothers living in poverty and helped to build solidarity.

The women in *Sexual Violence and Dislocation* traced social isolation in their youth to the contraction of HIV. It was discovered that,

> *Most of the women could not identify any source of support for them as children, including family, friends, counsellors, school and clergy*.[107]

Ironically, once the women became HIV positive they were able to obtain support from community based social programs. To ensure that others had better options, the women wanted relevant, culturally appropriate services aimed at raising awareness, promoting prevention, and

providing support to positive women. They confirm the importance of dedicated, culturally sensitive population health approaches.

## 8. Ensure Safe and Affordable Housing is Available for Poor Women and Their Families.

*Left In The Cold* documents the health problems that arise from poor housing and verifies that existing health issues, i.e. disabilities and addictions, are compounded by the ill-effects of poor housing. The report urges governments to develop a strategy that would see to the creation of stable, secure, affordable housing for women and children.[108] The women in *"We Did It Together"* connect safe, secure housing to good health.[109] They argue for increased supports for existing housing programs and dedicated funding for community development in poorer neighbourhoods.

CRIAW advances similar recommendations. They argue that existing housing should be made affordable through "rent-geared-to-income" subsidies.[110] Additional affordable housing should be created through rehabilitation and new construction.[111] Because adequate, reasonably priced housing is not lucrative, it is not appropriate to look to the market to resolve this issue.

*Sexual Violence and Dislocation* highlights the need for emergency housing, shelters and related services that would aid women and girls in resettling to urban communities. The report calls for transition housing, "safe houses", support groups and drop-in centres.[112]

## 9. Commit to Improving the Health and Well-being of Aboriginal Women

A key theme that emerged in several of the reports was the need to fully respond to gender and race in implementing strategies on the health determinants. In support of this view, Doyal states:

> *Sex and gender are not the only determinants of health and illness and we also need to explore the biological, social and cultural factors that separate different groups of women from each other. These differences too will have to be taken seriously if the healthcare needs of all women are to receive equal attention.*[113]

## 10. Develop Educational Programs for Women at Risk

*Sexual Violence and Dislocation* demonstrates that targeted, well-designed educational programs are essential to raise awareness and to facilitate reduction and prevention of illnesses like AIDS. Most of the participants report that they had "no knowledge or understanding of HIV" prior to contracting the virus. [114] Some women knew that AIDS existed, yet "did not know what it was."[115]

These findings suggest that innovative awareness strategies are crucial for reaching a high-risk population. According to the report authors, " . . . the fact that the majority of the women expressed a lack of knowledge of HIV should be examined further for its implications for prevention programs and strategies."[116]

It is acknowledged that the women were deeply into street life and drug use by the

time they became HIV positive. This finding highlights the need for early, focused intervention strategies that support communities and families and the individuals living within those structures.

## 11. Require Appropriate Training for Service Providers

Many of the reports highlight the need for additional training among professionals who deal with poor women.

*"We Did It Together"* substantiates that poor mothers have frequent contact with professional agencies. Often these encounters are negative. Common problems are difficulties accessing the appropriate people, staff turnover, conflicting information, contempt and unresponsiveness to issues and needs. Additional resources and enhanced staff training were recommended in *"We Did It Together"* to foster greater understanding and receptivity.

It was further recommended:

> *That additional, ongoing training be conducted, using innovative methods (e.g. sharing circles with staff and clients) to help staff develop greater understanding of and respect for their clients*.[117]

*Left In the Cold* also recommended gender-based sensitivity training for housing analysts and researchers.

## 12. Recognize Non-mainstream Professionals, Particularly Aboriginal Elders and Traditional Healers.

Traditional healers might provide more appropriate direction on individual health practices. Aboriginal women are given conflicting and confusing information about their health. Often, they are encouraged to adopt western medical practices.

*Sharing Our Stories* reinforces the need to recognize Elders and Aboriginal healers as health professionals. The Elders' stories relate incidences where recovery resulted from the use of traditional, not scientific, practices. Beatrice, Plains Cree in her early seventies, states that she avoided an operation on her ribs and lungs by drinking a mixture prepared by her grandmother[118]. Other women highlight the relationship between traditional practices and their own well-being.

The findings suggest that positive recognition of one's Aboriginal status is central to healing and to the internal cohesiveness that makes positive living possible.

On the other hand, it is acknowledged that western approaches have damaged Aboriginal health. For example, diabetes is an important health issue among communities. An Elder recommended: "we should eat the way we did when we were removed from our traditional lands."[119]

The complex and often stark realities faced by Aboriginal women mean that health promotion activities that encourage healthy lifestyles without addressing the social context have limited application. Smoking, for example, was identified as a source of stress relief along with watching television

and the use of recreational drugs. Health promotion paradigms discourage certain practices without acknowledging their use as coping strategies

## C. Action Plan for Prairie Women's Health Centre of Excellence

1. Continue to fund and promote research on the health of poor women. Expand the focus on poor women to all of the life stages, including young women and senior women.

2. Provide policy makers and researchers with the documents outlined in this paper and encourage their use in policy analysis and development.

3. Promote the use of gender-based analysis by policy makers and health planners.

4. Explore ways to involve poor women in promoting a women's health agenda. Provide opportunities to celebrate their strengths and resourcefulness

5. Encourage all levels of government to evaluate population health strategies and to fully endorse the population health model.

6. Promote health system change and renewal in ways that address the needs and aspirations of poor women. Advocate for measures that address poor women's health as well as their poverty. Emphasize the fact that services for poor women should be provided for the health of women and the health of the larger population. This will assist in locating women living with poverty on the health renewal agenda.

7. Continue to encourage and promote the Action Plan on Women's Health, with particular focus on the recommendations on alleviating women's poverty.

# PART 4. CONCLUSIONS

In the uncertain climate of health system reform, women health researchers and advocates continue to argue for the full acceptance of gender and income as essential determinants of health, worthy of in-depth study and concentrated action.

While federal and provincial governments remain cautious on implementation, they continually acknowledge the value of the health determinants approach. The fact that poverty is on the health agenda means that women have the opportunity to advance their goals. Methods of delivering and producing health are under review, making way for progressive and alternative models, including women-centred health care.

Woman centred reform is possible if the changes are implemented with this goal in mind.[120] Due to the strong linkages between poverty and health, acknowledging and addressing women's poverty will enhance the likelihood that reform strategies will improve women's health status.

# ENDNOTES

[1] Dennis Raphael's otherwise exemplary research on health inequalities is an example. In the article, *From Increasing Poverty to Societal Integration: The Effects of Economic Inequality on the Health of Individuals and Communities*, Raphael provides an insightful overview of links between income gradients and well being. The article is diminished, however, by the failure to comment on the gender dimensions of income and inequality. Dennis Raphael in Pat Armstrong, Hugh Armstrong and David Coburn, *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada* (Don Mills, Oxford University Press, 2001) at 223- 241.

[2] See for example: Dr. Karen Hadley, *And We Still Ain't Satisfied: Gender Inequality in Canada: A Status Report for 2001* (Toronto: The Centre for Social for Social Justice Foundation for Research and Education and the National Action Committee on the Status of Women, 2001).

[3] *Ibid* at 1.

[4] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[5] See for example, *The Social and Economic Causes of Disease* by Robert Chernomas, (Canadian Centre for Policy Alternatives, March 1999).

[6] Monica Townson, *Health and Wealth: How Social and Economic Factors Affect Our Well Being* (Ottawa: Canadian Centre for Policy Alternatives, 1999) at *iv*.

[7] *Ibid*.

[8] Canadian Council on Social Development, *The Canadian Fact Book on Poverty*, *Chapter 2: Working Definitions of Poverty"* at 13.

[9] *Ibid* at 14. The Canadian Council on Social Development argues that the Statistics Canada Low Income Cut-off is the best indicator of poverty due to its longevity and public acceptance. Unofficially, the LICOs serve as Canada's poverty lines. Statistics Canada generates 35 different LICOs, varying according to family size and size of community. Persons and families living below these income levels are Canada's poor.

[10] *Ibid.*

[11] *Ibid.*

[12] Tina Beaudry and Stephen Reichert, *Taking Control: A Wellness Program for Women Building Healthier Communities* (Regina and District Food Bank: 1998) at 12 quoted in Jayne Whyte, *Women, Heath and Poverty: Review and Looking Forward* (Population Health and Public Health Branch, Manitoba and Saskatchewan Region, Health Canada, May 2001) at 31.

[13] Lissa Donner (with contributions by Angela Busch and Nahinni Fontaine) *Women, Income and Health in Manitoba: An Overview and Ideas for Action* (Winnipeg: Women's Health Clinic, January 2002) "Executive Summary".

[14] *Ibid*: See "Chapter H: Making Public Policy Healthier for Women: Suggestions for Action" at pages 42-51.

[15] See, for example, Hadley, *supra* footnote 2.

[16] Donner *supra* footnote 13 at 6-7.

[17] *Ibid* at page 7, Sidebar 2.2 "Canadian Women and Poverty".

[18] *Ibid* at page 8, Sidebar 2.2, continued from page 7.
[19] Saskatchewan Women's Secretariat, *Income Statistical Update, March 2002*, page 11. (http://www.womensec.gov.sk.ca/statistics.html) Main site revised address (http://www.swo.gov.sk.ca).
[20] Donner *supra* footnote 13 at 6, Sidebar.
[21] Hadley *supra* footnote 2 at 7.
[22] Hadley *supra* footnote 2 at 8.
[23] Dennis Raphael, *Inequality is Bad for Our Hearts: Why Low Income and Social Exclusion are Major Causes of Heart Disease in Canada* ( Toronto: North York Heart Health Network, 2001).
[24] *Healthy People, A Healthy Province: The Action Plan for Saskatchewan Health Care* (Government of Saskatchewan: December 5, 2001) (http://www.health.gov.sk.ca/hplan_health_care_plan_intro.html).
[25] Health Canada, *Taking Action on Population Health: A Position Paper for Health Promotion and Programs Branch Staff*, Health Promotion and Programs Branch, Cat. No. H39-445/1998E.
[26] *Ibid* at 1.
[27] Townson *supra* footnote 6 at 32.
[28] *Ibid.*
[29] *Ibid* at 33.
[30] Donner *supra* footnote 13 at 16.
[31] See the discussion on the United Nations Committee on Human Rights, "Concluding Observations on Canada's Compliance with the International Covenant on Civil and Political Rights" in *Women, Income and Health in Manitoba: An Overview and Ideas for Action* (Donner *supra* footnote 13) at page 7. Whyte refers to initiatives by the United Nations, including the Beijing Declaration for Action, adopted at the Fourth World Conference on Women (September 4-15, 1995).
[32] Canadian Research Institute for the Advancement of Women, *Women and Poverty: A Fact Sheet* prepared by Marika Morris, March 2002 ( http://www.criaw-icref.ca/Poverty_fact_sheet.htm )
[33] Townson *supra* footnote 6 at 39.
[34] Health Canada, Women's Health Bureau, "The Health of Aboriginal Women" (http://www.hc-sc.gc.ca/english/women/facts_issues/facts_aborig.htm).
[35] Saskatchewan Women's Secretariat, *Profile of Aboriginal Women in Saskatchewan*, November 1999, Regina. The document in its entirety provided detailed information on the life circumstances and challenges facing Aboriginal women in Saskatchewan.
[36] Immigrant, Refugee and Visible Minority Women of Saskatchewan, *Post Traumatic Stress Disorder: The Lived Experience of Immigrant, Refugee and Visible Minority Women*, (Winnipeg: Prairie Women's Health Centre of Excellence, 2002). This disorder is characterized by high levels of depression and anxiety, as well as confused thought processes and "helplessness, shame, a sense of guilt and of being different from others." The sufferer may experience difficulty in making decisions and in engaging with the world in meaningful ways.
[37] *Profile of Aboriginal Women in Saskatchewan, supra* footnote 35 at 48.
[38] *Ibid* at 37.

[39] *Ibid.*
[40] Connie Deiter and Linda Otway, *Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project* (Winnipeg: Prairie Women's Health Centre of Excellence, 2001).
[41] Jayne Melville Whyte, *Women, Health and Poverty: Review and Looking Forward,* 2000.
[42] Connie Deiter and Linda Otway, *supra* footnote 40 at 1.
[43] *Ibid.*
[44] *Ibid* at 14, quoting from an interview with an Elder, Inez.
[45] *Ibid* at 7.
[46] Dr. Iris McKeown, Sharon Reid, Shelley Turner and Pam Orr; *Sexual Violence and Dislocation as Social Risk Factors Involved in the Acquisition of HIV Among Women in Manitoba* (Winnipeg: Prairie Women's Health Centre of Excellence, Project #25, January 2002) at 2.
[47] *Ibid* at 20.
[48] *Ibid* at 20.
[49] *Ibid* at 7.
[50] Kathryn Green, Principal Investigator, *We Did It Together": Low - Income Mothers Working Toward a Healthier Community* (Winnipeg: Prairie Women's Health Centre of Excellence, June 30, 2001).
[51] Kathryn L. Green and participants of *"We Did It Together", Telling It Like it Is: Realities of Parenting in Poverty* (Saskatoon: Prairie Women's Health Centre of Excellence, 2001).
[52] Kathleen Thompson and Darlene Rude, *Left in the Cold: Women, Health and the Demise of Social Housing Policies* (Winnipeg: Prairie Women's Health Centre of Excellence, November 2001) at i.
[53] Shirley Forsyth, *Mothers' Health and Access to Recreation Activities for Children in Low-Income Families* (Winnipeg: Prairie Women's Health Centre of Excellence, May 2001) at x.
[54] *Ibid* at 71.
[55] Hilary Graham, "Health at Risk: Poverty and National Health Strategies" in Lesley Doyal, ed. *Women and Health Services* ( Buckingham: Open University Press, 1998) at 36.
[56] In particular, see *Left in the Cold* highlighted in this document.
[57] McKeown et.al, *supra* footnote 46 at 18.
[58] *Ibid* at 18.
[59] Townson *supra* footnote 6 at 80.
[60] *Ibid* at 82. She states: "Whether or not Canada has the political will to tackle such problems in the name of population health - or even simply in the name of social justice - remains to be seen. To repeat: there has been ample documentation of the adverse effects that socio-economic factors have on the health of individuals, as well as on the overall health of the population. There is evidence that policy-makers are well aware of this reality. But actually addressing the fundamental basis of health inequalities is another matter."
[61] CRIAW *supra* footnote 32.
[62] Thompson and Rude *supra* footnote 52 at 2.
[63] For further details see for example, *Missing Links: The Effects of Health Care Privatization on Women in Manitoba and Saskatchewan*, Kay Willson and Jennifer Howard (Winnipeg: Prairie Women's Health Centre of Excellence, 2000).
[64] Deiter and Otway *supra* footnote 40 at 15.

[65] *Ibid* at 14.
[66] *Ibid* at 20.
[67] *Ibid* at 20.
[68] Beaudry and Reichert quoted in Whyte *supra* footnote 12 at 31.
[69] McKeown *supra* footnote 46 at 32.
[70] *Ibid.*
[71] Green *supra* footnote 50 at 37
[72] *Ibid* at 30.
[73] Forsyth *supra* footnote 53 at 71.
[74] "'You have to understand that you are not to blame': Anti-poverty activist Jean Swanson exposes poor-bashing in Canada: interview with Joanna Fine" (http://www.btlbooks.com/Links/swanson_interview.htm).
[75] Whyte *supra* footnote 41 at 27.
[76] Green and participants of "We Did It Together" *supra* footnote 51 at 40.
[77] See for example Donner *supra* footnote 13 at 16.
[78] Whyte *supra* footnote 41 at v.
[79] Thompson and Rude *supra* footnote 52 at 7-8
[80] *Ibid* at 8.
[81] *Ibid* at 8.
[82] CRIAW *supra* footnote 32.
[83] Whyte *supra* footnote 41 at 43.
[84] Whyte *supra* footnote 41 at page 43
[85] *Ibid* at 22.
[86] *Ibid* at 21.
[87] Deiter and Otway *supra* footnote 40 at 6.
[88] Green *supra* footnote 50 at 4.
[89] Whyte *supra* footnote 41 at 16.
[90] Green *supra* footnote 50 at page 34.
[91] *Ibid* at 24.
[92] *Ibid* at 34.
[93] Forsyth *supra* footnote 53 at xiv.
[94] Deiter and Otway *supra* footnote 40 at 25.
[95] *Ibid* at 14.
[96] Donner *supra* footnote 13 at 42 - 51.
[97] CRIAW *supra* footnote 32.
[98] Green *supra* footnote 50 at 37.
[99] Royal Commission on Aboriginal Peoples (1996). Report of the Royal Commission on Aboriginal Peoples, Volume 4: Perspectives and Realities. Ottawa, Canada, quoted in Annette J. Browne and Jo-Anne Fisk "First Nations Women's Encounters With Mainstream Health Care Services", *Western Journal of Nursing Research*, 2001, 23(2), 126-147 at 127.
[100] *Ibid*.
[101] Green *supra* footnote 50 at 24.
[102] Green *supra* footnote 50 at 18.
[103] *Ibid* at 15.
[104] Deiter and Otway *supra* footnote 40 at 21.

[105] *Ibid*.
[106] Green *supra* footnote 50 at 36.
[107] McKeown *supra* footnote 46 at page 14.
[108] Thompson and Rude *supra* footnote 52 at iii.
[109] *Ibid* at 35. The report states: "Living conditions in terms of both housing and neighborhood characteristics are a major determinant of health.
[110] CRIAW, *supra* footnote 32.
[111] There is currently a waiting list of 96,000 for subsidized housing in large Canadian urban centres, according to Thompson and Rude *supra* footnote 52.
[112] McKeown *supra* footnote 46 at 34.
[113] Lesley Doyal, "Introduction Women and Health Services" in Doyal, ed. in Lesley Doyal, ed. *Women and Health Services* ( Buckingham: Open University Press, 1998) at 11.
[114] McKeown *supra* footnote 46 at 6.
[115] *Ibid* at 6.
[116] *Ibid* at 6.
[117] Green *supra* footnote 50 at 36.
[118] Deiter and Otway *supra* footnote 40 at 15.
[119] *Ibid* at 22.
[120] For a discussion of principles and models of women centred care and of models, see: Robin Barnett, Susan White and Tammy Horne*, Voices From the Front Lines: Models of Women-Centred Care in Manitoba and Saskatchewan* (Winnipeg: Prairie Women's Health Centre of Excellence, 2002).