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PUTTING HEALTH IN ITS PLACE:  
WOMEN'S PERCEPTIONS AND EXPERIENCES  
OF HEALTH IN HAMLTON'S NORTH END

By

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A Thesis

Submitted to the School of Graduate Studies

in Partial Fulfillment of the Requirements

for the Degree

Doctor of Philosophy

McMaster University

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**PUTTING HEALTH IN ITS PLACE**

DOCTOR OF PHILOSOPHY (2004)  
(Anthropology)

McMaster University  
Hamilton, Ontario

TITLE: Putting Health in its Place: Women's Perceptions and Experiences  
of Health in Hamilton's North End.

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NUMBER OF PAGES: xi, 297

## ABSTRACT

This study explores the self perceived health status and health priorities of a diverse group of women living in the highly industrialized and stigmatized North End neighbourhood of Hamilton, Ontario. Through the use of qualitative methods such as in-depth interviewing, focus group discussion, and participant observation, this medical anthropology research locates the health of the study participants (n = 46) within their neighbourhood, explores their experiences in this environment, and examines their understanding of the relationships between those experiences and their health. Guided by biocultural and critical interpretive perspectives, the study focuses on the personal knowledge and interpretations that women themselves assign to health concerns in their communities.

The North End women in this study understand health as a multidimensional concept and articulate the ways in which their overall health and well being is enhanced and/or compromised by a variety of place-based characteristics. Despite the fact that they reside in the same neighbourhood, they offer diverse opinions about the effects that neighbourhood attributes have on their health. These differences reflect the variability in participants' health status and needs, socio-demographic circumstances, feelings of personal agency, satisfaction levels, time spent in the neighbourhood on a daily basis, and expectations of their neighbourhood.

Because health experiences are embedded in everyday life, I assert that women's own perspectives, experiences and priorities must be incorporated into place-based health research and integrated into program and policy development. Women provide an invaluable and rich form of experiential knowledge about their health and their environment that differs from the "objective facts" put forth by outside individuals with no vested interest in the neighbourhood. Place is an important determinant of health that warrants serious attention by medical anthropologists who thus far have tended to view it merely as a backdrop for their research.

## ACKNOWLEDGEMENTS

I first wish to express my gratitude to the women of the North End for their desire to participate in this research project and for their willingness to share their personal information and their knowledge of the North End. I hope that I have sufficiently represented the diversity of their experiences and perceptions in this thesis.

I wish to extend my heartfelt appreciation to my supervisor, Dr. Ann Herring, without whom I do not think this dissertation would have ever seen the light of day. Ann's sincere interest in my research topic, her insightful comments and her unwavering belief in my abilities kept me motivated throughout the thesis process. Her continued friendship, support, and humour over the years have been greatly cherished. Ann, I don't know what I would have done without you!

I also want to thank my two other committee members, Drs. Tina Moffat and Wayne Warry, for their helpful suggestions throughout the writing and editing stages of this dissertation. Tina was particularly giving of both her time and her advice, always willing to sit down with me and chat about different aspects of my thesis. Wayne provided me with a number of challenging but extremely helpful comments that pushed my dissertation to the next level. Thank you both! I'd also like to say a special thanks to Janis Weir for all her help in answering my many questions during my time in the Anthropology Department.

On a more personal note, I'd like to thank my friend and fellow colleague, Kristen Jacklin, for always being at the other end of the phone line in good times and bad. Her willingness to listen and offer constructive suggestions while I worked through the writing process was invaluable.

I wish to express my gratitude to my parents, Ian and Maureen Farmer, for their love and support throughout my academic career and for their obvious pride in my scholarly pursuits. In particular, I want to thank my mother for her stylistic input and for never hanging up when I called and asked "Does this sound okay?". I'd also like to thank my father for motivating me to finish the thesis by constantly asking if I'd "finished that damn thing yet?".

Finally, I want to thank my husband, Greg Mayne, for standing by me throughout the whole thesis process. Not only did he selflessly give up his Sunday mornings to help me put up hundreds of interview advertisements but he has been one of my biggest supporters, acting as a sounding board and providing me with a different point of view from which to understand the information.

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**CHAPTER ONE:  
INTRODUCTION**

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Although women make up half of the world's population, their health needs have often been neglected or ignored altogether. Until quite recently, the health of women was only considered important with respect to their role as childbearers, as primary caregivers and as caregivers in the household (Kielmann 2002; Denton et al 1994). The strong male representation in the fields of health and medicine allowed the male experience to become the standard upon which all health and illness events were evaluated (Dan 1994). As a consequence, not only were women excluded from health research, but the very paradigms created for health research were based solely on a male perspective (Dan 1994).

Health has traditionally been investigated using the western/male biomedical model as its dominant framework (Hahn 1995:97). Despite this model's inability to comprehensively analyze non-physical dimensions of both male and female health (i.e., social, psychological, and behavioral factors), over the years it has acquired the status of dogma (Engel 1977). This male-centred health paradigm effectively reduced women's health to reproductive health and fragmented it into medical specialties such as obstetrics, gynecology, and psychiatry (Dan 1994:x). However, as women's health has become more thoroughly investigated, the limits of the biomedical approach to understanding health and illness have become more obvious (Dyck et al 2001:1). Most health researchers have

slowly begun to acknowledge the problems associated with using such a restricted model, and are beginning to adopt a more holistic and gender-sensitive approach to exploring health.

Medical anthropologists have long recognized that human health, disease and healing are significantly influenced by an extensive array of interrelated factors and conditions. Their studies typically consider one or more of the following variables: economic status (occupation, employment, income); social factors (education, support networks, nutrition); biology (development, genetics); demography (age, sex, ethnicity); history (biography, place); culture; physical environment (altitude, climate, pollution); politics (local, national, international); gender; and health care (infrastructure, technology). Although there is no agreement about the relative importance of each of the factors, it has been acknowledged that their influences on health are mutually dependent, reciprocal, and non-linear (Tonmyr et al 2002). Medical anthropological research also tends to support a broader definition of health, considers health within a wider context, and addresses health issues at different levels concurrently (micro and macro; individual, family, community and society). It is this more holistic approach that allows medical anthropologists the opportunity to better understand and assess the health and disease condition(s) of those individuals, groups and populations under study.

Yet, while medical anthropologists do address a wide range of factors in their research, very few have seriously considered the effect of specific place-based characteristics on the overall health and well-being of local residents. This is an important oversight given the growing awareness that places have a direct or mediated effect on the

lives of community members. Phillimore (1993:176) has even gone so far to state that: “the characteristics of places may be as important as the characteristics of people for an understanding of particular patterns of health”. Although differences in health between areas have long been observed, the last decade has seen a shift from focusing on compositional effects (health differences due to individual characteristics) to concentrating on contextual effects (health differences due to features of the local social and physical environment). Such a shift signals a move away from research on individual-focused risk factors and lifestyles toward a more community-focused approach that considers life choices and opportunities within a broader context. Unlike medical anthropologists, researchers in medical sociology, medical geography, epidemiology and public health have begun to produce a growing body of research on how the features of the places where people live are related to a variety of health outcomes (Diez Roux 2002). For example, work done by Macintyre and her colleagues (e.g., Macintyre et al 1993; Sooman and Macintyre 1995; Macintyre and Ellaway 1998; Ellaway et al 2001) has revealed how individuals’ perceptions of their lived environment influences their overall well-being. Place factors such as local amenities, local area problems, neighbourliness, fear of crime, social capital, area satisfaction and area reputation have been shown to have the potential to promote or damage residents’ health.

While this study began as an exploratory look at the health status, health needs and health perceptions of women living in the North End of Hamilton, Ontario it quickly became apparent that the characteristics of the study location itself played a significant role in the perceived well-being of its female residents. For example, the chaotic mixture

of residential housing, heavy industry (e.g., steel companies), and copious brownfields is considered by residents to pose a significant physical health risk (with respect to air pollution and chemical contamination). Moreover, the perceived confluence of socio-economically disadvantaged individuals in the area and its sullied past have all contributed to the North End's marginalized position and longstanding stigmatized reputation. The North End is portrayed by most outsiders and some insiders as dirty, rough, poor and crime-ridden. Having lived in the City of Hamilton for a number of years prior to conducting this study, I was aware of the North End's negative reputation. Like most outsiders, my 'familiarity' with the North End was based not on actually having visited the area, but instead, on various stories I had heard. Although the North End has changed significantly over the last century and a half, the narratives have remained the same. Unfortunately, the stigma associated with the North End has been projected onto the residents of the area creating, in some, negative personal images and negative health behaviours and outcomes.

As a result of its storied past and deeply entrenched mythology, many positive characteristics associated with the North End have either been ignored or disbelieved. The views of outsiders with no first hand knowledge of the area are accepted as truth. As a result, health-enhancing, positive features of the North End, such as the people, parks, sense of community, social capital, and accessibility to many local amenities, are overlooked much to the detriment of the neighbourhood residents.

Since health outcomes have been shown to be directly and indirectly affected by where an individual lives, it appears that to understand women's health, it is imperative

that we be aware of the characteristics defining the places where women live and the circumstances under which women live. As Auerbach and Figert (1995:121) so aptly point out:

...an individual's physical and mental health are not phenomena out of context; that is, one's experience of illness or health is at least in part defined by the particular historical, cultural, geographical, and structural context in which one lives.

One cannot conceptualize women's health without taking into consideration women's lived environment, because it is within this lived framework that health and ill-health are experienced and understood. It is also important, however, that we consider individual differences among women even at the local level. The use of the term "women's health" must not lead to the conclusion that there is one health for all women or that women represent a homogeneous group (Stanton and Gallant 1995:572).

It is only through speaking with local residents that we can begin to appreciate both the shared and individual differences in neighbourhood experience. Asking women to discuss their perceived health status and health needs and to consider their health within the framework of their lived environment reveals a more comprehensive picture of their health, one that touches on what they consider to be the most important factors affecting their health and well-being. Despite a growing recognition that it is important to consider women's accounts of their health, seldom have women been asked to voice their opinions. The paucity of first hand information about women's health restricts health programmers' and planners' ability to create practical and beneficial health-oriented programs. This gap in our knowledge of women's health also limits policymakers' ability to generate successful policy initiatives and to ensure that funds are spent appropriately.

In recognition of the limitations and omissions inherent in a biomedical and positivist approach to women's health research, this study is guided by two theoretical paradigms used in medical anthropology, the biocultural model and the critical-interpretive model.

1. The "new" biocultural model, a framework promoted by anthropologists Alan Goodman and Thomas Leatherman (1998), is the synthesis of the approaches of cultural and biological anthropology. In this model, humans are seen as holistic beings with interrelated biological and sociocultural contexts. Researchers utilizing this model concern themselves with how factors such as culture, political economy, history and the environment affect human biology (e.g., nutritional status, disease spread, exposure to pollution) and, how biological consequences might then have further effects on cultural, social, and economic systems. This approach advocates the study of humans in the context of their lived environment and recognizes that human health and illness does not take place in a vacuum.
2. The critical interpretive approach arose in the sub discipline of medical anthropology, in response and protest to, the reductionism of biomedicine which assumes the 17<sup>th</sup> century ideal of Cartesian dualism (separation of mind and body) and employs a mechanistic approach to health and illness. The critical interpretive model, on the other hand, views the body from three different perspectives - the individual body, the social body and the political body – and supports the notion that the health of individuals is influenced by their lived context. Supported by individuals such as Margaret Lock and Nancy Scheper-Hughes, this model is concerned with how

meaning is created in culture and through the practice of anthropology, and involves interest in the constructive role of power, knowledge, ideology and inequality. This approach considers that "...knowledge relating to the body, health and illness is culturally constructed, negotiated, and renegotiated in a dynamic process through time and space" (Lock and Sheper-Hughes 1990:49).

Used in combination these two paradigms, along with the application of qualitative methods, offer a unique perspective unattainable by researchers still working within the boundaries of the biomedical model. At the centre of these theoretical approaches is the importance of truly understanding the individual in their social, economic, political and cultural context. Researchers employing these paradigms are more concerned with obtaining a comprehensive and meaningful understanding of an individual's life than with highly structured explanations and accounts. These models build on the personal knowledge and the interpretations that women themselves assign to the health concerns in their communities. At the same time, they take into consideration the fact that women's ways of thinking and acting are embedded in their lived environment and cannot be understood independently of this context.

### **Outline and objectives of the study**

This dissertation explores the self-perceived health status and health priorities of a group of women living in the highly industrialized and stigmatized North End neighbourhood of Hamilton, Ontario. It does so by locating women's health within their lived environment - exploring their experiences of residing in a specific neighborhood and examining the potential relationships between those experiences and their health.

The primary questions addressed in this thesis are:

1. How do women characterize the North End neighbourhood? What features of the lived environment do they like and dislike?
2. How do North End women perceive their own health and the health of women around them?
3. Do women believe that their health is influenced by their North End environment? If so, what environmental factors do they feel affect their health? Do these factors enhance and/or compromise their health?
4. Should lay perceptions of health and the lived environment be acknowledged by researchers and policy creators?
5. How important is 'place' as a determinant of health? Should more medical anthropologists begin incorporating the concept of place in anthropological studies of health?

Information used to answer these questions was gathered using qualitative methods that include in-depth, face-to-face interviews, one focus group and participant observation. In total, 46 women from the North End neighbourhood participated in either the interview process or the focus group discussion. These women represent a heterogeneous group of individuals with different socio-demographic backgrounds and diverse experiences and perceptions of the North End.

The thesis is organized into eight chapters. Chapter 2 describes the traditional approach taken to studying women's health, the importance of considering women's health as separate from men's health, and the problems associated with the continued use of standard indicators (e.g., life expectancy) as an overall measure of women's health. The value of listening to, and incorporating, 'ordinary' women's own ideas is introduced as a significant contributor to the well-being of women. This chapter shifts its focus to briefly consider the 'place' of women in anthropological research. I then discuss the meaning of 'place' and argue that the concept of 'place' is under theorized in contemporary anthropology. The chapter ends with an introduction to the study of place

effects on human health and a discussion about the need to re-conceptualize the relationship between health and place in anthropology.

Chapter 3 outlines the changing locale of anthropological fieldwork from 'abroad' to 'home'. It then offers a comprehensive overview of the qualitative research process used in this study. As well, a detailed socio-demographic profile of the female participants is presented.

Chapter 4 provides an historical account of the growth and development of the City of Hamilton, Ontario and highlights its importance as a manufacturing centre. The North End neighbourhood of Hamilton, the location of this study, is introduced and the colourful history of this place and its people is considered within the larger context of this highly industrialized city. This chapter also explores the creation of the North End's unsavory reputation and reasons for its continued negative portrayal are offered. Although often overlooked, I maintain that the history and reputation of a place have the potential to significantly affect contemporary health outcomes.

Chapter 5 presents a qualitative account of the diverse manner in which female residents perceive their neighbourhood. This chapter examines various definitions of the North End neighbourhood boundaries, reasons why women moved into the area and then explores women's satisfaction with their neighbourhood. It then goes on to discuss women's perceptions of the positive and negative features of the area, the quality of certain neighbourhood attributes, and their feelings about the North End's stigmatized reputation. It finishes with a look at the other areas of Hamilton in which North End women would prefer to live and why. I argue that because, "...neighbourhood life

contains many intangible qualities that defy measurement” (Parkes et al 2002:2413) and because individuals experience and are affected by their residential environment in different ways, it is important to listen to and consider the lived perspectives of residents if we hope to more accurately understand the neighbourhood unit.

Chapter 6 focuses on the multiplicity of health perceptions and experiences reported by the women in this study. More specifically, it presents the health concerns and priorities identified by women themselves at the personal, neighbourhood and national level. This chapter highlights the fact that not only are women cognizant of the diverse and complex nature of health, but they are aware that women do not represent a single homogeneous group of individuals all experiencing the same health problems and requiring the same type of health care. Because significant differences have been found between the health priorities identified by medical professionals and key informants and those put forth by ‘ordinary’ women, it is imperative that health researchers begin to consider and value the opinions and perspectives put forth by women. Women themselves are best able to identify their health needs and comment on the overall quality of their lives.

Chapter 7 begins with a discussion of the relationship between health and place. Together with the results presented in chapters 5 and 6, it then continues to discuss the perceived relationship between participants’ health and the North End neighbourhood and to identify specific factors in the environment that women believe enhance and/or compromise their health. The chapter then highlights the life stories of six women who took part in the study, in order to further illustrate and help contextualize the diversity in

responses provided by participants. The chapter ends with a discussion of the difficulties involved in investigating the relationship between health and place and considers reasons for the considerable variation in women's perceptions and experiences of the North End neighbourhood. Although the study of place effects on health has emphasized the importance of contextual features (the place) over compositional features (the people), I contend that the characteristics of both the people and the place are integral to our understanding of local level health outcomes.

Finally, chapter 8 argues for the need for medical anthropologists to consider place as an important environmental determinant of health. As Lomas (1998:1182) indicates:

...individuals (and their ill-health) cannot be understood solely by looking inside their bodies and brains; one must also look inside their communities, their networks, their workplaces, their families and even the trajectories of their life.

Because health experiences are embedded in everyday life, I assert that women's own perspectives, experiences and priorities must be incorporated into place-based health research. Women provide a subjective and personal form of knowledge about their health and their environment that differs from the "objective facts" put forth by outside individuals with no vested interest in the neighbourhood.

## **CHAPTER TWO: WOMEN, HEALTH AND PLACE**

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This chapter highlights the importance of studying women's health and provides a Canadian framework for evaluating the health of the women in this study. It discusses the traditional means of prioritizing health needs and the problems associated with employing those measures. This chapter also introduces the topic of place, a highly undertheorized concept in anthropology, and then goes on to discuss the importance of place as a determinant of women's health.

### **Why women's health?**

Although women make up more than half of the global population and receive more than half of the health care, until recently research on female-specific conditions was considered a low priority and received modest funding (Rosser 1994). What little research has been carried out tended to focus almost exclusively on issues surrounding fertility and the rearing of the next generation of children (Kettel 1996; Auerbach and Figert 1995; Koblinsky et al 1993). This constant preoccupation with the reproductive system, to the total disregard of other parts of the female body, including a woman's psychological and social well-being, resulted in a very narrow conceptualization of women's health, one that allowed the needs and concerns of women to be continuously neglected (Dan 1994).

During the past decade and a half there has been a growing awareness that women's health is affected by much more than the female reproductive system (Day

1998). Indeed, researchers now appreciate that women's health is determined by a number of factors such as:

education, income and social status, self image, behaviour and coping skills, personal health practices, housing, employment and work conditions, food and nutrition, environment, discrimination based on gender, culture and ethnic background, powerlessness and the degree of control in one's life, and healthy child development (Health Canada 1999b:35).

In addition, there has been an increasing appreciation of the influence that the strong male bias, inherent in prioritizing, designing and conducting many medical and health studies, has had on women's health. The tendency to use males as the norm in clinical trials means that much of our understanding of women's health comes from studies conducted almost exclusively on men that have then been inappropriately generalized to women (Fletcher 1994; Kitts and Roberts 1996). The penchant for using white<sup>1</sup> males as the standard also means that

...we do not know to what extent the majority of research findings, which influence health strategies around the world, include the 90% of the global population (white women and women and men in non-white racial and ethnic groups) not represented in these studies (Feacham et al 1989 cited in Dyck et al 2001:3).

Various reasons have been given to explain the obvious exclusion of women in clinical trials: (1) the possibility of fetal deformities (teratogenic affects) arising in a woman's unborn child and the potential liability this may cause for researchers; (2) the high level of variability caused by the menstrual cycle, pregnancy and menopause, which act to complicate and increase the overall costs of the study; (3) the belief that there are no significant gender differences that would influence treatment; and (4) the financial

---

<sup>1</sup> The term "white" refers to Caucasians or individuals of European descent.

limitations which require investigators to focus only on high risk populations (e.g., heart disease in middle aged white men and AIDS research on homosexual men and intravenous drug users) (Auerbach and Figert 1995; Larosa 1994; Rosser 1994).

This practice has tended to mask the fact that women are very different from men.

Wallis (1994:14-15) points out

[d]ifferences in women's health supersede the boundaries of the reproductive tract and affect every system: cardiovascular, gastrointestinal, immune, resistance to infection (HIV), and musculoskeletal, urologic, and psychological health. The physiological hormonal milieu and environmental, societal, and economic circumstances shape the course of illness and therapeutic outcome differently in women than men.

As a consequence of these differences, women tend to experience certain health problems that men do not (e.g., uterine cancer), are more vulnerable to certain health conditions than are men (e.g., osteoporosis), and experience some health conditions that are less easily detected in women (e.g., sexually transmitted diseases) (Rathgeber cited in Kitts and Roberts 1996:2). Accordingly, gender-specific research is now recognized as essential if researchers are to identify and prioritize correctly the health needs of women (Brems and Griffith 1993). In recognition of this, Health Canada amended its regulatory guidelines in 1996 to require that pharmaceutical companies include women in their clinical trials (Health Canada 1999c).

Despite the significant broadening and deepening of our understandings of women's health, there are still significant gaps in our knowledge (Health Canada 1999a). As recently as 1998, the Laboratory Centre for Disease Control (LCDC), a branch of Health Canada, acknowledged that there was no comprehensive monitoring and reporting

on women's health in place, primarily because of the lack of women's health data in Canada (Health Canada 1999d). In reaction to this, Health Canada identified women's health as a priority area and formed the 'Women's Health Strategy' in an attempt to begin responding to identified women's health concerns. The Strategy, which was developed to advance our understanding of women's health issues and to address the gender biases and insensitivities inherent in the health care system, also focuses on female mortality, morbidity, quality of life and socioeconomic conditions affecting women's health (Health Canada 1999d)

This program was followed by the creation of the Women's Health Surveillance, which is made up of a multidisciplinary advisory committee of health professionals from across the nation who have expertise in the field of women's health (Health Canada 1999c). The Women's Health Surveillance monitors health trends across time and space and provides an "evidence-based foundation for clinical decision making, health policy, program design and evaluation of targeted interventions" (Health Canada 1999c). In order to accurately guide the LCDC in its future health planning, "Canada's best experts in women's health" (composed of service and program administrators, activists, researchers, policy and program developers and health care providers) developed a realistic, yet comprehensive, list of women's health priorities that addressed both short- and long-term health issues and represented the diverse composition of the female population (Health Canada 1999c). This list included health conditions such as cancer, cardiovascular disease, chronic pain (and other musculo-skeletal disorders such as osteoporosis and arthritis), violence/abuse against women, and mental health problems.

While each of these Health Canada initiatives are to be celebrated for their dedication to promoting a better awareness and subsequent understanding of women's health issues, both rely solely on evidence put forth by academic and research 'experts', excluding the voices of 'ordinary' women who have the potential to bring a different type of expertise to the table. This is an important omission given that women identify problems that have at times received little validation and have rarely been the focus of women's health discussions (Walters 1991).

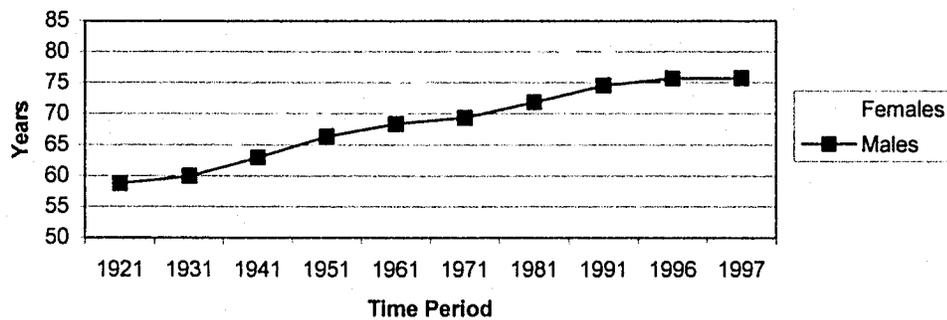
### **The health of Canadian women**

Canada has a standard of health that is among the highest in the world and Canadians, for the most part, enjoy a high level of health (Health Canada 1999b). The health status of Canadians, however, is not equal and evenly distributed across all members of society. Differences in health status exist as a consequence of factors such as age, ethnicity (e.g., Aboriginal status), socio-economic conditions, geographic location and gender. There are significant differences in the health experiences of males and females as a result of biologically determined characteristics (sex) and socially and culturally constructed roles (gender) (Vlassoff and Moreno 2002).

Paradoxically, women live longer than men but experience poorer health. In Canada, the life expectancy at birth is 81.4 years for women and 75.8 years for men (Normand 2000:55). For both men and women, life expectancy at birth has increased since 1921, although the increase has been greater for women than men (Figure 2.1). This reduction in premature mortality in women was thought to reflect decreases in fertility rates and maternal mortality, combined with improvements in overall nutrition (Goldman

and Hatch 2000). However, in recent years the gap between the life expectancy of women and men has narrowed (Normand 2000:54). This may be the result of factors such as increasing stress levels in women and decreasing rates of premature mortality from lung cancer and ischemic heart disease in men (Health Canada 1999b). As a consequence of their longer life expectancy, women make up a substantial proportion of the senior population; the fastest growing segment of the female population. In 1999, women constituted 57% of those aged 65 years or older and 70% of those aged 85 years and older (Lindsay 2000:17).

**Figure 2.1: Life expectancy at birth for Canadian males and females, 1921-1997**



(Normand 2000:75)

In 1996-97, 63% of Canadians, 12 years and older, described their health as excellent or very good while only 9% said their health was fair or poor (Health Canada 1999a:219). Table 2.1 reveals that there is little difference in self-rated health between men and women. Self-rated health status has been shown to be a dependable predictor of personal health problems, health care utilization and longevity (Health Canada 1999b).

**Table 2.1: Self-rated health status for Canadian males and females aged 12 and over, 1996-97**

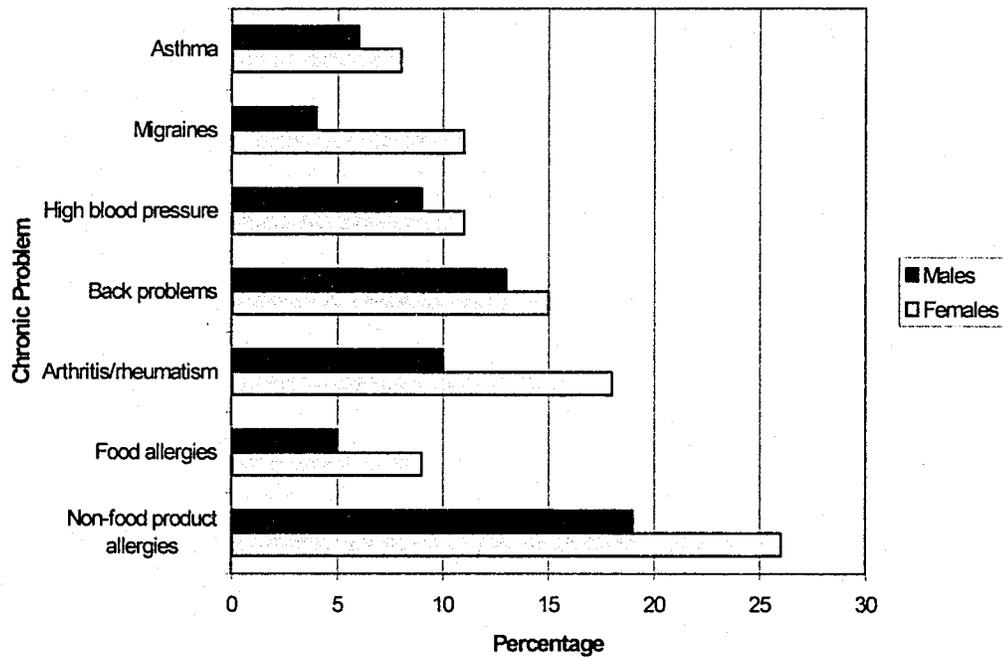
	Excellent (%)	Very Good (%)	Good (%)	Fair (%)	Poor (%)
Total, age 12+	25	38	27	7	2
Females	24	38	27	8	2
Males	26	39	26	7	2

(Health Canada 1999a:219)

Although most Canadian women consider themselves to be in good health, many are plagued by chronic and degenerative health problems that result in activity limitations, hospitalization and even death (Normand 2000). In 1996-97, 62% of females 12 years and older reported suffering from some form of chronic condition (diagnosed by a doctor) that typically lasted at least six months, while only 52% of men reported suffering from a chronic ailment (Normand 2000). Women are more likely than men to suffer from all the various health problems included in Figure 2.2. For example, the percentage of women suffering from arthritis or rheumatism is 18% compared to 10% in the male population, and the percentage of women suffering from migraines is 11% compared to only 4% in the male population.

In Canada, the two leading causes of mortality for both males and females are heart disease and cancer, although the deaths rates for these two diseases are much lower in women than men (Table 2.2). In 1997, heart disease and cancer, together, accounted for 52% of all deaths among women (Normand 2000). However, these diseases affect women at different ages; women between 30 and 79 are most likely to die of cancer while women over 80 are most likely to die of heart disease (Norman 2000).

**Figure 2.2: Percentage of the Canadian population diagnosed with a specific chronic health problem, 1996-1997**



(Normand 2000:68)

Although cardiovascular disease is the primary cause of death, disability, and healthcare costs in Canada (Health Canada 1999a), there has been a sharp decline over the past two decades in the mortality rate from this disease in the female population (Normand 2000). In fact, the age-standardized mortality rate reveals a 36% decrease in deaths from 1981 to 1997. On the contrary, there was almost no change in the overall death rate due to cancer for this period of time. The age-adjusted death rate for lung cancer from 1981 to 1997 in women, however, almost doubled while men experienced a slight decrease during the same period (Norman 2000). This may reflect an increasing prevalence of smoking in women and a decreasing trend in men. There is also recent evidence that suggests that women may be more susceptible to the negative effects of

tobacco-related carcinogens than men (Arnold and Eckstein 2000). Breast cancer, however, remains the leading form of cancer diagnosed in women. A slight decrease in breast cancer deaths may reflect earlier scanning or improved treatments (Normand 2000).

**Table 2.2: Age standardized death rates by selected causes for Canadian men and women, 1981 and 1997**

	Women		Men	
	1981	1997	1981	1997
	Deaths per	Deaths per	Deaths per	Deaths per
	100,000 females	100,000 females	100,000 males	100,000 males
<b>Cancer</b>				
Lung cancer	17.9	32.3	73.1	69.8
Breast cancer	30.1	27.4	...	0.3
Colorectal cancer	21.5	15.2	29.2	23.5
Total all cancers	148.8	148.5	238.9	229.7
Heart disease	202.7	129.7	379.2	230.8
Cerebrovascular disease	67.4	43.9	80.8	52.8
Respiratory disease	32.5	44.8	84.3	85.7
Chronic liver disease & cirrhosis	7.3	4.2	17.3	8.9
Motor vehicle accidents	10.7	6.1	31.2	14.5
Total all causes	606.1	521.6	1051.8	844

(Normand 2000:75)

The significant variability in both mortality and morbidity rates between Canadian males and females highlights the need to consider women's health separately from men's health. It is obvious from the statistics presented in this section that men and women are affected in varying degrees by different illnesses. This variation in morbidity and mortality reflects not only biological and genetic variability between the sexes, but differences in socio-cultural circumstances and lifestyle choices.

### **Prioritizing women's health needs**

In spite of our growing knowledge about the role that socio-economic, cultural and physical factors play in the aetiology of disease, and as the previous section shows, the most commonly used indicators of a population's health needs and status continue to be life expectancy, mortality rates, and morbidity rates (Hunt et al 1980). These neatly quantifiable measurements also form the primary basis upon which women's health priorities are set, new health policy created and funds for health programs allocated. Yet, how adequate are these measures in capturing the holistic nature of health and the lived experiences considered integral to understanding health?

#### ***Life expectancy***

It has been increasingly acknowledged that life expectancy is not a suitable indicator of an individual's quality of life. Since women tend to live significantly longer than men, it has often been assumed that women, as a group, are healthier than men. In reality, however, (as noted earlier) women tend to suffer more acute symptoms, chronic conditions, and short- and long-term disabilities than men (Pinn 1995). Verbrugge and Wingard (cited in Goldman and Hatch 2000:11-12) have suggested four possible explanations for women's poorer health and men's shorter lives:

1. Differences in inherent risk – At every age (including prenatally), males experience higher death rates than women suggesting that males may bear an inherent susceptibility to disease.

2. Differences in acquired risk – There exist significant differences between males and females with respect to risks associated with lifestyle, occupational and recreational activities, and with stress management.
3. Differences in illness and prevention orientations – The differences between males and females in their ideas about health and disease, and in their readiness to take preventative or curative actions, may account for women's longer lives. Women are typically more willing than men to seek help for their health problems and to participate in preventive actions.
4. Differences in health and death reporting behaviours – Bias in the reporting of health behaviours may account for differential rates of morbidity and/or cause of death reported on death certificates.

Life expectancy data has also been criticized because little consideration has been given to the fact that life expectancy differs between groups of women, such as Aboriginal women, women with disabilities, women from disadvantaged areas, and women employed in high risk jobs (Normand 2000).

### ***Mortality rates***

Mortality data has been criticized because it only captures the primary cause of an individual's death, rather than the preliminary or contributing causes. As such, chronic diseases that have the potential to produce long-term physical and mental disability and lead to considerable health care costs may be overlooked while certain causes of death, such as adverse reactions to prescribed medications, may be persistently underreported (Freund and McGuire 1999). As well, because most mortality data is based solely on a

doctor's assessment of the cause or causes of death and because autopsies are considered too expensive and are being carried out on a decreasing number of cases, there is room for error in the assessment (Freund and McGuire 1999). Basing policy and program development on mortality information masks day to day health experiences (Walters et al 1995) and reveals nothing about an individual's quality of life – how they felt or functioned while they were alive.

*Morbidity data*

Although morbidity data is a much better measure of quality of life, information based on health care utilization and hospital visits is seriously limited in that it reflects the type and rate of service usage but reveals very little about unmet needs (Walters 1991). Vlassoff and Moreno (2002:1715) note that a number of current studies have shown that health statistics that are based upon health centre or hospital data may actually underestimate female morbidity and mortality because: (1) women may not go to these facilities for detection and/or treatment; and (2) women are more likely than men to self-treat (i.e. self medicate) or to seek health care from other sources. This means that the health needs of some individuals are not even considered while the health needs of others may be hidden from view in the aggregate framework of health analysis (Kielmann 2002). Furthermore, little consideration has been given to assessing how factors such as cost, time, mobility and distance may differentially influence the way that men and women use health services (Vlassoff and Moreno 2002). In addition, morbidity data do not reflect the dissatisfaction that many women have with the level of health care they are receiving; some feel that their medical practitioners have ignored or misrepresented their

health needs. Moreover, medical practitioners, who are responsible for the reporting of health problems, have been criticized for their medicalization of women, control of women's bodies, and tendency to focus on women's reproductive health (Walters et al 1995).

### *Special interest group opinions*

In order to overcome some of these problems, social science researchers have incorporated a broad range of information put forth by special interest groups and key informants into the overall understanding of women's health issues. While this approach does include women's opinions about health matters, it has been criticized because only the most organized, well funded and most articulate groups are in a position to present ideas (Walters 1991). Furthermore, these groups may have their own organizational agendas that may only represent the health concerns of a small minority of women (Redman et al 1988), overlooking the majority or those most in need.

### *Lay women's perspectives*

Each of these approaches to measuring health highlights a different set of health priorities. When these indicators are considered in combination, they still fail to accurately portray women's health needs and experiences. Whose list of health priorities should be considered most legitimate? Increasingly, women's health researchers are advocating the inclusion of 'ordinary' women's voices in the decision making process around health planning and policy making (Redman et al 1988; Walters 1991; Denton and Walters 1996). Aside from the numerous problems associated with the usual means of priority setting, this is important because women's own health needs and concerns

appear to differ in their focus and scope from those identified by health care and government agencies (Walters 1992; Walters 1991; Redman et al 1988). As Ballem (1998:337) notes:

...the priorities of health care planners and providers and those of the population they serve are often far from congruent with one another. This is particularly true in the field of women's health, where there appears to be a significant gap between health status data on the one hand, and, on the other, women's perceptions of their own health and their priorities with regard to health care.

This is further supported by Kielmann (2002) who observes that individuals' perceived measures of morbidity are very rarely congruent with physician-obtained measures of morbidity.

It is precisely because 'ordinary' women's health concerns and experiences do not coincide with professionally identified problems that their opinions are coming to be seen as an indispensable adjunct to the more traditional health needs indicators (Hunt et al 1980:281). Women's views must be heard since they are best able to identify their own health needs (Redman et al 1998) and because it is women who are ultimately affected by funding decisions made on their behalf. Unlike most other health priority approaches, information gathered from lay women is based on actual experience and reflects the multidimensional nature of health. Walters (1991:33) notes, moreover, that there are practical reasons for including women's own health priorities in research agendas:

It is only when women's concerns are documented that there is the possibility of taking them into account in policy making. No longer can physicians and other key informants and experts claim the unchallenged right to define women's health needs.

Nevertheless, there are those who seriously doubt that 'ordinary' women have anything constructive to add to the discourse on women's health. Lay women's perceptions and perspectives about health have often been set aside as subjective, incomplete in their acknowledgement of serious health problems, easily swayed by media expectations/opinions and variable (Walters et al 1995). It can be argued, however, that these supposed limitations actually reveal the true lived experience of women and as such, indicate the importance of investigating, in more depth, women's understandings of health (Walters et al 1995). Women's health must be conceptualized within the larger social, cultural, economic and biophysical environment (natural and constructed) within which they occur (Stanton and Gallant 1995; Kettel 1996). At the same time, however, individual differences between women must be acknowledged and explored.

### **The place of women in anthropology**

One of the primary goals of anthropology is to examine and help explain the similarities and differences between and among people from different cultures around the world. Accordingly, one might expect both males and females to be given equal consideration in anthropological research and writing. However, women were historically treated as invisible and issues surrounding gender were overlooked. It was not until as recently as the 1970s, with the advent of the women's movement, that women became an important part of anthropological research, resulting in the creation of the sub-discipline of feminist anthropology (Mascia-Lees and Black 2000). Although some well-regarded research carried out on women by women did occur before the 1970s, it was not considered, at the time, fundamental to the discipline of anthropology (e.g., Margaret

Mead's the "Coming of Age in Samoa" (1928) and "Male and Female: A Study of the Sexes in a Changing World" (1949), and Ruth Landes's "The Ojibwa Woman" (1938) and "The City of Women" (1947)). Even today, there is resistance to including the contributions of feminist anthropology in mainstream anthropology because gender is considered to be a topic of concern only for women (del Valle 1993).

Early feminist anthropologists revisited many past and present studies and found significant variation in gender roles, in the importance placed on activities performed by men and women, and in men's and women's access to important resources (Mascia-Lees and Black 2000:9). Their findings led them to question deeply embedded gender assumptions that were at the root of women's social inequality in the West. Feminist reviews of traditional ethnographies, conducted and written primarily by men or women trained by men, revealed biased, male-oriented approaches that produced distorted images of women's work and women's place in society (Mascia-Lees and Black 2000).

As Alice Schlegel (1977:2) notes:

...one gets the impression from many ethnographies that culture is created by and for men between the ages of puberty and late middle age, with children, women and the aged as residual categories; women are frequently portrayed, at best, as providing support for the activities of men ( cited in Mascia-Lees and Black 2000:9).

Anthropology's tendency to exclude women in research and to use men as the standard upon which all others were measured, parallels the biases inherent in biomedical studies and reflects the social and academic climate of the time.

### **The place of women in medical anthropology**

Women have certainly been an integral part of medical anthropology studies since its inception over twenty years ago. They have been and continue to be the subject of numerous health-related ethnographies and studies. Many ethnographies, situated in both Western and non-Western settings, highlight women and women's issues. However, while some recent ethnographies consider issues surrounding disability (Frank 2000), cosmetic surgery (Davis 1995), dieting (Nichter 2000), AIDS (Sobo 1995), and drug use (Sterk 1999), there are still numerous ethnographies that concentrate on topics centred around female reproduction – infertility (Becker 1997), abortion (Ginsburg 1998), conception (Inhorn 1994), childbirth (Jordan and Davis-Floyd 1993), surrogate motherhood (Ragone and Ragsurp 1994), reproductive technologies (Becker 2000) and menopause (Lock 1994).

My review of the contents since the year 2000 of one prominent medical anthropology journal, *Medical Anthropology Quarterly*, revealed a large number of female-focused articles dealing with issues such as menopause (Agee 2000; Zeserson 2001; Kagawa-Singer 2002), prenatal care (Winston and Otris 2000), preparing for motherhood (Ketler 2000), and the knowledge and practice of birth (Obermeyer 2000) while a much smaller number of female-focused articles discussed issues such as sex and violence (Wojcicki 2002), STDs (Wardlow 2002), medicinal plant use (Wayland 2001), and mental health (Dossa 2002).

This continued focus on reproductive issues within medical anthropology perpetuates the biomedical and stereotypical concept that women's health is only

important when considered with respect to her maternal role. Given the multiplicity of women's health topics that have received considerably less attention or no attention at all, one is led to question the unflagging interest in this particular aspect of women's health. Does it reflect women's definitions of their own health concerns? Is it easier for women to talk about reproductive health than other facets of their health? Does it reflect researchers' health priorities? Does it reveal the direction of funding decisions?

One issue that has not been seriously considered with respect to women's health, or men's health for that matter, is the relationship between place and health. More specifically, there are few medical anthropology studies that consider the characteristics of place as important influences on health (exceptions are Nancy Scheper-Hughes', *Death Without Weeping: The Violence of Everyday Life in Brazil* (1992), and Paul Farmer's, *AIDS and Accusations: Haiti and the Geography of Blame* (1992)). More importantly perhaps, the entire concept of place has been an undertheorized concept in the field of anthropology as a whole. However, before considering the issue of place in anthropology, it is important to first explore the meaning of place.

### **The meaning of place**

Space and place are terms used to describe and analyze the geographical world (Kearns and Joseph 1993). Space is an abstract concept that represents the three-dimensional environment in which phenomena (objects and events) occur, are distributed, and have a relative position and direction (Curtis and Jones 1998:646). Place, on the other hand, is a more tangible concept, "anchored in the world of human experience" (Kearns and Joseph 1993:711-2). According to Curtis and Jones (1998:646-647), place may be

thought of in a number of different ways: (1) as a location; (2) as a locale (a particular setting in which social relationships are represented); (3) as locality (“a particular area or region...in which various social and economic processes come together in combinations which may be specific to the place and may themselves be influenced by the conditions prevailing in the locality”); and (4) as sense of place (the meanings, values and expectations individuals attach to a place).

Thus, although place can be spatially defined, it is also socially, culturally, economically, politically and psychologically constructed (Fitzpatrick and La Gory 2000:9). The meanings attributed to place are produced internally - by residents - and externally - by the media, government officials and other non-residents (Perez 2002). Relph (1976:61) points out that the character of a place is composed of three interconnected factors, each of which is infinitely variable: (1) physical features or appearance; (2) observable activities and functions; and (3) meanings and symbols. Because there is an unlimited number of ways that these components can interrelate with one another, there is “...no discernable limit to the diversity of identities of places, and every identifiable place has unique content and patterns of relationship that are expressed and endure in the spirit of that place” (Relph 1976:61). Ingold (2000:192) comments that “A place owes its character to the experiences it affords to those who spend time there – to the sights, sounds and indeed smells that constitute its specific ambience”.

### **No space for place in anthropology**

Relph (1976) notes that ‘place’ has typically been an under-examined concept in social science research. He believes this may stem from the inherent complexity of the

term which does not lend itself easily to scientific scrutiny. Place has most definitely been an understudied component of anthropological studies<sup>2</sup>. Appadurai (1988:17) remarks that while the "...circumstances in which the evidence is gathered (those of fieldwork) and the circumstances of the writing up of the field work have been much discussed recently...the spatial dimension of this circumstantiality has not been thought about very much". As Geertz (1973:22) pointed out almost thirty years ago: "Anthropologists don't study villages (tribes, towns, neighborhood...); they study in villages".

Margaret Rodman's 1992 paper, *Empowering Place: Multilocality and Multivocality*, discusses the problem of 'place' in anthropological theory. She argues that anthropologists typically tend to equate 'place' with their ethnographic locations and as a result, 'place' becomes viewed simply as a physical setting - an "inert container" - in which events occur (Rodman 1992:640-1). But as mentioned earlier, places are more than just physical entities in space, they are:

...also mental constructs, psychologically defined by individuals who possess culture and occupy certain positions within society. Each person carries around a set of mental maps that are a product of personal experiences, cultural stereotypes, preferences, objective information, and so on (Fitzpatrick and LaGory 2000:9).

Places are also politically and historically defined, and represent local and multiple constructions (Rodman 1992:641).

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<sup>2</sup> An exception to this is work done by cultural anthropologists, Matthew Cooper and Margaret Rodman (1992), whose ethnographic research focuses on non-profit, housing co-operatives in Toronto, Ontario. Their interviews focused on housing history, expectations of what life in a housing co-op would be like, and their experiences with the co-op.

There are parallels between place and voice (Rodman 1992). While anthropologists have been forced to acknowledge and deal with the issue of accurately representing the numerous and diverse voices in their ethnographic writing, such has not been the case for place. Places, like voices, are multifaceted and complex and require more serious attention. However, there has been very little appreciation of the fact that "...place is more than locale, the setting for action, the stage on which things happen" (Rodman 1992:643). In Appadurai's (1988:17) words, "the problem of voice ("speaking for" and "speaking to") intersects with the problem of place ("speaking from" and "speaking of").

Rodman (1992:641) contends that it is time for anthropologists to realize that places, like voices, are local and multiple and recognize that "...they hold no patent on place-making". Place is more than the singular interpretation and representation set out in ethnographic writings (Rodman 1992). The diverse lived experiences of residents must be acknowledged and understood in isolation from the construction of place fashioned for the purpose of ethnography. Anthropologists must be willing to empower the concept of place and represent its dynamic and complex nature. We must also be willing to "consider how different actors construct, contest, and ground experience in place" and allow for the existence of overlapping and multiple accounts of the same place (Rodman 1992:652). By embracing these changes anthropologists will come to realize that place is more than just a backdrop for anthropological research.

## **Health and place**

Another reason for anthropologists, and in particular medical anthropologists, to incorporate the concept of place into their studies is that research has long revealed that human health is influenced by place. The study of place effects on health status has a particularly lengthy tradition in Britain where early research focused on associations between collective community characteristics and the collective health of people who resided in these communities (Kaplan 1996). The last few years have witnessed a resurgence of interest in place effects on health. Diez Roux (2001:1784) suggests that this is primarily due to a rebirth of interest in the various social determinants of health and the realization that place may be an important non-health care related variable that has the potential to, directly or in concert with individual traits, enhance and/or compromise the physical and mental well-being of residents.

Area effects on health have typically been examined in two main ways:

- (1) Ecological studies relating area features to morbidity and mortality - These studies tend to focus mainly on the relationship between a specific cause of death or infirmity and a specific feature of the physical environment (e.g., air pollution, water hardness, temperature, rainfall, altitude) (Macintyre et al 1993). Such precision may be suitable for studying infectious disease outcomes but is less so for investigating chronic ailments that may result from a number of related factors or for studying risk factors that may lend themselves to a range of health outcomes (Macintyre et al 1993:214).
- (2) Analyses of aggregate measures of individual residents are used to classify areas - The areas used in these studies (postal code divisions, government districts and

wards) are categorized according to socio-demographic characteristics established by the most recent census. Investigations of this type are not interested in area features except those produced by the aggregation of residents' characteristics. Areas are used merely as instruments for determining whether or not conditions such as material deprivation account for variations in morbidity and mortality at the area level (Sooman and Macintyre 1995; Macintyre et al 1993:215).

Rarely, however, do any of these investigations consider the role that local level socio-environmental or cultural features have in determining health outcomes; neither do they attempt to explain how area features might influence health (Sooman & Macintyre, 1995). In other words, "Most studies on area variations in health actually examine who lives in certain places rather than what certain places are like, or used to be like, to live in" (Macintyre et al 1993:218). Macintyre and her colleagues (1993:218) attribute this oversight to three main factors: (1) the belief that census generated socio-demographic characteristics actually highlight area features rather than residents' characteristics; (2) the belief that residents' characteristics are responsible for area influences on health and; (3) the assumption that 'we all know' (self evident) what different areas are like to live in.

Recent studies, however, have begun to address past omissions and rectify current errors in thinking thereby revealing that a wide variety of area/contextual features (and residents' perceptions of these features) may promote and/or damage physical and mental health: landscape appearance, socio-cultural features, availability of local amenities, availability and accessibility of local health services, housing, green space, social capital,

perception of crime and reputation (i.e., Pickett & Pearl 2001; Ellaway et al. 2001; Chandola 2001; Dunn & Hayes 2000; Macintyre & Ellaway 1998; Sooman & Macintyre 1995; Macintyre et al. 1993). Macintyre and colleagues (1993:220-1) suggest that five broad organizational categories may facilitate the holistic analysis of the collective and interactive influences of these features on resident's health:

1. Physical attributes of the neighbourhood shared by all residents (e.g., air, water);
2. Availability of healthy/unhealthy environments at home, work, and play (e.g., livable housing, safe working environment, affordable and nutritious food, and safe recreation);
3. Availability and accessibility of local level services (e.g., schools, transportation, policing, churches and other community organizations, and health and social services);
4. Socio-cultural features of an area (e.g., contemporary and historical political, economic, ethnic, and religious characteristics of the area, norms and values, level of community integration and networking, actual and perceived levels of crime);
5. Area reputation (e.g., how areas are construed by insiders, outsiders, local government and service planners and providers).

Popay et al (1998) point out, however, that a re-conceptualization of the notion of place must also begin to consider the experiences and perspectives of the people who live in the areas that are being studied. While there is some indication that lay knowledge is

now being considered<sup>3</sup>, the quantitative methods employed in many of these studies means that residents' subjective, lived experiences are not explored or heard. On the other hand, the qualitative approach that considers lay knowledge in its narrative form,

...makes 'place' more than a set of static environmental deficits or provisions, no matter how imaginatively these are operationalized, and it makes the 'lifecourse' more than a biological trajectory during which the individual is inertly exposed to various accumulating risks and benefits. It highlights the need to look not just at the statistical associations between significant events in people's lives as defined by researchers, but at the meanings people give to the relationship between these events – how they translate events into meaningful episodes (Popay et al 1998:639).

In addition, most research to date has tended to compare the health of individuals living in contrasting socio-economic areas (inter-area variability) without really considering the possibility of heterogeneity existing within a specific area (intra-area variability). Such an omission may stem from our misplaced belief that community and neighbourhood are themselves homogeneous entities. As will be discussed later on in this thesis, although people may be part of the same community, they occupy different life spaces, and as such, experience the community in different ways (Kearns and Parkinson 2001; Chaskin 1997).

Moreover, a re-thinking of place in health research must focus more attention on the significance of time - "both historical and biographical" (Popay et al 1998:633). Although the history and biography of an area has been shown to have an effect on contemporary health outcomes (e.g., refer to Barker and Ormond (1987)), the historical

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<sup>3</sup> Macintyre et al (1993) studied residents' perceptions of their local environment in four socially contrasting neighbourhoods in Glasgow.

element of place has, more often than not, been ignored. It is necessary to consider the dimension of time because,

Places have different histories and the history, and the present, of a neighbourhood or locality will mean different things to individual people who have their own temporal and historical associations with the area. People's relationships to places will be variable and diverse (Popay et al 1998:636).

While geographers (e.g., Airey 2003), sociologists (e.g., Macintyre et al 1993; Roberts 1999; Huie 2001), psychologists and gerontologists (Talyor et al 1997), and epidemiologists and public health researchers (e.g., Diez Roux 2001; Frumkin 2003; Thomson et al 2003) have begun to tackle the complicated process of understanding the relationship between human health and place, most medical anthropologists have yet to address the issue. This is unfortunate and somewhat surprising especially given medical anthropology's long history of assessing community health needs and its claim to a holistic approach to understanding health and disease. In addition, medical anthropology's ethnographic research techniques place the field in an ideal position to understand and communicate the intricacies of the concept of place.

This study endeavors to address some of the current limitations in place and health research and to advance the concept of place in health studies. It does so by exploring women's diverse opinions of, and experiences with, the North End neighbourhood, by examining women's perceptions of their own health and well-being, and by investigating the relationship between health and place. Taking a qualitative approach to place and health research reveals the lived, subjective experience of

residents, allows the variability in perceptions between local residents to be revealed, and permits the changing nature of place over time to be acknowledged.

### **Summary**

Understanding women's health requires that researchers employ a broad definition of health that encompasses a wide variety of health determinants. Although it is important to consider women's reproductive health, it is also important to move beyond women's role as "bearers and nurturers of children" (Denton et al 1994:2) and focus on the impact that social, cultural, economic and environmental factors have on their health. It is also essential that health researchers and policy makers move beyond the traditional and biomedical means of priority setting – life expectancy and national level mortality and morbidity rates – and acknowledge and incorporate 'ordinary' women's ideas about health into health planning and programming.

It is also time for anthropologists to consider the role of the lived environment on perceived health. Anthropologists in general have overlooked or even ignored the concept of place in their research, while medical anthropologists in particular have neglected to consider the impact of place on health. Medical sociologists and medical geographers, on the other hand, have shown that the perception of place is an important health determinant, worthy of further study. Sims (1994) points out moreover that women, health and the environment are still often considered to be separate topics of inquiry. While relationships between women and health, and more recently between women and the environment, have been recognized, there has been little interest in how the three subject areas interconnect with each other.

Before I begin to address this issue, however, I turn to a discussion of the methodology used to carry out this place-based, women's health research and provide a socio-demographic overview of the women who participated in this study.

### **CHAPTER THREE: THE RESEARCH PROCESS AND THE STUDY GROUP**

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Most published research presents a sanitized view of the research process. A newcomer to research would gain the impression from published accounts that research was generally a smooth, logical process in which little goes wrong and which is immune from vagaries and politics of everyday life. In practice, it is rare for such immunity to operate (Baum 1998:122 cited in MacDougall and Fudge 2001:117).

Where anthropologists choose to carry out their research, how they go about conducting their research and who they include as participants in their research are all important facets of the study process. This chapter begins by discussing the changing locale/place of anthropological research projects in general and then shifts to consider some of the problems encountered in attempting to set up an independent, community health centre based project. It then goes on to highlight the qualitative methodologies – in-depth interviewing, focus group discussion, participant observation and documentary research - utilized in this study. It ends with a profile of the women who took part in this study.

#### **Anthropology at home**

The last two decades have seen a definite shift in the location of medical anthropology fieldwork. In the past, medical anthropologists focused their time and energy on investigating health and illness in cultures other than their own (van Dongen and Fainzang 1998). Now there is a growing trend toward conducting health research with members of our own society and culture (Van Ginkel 1998), a development that not

only challenges the long held belief that 'real' anthropology must be done abroad (van Dongen and Fainzang 1998) but, contests the long held assumption that going into 'the field' means going into a place that is not 'home' (Gupta and Ferguson 1997).

There are numerous reasons for this recent "repatriation of anthropology", as Marcus and Fischer (1986:113) describe the increasing interest in domestic anthropology: (1) the end of the colonial era allowed newly independent states to object to research conducted by outsiders; (2) an increase in student numbers and a decrease in social science funding opportunities; (3) the 'crisis' in anthropology which led to an overall questioning of established theories and methodologies; and (4) recognition of our basic ignorance of societies 'at home'(van Ginkel 1998; van Dongen and Fainzang 1998; Hadolt 1998; Marcus and Fischer 1986).

Another reason why anthropologists may be turning toward studies done at home is the belief that it is easier to gain access to, and conduct research in and on, one's own society. As Michael Moffat (1992:206) notes:

Studying subjects relatively 'like themselves,' local ethnographers may be more attuned to cultural nuance than far-from-home anthropologists, better able to draw on experiential understanding. They can often 'blend in' more completely – verbally, behaviorally, physically – possibly making for better *rappport*, possibly affecting who and what they are studying less by their presence.

The assumption that doing fieldwork in familiar places is less complicated is also based on the deeply embedded anthropological notion (referred to as "spatialization of difference") that posits that "'home' is a place of cultural sameness and that difference is to be found 'abroad'..." (Gupta and Ferguson 1997:32-33). Such thinking has led us to

seriously underestimate both the level of diversity and complexity found just around the corner and the effort it takes to carry out fieldwork at 'home'.

As van Dongen and Fainzang (1998:247) point out: "just as distance is not a guarantee of objectivity, familiarity is not knowledge". While on the one hand insiders may have an *a priori* intimate knowledge of their own culture which allows them a deeper understanding of their study society, on the other, they have to cope with the hazards that familiarity brings, such as preconceptions and prejudices (van Ginkel 1998). Edmund Leach (1982) states that "...fieldwork in a cultural context of which you already have first-hand experience seems to be more difficult than fieldwork which is approached from the naïve viewpoint of a total stranger" (cited in van Ginkel 1998:252).

However, van Ginkel (1998) warns us not to get too caught up in comparing and contrasting the advantages and disadvantages of research abroad versus research at home because the fieldwork experiences of anthropologists differ considerably regardless of the various pros and cons associated with the site. Irrespective of location, we still bring our "autobiography and the presentation of self" to the field, which in turn impacts on the nature and results of our fieldwork (van Ginkel 1998:254).

In keeping with this growing trend, I conducted my fieldwork 'at home'. In my case, 'at home' literally meant at home since the field site is located within a ten-minute drive from my house in Hamilton, Ontario. Given that I was born in the City of Hamilton and that I have lived here for the majority of my life, I thought that I would be somewhat immune to the problems and frustrations that researchers in remote locations experience. After all, who better to carry out a study here than a local native of the area, one who

“knows” the people and the places? I was to discover very quickly, however, that choosing a familiar location does not necessarily mean that the research process is any more straightforward or that the researcher is any more knowledgeable than would be the case abroad. In fact, the experience may prove to be more exasperating because the actual act of conducting fieldwork is much more complicated than expected.

The following sections outline the methods I employed to gather information on women’s health in the urban environment of Hamilton. They reflect some of the difficulties I encountered in attempting to conduct independent, health-related fieldwork, both inside and outside a clinical setting.

### **The research site**

Initially, the focal point of my project was to be a local community health centre (CHC) in inner city Hamilton. The idea of centering the project around a health centre was appealing because in addition to providing clinical aspects of health care, health centres are also concerned with the interests of the community as a whole. As such, they tend to offer both health- and social-oriented programs designed to address common community problems. Moreover, associating the research project with a CHC meant that I had somewhere from which to recruit participants, as well as the ability to gain access to aggregate socio-demographic and health information.

I was particularly interested in two sites, the downtown core and the North End, because they are both located within the inner-city centre of Hamilton and serve a diverse clientele. I never imagined that trying to situate my project within a health care setting would prove to be so difficult. From my standpoint, I imagined that the free research

information I would provide would be welcomed. I thought (naively, as it turns out) that I would investigate important client- or staff- perceived health topics that the centre neither had the time nor money to investigate. In exchange for this, I would be permitted to use their health centre as the site of my project. Unfortunately, I learned that personal history, personal agendas and time constraints play a large role in determining whether or not a project comes to fruition.

### *Community Health Centre #1*

In the summer of 1998 I approached the first inner city CHC with the hope of being able to carry out my thesis research at this site. This primary health care facility targets homeless and under-housed women, men and youth, as well as poor ethnic families and poor elderly living in the urban core. This centre is committed to providing Hamilton's urban core with the highest level of health care, education and advocacy, especially for individuals who face barriers to improving their health and well-being.

After meeting briefly with a staff member at the health centre, I was asked to put together a short proposal outlining my research project. I was told that my proposal would be forwarded to the Executive Director (E.D.), who was ultimately responsible for determining whether or not the project could proceed. The objectives of the project were purposely kept broad with the intent of narrowing them down once I had a better feel for the health centre and the problems and concerns experienced by the clientele and/or those expressed by the staff. One staff member, for example, mentioned that maternal nutrition was a concern.

The first stumbling block arose when the individual I had been dealing with left the health centre without passing on my proposal. Upon discovering this, I contacted the E.D. directly and arranged a meeting. I explained the project and, at the time, the E.D. seemed quite interested in the plan. I gave her a copy of the proposal and waited to hear back. When a significant amount of time had passed and I still hadn't had a response, I called to see if she had had a chance to read the proposal. She said she had not but told me she had set up a meeting with two individuals that worked at the CHC. When I went to the health centre at the designated time to meet with these individuals, neither showed up. This led me to suspect that the meeting had not been arranged in the first place. Meanwhile, one of my supervisory committee members, who had occasion to work with the E.D., gave her a call just to let her know that he was helping to supervise the project and would be giving me a hand.

When I finally heard back from the E.D., she proceeded to tell me: (1) what was lacking in the proposal, even though I had only been asked for a short outline of the project; (2) about the problems involved with academics doing research in clinics, especially when it concerned people of colour (although I had not singled out any ethnic group in my proposal); (3) that she wasn't impressed with my lack of experience in this type of research; and (4) that she had no idea why I would ask a faculty member to call her. I responded to all of her concerns, and she once again seemed satisfied with the project although she still had not given me permission to begin. Throughout the entire process and after several meetings over a four month period, it was still not clear whether the project would be allowed to proceed. After being kept dangling all summer I decided

to withdraw before I invested anymore time and effort into what felt like a losing venture. This is when I turned to the North Hamilton Community Health Centre.

### ***Community Health Centre #2***

I approached the North Hamilton Community Health Centre (NHCHC) in the fall of 1998. The NHCHC is a non-profit organization that opened its doors in 1987 with the intent of providing the previously underserved North End community with primary health care. The clientele who frequent the NHCHC live within the geographic area bounded by Sherman Avenue, Barton Street, Queen Street and Guise Street, and represent the socio-demographic diversity found within these boundaries (NHCHC 1999). Over 7000 people identify the NHCHC as their primary care facility. The health centre endeavours to provide accessible and comprehensive services which promote wellness and illness prevention and empower individuals and communities through programs such as: physiotherapy, immigrant/refugee services, social work, nutrition, chiropody, obstetrics, HIV care and psychiatry (NHCHC 2001). The Mission Statement for the centre is:

Individuals, families and communities have the ability and the right to make life and health affirming choices. NHCHC is dedicated to working in partnership with our patients, clients and community to achieve with them their unique health and life goals. As well, we are committed to the education of health professional students in an environment in which they will become compassionate and effective caregivers (NHCHC 1999).

In addition, the CHC works alone and in partnership with other community organizations to offer youth- and child-oriented programs such as junior achievement, Welcome Inn youth program, the children's garden and the breakfast program. Many of their programs are run with the help of numerous dedicated, community volunteers.

Arriving at the NHCHC I asked to meet with the Executive Director and as I was waiting, I quickly began to realize that I had come to this site with certain preconceived ideas about the local residents. Like many people who live in Hamilton, I was made aware of the differences that existed between North End residents and those who reside elsewhere. I don't think I was overly conscious of these perceptions but as I sat in the waiting room I began to appreciate the fact that I was looking for certain characteristics in the individuals who were waiting with me. I expected them to be rough, ill kept and poor-looking in appearance. Instead, I was struck by how similar the people in this waiting room were to those in my own doctor's office.

Upon being referred to the coordinator of research and education at the NHCHC, I was told about the research protocol for the Health Centre. Unlike the first CHC I approached, NHCHC has a board of individuals who review each project that is put forth, much like the McMaster University Ethics Review Board. Because the NHCHC is a clinical teaching CHC and affiliated with McMaster University, numerous students use this centre as their research focal point. In order to protect the interests of the clients and surrounding community, the board rigorously reviews each project. The coordinator informed me that a number of studies had already been conducted on residents of the North End and that some of the residents were beginning to feel as if they were being studied to death. Moreover, the results of these investigations tended to portray the residents in a poor light, thereby reinforcing negative stereotypes. Upon hearing this, I explained that this was certainly not the intent of my project but rather, this study

represented an opportunity for women in the area to voice their opinions about matters related to their health.

After submitting my proposal to the Health Centre, I waited until the research committee met to determine the future of my project. Meanwhile, a proposal was also submitted to the McMaster University Ethics Advisory Board and to the School of Graduate Studies for funding required in order to pay individuals who participated in interviews. In the early spring of 1999, the NHCHC and McMaster University both accepted my research project entitled "Health Needs and Perceptions of Women Utilizing the NHCHC: The Influence of the Urban Environment on Overall Feelings of Health and Well-being", and money was awarded to facilitate the interviewing process.

#### **Continuing evolution of the project**

Just as the site of the project changed, so too did the original objectives. Initially the project was intended to evaluate the health of individuals who utilize a CHC, to gather information on their perceptions of their health and to assess the usefulness of the CHC and its programs. These goals were gradually narrowed to focus only on the health status and health perceptions of women in an urban-situated health care setting. As the project progressed the research focus shifted once again so that the CHC no longer played a major role in the study but instead, environmental aspects of life in the North End came to be emphasized. This metamorphosis occurred as a result of: (1) barriers encountered in attempting to access local level health data from the CHC; (2) information gathered during early interviews; and (3) observations made while participating in programs run in the North End.

### **Research methods**

Because I was interested in obtaining women's perspectives on health and the environment, it was important that I choose a research technique that allowed women the opportunity to voice their own concerns. For this reason I employed a qualitative approach, involving methods such as in-depth interviewing, focus group discussion, participant observation and review of pre-existing written and documentary information. Qualitative research is interpretive and naturalistic and is designed to best reflect an individual's experiences in the context of everyday life (Jones 1995). Qualitative approaches seek to capture what people have to say about their experiences in their own words. Qualitative research recognizes that there is an array of different ways of making sense of the world (Jones 1995:2) and it allows researchers to "...understand people as they interact in various social contexts and to define social reality from their own perspective and meaning rather than from that of the researcher alone" (Ellis 1986:138 cited in Kitts and Roberts 1996:37).

Because the health of individuals and communities is influenced by a number of socio-economic and environmental factors, many of which cannot be neatly quantified, qualitative methods are being used increasingly to enhance or replace quantitative methods (Young 1998). Qualitative methods typically generate an extensive amount of detailed information from a much smaller number of individuals (Curtis et al 2000; Carey 1993). The goal of a qualitative researcher is to assemble a sample of participants who provide information rich enough to understand the phenomenon being studied (Needleman and Needleman 1996). Study samples are intended to make possible analytic

generalizations (information can be applied to wider theoretical frameworks) but not statistical generalizations (information can be applied to larger populations on the basis of representative statistical samples) (Curtis et al 2000:1002). Consequently, qualitative samples are small and purposive instead of large and random.

### ***Triangulation***

In order to overcome some of the intrinsic biases and problems that come from single method, single observer and single theory studies, triangulation was used in this research project. Triangulation refers to the deliberate application and combination of a variety of different research methodologies in the study of the same phenomenon (Mays and Pope 1995). The purpose of triangulation is to obtain confirmation of findings through convergence of different perspectives. If the findings from each of the methods are the same, then validity is established and the perspectives are seen to represent reality. There are four basic types: data triangulation; investigator triangulation; theory triangulation; and methodological triangulation (Patton 1980). This study employs both data triangulation (the use of several different sources of information) and methodological triangulation (the use of more than one method) to increase the reliability of the study results by decreasing the chance of systematic bias in the study data.

### ***Interview recruitment***

The primary means of collecting information for this project was through in-depth, face-to-face interviews that incorporated both structured and semi-structured questions. This type of in-person interviewing is directed toward understanding a participant's perspectives on their life experiences, expressed in their own words. For the

purposes of this study, women 18 years of age or older who lived in the North End of Hamilton were interviewed. Initially, I planned to recruit all the participants from the female clientele frequenting the North Hamilton Community Health Centre. I had hoped that the NHCHC staff would recommend individuals willing to participate, even though I did recognize that the staff was extremely busy. To facilitate recruitment, I posted colourful flyers (refer to Appendix 1) around the NHCHC and sat back to await the calls. They never came! Only 5 people were recruited from the flyers I placed in the NHCHC and another individual was referred to me by a podiatrist who works at the health centre.

This lack of response ultimately led me to shift the advertising, and more importantly the focus, from the CHC into the community itself. I began placing flyers in local organizations such as churches, the public library, and pharmacies. I had no response from any of these locations. I then advertised on three different occasions for participants in the *North End Breezes* (a community-level publication) and managed to secure 6 participants from this source. The majority of participants ended up being recruited through flyers placed on street posts throughout the neighbourhood. Each flyer had a short description of the study and rip-off tabs with a phone number where I could be reached. At three week intervals I drove around the North End, stapling and taping up flyers. I must have tacked up hundreds of flyers over the course of the study. For all of my hard work, I managed to recruit only 18 people. Two more participants joined the study through my association with a local walking group (Sunny Strollers). The remaining three individuals were referred by people who had already taken part in the

study (snowball sampling). When all was said and done, 36 in-depth interviews were conducted from May 1999 to September 2000.

Because of the qualitative nature of the interviews, more emphasis was placed on the quality of information (i.e., depth and richness) than on the quantity. The purpose was not to attempt to maximize the sample size, but rather, to collect information until a saturation point was reached (i.e., the point at which all respondents are revealing the same or similar information and no new insights are likely to be obtained). Initially I aimed to recruit one hundred women – an arbitrary number I considered to be easily attainable. After all, who wouldn't be interested in participating in a study about women's health in the North End and obtaining a monetary stipend of ten dollars? Obviously, not as many people as I thought! I can only speculate as to why women may not have chosen to take part: (1) they were not interested in the topic of women's health within the context of their neighbourhood; (2) they felt they were too busy to participate; (3) they didn't like the idea of sharing information with a stranger; (4) they didn't feel they had anything of importance to say; (5) the money was insufficient inducement to overcome some of these barriers and/or; (6) they were uncomfortable having to call the university to reach me. One participant mentioned that advertising in the NHCHC would have been unlikely to produce many participants because people feel uncomfortable in the clinic setting and therefore were unlikely to take part in anything perceived as prolonging their interaction with the CHC.

One factor that definitely limited participation in the project occurred at the start of the study. I was asked by a doctor at the NHCHC not to interview women between the

ages of 50 and 69 years because there was a study currently being conducted on women within this age bracket. The physician was concerned that if women participated in my study they would not participate in her team's project. As a result, all of my early advertisements had the following age restrictions listed: only women aged 18 to 49 years and 70 years and above. Unfortunately, I had to turn away a number of participants because of this restriction. A few months later I discovered that these researchers only wished to interview a few women and that my efforts to solicit participants of this age group would not have been a problem. Consequently, I re-advertised for all women aged 18 years and over. I called back some of the women in the restricted age group who had contacted me earlier, but either could not get in touch with them or they were no longer interested in taking part. Clearly, my experience has shown that when people say they are interested in participating in a study, act on their interest immediately or the chance may be gone.

While it is obvious that there is an age bias in my study, there is also a self selection bias. At the end of the interview session, I asked women why they had agreed to participate in this study. While money (the \$10 stipend) was a motivating factor for four of the interview participants, women in the study also identified other factors that propelled them to participate: (1) they were interested/curious about the study (12 women); and (2) they felt it was important for them to contribute to North End neighbourhood (6 women). A couple of women said they wanted to take part in the study so that I would get a broader perspective of women living in the North End while another two women said that it was important to participate so that their voices could be heard.

*The interviews*

The interviews lasted from 40 to 146 minutes, with an average length of just over an hour (69 minutes). The interviews were conducted in a setting determined by the participant. The vast majority of women were interviewed in their home (27 people). The remainder were interviewed in the following locations: a local Tim Horton's coffee shop (3 people); a local park (2 people); the Welcome Inn (2 people); the NHCHC (1 person) and at McMaster University (1 person).

Easton et al (2000) underscore the need to avoid environmental distractions in the home and the workplace when conducting an interview. Distractions include: the noise of children and other family members, pets, doorbells, telephone calls and visitors in the home, loudspeakers, pagers, doors opening and closing, telephones ringing and staff interruptions in the workplace. Although it may be best to avoid these pitfalls, it is not always possible and, more importantly, realistic to expect that the outside world will cease to exist because one wishes to conduct the perfect interview. People are giving up their time to speak with you and often it is not possible for this time to be devoid of so-called environmental distractions.

Such was often the case with the interviews I conducted. Many of the women interviewed at home were taking care of their children (watching them, preparing breakfast or lunch, keeping them entertained), had pets visiting throughout the interview (sat on my lap, my feet or in my knapsack), were answering the phone and/or having short discussions with family members who were present, off and on, during the interview. While this type of environment may not lead to the perfect interview, it did

offer a wonderfully revealing glimpse into the daily life of these women. In fact, I would argue that these home-based interviews were the best ones I conducted because the women were more at ease.

One interview took place at a local church/community centre as the participant was fulfilling her volunteer hours answering the phones. The interview was filled with numerous starts and stops but, because the centre plays an important role in her everyday life, the discontinuity did not take away from the quality of the information that she provided. Another interview took place in the NHCHC as one of the participants was receiving physical therapy. Because the health centre was such an important component in her life – she went there for therapy, health care, volunteered with some the programs and knew most of the people working at the centre - she felt more comfortable speaking to me there than she might have done at home.

It would appear that interviews done in familiar settings allow women to feel more comfortable and possibly more in control of the interview process. This may lead to a more participatory (open) interview and consequently, the collection of richer data.

### ***The questionnaire***

At the start of these face-to-face interview sessions, each participant was asked to read over a short consent form and then sign two copies; one copy was to be retained by the investigator and the other to be kept by the individual. The consent form briefly introduced the researcher, described the focus of the research, and addressed issues of confidentiality, the individual's right to withdraw at any time and her right to refuse to answer any questions that she was not comfortable with (Appendix 2).

All of the interviews were conducted using a set questionnaire that was comprised of both structured/close-ended (e.g., yes/no, scaling) and semi-structured/more open-ended (free to answer the question in anyway that they wished) questions (refer to Appendix 3 for the final copy of the questionnaire). The initial questionnaire inquired about the following subject areas: perceptions of personal health, identifying health problems, stress, health worries, health care, perceptions of the North End neighbourhood, identifying positive and negative aspects of the neighbourhood, health and place, work environment, and socio-demographic information. A number of these subject areas also included questions about the woman's children and/or spouse/partner.

After completing nine interviews, questions pertaining to the interviewees' children and/or spouse/partner were eliminated because the responses proved to be redundant (i.e., concerns that women had about their own health were reiterated with respect to their children/partner). Also, any questions pertaining to workplace health were removed because many of the women no longer worked outside the home. Given the quality of information collected and the time it took to ask these questions, I decided to omit these areas of inquiry. In their place a few more short questions about the neighbourhood environment were added. From interview number 11 onwards, no further changes were made to the questionnaire.

The interviews were tape recorded and I took hand written notes in the event that the recorder malfunctioned. This unfortunately happened on a few occasions. Each interview was transcribed verbatim and treated as text. Each text was read as a whole to gain a sense of context and meaning and then, salient themes were identified. Analysis of

these themes was guided by the combined application of the biocultural and critical interpretive models employed in medical anthropology (Goodman and Leatherman 1998; Lock and Scheper-Hughes 1990). As much as possible, analysis was supplemented with the women's actual words in order to more accurately represent their health perceptions and perspectives. These quotations form an integral part of the overall data presented.

### *The focus group*

Although at the outset of the project I had not planned to conduct a focus group, when the opportunity presented itself, I jumped at the chance. Recently, focus groups have become recognized as an important method of collecting health and health-related information (MacDougall and Fudge 2001).

The individuals who comprised the focus group are members of an existing Mom's group that functions as a social support network. All of the women in the Mom's group either have or had children that attend(ed) Robert Land Public School, where they meet weekly. One of the women in the group saw my neighbourhood flyers and called to see if I would come and talk to the group about my research. I went to one of their meetings, explained my project and answered a few questions. After I was done, they let me stay while they continued an ongoing discussion about the possible shutdown of the school. There was also some discussion about the difficulties involved in getting access to some of the social services that a few of the women required. At the end of the meeting I handed out flyers to those who were interested in participating in a face-to-face interview. All of the women took a flyer and a few indicated an interest in taking part, but no one called. Due to the lack of response and because I felt that these women had

information that would be very useful to my understanding of health and the neighbourhood, I called back the woman who had invited me to speak and asked if she thought the group would be interested in participating in a focus group session. She got back to me and said that they were interested and we set up a date (April 12, 2000) to run the session.

Eleven women took part in the focus group<sup>4</sup>. At the start of the session I asked each woman to fill out a short questionnaire that would provide some background socio-demographic and health information (Appendix 4). The focus of the session was neighbourhood issues (Appendix 5). Because I was running the session on my own, I brought a tape recorder and a flip chart. While the tape was running, I stood next to the flip chart and wrote down the responses just in case there were problems with the tape recorder. I was unable to identify the speakers in the transcription. However, it appeared that most of the women shared similar views about the questions that were asked. This, of course, is not really unexpected given that they meet regularly to discuss issues of importance to them. Each woman was given a ten dollar stipend for participating.

### *Participant observation*

Participant observation was my third method of obtaining research data. This approach allows the researcher to observe people and events in their natural settings (Bernard 1995). This approach is useful in distinguishing what people say from what they actually do (Young 1998). In my case, I was more of an observing participant than a participant observer. During my fieldwork phase, I volunteered my time in local

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<sup>4</sup> Information provided by one of the eleven women was dropped from the study because she did not live in or near the North End area.

programs run by, or in conjunction with, the North Hamilton Community Health Centre. I did this for two reasons: (1) to allow me the opportunity to interact more closely with residents of the area and (2) to give something back to the community in return for individuals taking part in my study.

I volunteered as the program coordinator for the Sunny Strollers, a walking group that met every Monday and Thursday morning from May until the end of August, 1999. The group was comprised of about 10 people, primarily women, although we did have one male member<sup>5</sup>. Leading the group on these bi-weekly treks provided me with the opportunity to be seen on a regular basis in the North End, gather some extra information about the North End community, get to know some of the women who have lived there for ages, and interact with the NHCHC staff on a regular basis.

During the months of May and June, 1999, I also volunteered with a Teen Program run out of the Welcome Inn. Each Wednesday evening youth, aged 12 to 16 years, met and took part in organized activities. The boys usually went to the local community centre to play basketball while the girls stayed at the Welcome Inn and took part in a cooking class. The point of the cooking class was to teach them about nutrition through the preparation of various, inexpensive meals. After the meal was prepared we sat down and ate (if someone didn't cause an uproar). In some cases, this was the only meal these teenagers received all day; some of them took the leftovers home. This

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<sup>5</sup> The male participant in the walking group unfortunately died midway through the summer. It was quite a blow for the group members and the NHCHC staff because he was well known in the community. The Sunny Strollers and many community members attended his funeral.

experience afforded me the opportunity to see and/or hear about the home life of some of these young teens.

I also volunteered with the North End Breakfast Club from the fall of 1999 to the spring of 2000. This program runs every week-day at a local church from 8:00 am until the children have to leave for school. About 20-35 elementary school children show up each morning. Some children come to have breakfast, others come so that they have somewhere to hang out until the school opens and others show up just to cause problems. Volunteering at the Breakfast Club meant helping to prepare the food, serving the children, keeping an eye on them, talking to them and then cleaning up after they all left. This was a very revealing experience. Knowing that children are an important indicator of a community's well-being, what I saw at times left the indelible impression that this community has some serious problems. A number of the children looked ill kept (they had dirty faces and dirty clothes) and many were not properly clothed for the cold winter months (showing up in thin sweaters in the middle of the winter). Although the main reason for children to participate in the program was to receive breakfast, a few children brought chocolate bars (which were meant for their lunch) and ate them instead.

I also spent time in the North End neighbourhood just "hanging around" and taking photographs to capture the essence of the area. I believe that my time spent as a participating observer led me to have a more comprehensive understanding of what people were telling me during the interviews. By becoming familiar with the local geography of the neighbourhood and the people who live there I had a much better sense of what people were saying.

***Written and documentary information***

In addition to the above mentioned qualitative methods, other sources were consulted in order to situate the North End community in the past and the present. Much of what the North End is today is a reflection of past events. Current and archived newspaper articles from the local newspaper, The Hamilton Spectator, were studied to ascertain how local media sources represented the North End neighbourhood and its residents. Documentaries about the North End, such as Andrew Stevenson's (2002), "My part of town", and books such as "Tales from the North End" written by North Enders Lawrence and Philip Murphy (1981), provided first hand accounts of life in the North End neighbourhood. I obtained census data obtained from Statistics Canada's online data service, ESTAT, for up-to-date socio-demographic data on the residents of the census tracts located within the designated boundaries. These data formed the basis of a comparison the study participants and the North End population as a whole.

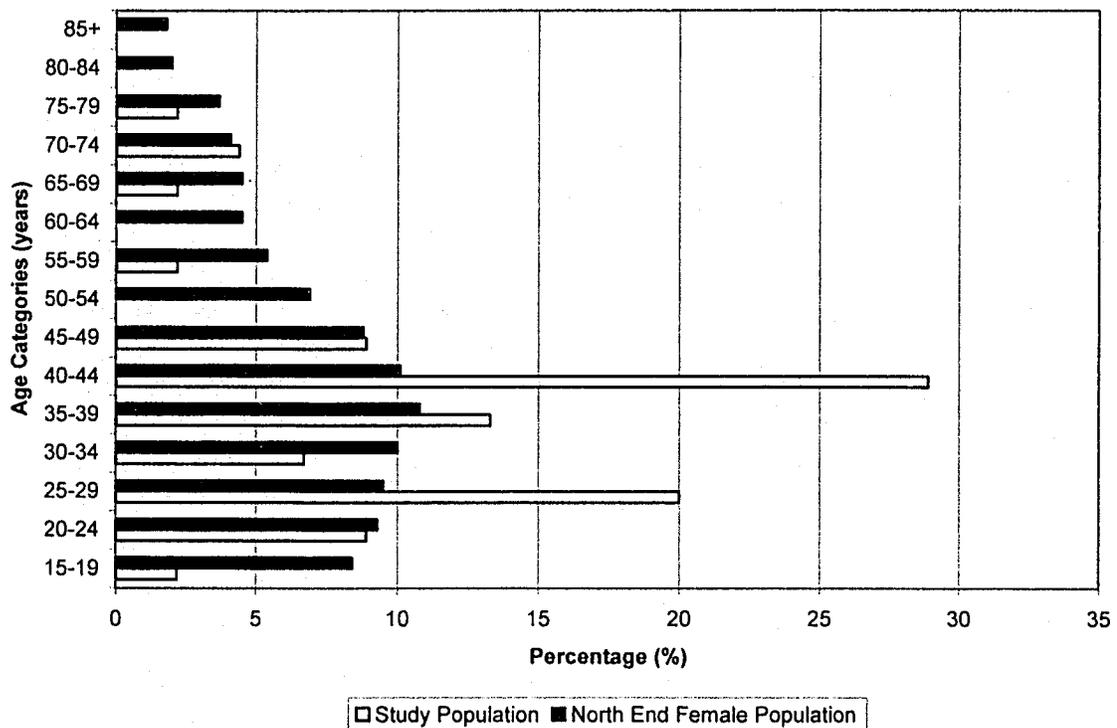
**Profile of the study participants**

The information provided in this section reveals the diverse socio-demographic composition of both the interview and focus group participants and compares the women in this study to the 2001 census data for the North End population as a whole. Because women were permitted to omit answering questions, I do not have a complete socio-demographic profile for all 46 women who took part in the study.

All women in the study were eighteen years of age or older, and lived in the North End of Hamilton. The length of time spent living in the North End ranges from two

months to 58 years with an average of 13.7 years and a median of 9 years. In total, the participants have lived in the North End for 618.25 years.

**Figure 3.1: Age distribution of women in the study sample (n=45) versus women in the North End neighbourhood (2001 census tracts 60-64, 66-68)**



(Statistics Canada 2003)

The average age for 45 of the participants is 39 years. Figure 3.1 shows the distribution of women by age group. Most women in this study fall between the ages of 20-49 years (86.7%), with a large number representing the 40 to 44 age range (28.9%) and the 25 to 29 age range (20%). While there is a definite over-representation of women in the reproductive age categories, there is also a distinct deficit of women aged 50-69 years which may reflect, as mentioned earlier, the age restriction placed on the project by

researchers associated with the NHCHC. The percentage of study participants in each age category differs significantly from the proportion of female North Enders in the same age groupings.

**Table 3.1: Self-identified ethnicity of study participants (n=36)**

<b>Ethnic Category</b>	<b>Number (n)</b>	<b>Percent (%)</b>
Canadian	13	24.5
Irish	7	13.2
English	4	7.5
Italian	4	7.5
Scottish	4	7.5
Aboriginal	2	3.8
Dutch	2	3.8
French	2	3.8
French Canadian	2	3.8
Ukrainian	2	3.8
Other <sup>1</sup>	10	18.9
None	1	1.9
<b>Total*</b>	<b>53</b>	<b>100.0</b>

\* A number of participants described themselves as belonging to more than one ethnic category.

<sup>1</sup> The Other grouping contains 10 ethnic categories (American, Anglo Saxon, Czechoslovakian, European, Flemish, German, "Heinz 57"<sup>6</sup>, Polish, Portuguese, Welsh) each identified by only one individual.

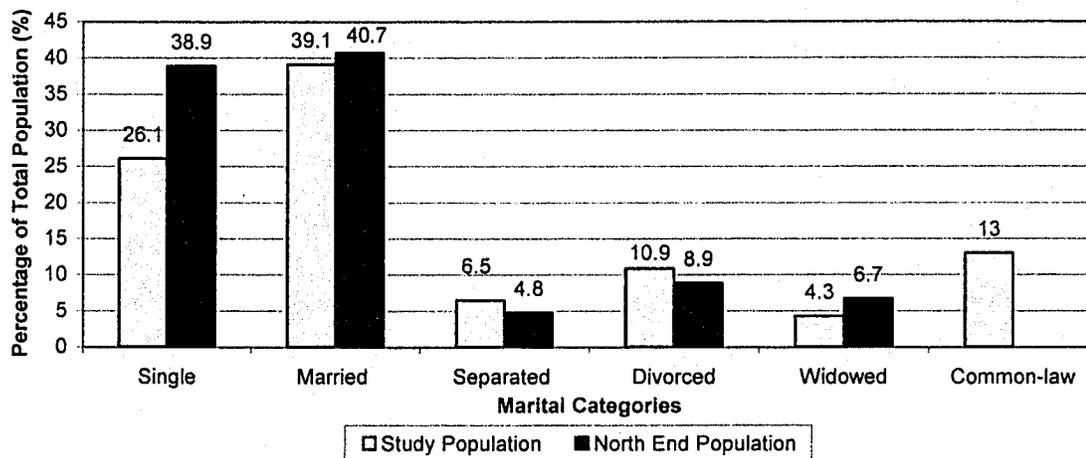
Table 3.1 lists the ethnic composition of the interview participants. A number of women identified themselves as having more than one ethnic identity. One quarter of all the women identified their background as Canadian, while 13.2% stated their origins were Irish and 7.5% declared they were English, Italian or Scottish. In the North End neighbourhood (2001 census tracts 60-64, 66-68) the top six ethnic origin categories (total responses, includes single and multiple) in descending order are Canadian, English, Portuguese, Scottish, Irish, and Italian (Statistics Canada 2003). With the exception of

<sup>6</sup> "Heinz 57" is the term used by some women to describe their multiple ethnic backgrounds.

Portuguese<sup>7</sup>, the participants' ethnic origins resemble that of the North End population.

The major ethnic groups in the North End today reflect historical immigration patterns.

**Figure 3.2: Marital status of the study population (n=46) and the residents of the North End neighbourhood (2001 census tracts 60-64, 66-68)**



(Statistics Canada 2003)

More than half of the study participants (52.1%) were either married or involved in a common-law relationship at the time of this study (Figure 3.2). Comparing the marital status of women in this study to that of North End residents reveals a similar pattern. In both instances the majority of individuals are either married/common-law or single. For the first time ever the 2001 census considered the issue of common-law relationships. The results revealed that 8.9% of respondents in the census tracts 60-64 and 66-68 were involved in a common-law relationship (Statistics Canada 2003). This

<sup>7</sup> I attempted to enlist Portuguese women in my study because I knew that they accounted for a large segment of the North End population. I contacted a local physician who I knew had a large number of Portuguese people in her practice. She said that she would see if anyone was interested in participating but not to expect much because they tended to keep to themselves. I did obtain one participant from this source.

compares quite closely to the 13% of study participants who indicated their involvement in a common-law affiliation<sup>8</sup>.

The number of children each woman had at the time of the study is presented in Table 3.2. Almost two-thirds of all participants have at least one child (65.2%). While the average number of children (living at home) per family in Canada in 1996 was 1.2 (Almey, 2000), 39.2% of the women in my study have three, four or even five children. There is a preconceived idea that women in the North End give birth to higher numbers of children so that they are eligible to receive extra money from the government in the form of family benefits. However, of the 18 participants with higher than average numbers of children, only five (30.1%) are receiving some type of social assistance.

**Table 3.2: Number of children per woman in the study (n=46)**

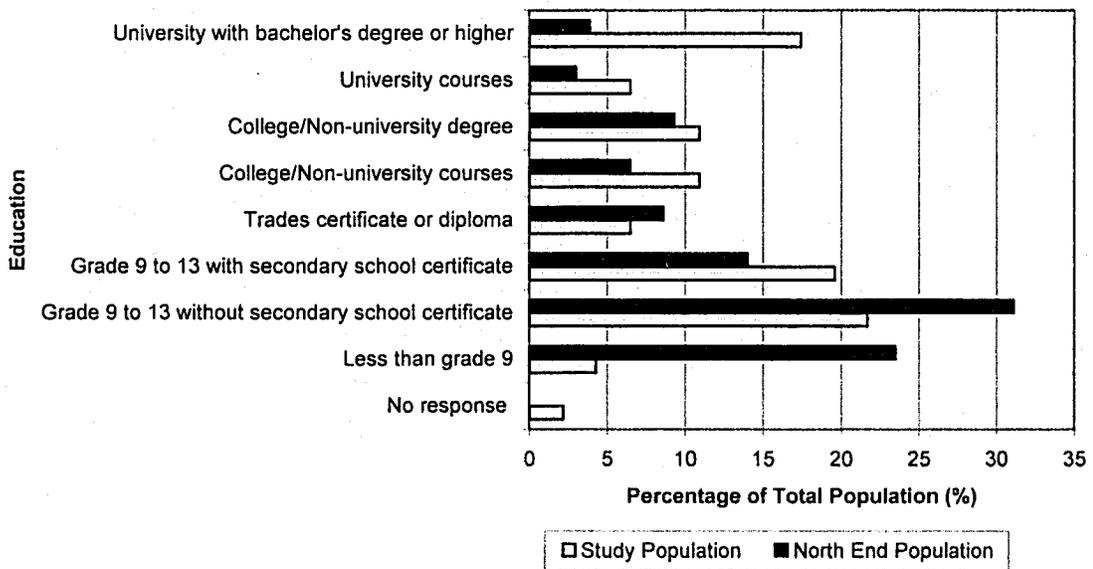
<b>Number of Children</b>	<b>n</b>	<b>per cent (%)</b>
0	16	34.8
1	6	13.0
2	6	13.0
3	9	19.6
4	8	17.4
5	1	2.2

There are a considerable number of female single-parent families residing in the North End of Hamilton (22.7%) compared to the City of Hamilton as a whole (13.7%) (Statistics Canada 2003). This clustering may be the result of low income housing and/or the availability of low cost housing. In the North End in 2001, 85.9% of all lone-parent

<sup>8</sup> It is important to note that although the 2001 census did a separate query as to the number of common-law versus non-common-law relationships of individuals 15 years of age and older, it did not include common-law as a marital category. Consequently, I have not included the North End common-law census figures in Figure 3.2.

families were headed by females (Statistics Canada 2003). Single-parent families, especially those headed by females, typically incur greater economic and social hardships as a result of limited funds and inadequate social support. Of the 30 women in this study who have children, 10 are single parents (33.3%) with their children still living at home<sup>9</sup>.

**Figure 3.3: Highest level of education attained by the study participants (n=46) and by residents of the North End neighbourhood (2001 census tracts 60-64, 66-68)**



(Statistics Canada 2003)

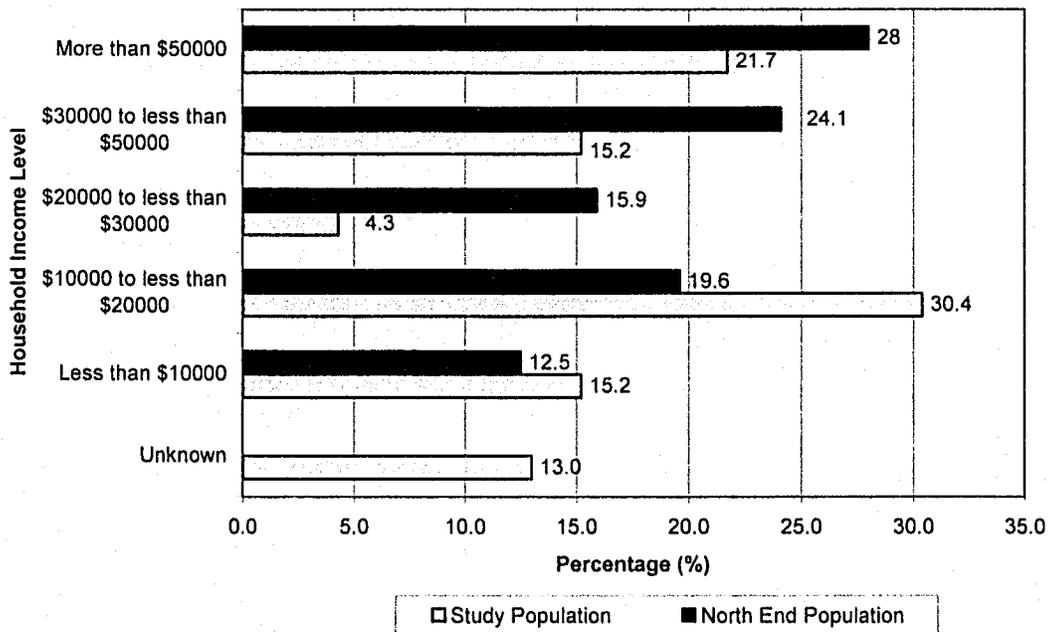
The majority of participants, 61.8%, reported that they had their high school degree or a higher level of education (Figure 3.3). Almost half of participants (45.7%) have some university or college education with 17.4% earning a university degree and 10.9% receiving a college degree. Only 2 women reported having less than a grade 9 education and each of these women is 70 years of age or older. Compared to the North End population as a whole, the women in this study have a higher than average number

<sup>9</sup> One woman who is 78 years of age and widowed with 4 children has not been included in this category since her kids are grown.

of individuals with a bachelor’s degree or higher and, a significantly lower number of individuals with less than a grade 9 education.

The household income of the women is represented in Figure 3.4. In some instances the income is composed only of money contributed by the woman herself, while in others, it includes money contributed by her partner or other individuals sharing the same residence. The household earnings reported by the participants are similar to those reported by the North End population; in particular, those earning less than \$10,000, and those earning over \$50,000. It is important to note, however, that 13% of participants either did not know their total household income or refused to answer the question.

**Figure 3.4: Household income level for the study population and the residents of North End neighbourhood (2001 census tracts 60-64, 66-68)**



(Statistics Canada 2003)

Based on low income cut-offs (LICOs) reported by Statistics Canada, 43.5% of participants live below the poverty line<sup>10</sup> and 43.5% live above it<sup>11</sup>. The incidence of low income in the North End (census tracts 60-64, 66-68) in 2001 ranged from 25.1 to 45.9% in economic families; 53.4 to 72.0% in unattached individuals; and 27.9 to 50.2 % in private households (Statistics Canada 2003). In the City of Hamilton the incidence is significantly lower with only 16.1% of economic families, 45.9% of unattached individuals, and 19.8% of private households reporting low income (Statistics Canada 2003). Families living below the LICOs are considered to be living under difficult circumstances (CCSD 2001).

The North End is often portrayed as a haven for welfare recipients, an area comprised exclusively of poor individuals existing solely on government assistance. When the women were asked about their current employment status, 43.5% reported that they were working full-time, part-time or were self-employed. However, 41.3% of participants reported that the majority of their income comes from government transfer payments such as disability, unemployment insurance, family benefits, welfare and old age pension. For the North End neighbourhood population as a whole (2001 census tracts 60-64, 66-68) 67-76% of their income comes from employment while 19-28% comes from government transfer payments (Statistics Canada 2003). In the City of Hamilton, 77.1% of earned income comes from employment and only 12.1% from government payouts (Statistics Canada 2003).

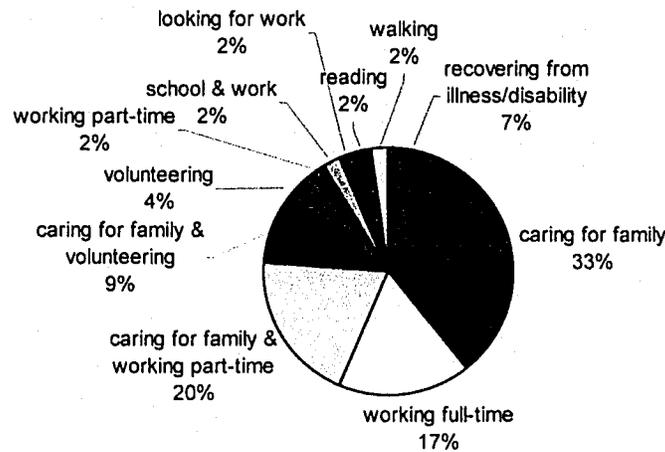
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<sup>10</sup> The poverty line used in this paper is based on Canada's 2000 low income cut-offs (LICOs) published by Statistics Canada. LICOs vary according to family size and size of the community (Canadian Council on Social Development 2001).

<sup>11</sup> Thirteen percent of participants did not answer the question about household income.

Figure 3.5 reveals the primary activities that women are involved in on a daily basis. A large number of the women in this study (32.6%) spend the better part of their day caring for their family while a much smaller number (17.4%) work full-time outside of the home. A significant group of the women (28.3%) spend their days caring for their family and work either part-time or on a volunteer basis. Only a couple of women spend their days in leisure activities such as reading and walking.

**Figure 3.5: Main daily activities for the study participants, n=46**



### Summary

The difficulties I encountered throughout the fieldwork stage (which in the end lasted from June 1998 to September 2000) resulted in some significant changes to the overall objectives of the project. They also resulted in a shift from a mixed methodological approach - a combination of qualitative and quantitative data – to an exclusively qualitative approach. However, in retrospect I think that some of the changes that stemmed from the numerous stumbling blocks may have actually resulted in a better,

more original project. Instead of focusing on typical socio-demographic health data, I was forced to search for other more interesting aspects of health in an urban setting. This led me to the concept of health and place which in turn, revealed the existence of local level diversity, the role of history (and stereotypes) in people's perceptions of their community and ultimately their health, and the manner in which a place can influence the health and well-being of its residents.

The socio-demographic profile of the study participants reveals a group of women primarily between the ages of 20-49 who have lived in the North End for a variable amount of time. The primary ethnic categories identified by the interview participants – Canadian, Irish, English, Scottish, Italian – closely resemble the main ethnic grouping represented in the North End. The majority of women are married or living common-law and have at least one child. Of those who have children, almost a third represent female lone-parent families, a percentage significantly higher than that of the North End and Hamilton's CMA.

The cohort as a whole is considerably more educated than the residents of the North End generally, with many having attained a university degree and fewer having less than a grade 9 education. Although almost half of the women are employed either full-time, part-time or self-employed, almost half of the participants and their families are living below the poverty line. While these results fall within the range of the North End, they are considerably higher than the incidence of low income in Hamilton's CMA.

Having described the socio-demographic profile of the participants, the next chapter will present information on the history and reputation of the North End neighbourhood in which these women live.

## **CHAPTER FOUR: HISTORY OF THE NORTH END AND ITS STIGMA**

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Every social science – or better, every well considered social study – requires an historical scope of conception and a full use of historical material (Mills 1959:145 cited in Popay et al 1998:634).

This chapter situates the North End within the larger geographical context of Hamilton, Ontario, Canada. In order to fully understand the circumstances that have occurred, and continue to occur, in the North End neighbourhood it is necessary to consider the development of Hamilton as a whole. Accordingly, this chapter outlines the general history of Hamilton, focusing on the strong role of industry in its development, and moves on to introduce the North End neighbourhood, highlighting its colorful history and explaining the reasons for its segregated place in Hamiltonian society. It then proceeds to discuss the creation, evolution and continued persistence of negative stereotypes associated with the North End and its residents.

### **“The Ambitious City”**

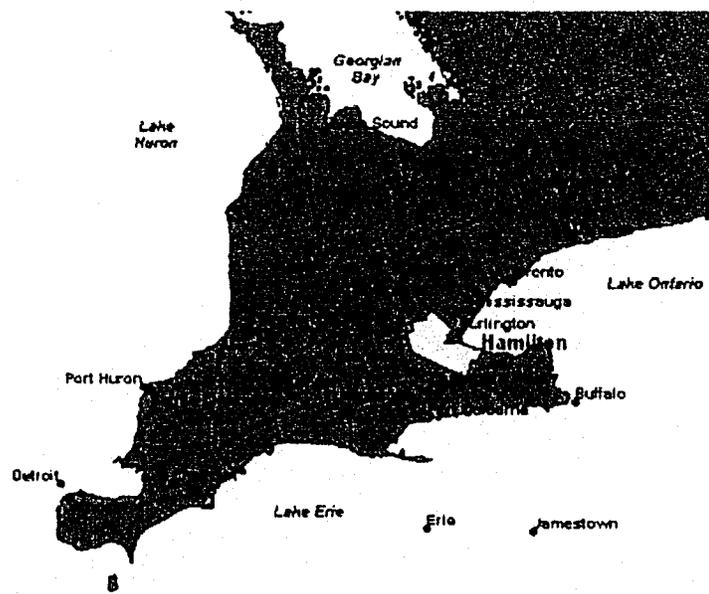
The City of Hamilton, which was founded in 1813, was named after a local politician and entrepreneur, George Hamilton, who along with local inhabitants such as James Durand and Nathaniel Hughson, recognized the advantageous attributes of the area and rallied together to promote its development (Gentilcore 1987). Although it was designated the administrative seat for the newly created District of Gore in 1816, it was Hamilton’s location at the head of Lake Ontario that was ultimately responsible for its tremendous growth and prosperity (Davey and Doucet 1975) (Figure 4.1). As L. J.

Chapman and D. F. Putnam point out, there are a number of reasons why a lake-head location is apt to result in the development of a city:

It is likely to be a port – a point at which transfer is made between water carriage and land carriage of persons and goods, a place of trade with the large hinterland, a place of processing of goods brought thither by both land and water and a place for the establishment of secondary manufacturing (cited in Davey and Doucet 1975:322-323).

Hamilton's location at the crossroads of two major continental corridors – the Great Lakes-St Lawrence route and the Mohawk Valley-Niagara Peninsula route (Gentilcore 1987) almost guaranteed that this head-of-the-lake site would enjoy immense success.

**Figure 4.1: Geographic location of the City of Hamilton**



(City of Hamilton Geographical Information Systems 2004)

At the same time, however, there were a number of geographical limitations that had the potential to restrict the advancement of the newly recognized area: (1) it was shut off from Lake Ontario by the Burlington bar (landlocked); (2) a great deal of the lakeshore was both low and swampy; and (3) inland there were numerous steep slopes

and ravines, not to mention the Niagara escarpment (Gentilcore 1987). Though none of these barriers were insurmountable, they did influence Hamilton's early spatial pattern of development. One might expect the town's centre to be located near the waterfront but, as one observer noted in 1846, "on account of the swamp in the vicinity of the bay, the principal part of town has been placed about a mile back from the bay, on a gently rising ground" (cited in Davey and Doucet 1975:322-323).

Fortunately, the positive aspects of the region prevailed over the negative and Hamilton began to experience growth. Bailey (1983) points to three factors that were responsible for Hamilton's transformation from a quiet settlement to a dynamic frontier town: (1) the Burlington Canal; (2) immigration; and (3) enterprise. Of these three, Bailey considers the excavation of a permanent canal (channel) across the beach strip, which had rendered Hamilton a landlocked harbour, the most significant. The creation of this channel through the Burlington bar (in 1827) allowed Lake Ontario to be reached via Hamilton (HPL 2000a), negating the need to reach the open waters by way of Dundas. Hamilton was now able to take advantage of both its direct access to the lake and to the surrounding areas above the Niagara escarpment (Gentilcore 1987). The opening of the canal led to an increase in waterfront activity as wharves, shipyards and warehouses were built to facilitate the steady stream of ships (Evans 1970:96). The town became a distribution centre – receiving and sending out goods, sorting and selling goods, and promoting trade with other ports (Gentilcore 1987).

Prior to 1834, Hamilton's population was not counted separately from Barton Township. As a result, it is not possible to determine the rate of growth during the first

third of the 19<sup>th</sup> century; however, it does appear that there was moderate growth from 1816 to 1821, followed by almost no growth until 1827. From 1827 to 1831, the population experienced an increase of 25 percent (Weaver 1982) and from 1834 to 1841, the City of Hamilton, which was also known as “the place where the immigrant took breaks,” increased 2.5 times in population size from 1367 to 3414 individual (Gentilcore 1987:106). This tremendous population growth was due to the influx of newcomers emigrating primarily from the United Kingdom but also from the United States (Doucet 1976). While overcrowding at the ports in Montreal and Quebec forced European immigrants to head further west, Americans were attracted to Hamilton’s commerce (Bailey 1983). The increased influx of individuals and the proliferation of trade created a mood of optimism which enticed individuals into land and building speculations (Bailey 1983).

By 1851 Hamilton’s population had grown to 10,000; six years later it had reached 25,000 and by the year 1881, it had increased to 36,000 individuals (Gentilcore 1987; Weaver 1982). While this population explosion was due in part to industrialization, the emergence of Hamilton as a hub of railway activity in the 1850s and the opening of the Burlington canal in 1827 was the true key to the region’s success (Doucet 1976). As the railway expanded into Hamilton, factories that had at one time been located near the city’s core began relocating near the harbourfront so they would have easier access to both rail and water transport (HPL 2000b).

Although Hamilton had experienced significant growth during the 1850s it never measured up to Toronto’s commercial success. Following the 1870s, Hamilton

pragmatically switched its focus from the commercial to the manufacturing sector. The resulting success of this change was evident in the increasing number and diversity of businesses in the city (Middleton and Walker 1980). It was about this time that Hamilton's rise as a great steel city became undisputed, and by the 1890s Hamilton's favorite slogans became "The Birmingham of Canada" and the "Ambitious City" (Middleton and Walker 1980:20-21). One consequence of the growth of heavy industry was that it led to a change in the make-up of the work force and, for the first time, Hamilton began to attract a sizeable number of workers from continental Europe. From 1891 to 1911, the number of individuals from this geographic area increased from 6 to over 15 per cent (Wood 1987).

As Hamilton was enjoying the fruits of its labour, events occurring outside of the city were to have profoundly positive effects on its future. The reconstruction of the Welland Canal was one of the most important events. Increasing the length, depth and width of the canal improved the travel of ships from Lake Ontario to Western Canada and made natural resources such as iron ore from Minnesota, more accessible. In addition, the Government of Canada adopted new legislation in 1890 and 1891 which protected Canadian industries from outside competition. As a result of this legislation, it became cheaper to manufacture pig-iron in Canada rather than to import it from Great Britain (Wood 1987; HPL 2000b) and Hamilton became undeniably an industrial rather than commercial centre. It was also better able to attract American investors who were anxious to preserve or even increase their hold on the Canadian market while at the same time keeping their investments as close to the international border as possible (Wood 1987).

In addition to these national-level events, the local government introduced economic inducements (reforms) designed to attract new industry into Hamilton, to promote expansion and to maintain existing local companies. These enticements included bonuses (gifts of money), lower rates of taxation (tax exemptions, fixed taxation, maximum levels of taxation, maximum levels of assessments on which taxes were levied, extension of tax supports for a number of years) on their buildings, tools, income and personal property for a period of ten years, cheap land and low water rates (Middleton and Walker 1980; HPL 2000b). Watson (1946:21) believes that Hamilton's success as an industrial city was due to both historical initiatives and geographical opportunity:

The success of Hamilton as an industrial centre has depended on individual recognition and use of its geographical location with respect to raw material, proximity to markets, low cost of power and transportation, and a plentiful and skilled labour supply. Where individual and corporate endeavour have capitalised geographical advantages, manufacturing has forged ahead. The progress of Hamilton, then, is a combination of place and people.

From 1905 to 1915 industrial investment tripled in Hamilton and from 1900 to 1911 industrial employment grew by more than 100 per cent. This is double the speed of growth of Toronto and eighteen times faster than the growth of Hamilton in the previous decade. By 1913, forty-six American businesses had set up branch plants in the City of Hamilton (Wood 1987). From 1915 to the end 1945, industrial development and employment levels in Hamilton ebbed and flowed in response to such national and international events as a North American recession, World War I, the Great Depression, and World War II. In the years following, Hamilton continued to prosper as businesses

such as Stelco, Dofasco and Westinghouse, to name just a few, provided jobs for many workers.

Residents assumed that these industries, particularly the steel mills, would always be there for them, producing wealth and furnishing them with economic opportunities (Wilkins 1993). Unfortunately, the 1980s saw a decline in the steel industry as (1) competition arose from cheaper, and often more automated international steel producers, (2) the need for steel decreased, (3) free trade was introduced and (4) a recession hit. Thousands of Hamilton's steel workers lost their jobs as did individuals working in related service and spin-off industries (Wilkins 1993). Although the steel industry is no longer the primary employer, Hamilton showed its 'resilience and combative spirit' by bouncing back as new knowledge-based industries arose to take up the economic slack. Today, more Hamiltonians work in the field of health and health technology than in the steel mills (Wilkins 1993). Despite the shift from a manufacturing to a knowledge-based city, Hamilton will always be known as 'Steeltown' and outsiders, particularly Torontonians, will continue to associate Hamilton with "Lunch buckets, work boots, [and] beer" (Lois O'Sullivan, cited in Wilkins 1993:44).

#### **The North End: "a community divided"**

Almost from the start, the physical and spatial components of the City of Hamilton gave rise to a highly conspicuous residential stratification (Doucet & Weaver 1984), which segregated residents along social, economic and ethnic lines (Gentilcore 1987; Wood 1987). The existence of a wealthy and powerful elite class, who were in control of almost ninety percent of all property, were also responsible for influencing the

social geography of Hamilton (McGahan 1995). Municipal and commercial buildings were built in what was then the centre of the city (Main and John Streets). Upper class residential areas, parks, recreational facilities and some light industry emerged at higher elevations to the east and to the west of the town core (Evans 1970). Meanwhile, a rather chaotic combination of industry and working-class houses became established at lower elevations to the north and east of the city (Wood 1987).

For a time, Hamilton actually functioned with two nuclei: the older town-site and the younger port. Although the two sites were located only a few miles apart, the swampy terrain of the North End acted to isolate the area from the downtown core (Gentilcore 1987:104). "Early Hamilton was a community divided" (Weaver 1982:32). In fact, for a brief time in the 1830s the geographic and social distance between the two areas incited a rivalry; Port Hamilton endeavoured to obtain its own bailiff and marketplace (Weaver 1982). The physical topography tended to cut the North End off from the remainder of the town and as a result, "the two areas developed, for all intent and purposes, separately" (Murphy and Murphy 1981:12).

The late nineteenth century saw a shift in both residential and industrial locations. As the city grew, the distance between the rich and the poor increased (Doucet 1976). Hamilton's privileged strengthened their hold on the prime residential areas. These areas in the South End of the city were well-drained and situated primarily on gently rising ground leading from the city's core to the base of the Niagara escarpment. The South End was considered to be an aesthetically pleasing and respectable place to live (Doucet 1976). The working class, on the other hand, were over-represented in the city's North

End (Gentilcore 1987), an area characterized by low-lying, poorly drained land and the presence of heavy industry and numerous railway lines and rail yards (Doucet 1976; Evans 1970).

From 1852 to 1881, the proportion of working class people in the area rose from 27 to 47 percent (Doucet 1976). Most of the early North Enders were bound to the area because of its proximity to Hamilton Harbour where many worked as labourers on the boats, on the docks and in the shipyards (Murphy & Murphy 1984) and as time passed many became manual workers in the many locally situated industries. The obvious concentration of working class people in and around the North End industrial area was also the result of a number of other factors: (1) the physical limitations imposed by the Niagara escarpment; (2) the fares required for the inclined railway imposed monetary limits; and (3) the air pollution, noise pollution and railway tracks and yards, which led to decreased land prices in the vicinity while inflating the price of more remote and pleasanter areas (Weaver 1982).

While Hamilton Harbour acted as the focal point of employment for most Northenders, it was also the principal site for food and recreation year round (Murphy and Murphy 1981). The Bay was the favourite playground for all Hamiltonians, providing a venue for picnicking, swimming, sailing and fishing in the summer and hunting, skating, ice fishing and curling in the fall and winter months (Stevenson, 2002; Freeman and Hewitt 1979; Halcrow 1971). Over time, however, the waterfront changed radically and the Bay became increasingly unsafe and inaccessible to local residents. The waterway was no longer used to transport passengers and freight but rather to import raw

materials and export steel and manufactured commodities (Murphy and Murphy 1981). The water became heavily contaminated as a consequence of the increased industrial use and the fact that the city was using the Bay to dispose of residential and industrial sewage. The dumping of waste into the Harbour posed serious health risks to those individuals who lived closest to the water (Cruikshank and Bouchier 1998). What was once an “environmental amenity” had become an “environmental hazard” (Cruikshank and Bouchier 2004, in press). While all Hamiltonians were “...robbed of one of their finest natural resources” (Hewitt 1979:148), Cruikshank and Bouchier (2004, in press) point out that it was working class residents living closest to the harbour who were most affected by the loss:

Their children were more likely to encounter and swim in the seriously-degraded water of the harbour, or to be playing in yards and vacant lots that were once polluted inlets, filled in with potentially toxic or dangerous materials. Further, their families were the least likely of Hamilton’s population to be able to financially afford to escape the city to cleaner spaces in nature, or to pay for indoor recreation facilities.

The notion that high socio-economic neighborhoods tend to be located away from areas of poor environmental quality – especially sites of industrial development – appears to be clearly supported by the socio-demographic arrangement found within Hamilton (Taylor 1987). While individuals of economic means were protected from industrial insults, working class, low-income and immigrant individuals were made especially vulnerable to it (Weaver 1982). The monetary benefits associated with industrial development were considered far more important than the health and well-being of nearby individuals who were constantly subjected to noise, fumes, and railway traffic. An example of the pre-eminence of industry can be seen in a quote from 1881 in which

individuals who complained about the night-time operation of a noisy and toxic iron foundry were reminded:

The common law requires a distinction between a nuisance in a manufacturing town or city and a nuisance in a village chiefly composed of residences and stores, and the distinction is a just one. The work of a manufacturing city must be carried on. It is [in] the interest of the community that it should be, even if it does cause some people inconvenience. The man who cannot bear that inconvenience must remove himself from it, instead of having it removed from him (cited in Doucet 1976:85-86).

Local residents, most of whom were poor and had little choice about where they resided, were inclined to accept the resulting noise and pollution as an inevitable part of the price they had to pay for civic progress (Evans 1970). Jobs and increased prosperity were viewed as immediate benefits while health and environmental hazards appeared as remote possibilities (Weaver 1982).

Wood (1987) notes that residential separation along income lines appears to have been accompanied by segregation based on place of birth. The North End neighbourhood has always acted as an entry point for new immigrants, initially because of its proximity to the immigration dock and later, because of its affordable housing, proximity to manual labour jobs, and the existence of an already large number of foreign-born individuals. Gagan (1989:162-163) points out that the immigrants,

...joined the substantial industrial working class concentrated in Wards 5, 6, 7, and 8 in the north-east, an area of low land adjacent to Burlington Bay near the sewage outlet, and the site of industrial complex and its transportation corridor. The more prosperous middle and upper classes, on the other hand, resided in Wards 1 and 2 in the southern part of Hamilton, against the base of the Niagara escarpment and well away from the "dark satanic mills".

The majority of early residents were newly arrived Irish immigrants who made up, from all accounts, a 'colourful' and eclectic host of characters. It appears that independence, individuality, adventurousness and eccentricity were characteristics that were encouraged in those living in the North End area (Murphy & Murphy 1981), although these same traits may not have been celebrated by those living outside the area.

Ethnic and economic segregation, along with the physical topography of the area, acted to isolate the North End from the remainder of the town:

With the population close to the harbour consisting predominately of Irish immigrants, this led naturally to the development of a community identity in the North-End of the city, which was quite distinct from the rest of Hamilton's population. Even after the area became more habitable during succeeding years, and additional roads were built, the physical separation of the North-End by the inlet from the Bay at Wellington St., the Bay to the north and west, and the railway tracks to the south, resulted in a perpetuation of the community identity of the area long after immigrants from many other origins changed the ethnic mix of the region significantly (Murphy & Murphy 1981:12).

The fact that the North End was surrounded by a city population from which the local residents thought themselves to be quite different led to the development of a strong and spirited North End community (Murphy & Murphy 1984). North Enders were ultimately united by their culture, the physical separation and their shared financial circumstances that were fundamentally the same for everyone. As a result, the daily hardships of survival were mutually understood and shared.

Over time the cohesiveness of the North End has been challenged. The enforcement of urban renewal in the mid-1960s acted to erode the cohesiveness of the North End. Perez (2002:44) notes that although

...city officials, developers, local media and even some residents welcome the consequences of gentrification (declining crime rates, increased property values and municipal tax base, the arrival of city services and upscale commercial activity), others have convincingly argued that gentrification displaces poor and working-class residents from neighborhoods where they have established rich networks of support among family, friends, and local businesses crucial for their material survival.

This is an apt description of the North End experience. In an effort to inject new life into what was considered a rundown section of town, city planners gave the okay to demolish a large number of sub-standard houses and small local shops (Campbell 1977), replacing them with new homes and a shopping mall. Urban renewal forced a significant number of North Enders, people who had spent most of their lives in the neighbourhood, to relocate outside of the North End. It also resulted in the demise of many corner grocery stores, barber shops and restaurants that were popular meeting spots for local residents (Campbell 1977). For the most part, the new houses were occupied by individuals who had “no roots in the North-End and, consequently, no sensitivity for its history of traditions, and no ties to the area’s families” (Murphy and Murphy 1981:286).

Prior to urban renewal the North End was described, by those who had lived there for years, as being similar to a small town where everyone knew one another and stuck together (Campbell 1977). After urban renewal, a survey carried out by the North End Residential Organization (NERO) to assess the impact of the program, found that old-time residents felt community spirit and comradeship had dropped by fifty percent (Campbell 1977). In one fell swoop, the fundamental character of the North End was irreversibly altered. Murphy and Murphy (1981) point out, however, that it is too soon to mourn the death of the North End community because there are signs of the resilience

that held it together during hard times. The spirit of the past is seen in the enthusiasm shown for North End reunions and in the way that many old-timers are quick to protect their neighbourhood against verbal insults. As Phil Murphy, who lived and grew up in the North End, points out, "I understand the spirit. When I left I was surprised that the rest of the world wasn't the same. It wasn't friendly, courteous, responsive or neighborly. It was lonely and hard in comparison" (cited in Nyman 1980).

The North End neighbourhood is one of Hamilton's oldest communities and certainly its most storied. It was well-established by the early 20<sup>th</sup> century - complete with its own history and folklore (Murphy & Murphy 1981). While some of the myths highlight positive characteristics, such as resiliency and toughness, others emphasize more demoralizing features that outsiders associate with North Enders: "that they're poor, drunk, dirty or worse" [and that] "they're seen by some as members of a lower order – industrial cannon fodder for the factories..." (Hemsworth 1997). It is likely that the North End's proximity to the waterfront district which consisted of boarding houses, gaming rooms and drinking establishments peculiar to North American port cities (Weaver 1982) played into the development of the area's unsavory reputation. Worse, it was also home to Hamilton's most illegal activities during Prohibition - liquor running, gambling and smuggling - and its most notorious individuals (e.g., mafia boss, Rocco Perri and his wife Bessie Starkman, and rumrunner, Ben Kerr) (for more information refer to Hunt 1995; Dubro and Rowland 1987; and Freeman and Hewitt 1979).

### **The North End stigma**

Unfortunately, the negative nature of the folklore in conjunction with the perceived differences between those who reside in the North End and those who live outside the area, resulted in the North End maintaining a rather sullied reputation. Irrespective of where one lives, most Hamiltonians have heard discrediting stories about the North End. When a place becomes discredited the negative stereotypes that come to characterize that geographic area may also be referred to as stigma. The term stigma can be traced to classical Greeks who used it to refer to individuals with obvious bodily deformities which they felt indicated some type of immorality (Goffman 1963). Goffman (1963), a sociologist who developed the concept of stigma, identified three types of stigma: (1) physical deformity; (2) blemishes of individual character; and (3) tribal stigma of race, nation and religion.

Over time the notion of stigma has been expanded to mean more than just discrediting personal attributes (Goffman 1963). Now stigma can refer to a situation, "...something that is to be shunned or avoided not just because it is dangerous but because it overturns or destroys a positive condition, signaling that what was or should be something good and acceptable is now marked as blemished or tainted" (Gregory et al. 1996:216). Consequently, we now refer to certain products, technologies and geographical areas becoming stigmatized as a result of individual perceptions of toxic risk (Gregory et al. 1996). Bush and her colleagues (2001) point out, however, that geographic stigma is a multifarious concept that can occur in the absence of toxic contamination and/or close proximity to stigmatized technologies. A place can become

stigmatized as a consequence of associated social, cultural, historical, environmental and/or health factors that work alone or in concert with one another.

When participants in this study were asked to comment on the existence of a North End reputation and on how they felt outsiders viewed the area, the vast majority of women agreed that the North End has a very bad reputation and is constantly thought of in a negative light. Participants had the following things to say:

*MD: I would probably say in general that it does not have a good reputation. I think people see the physical aspects and then only what they see when they drive by. And they like to tell stories...you know somebody at work said such and such a thing. I've heard people say that there is a lot of violence, gangs. Hear the classic things like welfare people buying beer, parents neglecting their children.*

*KB: I don't think that it has a very good reputation. It may be a little better now. But just stories I've heard. People think that it's a poor area. I heard that there used to be a lot of roughness, fights and stuff like that. Years ago I guess there was gangs and whatever. People would say "You don't see anything, you don't hear anything".*

*HS: Not a very good one. Not necessarily a fair one. I had somebody, not long ago, some kind of researcher in the area and it was like she was really paranoid because she had heard all these stories.*

Not only do these responses highlight the fact that residents feel that outsiders look down on them, but they also reveal the role that interpersonal rumour plays in perpetuating the poor image associated with the North End. Hayden (2000:223) notes that

Reputation is at base social; its existence depends upon people interacting. It takes on a life of its own, but not apart from its performance by social actors in the act of speaking. The reputation's genesis, history, and regeneration depend upon the people's fascination with it and their willingness to perform it – to call upon it when the occasion warrants.

It would seem that story telling is an important factor in the continued "spoiled" identity of the North End. In a study investigating the dissemination of crime

information, Susan Smith (1984) found that rumours may be as important for circulating information about crime as news reporting. Almost 36 per cent of her survey respondents identified gossip or the supposed experiences of friends and neighbours and not the mass media, as their main source of information about crime. Smith's (1984:289) results seem to imply that rumours are created in order to "fill the information vacuum left when institutionalized news media fail to provide the required amount of detail about specific types of events". Although this chapter is not focusing on the issue of crime, it appears that Smith's ideas about the root of negative messages may be extrapolated to explain, in part, how a stigmatized community image is able to spread.

In responding to the question about the existence and type of North End reputation, a number of participants also mentioned that they felt the present reputation tended to reflect events of the past instead of current happenings:

*PT: Terrible reputation. I think that they judge it from what it was 20-25 years ago and it's not like that anymore.*

*AG: When we were here before, people considered it a pretty frightening place to live... And well it's changing but it was never really that bad anyway. It's not the same as in the 1930s when it was bootleggers and mobsters. Although that history is part of its charm. Depends if you ask people who live here or people who don't live here. For people who don't live here, it's still a scary place full of bikers and hoodlums.*

*PB: A bad one. Not a fair reputation. When I was growing up there used to be bikers, gangs, this and that all over the place. Now the North End hardly has any of that. You see it mostly in the West End, East End, whatever...*

As with all neighbourhoods, the North End has undergone change. These changes reflect the shifting demographic make-up of the community, as well as the power of individual community members to exact local level change. One young woman who grew

up in the North End recalls how her parents helped to make their street a cleaner and safer place to live:

*CDB: This neighbourhood was really rough. Now it's quite nice actually compared to when I was growing up. There were gangs, and all kinds of vandalism going on and my parents would almost daily be calling the police and they didn't care if people knew it was them calling. They just wanted to make sure they cleaned up the neighbourhood, and they did. I think my parents almost single handedly, on this street, cleaned up a lot of stuff.*

Today, the North End is experiencing a revitalization brought on in part by individuals buying and renovating old century houses. This rejuvenation may also be fuelled to some extent, by the creation of the Waterfront Park; one of the most important and alluring features of the North End (Elliott 1997). The Waterfront Park (consisting of Bayfront Park and Pier 4 Park), which is situated next to Hamilton Harbour, offers local residents and outsiders the opportunity to enjoy the waterfront by taking advantage of the nicely landscaped trails.

#### **Rationale for the persistence of the North End's stigma**

The question then becomes, why has the poor North End image been allowed to continue in the light of positive change? Shields (1991:256) argues that even when the features of a place are drastically modified, the negative ideas associated with that place may not change. The reason for this persistence is thought to be "...that changes necessitate not just an adjustment of the myth, 'cleaning out' the inappropriate images and installing new ones, but a restructuring of the entire mythology and the development of new metaphors by which ideology is presented". In addition to the history of the area and rumours, a number of other significant factors appear to support or even enhance the

stigma attached to the North End: (1) local newspaper portrayals; (2) lack of interest by local politicians and; (3) the social, economic and cultural make-up of the North End population.

***(1) Local newspaper portrayals***

The local newspaper, *The Hamilton Spectator*, is responsible to some extent for perpetuating both a sense of otherness and a poor community image in the North End. Headlines such as the following illustrate this: *Inner-City Schools: A tale of unfulfilled hope and frustration* (McNeil 1990); *Pride next door to poverty on North End streets* (Hemsworth, 1997); *It's still a tough neighbourhood, but residents are proud* (Davy, 1990); *The other world next door* (Wells, 1999); *Making Ends Meet* (Bongers, 1999); and *Neighbourhood under siege* (Hughes, 1999).

Weinroth and colleagues (1996:35) draw attention to the power that local newspaper headlines and descriptors have in changing or corroborating readers' opinions - they have the capacity to contribute to the development and reinforcement of stereotypes of a neighbourhood and its people. Perez (2002:54) points out that media coverage of neighborhoods like the North End, "...tend to reinforce public perceptions of these places and their inhabitants as dangerous and in need of strong discipline and control". The Coalition Against Neighbourhoodism (CAN), a Toronto based organization, is concerned about the stereotypical ways in which communities are portrayed in the media. CAN uses the term 'neighbourhoodism' (similar to the way terms such as classism, sexism and racism are used) to refer to:

...prejudice and stereotypes based on one's neighbourhood or community". "Neighbourhoodism can be seen as incorporating racist and

classist prejudices into the stereotyping of certain areas. This in turn can result in neighbourhoods being labeled as “bad” places, “ghettos”, “low-income”, “poor”, or “high-immigrant” areas (Weinroth et al., 1996:4).

While it only takes a few negative articles to result in the creation or persistence of a stereotype, it may take numerous positive and neutral articles to counterbalance or alter how people perceive a neighbourhood.

How the media choose to depict a neighbourhood is apt to be influenced by “the social context in which newspapers operate, what journalists and editors think the public will want to read, and which stories are more likely to sell newspapers” (Weinroth et al., 1996:7). There is a tendency for the media to present an idealized image of local neighbourhood living resulting in a clear division between “normal” (i.e., suburban) and stigmatized (i.e., inner-city) communities (Krase, 1979). News items that highlight events that are dramatic, contrary to the everyday norm and go against the usual pattern of expectations, are considered by journalists to be more newsworthy than others (Weinroth et al., 1996). Consequently, “...negative stories about certain neighbourhoods or the people who live there may fit with these news values, and become “news”” (Weinroth et al., 1996:7). Those who are not familiar with the neighbourhood may take for granted that everything written about that area is true and thus develop an incorrect or imbalanced view. Those who live in the area may choose to believe these negative stereotypes if they read them often enough.

On the other hand, some individuals who reside in these media-stereotyped communities may begin to seriously reflect on how their neighbourhood is portrayed by the newspaper. A few negative headlines and articles can lead local residents to believe

that their neighbourhood is constantly being portrayed in a pessimistic way (Weinroth et al 1996). Some North End residents, for example, are incensed by the articles written about their neighbourhood. Such was the case when a series of articles in 1990 focused on the health and social problems associated with the North End. The Hamilton Spectator received angry calls and letters from North Enders saying that they were sick of reading and hearing bad things about their neighbourhood:

*"We've always had a real bad image in the press", said Ron Corsini, of the Jamesville Business Improvement Association. While he didn't call to complain about the series, he called the image "a bum rap". Mr. Corsini and other North End residents say they're tired of the poor image and resent outside experts telling them what's wrong with the way they live. They say there's plenty right with the North End. Mr. Corsini says the negative image comes from people who don't spend any time in the North End. (Hamilton Spectator 1990)*

*"I have never been so disgusted or insulted!" Denise Davy and Mark McNeil [article journalists] managed to portray the North End as an area of poverty and hopelessness. They obviously knew what kind of article they wanted to write before starting this "project" and proceeded to use the information and statistics they were given to point out all the negative aspects of this community. I agree with them that there are numerous problems "down" here, but there are many positive things happening here as well.... We are not all on welfare and we do not send our children to school without breakfast, proper clothing or with "shoes that are so worn they barely stay on the child's feet" (Davidson 1990).*

## **(2) Lack of Concern**

Some interview participants feel that the North End's poor image is allowed to persist because of a lack of concern on the part of local politicians. Local North Enders see their neighbourhood as a "victim of neglect". Some point to the city-owned vacant lots that are scattered around the area, others to the existing brownfields and still others to what they feel is an unequal distribution of city funds. One woman noted that:

*RC: The city doesn't put in as much money here maybe because we're not so vocal around here. They appease the tax payers it seems more in the West End or on the Mountain.*

Another woman stated that:

*CDB: ...[politicians] should realize that this is where the city kind of started and you can't just ignore it because it is kind of like the heartland of Hamilton.*

The fact that the North End is located near heavy industry, which has been allowed to spew out toxic chemicals into the air and water, only acts to reinforce the indifferent attitude of local politicians to this area. Jobs and increased prosperity were, until very recently, always placed before the immediate health concerns of local residents and the integrity of the environment (Weaver, 1982). As local resident Denis O'Sullivan recently observed, "The smell of money was indistinguishable from the air pollution. And the toxic sludge at the bottom of Hamilton harbour was the tolerable cost of business and prosperity" (cited in Wilkins, 1993:46).

Bush and her colleagues (2001:51), who conducted a study in the heavily industrialized area of Teeside in north east England, found that the stigma associated with air pollution was differentially applied within the city itself. Individuals located within close proximity to the industry were stigmatized while those located at a distance attempted to "dis-associate" themselves from the pollution by arguing that "...although pollution was a problem in Teeside as a whole, it was not a problem in their particular community". This same type of rationale is found in the City of Hamilton. While people outside of Hamilton look at the city as a whole as being affected by industrial air

pollution, Hamiltonians (North Enders not included) tend to view air pollution as something that happens in the North End.

Many participants felt that the Plastimet fire was the ultimate example of the lax attitude paid to the North End by government officials. On July 9, 1997 a fire broke out at a plastics recycling plant, Plastimet Inc., located in the North End of Hamilton in an industrial site adjacent to a heavily populated residential area. The industrial site was filled with off-quality auto parts, consisting mostly of polyvinyl chloride plastic and polyurethane foam (Upshur, 1997). The fire burned for four days releasing dioxin and other toxic chemicals into the air and water. Nearby residents were temporarily evacuated (on the second day) from their homes and told not to eat the produce from their gardens, which was by then covered with a black soot (Lousley, 1999). Residents later questioned the timing and appropriateness of the evacuation, the adequacy of communication during and after the fire, the timeline of response efforts, and the inaction of government officials who ignored the fact that the recycling plant had outstanding fire code violations and no functioning sprinkler system (Upshur, 1997). Some of the women I interviewed also questioned why dangerous products were allowed to be located so close to local housing and why so many individuals failed to take the appropriate preventative measures that were called for. Many felt that the entire situation would have been handled much differently had it occurred in another part of town, a part that didn't include high numbers of welfare recipients, immigrants and blue collar workers.

**(3) Socio-demographic composition**

Some participants felt strongly that the stigma attached to the North End was due primarily to the socio-economic and ethnic composition of the neighbourhood. For instance:

*HS: ... I know that people look rough down here...but really, they're not as bad as they're made out to be. Sure there's more poverty and whatever, but you know, taking away all that, just because they're poor doesn't mean that people are bad.*

Another woman commented on the predetermined ideas outsiders have about the area because of the higher than average rates of poverty:

*MD: Living in the North End and being labeled as poor and all the things that come with it like being lazy and drinking too much beer. These are all misconceptions.*

As noted earlier, the North End has always housed a large immigrant population due to the cheaper housing, the proximity to social/health services and the closeness of individuals of similar ethnic backgrounds. One participant felt that the area's poor reputation was a result of racial discrimination:

*JDS: I think like so many things it's a prejudicial thing. There's a lot of Asians and Blacks so therefore, it has to be a bad area. And that is nonsense.*

Participants' belief that the socio-demographic make-up of the neighbourhood helps perpetuate the North End's reputation is supported by Krase (1979:254-5) who notes that stigmatized (or inner city) neighbourhoods are typically perceived as being composed of:

No-one, nobodies, renters, welfare clients who move from place to place, and old ladies and men on pensions or Social Security or perhaps,

immigrants – who don't know any better – looking for better places to live, any places.

Weinroth and his co-authors (1996) point out that generally speaking, ignorance about certain groups of people, combined with one's own group self-interest, results in the development of stereotypes and prejudices.

Given the multitude of factors that act alone or in combination to perpetuate and create the North End's poor image, it is hard to imagine that everyone would not just accept what was said. However, as we will see later on in this thesis, participants in this study demonstrated through their interview and discussion responses that individuals react to, and are affected by, their shared environment in very different ways.

### **Summary**

The City of Hamilton has experienced significant change since its inception, transforming itself from a quiet little town, to a manufacturing powerhouse, and then to a knowledge-based industrial city. Although the North End has also undergone considerable positive change, most outsiders and some residents cannot seem to see beyond the negative myths associated with its history, population and location. Regrettably, most people living in Hamilton look down on the North End in much the same way that people in other cities look down on Hamilton itself. For example, "When somebody from Hamilton calls his city 'Steeltown,' there's pride in the word. When somebody from Toronto says it, it sounds like an insult" (Blum cited in Wilkins, 1993:45).

The combination of history, rumour, media portrayal, lack of political concern, and demographic composition are responsible for both creating and maintaining the

North End's stigmatized image. Evans & Cattell (2001) point out that these "image creators" (in particular, the media and government officials) may bring about real policy problems for neighbourhood rejuvenation, since development may be undermined by these strongly supported stereotypical beliefs. It is important that we acknowledge and attempt to understand the development of negative public attitudes towards certain places (and by extension the people who live there) because these damaging viewpoints have the potential to negatively influence the physical and mental health of residents in these places. Moreover, it is essential that we consider the lived experiences and perceptions of individuals residing in these 'spoiled' neighbourhoods. Later on in the thesis, I will explore the connection between study participants' perceptions of the North End neighbourhood and their overall health.

In the subsequent chapter, I examine the images of the North End neighbourhood presented by women who participated in this study.

**CHAPTER FIVE:  
WOMEN'S PERCEPTIONS OF THE NORTH END**

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I have often amused myself with thinking how different the same place is to different people (James Boswell cited in Briggs 1968:83 cited in Relph 1976:57).

The connection that individuals have with their lived environment is both variable and diverse (Popay et al 1998). Individual perceptions differ because as Relph (1976:57) notes: "everyone has his own mix of personality, memories, emotions, and intentions which colours his image of that place and gives it a distinctive identity for him". This chapter highlights the diverse perceptions and experiences of women living in the North End neighbourhood.

**Community/neighbourhood definitions**

The North End is referred to as both a community and a neighbourhood by residents and outsiders. The terms community and neighbourhood can be defined in a number of different ways depending upon the criteria employed. As Diez Roux (2001:1787) notes, the criteria can be historical, based on people's characteristics, based on administrative boundaries, or based on individuals' perceptions; and the boundaries determined by these various criteria may not overlap. The way in which a neighbourhood/community is operationalized and measured has an affect on the outcome of health research (Huie 2001).

### *Community*

While there is no clearly agreed upon definition of the term community (Jewkes and Murcott 1996), it is generally accepted that a community exhibits some or all of the following characteristics - a group of people who: (1) reside in a limited geographic area; (2) have shared socio-economic and cultural backgrounds; (3) have similar interests, values and aspirations; and (4) are socially interdependent, participating together in discussion and decision making.

Although there may actually be a few groups of people for whom this broad definition is suitable, there are probably many more for whom this definition corresponds only with respect to some features but not others (Jewkes and Murcott 1996). Imposing this definition on a group of individuals leads us to assume that community membership is based on a combination of shared beliefs, circumstances, practices, relationships and concerns. Not only does this definition emphasize similarities while masking differences but it also depicts community as a fixed entity through time – always constant, never changing.

This representation, moreover, does not reflect the fact that although people are part of the same community, they occupy different life spaces, and as such, experience the community in different ways (Kearns and Parkinson 2001; Chaskin 1997). Cornwell addresses this issue in her book entitled, “Hard Earned Lives,” which is based on life in East End London. She comments on the existence of such “radical differences in the way people experience community and in what they know about it, that the idea of ‘a community life’ existing at anytime, in the past or in the present, seems something of a

fiction” (1984:49-50). For example, in one interview, Cornwell (1984) found that even a husband and wife do not experience community in the same manner because of the different social and geographical spaces they occupy; consequently, neither of them is able to provide a complete and comprehensive account of community.

With respect to health, the use of this homogeneous interpretation leads to the presumption that community members all experience similar health problems and have comparable health needs (Wayland and Crowder 2002). It also leads to the presupposition that people will pull together to communicate their health needs and help plan the required services (Jewkes and Murcott 1996). This definition also overlooks the possibility that a number of powerful, locally-situated interest groups, with diverging interests, may manipulate or distort community health needs for their own aims (Jewkes and Murcott 1996). Accepting these assumptions at face value may create serious health policy and planning implications, which may carry with them the potential to adversely affect the health of community members if funding and programming decisions are based on inaccurate information.

### *Neighbourhood*

As is the case for the term community, there is no absolute or overriding definition for the term neighbourhood. As early as 1921, Roderick McKenzie (1968e:73) observed that: “Probably no other term is used so loosely or with such changing content as the term neighbourhood, and very few concepts are more difficult to define” (cited in McGahan 1995:205). Along these same lines, Galster (2001:2111) claims that urban

social scientists have often treated neighbourhood as “a term that is hard to define precisely, but everyone knows it when they see it”.

Although communities may potentially be place-based, neighbourhood definitions tend to employ a purely ecological perspective (Galster 2001). Neighbourhoods typically refer to a physically delimited area in which residents share proximity and the circumstances that come with it (Chaskin 1997:522-523). However, while neighbourhood has largely been viewed as a physical construct, in the urban context this definition is changing and assuming community-like attributes:

...the neighborhood is often considered the more primary unit of actual and potential solidarity and social cohesion. There is thus a conflation of community-like expectations for solidarity and connection within the geographical construction of neighborhood and a range of possible expectations, at varying levels of intensity, for the neighbourhood and the local community as units of identity, use, and action (Chaskin 1997:523).

Neighbourhoods have typically been represented by census tracts, postal code areas, school districts and health districts, political and administrative units of measure which allow for the convenient collection and statistical analysis of quantitative data (Huie 2001). In studies of area influences on residents, census tracts have been employed as suitable geographical units upon which to base neighbourhood measures. This is because the decennial census contains a substantial amount of socio-demographic information that can be integrated with administrative data, such as health statistics or police/crime reports.

Although researchers recognize that these measurement units do not necessarily constitute ‘real’ neighbourhoods and have begun to question the ability of these units to

“capture a sociologically meaningful neighborhood”<sup>12</sup> (Huie 2001:344), they still continue to be used. Researchers are, however, beginning to acknowledge that considering residents’ perceptions of neighbourhood borders might actually produce more meaningful and appropriate boundaries that more closely represent the neighbourhood construct (Coulton et al 2001). At this time, though, there is no well established system for using residents’ perceptions to define neighbourhoods (Coulton et al 2001).

In health and health-related research, the terms community, neighbourhood and area, are used to refer to the material and social components of an individual’s residential environment (Diez Roux 2001). Little effort has been made to clearly define these terms or to consider whether they correspond with residents’ perceptions of surrounding boundaries.

### **North End boundaries**

The North End is a spatially bounded community, as the name implies. The actual boundaries of the community, however, are contentious and difficult to delineate. For the purpose of this thesis, I adopted the broad definition of the North End used by the Hamilton-Wentworth Regional Public Health Department in a neighbourhood profile published in 1997. This publication identifies the North End neighbourhood as being bounded on the west by Queen Street, on the east by Gage Avenue, on the south by Cannon Street and on the north by Hamilton Harbour (Wong 1997) (Figure 5.1).

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<sup>12</sup> A “sociologically meaningful neighbourhood” depends primarily upon the research question. For example, a study interested in morbidity and mortality rates would be best to employ health district boundaries (Huie 2001) since it would be much easier to compare present data collected with past studies.

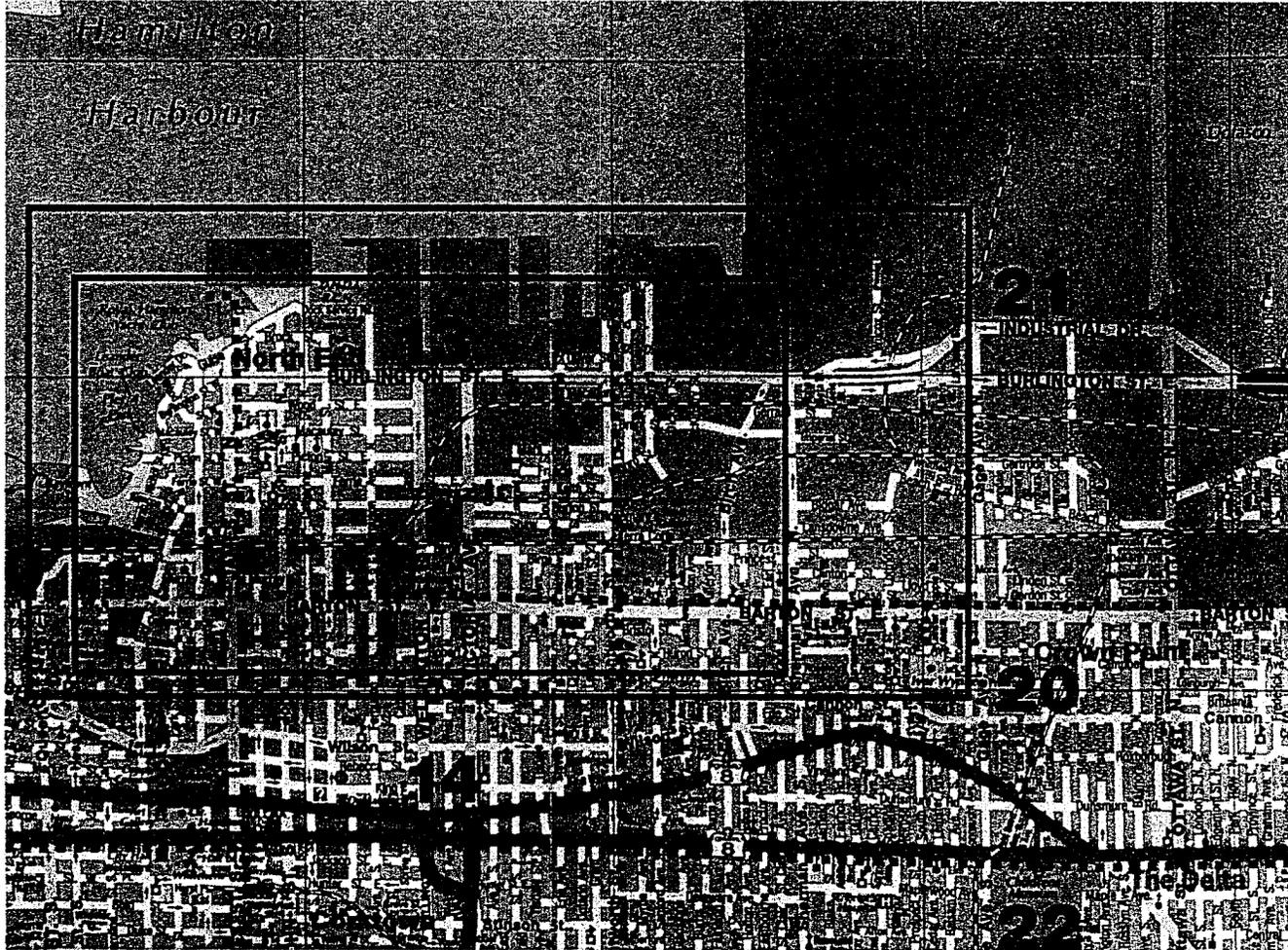


Figure 5.1 Street map of the North End neighbourhood\*

\*The red square denotes the North End boundaries used for this study. The blue square indicates the boundaries within which women who participated in this study live.

This geographic range encompasses eight contiguous census tracts: numbers 60 to 64 and 66 to 68. In order to advertise this study and recruit individuals, I had to select the parameters of the North End boundaries before I started the study. Because of this, I purposely chose a neighbourhood definition with expansive boundaries so as not to restrict the participation of individuals who felt that they were residing in the North End.

Upon beginning this study, it quickly became apparent that a number of possible North End boundaries exist. The geographic limits of the North End vary significantly depending on which set of boundaries one employs: federally determined census tracts, neighbourhood and planning units, postal code areas, electoral wards, social service districts, physical barriers such as railway lines and major streets, or borders identified by community members themselves. While the limits of these various community boundaries overlap in most cases, they do not correspond absolutely, meaning that in some instances people are considered part of the North End community and in others they are not. The high degree of variability between administrative organizations' definitions of neighbourhoods makes it very difficult to determine where the 'true' boundaries lie. It also calls into question which individuals/organizations should be establishing neighbourhood definitions.

Recognizing the importance of considering residents' perceptions of neighbourhood borders, I asked study participants to identify the north, south, east and west boundaries of the North End. Table 5.1 reveals the level of variability in their responses.

**Table 5.1: North End boundaries as identified by study participants (n=34)**

North	South	East	West	Number of Responses
The Bay	Barton St.	Sherman Ave.	James St.	4
Burlington St.	Main St.	Gage Ave.	James St.	1
The Bay	Barton St.	Woodward Ave.	James St.	1
Burlington St.	King St.	Wellington St.	James St.	1
The Bay	Barton St.	Wentworth St.	James St.	1
Burlington St.	Wilson St.	Gage Ave.	James St.	1
The Bay	Barton St.	Wellington St.	James St.	1
The Bay	King St.	Sherman Ave.	James St.	1
Stelco/Dofasco	King St.	Stelco/Dofasco	James St.	1
Unknown	Barton St.	Unknown	James St.	1
Burlington St.	Cannon St.	Wellington St.	James St.	1
Burlington St.	Mountain Brow	Ottawa St.	James St.	1
Burlington St.	King St.	Sherman Ave.	James St.	1
Burlington St.	Barton St.	Sherman Ave.	James St.	1
The Bay	Barton St.	Wellington St.	Bay St.	1
The Bay	Barton St.	Sherman Ave.	Bay St.	2
Burlington St.	King St.	Gage Ave.	Bay St.	1
The Bay	Main St.	Kenilworth Ave.	Bay St.	1
The Bay	Barton St.	Wentworth St.	Bay St.	1
The Bay	Cannon St.	James St.	Bay St.	1
Burlington St.	Barton St.	Wellington St.	Bay St.	1
Burlington St.	Barton St.	Wentworth St.	Victoria Ave.	1
Burlington St.	Barton St.	Sherman Ave.	Victoria Ave.	2
Burlington St.	Barton St.	Gage Ave.	Victoria Ave.	1
The Bay	James St.	York Blvd	Queen St.	1
Burlington St.	St. Joe's Hospital	Eastgate (Square)	McMaster University	1
The Bay	King St.	Parkdale Ave.	York Blvd-Wilson St.	1
Burlington St.	Main St.	Ottawa St.	Dundurn St.	1
Burlington St.	King St.	Gage Ave.	Highway 20	1

Among the 25 interview participants<sup>13</sup> and 9 focus group members who responded, there were almost as many border permutations as respondents. However, when the borders were considered based on direction - north, south, east and west - there was a significant level of agreement among the respondents. The most common responses identified were the Bay and Burlington Street to the north (47.1% each), Barton Street to the south (52.9%), Sherman Avenue to the east (32.4%), and James Street to the west (50%).

<sup>13</sup> The question pertaining to boundary limits was added after 9 interviews had already taken place. Two people did not respond to the question.

Although I did not ask individuals how they arrived at their reported neighbourhood boundaries, it does appear from the responses that natural physical boundaries such as the Hamilton Harbour and human-made boundaries such as major street intersections were the primary means of border selection. Chaskin (1997:532) remarks that:

One way in which neighborhood boundaries are drawn is by individuals as they conceptualize and negotiate their movement through and relationship with their surroundings. Every day, people observe and interpret their surroundings and construct mental maps that guide their relationship to space, their choices of movement, and their approaches to social interaction.

It is important to consider residents' perceptions of the neighbourhood boundaries because the boundaries they identify determine whether or not individuals take advantage of local level services. For example, participants' boundaries of the North End community were in some cases far greater than those identified by NHCHC and in others smaller. This means that some community members may not be aware that they can access the services offered by the NHCHC, while others believe that they can but in reality cannot because their residence falls outside the area limits. It should also be pointed out that a number of the women I interviewed, all of whom live within the designated geographic boundaries set by the NHCHC, either did not know the community health centre (CHC) existed or were unaware of the programs offered. At a time when finding family physicians with client openings is almost impossible in the City of Hamilton and surrounding areas (Boyle et al 2002), it is more important than ever that community members be aware of accessible health services. The conflicting boundaries of the North End, in conjunction with a lack of knowledge about the CHC's existence,

may account, in part, for the low level of community utilization and participation in health services and health promotion programs offered by the health centre.

The next sections explore the study participants' perceptions of the North End neighbourhood in which they reside.

### **What made you decide to live in the North End?**

Given the poor reputation of the North End and the perception by outsiders that no one would willingly choose to live "down there", it is interesting to consider why people end up living in this neighbourhood. When I asked participants what made them decide to live in the North End of Hamilton, the vast majority indicated that cost (to rent or purchase a home) and housing availability were the key forces behind their move to the area. For example, two women who really like the area and each bought a house there explained their reasons:

*SS: Part of it was when we were looking for a house we drove around and we liked the neighbourhood. Things like the environmental supports - like Bayfront Park - that was a really big selling point. It's close to the downtown. And just my husband and me are not sort of suburb types.*

*AG: We had lived here when we first got married both my husband and I and then we had moved to England and we lived in Toronto. And when we were purchasing a house we knew we couldn't afford Toronto and the only place we did want to live was in the North End of Hamilton. I like the area.*

Another participant who lives in an apartment complex with her husband and daughter said that she moved into the area because:

*SF: I like the social web as far as people are very friendly. There's not as much crime as there is downtown, or the East End or the West End for that matter at times. I like that there's a lot of parks down here.*

A few women mentioned that they didn't really have a choice about whether they lived in the North End, that instead, it was their parents' decision that brought them there:

*JMI: I've been living here all my life. It's where my parents moved to. I didn't have much of a choice. I couldn't go, wahhh, I wanna go. No, I've lived here since I was born pretty much. Not born in Hamilton but...not really long after I was born we moved.*

When I asked if she had ever wanted to move out of this area, she replied:

*JMI: I'm so used to it. I mean I don't mind Hamilton. I'd rather live in Hamilton than Toronto. Too many weirdos in Toronto and, it's a lot more expensive in Toronto and the crime's higher in Toronto. Even the crummier areas of Toronto are more expensive.*

Another woman, whose parents immigrated to Canada from Europe and settled in the North End said:

*EDB: It wasn't my decision. It was my parents' decision because it was what they could afford at the time and most of the immigrants lived in the North End. And the reason why I'm still living with them is basically, care-giving<sup>14</sup>.*

There are, however, another group of individuals who moved to the North End for financial reasons. They feel they are trapped in this neighbourhood until their monetary situation changes. One young woman who lives in assisted housing said that:

*CS: I applied for housing when I was pregnant and this is what I got. You only get three times to get a place. You take the first thing that comes along because the next thing could be worse.*

One woman expressed frustration at the lack of choice involved in determining her family's place of residence:

*AW: Well sometimes you don't always have a choice of what you can do in life and what you can't do. Financial, more or less. We were looking for*

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<sup>14</sup> Participant, EDB, lives with her parents although she is in her 40s. Her parents are quite elderly and require her assistance.

*a house and at that time, when we were looking for a house to rent, there was not that many houses available and this one was available and it looked okay when it was empty. We came in, my husband repainted, and tried to freshen things up a bit more. But otherwise I wouldn't have chosen this area but there was just nothing in the other areas. And another thing is too, this area, of course everyone knows, it's cheaper. The rents are cheaper. You look at anything in either the East End or the West End and your rent is higher than what you can really afford. So, financially has a lot to do with it too.*

Kearns and Parkinson (2001:2105) discuss the significance of choice in determining residential location. They contend that it is important for residents to feel (1) that they have a choice of location – “they opted into the neighbourhood and can opt to remain or depart, rather than simply ending up there” and (2) that others might also choose to live in their neighbourhood. Given that ‘place’ says something not only about where you live and come from but about who you are, how might an individual feel who is forced to live in an area they consider unsuitable and which others deem unlivable? It is quite possible that this lack of choice has negative consequences on how a woman perceives herself and the area. Participants in this study who lacked the opportunity to leave the North End tended to believe negative stereotypes attached to the area more frequently than those who chose to live there. When asked to comment on what they liked most about the area, many of these same individuals responded with “nothing”.

Kearns and Parkinson (2001:2106) point out that

In an increasingly competitive and uncertain world in which people seek to establish themselves alongside or over and above others, the neighbourhood can play an important role in people's personal and social identity, and social position, but with highly varying outcomes.

Some women made a concerted effort to point out that while they may not have chosen to move into the North End initially, they could now leave whenever they wished:

*HS: I moved here because of finances at the time. It was supposed to be temporary. I could move if I wanted to. I've had the opportunity.*

*JDS: People that we know that live in Dundas, Ancaster and the Mountain say "Why are you living there?", like it's a bad area. We've been here a long time because we have the availability to move out or to at least get out of the area in terms of transportation and finances and stuff. We can go where we want.*

It seemed very important to these two individuals to differentiate themselves from those who *have* to live in the North End because of financial reasons and those who *choose* to live there but can leave anytime.

There was also another, larger group of women who chose to remain in the North End because they truly enjoy living there. They like the multicultural make-up of the population, the view of the water, the Waterfront parks, the closeness to amenities, the sense of community and the community involvement. One woman stated that the reason she had decided to live in the North End was because she liked the feeling of comfort and well-being that she got from the neighbourhood. Another participant said that she wanted more people to

*LB: ...live down here because they want to and not because they have to because, it's a nice area...*

### **Satisfaction levels**

In order to get a sense of how content people are with the North End neighbourhood as a place to live, women were asked to rate their satisfaction level. Table 5.2 reveals that the majority (80.4%) report being very satisfied or somewhat satisfied with the North End. This gives the impression that most women are quite happy with their living situation. These findings are in keeping with studies of residential satisfaction

which find that most people have positive views about their local areas. However, these studies also revealed that people rarely express absolute satisfaction with their surroundings (Fried 1982). Such was the case in this study. When respondents were asked to identify how much they would like to move from the North End of Hamilton<sup>15</sup> (Table 5.3) only 27.7 percent said that they very strongly wanted to stay or preferred not to move, while 47.2 percent stated that they preferred to move or very strongly wanted to move. Fried (1982) suggests that the reason for this apparent contradiction is that most people adapt to or become desensitized to sources of residential dissatisfaction and stress over time. Fried (1982:111) also notes that a “selective factor” is involved; by continuing to remain in the area, people are demonstrating their willingness to accept their lived environment even if they are not totally satisfied. Individuals who are dissatisfied, but unable to move out of the neighbourhood because of finances or availability of housing in other neighbourhoods, may attempt to modify their immediate surroundings. For example, they may fix up their homes, select which neighbours to associate with, and spend less time in the neighbourhood (Fried 1982).

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<sup>15</sup> I added this question to my interview questionnaire at a later date; consequently only 26 interviewees and the 10 focus group members were asked this question.

**Table 5.2: North End neighbourhood satisfaction levels**

<b>Satisfaction Levels</b>	<b>Number<sup>1</sup> (n=46)</b>	<b>Percentage (n=46)</b>	<b>Number<sup>2</sup> (n=36)</b>	<b>Percentage (n=36)</b>
Very satisfied	11	23.9	7	19.4
Somewhat satisfied	26	56.5	21	58.3
Not too satisfied	4	8.7	3	8.3
Not at all satisfied	5	10.9	5	13.9

<sup>1</sup> The numbers in this column represent the satisfaction levels of all participants.

<sup>2</sup> The numbers in this column represent the satisfaction levels of those participants who were also asked to rate their level of desire to move.

**Table 5.3: Level of desire to move away from the North End**

<b>Desire to Move</b>	<b>Number (n=36)</b>	<b>Percentage (n=36)</b>
Very strongly want to stay	3	8.3
Prefer not to move	7	19.4
Don't mind either way	9	25.0
Prefer to move	7	19.4
Very strongly want to move	10	27.8

Parkes and colleagues (2002) caution that neighbourhood satisfaction levels may not be an accurate indicator of how individuals actually feel about their neighbourhood. They cite definitional problems with terms such as 'satisfaction' and 'neighbourhood' and difficulties with the measurement and relevance of the latter concept. Parkes et al (2002:2415) suggest three main reasons for the continued use of neighbourhood satisfaction as an indicator of how individuals feel about their neighbourhood:

1. It is a unifying concept that can accommodate the variety of neighbourhood priorities held by different people;
2. There are indications that it is related to overall life satisfaction and thus perhaps also an influence on well-being;
3. It is routinely collected in social surveys but is an underexplored and underutilized variable worthy of some analytical scrutiny.

The majority of studies that have addressed neighbourhood satisfaction have focused on residents' sociodemographic characteristics, housing characteristics and features of the neighbourhood. Early ecological approaches envisaged neighbourhood satisfaction as being inversely related to neighbourhood size, density and heterogeneity, while more empirical approaches predicted neighbourhood satisfaction depending more on social factors related to length of residence, neighbourhood turnover rates, presence of family and friends and the amount of social interaction (Parkes et al 2002). Parkes and colleagues (2002:2416) identify five additional factors which may affect neighbourhood satisfaction levels:

1. The economic capacity of an individual that allows them to choose or control the type of neighbourhood environment in which they live.
2. The reputation and level of income of the neighbourhood.
3. The degree to which residents are exposed to neighbourhood insults (e.g., noise, pollution)
4. The degree of local support from family and friends.

5. The expectations that people have of their neighbourhood and the extent to which these can be fulfilled.

Of these five factors, Parkes et al (2002:2416) suggest that the key determining feature of neighbourhood satisfaction levels may be "...an individual's financial resources, which give the individual the power to choose or control the type of neighbourhood environment inhabited". In addition to these features, attributes such as proximity to shopping and jobs and safety (measured as perceived safety, fear or perception of crime, or level of reported crime) are associated with neighbourhood satisfaction (Basolo and Strong 2002).

It is difficult to determine which of these neighbourhood characteristics is the most important for predicting satisfaction because they vary, depending on the variables and the population under consideration. It has been noted that different groups of individuals may attach more importance to particular characteristics than others (Parkes et al 2002). For instance, Cook (1988) found that although neighbourhood safety and neighbourhood quietness contribute to satisfaction levels for both urban and suburban women, the overall satisfaction of these two groups was affected by different attributes. Suburban women were influenced by features such as satisfaction with housing, neighbours, proximity to local amenities and good schools, while urban women were influenced more by housing opportunities and anticipated discrimination in the rental market. There is some consensus though, that socio-demographic characteristics and length of residence are not as important in determining satisfaction levels as are perceived neighbourhood characteristics such as safety, noise, friendliness of other

residents and quality of local stores and schools. To get a sense of how residents' perceive their neighbourhood, I asked women in this study to identify what they liked most and least about the North End.

### **Positive neighbourhood attributes**

Researchers have tended to study populations and communities with a view to identifying the weaknesses of these individuals and places rather than their strengths. Consequently, the majority of research time and money has been channeled into studies that seek solutions by focusing on needs, deficiencies and problems (Kretzman and McKnight 1993). Recently, however, there has been a shift away from this problem focus towards an asset-based approach that involves building upon existing positive attributes (Kretzman and McKnight 1993). In order to get an overall view of the perceived needs and resources of the North End, this thesis considers both the capacities and the challenges of this neighbourhood. Although some may question the existence of *any* positive factors connected to living in the North End, when participants were asked to identify what they liked most about the North End, there was no shortage of responses.

Table 5.4 classifies participants' responses into 6 socio-environmental categories (based on a combination of groupings set out by Macintyre et al 1993:220-221 and Basolo and Strong 2002:87-88): physical environmental characteristics; locational characteristics<sup>16</sup>; local services/facilities; socio-cultural environment; neighbourhood reputation; and other. Based on these groupings, locational characteristics were the positive attributes mentioned most often by North End women in this study (46.1%).

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<sup>16</sup> Refers to the availability of such things as decent housing and proximity to affordable and nutritious food stores and safe and healthy recreation.

**Table 5.4: What participants like most about the North End<sup>1</sup> (n=45)**

<b>Likes</b>	<b>Number</b>	<b>Percent</b>
<b>Physical Environment</b>		<b>1.3</b>
Warmer than the Mountain	1	
<b>Locational Characteristics</b>		<b>46.1</b>
Convenience/Accessibility	20	
Close to the water	7	
Parks	3	
My apartment/house	2	
Affordable	2	
Looking out at the escarpment	1	
<b>Local Services/Facilities</b>		<b>2.6</b>
North Hamilton Community Health Centre (NHCHC)	2	
<b>Socio-cultural Features</b>		<b>43.4</b>
People	11	
Community involvement/sense of community	7	
Multicultural/diverse makeup of people in neighbourhood	5	
Familiarity/feeling of home/comfort	3	
Family is here	2	
Lots of kids	1	
Kids can play on the street	1	
Neighbours look after kids	1	
Safety	2	
<b>Reputation</b>		<b>1.3</b>
Freedom in living in a stigmatized area	1	
<b>Other</b>		<b>5.3</b>
Nothing	3	
Everything	1	
<b>Total</b>	<b>76</b>	<b>100</b>

<sup>1</sup> Respondents were permitted to give multiple responses.

For example, the feature that participants like best about the North End is its convenience/accessibility:

*JM2: It's close to everything. Like you can walk from one part to the other. You can go to the mall, all the bus stops are there. As opposed to if you live on the Mountain, you have to get in your car and drive because everything is so spread out.*

They noted that living in the North End means that they are within close proximity to their doctors (NHCHC, Wilson Street Medical), the General Hospital, the fire department, public transportation, department stores (in Centre Mall), grocery stores (Price Shoppers, Food Basics), Jackson Square, the downtown area, drug stores (Marchese, Shoppers Drug Mart), highway access (403), parks (Bayfront, Pier 4, Eastwood), the beer store, the library, recreation centres (Pinky Lewis, Bennetto), the market, schools and work.

Quite a few women also stated that they really enjoy being close to Hamilton Harbour. They like walking along the Bayfront Park and Pier 4 Park trails (Figures 5.2 and 5.3). For some women this creates an opportunity to exercise and for others being close to the water acts as a relaxing influence:

*SS: I love that it's by the water. I think that's a really big bonus. You can go walking around the park there and you don't even know that you're in Hamilton.*

*HS: One of the things I really like is being so close to the water. I love going for walks down there. I find it very soothing, very calm. There's something about the water.*

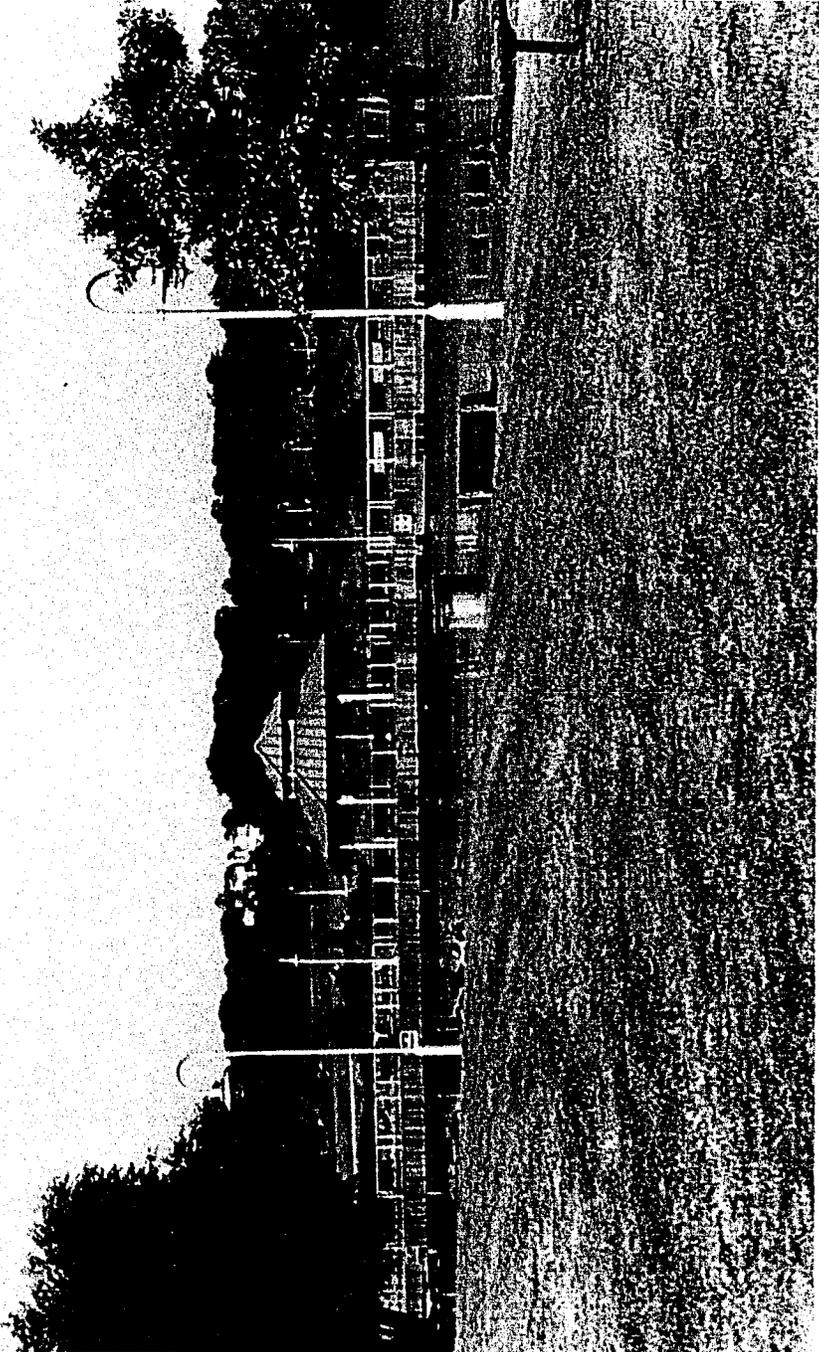


Figure 5.2: Pier 4 Park



Figure 5.3: Bayfront Park

Socio-cultural features (which include social relationships and networks, political, economic, ethnic and religious characteristics, and issues surrounding safety) were also identified as important advantages of living in the North End neighbourhood. In fact, three of the top five positive responses reflect the importance of the diverse group of individuals who comprise the North End neighbourhood. For instance, one of the older women who participated in this study responded to this question in the following manner:

*SA: The people! The people are great - very, very friendly!*

Many women commented on the friendliness of the people in their neighbourhood. They feel that they can turn to their neighbours in times of need. For example, one woman recalled when a child went missing and everyone in the neighbourhood went out to help with the search. Participants said that they can trust their neighbours to look out for their property when they are away and keep an eye out for their children when they are outside.

A number of women believe that the cultural diversity of the neighbourhood makes the North End a better place in which to live. Some women feel that living in a multicultural neighbourhood makes life much more fascinating and teaches people how to get along with others.

*SS: ...and I do like the fact that it is a mixed type of neighbourhood.[What is the composition of the neighbourhood?] I know traditionally it's had a high immigrant population - being Portuguese and Italian - which I think is great because it lends a wonderful flavour to it.*

*EDB: You know, I've always been exposed to multiculturalism and to the variety of people that live in the neighbourhood. That to me is interesting and it's something that you learn to live with and you learn to get along. Learning to get along with each other.*

A few participants mentioned that community involvement and a sense of community (“*people looking out and helping each other*”), are definite assets associated with living in the North End.

*JA: The community involvement. It seems to be a very tight knit community. People care about people. There is a great deal to offer here.*

The women from the focus group were almost all in agreement that the people and the feeling of community in the North End are what they like most. They feel that the North End is very community oriented and, as a result, people really know their neighbours. They attributed this to the fact that the houses and porches are so close together that people can't help but get to know one another. They also value the amount of communication between groups, families and neighbours which allows information to be easily disseminated. They described North Enders as very helpful (especially when people first moved there and needed help making connections), more accepting of individual faults (e.g., economic situation), and having realistic expectations of the people who live there.

Although most participants had no trouble identifying at least one positive feature of the North End, a few women felt that there was absolutely nothing to like about living in this area; several others were hard pressed to come up with a single positive attribute. Clearly, these women share the same space, but they do not experience that space in the same way.

### **Negative neighbourhood attributes**

When asked to identify what they like least about living in the North End, once again there were a large number of responses, but much less consensus among

respondents. Table 5.5 reveals that while socio-cultural characteristics of the North End are identified as one of the main assets, they are also considered the primary liability of the area (38.2%). North End women mentioned disliking some of their neighbours because they are too nosy, noisy, and unfriendly; have bad attitudes; use bad language; and/or lack respect for themselves and their surroundings.

*CS: I'd say the people. They're not friendly cause they're all pretty much depressed about their own life. Not very happy people.*

*JM2: People's like...the morality. Cause like everyone that lives here...just the way they act and they have no self respect or respect for anything. Like the garbage that sometimes piles on our lawn, like Tim Horton's cups, burger wrappers, and it's not from us. So we know that...I don't litter. I don't know if anyone else in my family does but I doubt it. And there's just garbage sometimes sprawled all over own lawn and we have to sweep out our driveway because cups and garbage. It just makes like it look dirty.*

The prevalence of crime was also identified as a negative aspect of living in the North End. In particular women noted the high levels of vandalism, drugs and prostitution in the neighbourhood. A number of women also revealed that they don't like the high rates of poverty and welfare dependency that exist among many North End families:

*CK: Evidence of what poverty can do. A mindset and people lose hope and don't think that they can get anywhere. Perpetuating the vicious poverty cycle with more kids.*

Another young woman stated that she can't stand the discord evident in some families:

*AC: I think basically you know just what you see going on in the families and...just the yelling and things like that. Those are the things I hate the most.*

**Table 5.5: What participants dislike most about the North End<sup>1</sup> (n=45)**

<b>Dislikes</b>	<b>Number</b>	<b>Percent</b>
<b>Physical Environment</b>		<b>27.9</b>
Pollution	5	
Noise	3	
Dirty/garbage thrown around	3	
People don't take care of their property	3	
Smells	2	
Sidewalks	1	
Constant construction	1	
Water quality	1	
<b>Locational Characteristics</b>		<b>17.6</b>
Close to factories/pollution sources	4	
Closeness of houses	2	
Not convenient	2	
Lack of parks	1	
Plastimet area	1	
Threat of perimeter road	1	
Closeness to water	1	
<b>Local Services/facilities</b>		<b>2.9</b>
North End bears the brunt of social services for the region	1	
Bayfront bus doesn't run frequently enough	1	
<b>Socio-cultural Features</b>		<b>38.2</b>
Some neighbours/people	7	
Crime (vandalism, robberies, and/or prostitution)	4	
Poverty/evidence of what poverty can do	3	
Neglect of kids/inadequate supervision	3	
Swearing/yelling	2	
Dependency of North End people on social services	2	
Lots of mental illness, alcoholism and drug abuse	1	
Bad kids	1	
Too many kids	1	
Family here	1	
Car bombs	1	
<b>Reputation</b>		<b>8.8</b>
Stigma/reputation of North End	3	
Lack of concern towards and funds for the North End	2	
Watched by the police more	1	
<b>Other</b>		<b>4.4</b>
Nothing	3	
<b>Total number of responses</b>	<b>68</b>	<b>99.8</b>

<sup>1</sup> Respondents were permitted to give multiple responses.

Other women dislike the neglect and lack of parental supervision of local children:

*MC: The kids. There are a lot of bad kids. The parents don't do nothing. Kids run wild around here. My kids are in bed at eight o'clock at night and they're not allowed on the street when it gets dark. And you see constantly kids...there's no authority around here and that's where a lot of problems come from.*

Certain characteristics of the physical environment (refers to features of the lived environment that are shared by all residents) were identified as negative aspects of living in the North End (27.9%). This is not surprising given that only one participant considered the physical environment to be an asset of the North End. Air pollution, and the noise and stench associated with industry, were causes for concern:

*AG: I'm very satisfied, with a few hitches to that.[For example?] I would have to say things like the pollution/environment type of things, like some of the businesses/industries in the area I don't think are good neighbours.*

In addition, poor property upkeep and litter were mentioned as local problems. One woman, who works for a housing rental agency, pointed to a lack of concern and respect shown by landlords and renters alike. She feels that because these individuals either do not live in the area or do not own the houses themselves they do not care about the appearance of the property. Consequently, these residences become rundown and dilapidated. This in turn brings down the value of the surrounding homes. She feels that people who own their homes and actually live in them take more pride in maintaining their property.

A few women (8.8%) noted that what they like least about the North End is its sullied reputation. One rather vocal participant remarked:

*ED: The crappy rap that we get. I'm so surprised when people come to the North End and then go "Oh my God, it's so nice". Well, like what do*

*people expect, the bowels of the earth? Do you think that we've got Stelco right here? I mean even if somebody likes my house I really couldn't give a shit if anybody likes it or not. I have to live here. This is my little castle. So I don't really care once the door gets closed. I don't think I live in the North End anymore. I can be very, very imaginative when I need to be.*

Another woman also mentioned her dislike of the North End stigma and of constantly being asked by outsiders: "*Why do you want to live in the North End?*" (PTW). Both of these responses reveal the way that outsiders view the North End, even today, and show how defensive residents can be about having to justify their decision to live there. Most participants feel that non-residents look down on the North End and judge it based on events from the past. While many believe this is an unfair evaluation of the neighbourhood, some agree that it correctly captures the true character of the North End.

However, it is important to point out that a few women stated flatly that there was "nothing" that they didn't like about living in the North End. A number of participants, although dissatisfied with certain aspects of the North End, indicated that they would not move out of the area. For example, a longtime resident commented:

*JMI: Like I said being close to the polluters. I wish some of the neighbours were a little different than what they are...in other words...quieter. A quieter neighbourhood. There really is many negative things I have to say about it. If I was really that worried about it, I would have moved out a long time ago. But I'm used to the area.*

Apparently in some cases, the familiarity and comfort associated with the North End outweigh the negatives, revealing the subtle complexity involved in attempting to understand neighbourhood satisfaction levels.

In order to determine if there were other shared day-to-day features that affect the lives of North End women, participants were asked to comment on the socio-environmental quality and condition of their neighbourhood.

### **Neighbourhood quality**

To get a better sense of how residents' perceive their neighbourhood, I asked women to consider a list of possible neighbourhood situations and indicate whether they considered these to be concerns in their neighbourhood. Table 5.6 reveals that the situations considered least problematic by interview respondents were access to transportation (80.6%), housing availability (63.9%), and accessibility of recreation facilities (61.1%). The neighbourhood problems most commonly cited by interview respondents were smells and fumes (96.2%), air pollution (88.9%), unemployment (88.9%), water pollution (86.1%), poverty (85%) and neighbourhood homes in disrepair (69.4%)<sup>17</sup>. This corroborates participants' comments on what they dislike most about the North End. Participants were then asked to explain why they thought these situations were worrisome. Because all of the responses cannot be included here, I have chosen to highlight a few of the important issues that emerged from the interviews and focus group.

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<sup>17</sup> One of the interesting features of Table 5.6 is the high level of agreement about some neighbourhood problems, but low levels of agreement about others. For instance, the proportion of women who feel that personal safety (52.8%) and noise levels (55.6%) are a problem is very similar to the proportion of women who don't deem them to be problems in the North End (44.4% and 44.4%).

**Table 5.6: Perceptions of neighbourhood conditions**

Neighbourhood Situations	Considered a Problem						Total Responses
	Yes		No		Don't Know		
	n	%	n	%	n	%	
Smells and fumes <sup>1</sup>	25	96.1	1	3.9	0	0	26
Unemployment	32	88.9	2	5.6	2	5.6	36
Air pollution	32	88.9	3	8.3	1	2.8	36
Water pollution	31	86.1	4	11.1	1	2.8	36
Poverty <sup>1</sup>	17	85.0	1	5.0	2	10.0	20
Neighbourhood homes in disrepair	25	69.4	10	27.8	1	2.8	36
Health of children	22	61.1	8	22.2	6	16.7	36
Crime	22	61.1	10	27.8	4	11.1	36
Traffic	21	58.3	15	41.7	0	0	36
Alcohol	21	58.3	8	22.2	7	19.4	36
Noise levels	20	55.6	16	44.4	0	0	36
Personal safety	19	52.8	16	44.4	1	2.8	36
Drugs	16	44.4	6	16.7	14	38.9	36
Affordable housing	14	38.9	19	52.8	3	8.3	36
Access to recreation facilities	14	38.9	22	61.1	0	0	36
Availability of health services	13	36.1	20	55.6	3	8.3	36
Youth gangs	13	36.1	13	36.1	10	27.8	36
Available housing	11	30.6	23	63.9	2	5.6	36
Access to transportation	7	19.4	29	80.6	0	0	36

<sup>1</sup>These neighbourhood attributes were added to the questionnaire at a later date and consequently reflect fewer responses.

### *Smells and fumes*

Smells and fumes were identified as a serious problem by almost every participant. The majority of noxious smells reported come from the CanAmera plant located on Victoria Street North (Figure 5.4). This company, which is the “technological leader” in the processing and marketing of oilseeds, protein meals, and edible oil products, is responsible for strong odors permeating the area. Having visited the area on a number of occasions, I can attest to the strong stench associated with the production of soya and canola oils.

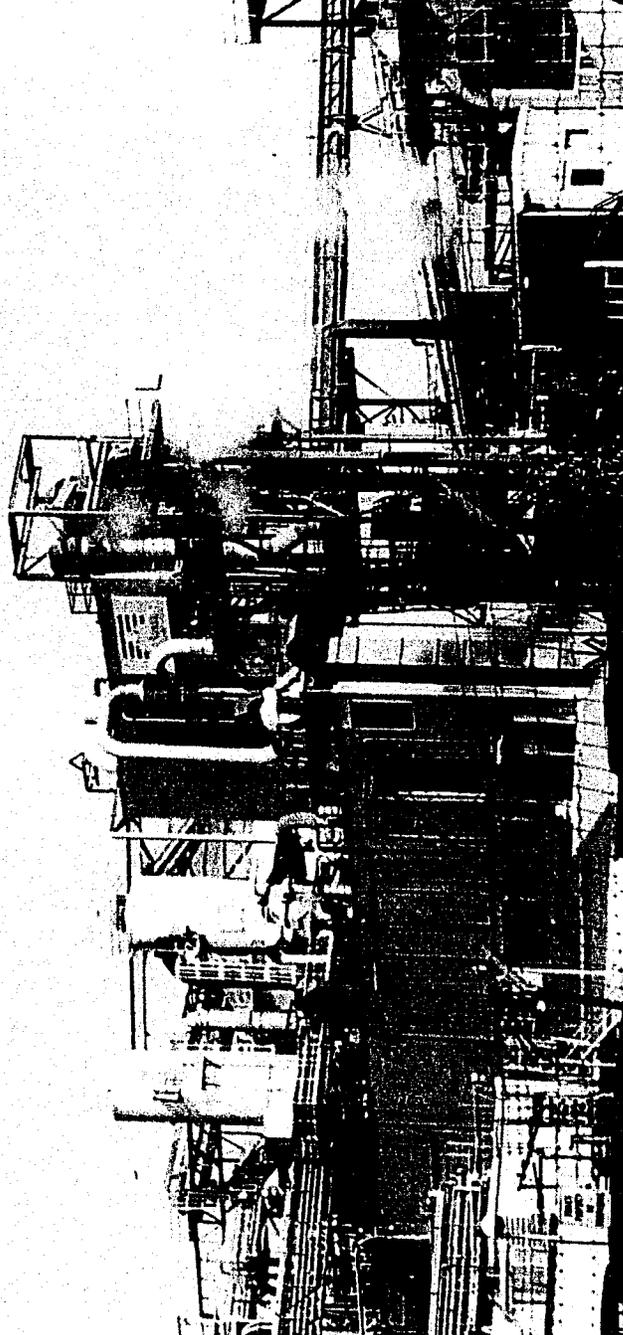


Figure 5.4: The Can-Amara plant on Victoria Street North

One participant stated:

*JM2: It's that pea factory on Burlington Street. It stinks to high heaven. Yeah. I think it stinks. Like I've been camping and then we drive down York to come in off the highway - you roll down the window and it's just this stench. I can't explain it, it's just a very bad stench.*

When asked to explain what it smelled like, another woman described the odor as:

*MC: Like the smell of rotten eggs mixed with smoke. It's hard to explain. Like bad garbage.*

Women also attribute the bad local smells to car fumes and industrial pollution from Stelco and Dofasco.

### ***Unemployment***

A large number of women identified unemployment as a problem in the North End, commenting on the high proportion of welfare recipients living there. Some feel that these individuals are over-represented because of the abundance of low cost housing; others believe it relates to the over-abundance of social services located in the North End. Although a few women expressed the belief that people get caught up in the vicious welfare cycle and can't help themselves, many more think that people remain unemployed because it is worth their while:

*LB: Yeah, I know a lot of welfare bums who live up here. Case in point, two families down at the end of the street. One of them is a breeder too. Well she's on welfare and she breeds children to get more money. She's got four kids and she really doesn't give a shit. One of them got hit last year and she was going to let the guy go off and she didn't even know if the kid was okay yet. I mean what does that say about a person. She doesn't care about her kids just... how much money she gets.*

*EDB: ...there's people that are on social assistance and whether they're capable of going to work or, they just don't want to work, that's another situation. So if they choose not to work, and I could see why, they're making good money from social assistance. Excuse me you know. You*

*know...I've seen a lot, again because I see it in the classroom. They'll have children just to collect more money. If they all have a different father it doesn't matter; they're going to get more money. And they're going to get all of these wonderful services provided for them. It's almost like they're encouraging them to have kids. You know they get free medical, free school caring, daycare whatever. They can even take courses. Hey what a life!*

### ***Air pollution***

Air pollution is an important issue in the North End. Most individuals feel that air pollution is worse in the North End because of its close proximity to industries such as Stelco and Dofasco (Figure 5.5); others believe that it is no worse than in other parts of Hamilton and Southwestern Ontario. The following responses capture the variation in perceptions about the problem of local air pollution:

*EDB: Yes. I'm going to say yes. [Do you think it's more of a problem in North Hamilton than anywhere else?] I think so. [Why?] Proximity to the industries. Sometimes it depends on the day, like a day like today and direction of the wind.*

*ED: Serious problem but it's not just for the North End again. All you have to do is come down off the Mountain and look at it. I mean, my heart sinks every time I have to come back to this pit hole as they call it because you see the metallic haze across the city.*

*GS1: If there is air pollution, it is probably pretty general you know. It is not something specific to the North End really. I mean here we are in Southwest Ontario as it were so we're in the path of a whole lot of junk.*

Regardless of whether air pollution is considered worse in the North End or not, most women agreed that it is a problem for the City of Hamilton as a whole.



Figure 5.5: Industrial pollution

***Neighbourhood homes in disrepair***

Some property owners feel that dilapidated homes are a serious problem in the North End because they bring down the property value of the houses around them. A lifetime resident remarked:

*JM1: Ah huh. Well, it's just the area too because a lot of people they're on social services. So I'd say yes. My mom has put a lot of work into the house from...it hasn't been done recently, but the roof, the siding, the fence, the lawn. A lot of internal stuff done to it. Whereas the sales representatives for one of these real estate people says it's one of the better looking houses on the street. ...and when you compare it to some of houses nearby, it brings the value of it down no matter how good looking the house is if you've got one that looks like the Adam's family lives there.*

Many also observed that the poor property upkeep results from absentee landlords and renters who have no personal attachment to their place of residence. Participants mentioned that it is quite easy to tell which homes are rented and which have property owners living inside. One relatively new homeowner shared her thoughts on the impact of property maintenance on the overall perception of the area:

*SS: Yes, there are some. I guess I sort of look at it to like...as somebody who admires historical architecture. And you do see some places... I think some...like again in any place... some of the rentals can be poorly up-kept and then there are some places that are quite bad and in disrepair and I think that impacts on sort of the perception of an area. There's a book that's written on this whole theory of broken windows and I think, I can't remember if it was in New York or where they did it but basically sort of...if you have a broken window and its not repaired it gives the impression that people don't care and then opens the door for more vandalism and that sort of thing.*

Another respondent sees poor upkeep as a reflection of the apathy of some North Enders:

*JM2: I don't think they really care. I haven't seen anyone, like you can fix your house up just by buying a few seeds and maybe a thing of paint. But I think they'd just rather sit and do nothing.*

Another woman views rundown homes as an indication of the need for some residents to “...get off their duffs and fix them”. A few participants believe that North End homes have actually improved over the years as new homeowners have moved in. An older woman credited immigrants with fixing up the properties.

### *Noise Levels*

Quite a few women were unhappy with noise levels in the neighbourhood. They pointed to a variety of noise sources such as local events (Aquafest); cars and trucks; music being played by neighbours; kids screaming and families fighting; ambulance and fire department sirens; and local dogs and cats.

*EDB: Our houses are very close together. Between my neighbour and I we're about a meter apart so there's within a square mile let's say, there's a lot more congestion. So, you're going to run into a lot more problems that way.*

*AC: Yeah, that can be at times. [Anything in particular?] Just neighbours deciding they don't have to turn the music off at a certain time. Yeah, just, it's not terrible but, just, it's more just the screaming and yelling things that, yeah.*

*JDS: The noise levels have dimmed because the work area has sort of decreased but the ambulance level has increased, the fire departments noise level has increased. Fighting, stuff like that is on the increase here on the streets. Like I'm talking about family members fighting with each other. Carrying it onto the streets. Serious.*

### *Crime*

Crime emerged as a significant concern for women in the North End. Many participants discussed the growing problem of vandalism and burglary, providing both first- and second-hand accounts of local incidents.

*MC: They've broken into our van a couple of times and trashed our stuff and broke our windows. Yeah, there is lots of vandalism.*

*SA: This man next door, bless him, he got robbed a couple of months ago. He was at work and they got in through his veranda door.*

*RC: There's been, I believe, 7 or 8 [burglaries] on this street in the last year. My neighbour across the street has been broken into a couple of times. Which is funny because you have people not working on this street and they sit outside and look at what everyone's doing but they never see the robbery. But I personally have not been robbed yet.*

*GS2: Just some. Well, Mrs. Campbell across the street got her, got the back of her garage sprayed. And they, I don't know his name, he's the East Indian guy that lives over there, they broke all his moon-ray lights. There's no respect for property. [From people on the street?] Kids have done this.*

Another woman commented on her personal experiences with both vandalism and burglary:

*KB: We've had a beer bottle thrown at our door. It's kids. We've had our window broken out front. Stones or whatever. [Burglaries?] Yeah, we've had two cars stolen {laughter}. Well the one day my husband went out and started the car. It was really cold and he came back in. He was only in for like a minute and went back out and the car was gone {more laughter}. It was a kid who took it. He went and crashed it. Another time the car broke down on the highway and we had the CAA come and pick it up and they took it over to a garage on Victoria Street. We were going to Brampton and my parents came and got us. So, we got home that night and the police phoned us at 9:00 that night asking us why my car was in an alleyway. And I'm like "excuse me my car is supposed to be in a garage". Kids. Eleven year old kids went in, stole it, and took it down the tracks. Blew the transmission in it. And it's been broken into a couple of times, the car. And I've also had in the house, I had a lady when my oldest daughter was a baby that was baby sitting because I take ...because I had to go to appointments or whatever, right. And she was stealing our jewelry. You know, they don't have any money themselves. It's their means of finding more money. You trust them not to steal off you.*

One respondent noted a recent increase in crime:

*LB: Well, I'll tell you, in the last three years I've seen more crime in this last year than I have at all. I mean I didn't see crime here until last year when someone stole my bike. I've been here two years and no one stole anything until last year. And just two weeks ago somebody broke into our*

*car. They didn't get anything but still. It wasn't until this last year that we started seeing crime around here. I mean even the people around here who have been living on the street for years that they always... they would leave things out and never have to worry about them being stolen. And then all of a sudden lately, things are...they're starting to break in...*

One woman discussed the difficulty of getting insurance in the North End because of the perceived crime rate:

*GS2: Well you can't get insurance most places. [What type of insurance?] Content insurance. [What do the insurance companies say when you ask for it?] Crime rate's too high.*

On the other hand, one participant expressed the view that theft might be lower in the North End because people didn't have much worth stealing:

*AC: ...I don't know if it's [crime] necessarily any different. Like for theft I think it's almost a bit less because most people don't come to the North End to steal something but, they go to Ancaster or something to get something good.*

### ***Personal Safety***

When participants were asked to comment on whether or not they considered personal safety to be a problem in the North End, quite a few women responded that it is. Although a number of the women see personal safety as a problem for women everywhere, others suggested that it is a more severe problem in the North End because it is a low income, high transient area with a number of abandoned buildings. Some described very serious personal experiences that caused them to question their safety.

One woman described the night a car bomb exploded on her street:

*AG ...I don't wander around the streets not thinking about things. If I'm out at night I've got my keys in my fist ready to... what have you. We had an incident last week where, and this another reason I want to move if something came up. We had gone to bed on Wednesday night. We were supposed to have a sleep over with my niece but she ended up getting sick*

*and I called her parents and they came and took her home. And I'm glad they did because we went to bed at 11:00 and at 11:30 we'd just turned off the lights there was a huge bang – like a car backfired but not – so we jumped up and I just opened the blind in time to see a huge explosion. And it was a car bomb. It never was in the papers but and I have actually been meaning to phone the cops to say “what the hell are you doing?” It was like five doors down and you can still see the big burned out hole in the road. But, it was a little issue about somebody selling somebody a car that wasn't working properly and this was how they responded. And my big concern was that my husband and I every night between 11:00 and 11:30 walk our dog exactly right by that spot...Somebody, my mother said “Are you sure it was a bomb?” I said “Mom, the guys wheeled the car down the street and left it in front of this house at 8:30 and three hours later it exploded. Not just exploded, like the flames were 20 feet high. The front of this house [her house] is warped and all the siding is melted”. So, stuff like that doesn't happen in other neighbourhoods. That I would say was a concern. I was a little freaked out about that.*

Another woman discussed the assault on her elderly father and the subsequent burglary of their home:

*EDB: My father was attacked right after his stroke. He went for a walk, you know you're supposed to do a lot of walking when you're recovering and somebody grabbed him from behind and took his wallet. It bothered him. It bothered all of us. It wasn't even late at night. So yes, we do feel that it's affecting us. And, when our house got broken into my dad had just had his stroke and we called the ambulance and whoever was observing what was going on, knew that there was something going on at the house and that we were all at the hospital and that's when they broke into our house. So that added to a lot of stress at that time. (Someone casing the joint) Yes, and they ransacked our whole house from the attic to the basement. And they were juveniles. They caught them a few months later because they were on a rampage. They were doing a few other houses in the neighbourhood. When they finally caught them, they confessed, our address was one of the houses they had broken into.*

Another woman implied that criminal events happen so much more frequently in the North End than elsewhere that we don't even hear about many of the occurrences:

*JDS: Like I mean, if you were mugged or whatever say in Dundas, Ancaster, up on the Mountain, East End, West End, you'd be more*

*inclined to hear about it. Whereas in this area, it's happening on a daily basis.*

In an attempt to protect themselves from the possibility of assault, a few women said that they keep their keys in their hand when they walk along the street just in case they need them:

*JM2: I worry about it. Like when I walk up the street, I always walk with my keys in my hand just to be safe. And, if I could carry pepper spray in this neighbourhood, I would. If it was legal I would. [Serious problem?] A serious threat. [Do you know of anyone that's been assaulted?] I've known people that have been harassed. Like I've been harassed. Like you walk up the block and you know what I mean, those things could lead to other things.*

This same young woman described the safety precautions her family has taken to protect themselves and the contents of their home:

*JM2: Like we've tried our best to put up a camera but, what if you can't afford that stuff? And what if you do have nice things in your house? We have a deadbolt on our house. We have bars on the windows. Thank God for the bars. But what if you don't have that stuff? I'd feel very unsafe.*

A few women intimated that they had suffered from spousal abuse and one woman implied that her daughter had been the victim of incest. One woman said that personal safety was sometimes a problem when she was arguing with her spouse:

*MC: When he doesn't have a job or I don't have a job. It's stressful. He gets upset and irritable. [And you worry when he's like that?] Yeah. [Things have happened in the past?] Yeah.*

Although these women did suggest that abuse in the home occurred, none of them were particularly willing to discuss the event(s) in detail.

### **Civic action**

I was interested in exploring whether women in this study had taken any steps to remedy the negative neighbourhood conditions and situations they identified. Most participants who indicated they had taken action reported phoning the police to report incivilities such as of prostitution, vandalism, fighting and intoxication. One woman who is upset about the appearance of the North End spoke to her neighbours about cleaning up their property. Other women joined neighbourhood associations (e.g. Central and North End West Neighbourhood Association (C.A.N.E.W.)), parents' councils and/or environmental groups (Hamilton Industrial and Environmental Association (H.I.E.A.)) in an attempt to address negative aspects of the North End. For instance,

*SF: Through the parent council we've had a few clean up days and things like that. You know, I've signed a few petitions here and there. I went and marched once in front of an adult video store so that they would go away.*

Some are frustrated that their actions have had little impact on rectifying the situation:

*JDS: We have a problem on our street because it's a cut off between Sanford and Wentworth and so they're going to Barton Street. We've complained about this a number of times because some day a child's going to get hit on our street. Because we're talking about traffic that goes down at 60-80 miles/hour. They said they won't do anything else unless someone is killed. Or something like that. That's too late isn't it. Serious problem. We've taken this to City Hall a number of times. Even just making it a one way street. They won't do that either.*

On the other hand, one young woman reported positive results from her constant letter writing and phone calling to City Hall:

*CDB: I think that everything is in your control so if you do live in the North End I don't think you have to put up anything. Like I don't think that anyone should be afraid to move to the North End. I think if you like a house or you like a street or whatever, I think you should do whatever you want to move there and if there are any problems, like if you see any type*

*of vandalism or you see any problem that you think is associated with the North End I wouldn't be afraid of it, you just get rid of it. Like it's very easy to take control because it is your place. I think it's just people have this attitude that the government is something separate from yourself. You would be surprised what a word or a letter will do. I've written to the City of Hamilton so many times and its done something. Or a phone call. I'll get a phone call back right away. It's just that people just don't try. I think that's what happens and people just settle for certain standards.*

### **The North End reputation**

One aspect of neighbourhood quality not addressed in Table 5.6 but dealt with in another section of the questionnaire, is the reputation of the North End. In chapter 4, I presented information on how outsiders are perceived to view the area. Most participants feel that non-residents look down on the North End and judge it based on past circumstances. While many participants consider this to be an unfair evaluation of their neighbourhood, others feel that it correctly captures the true character of the North End.

Although the North End reputation did not emerge as a dominant theme when participants were asked to comment on what they disliked most about the North End, my experiences working as a volunteer and the comments from participants in the early stages of the research process revealed concerns about negative stereotypes associated with the North End locale and by extension, the residents themselves. Because of this and the unfavourable media coverage of the area, I added a question to the interview and focus group instruments about the North End's reputation and about its legitimacy. The passion with which participants responded to this question and the number of times the North End's reputation came up in discussion without prompting, underlines the importance of this issue.

When asked to comment on the unsavoury reputation associated with the North End, a few women agreed that it is accurate:

*MC: It's like the ghetto. I consider it a ghetto. We might as well have drive-bys. Yeah [it's a justified reputation]... nobody has respect for anybody around here. It's just bad.*

*GS2: We have two coke dealers on the block. There were some men that used to live here and would break into your house and things like that. But they've moved. Last summer the prostitution was bad. I mean you walk down the alley across from my place and you see condoms in the alley. Reputation probably correct.*

Yet a further individual described the North End as more like a “slum” filled with “welfare-type people”. Another woman who agrees with the sullied reputation remarked that what happens in the North End probably happens elsewhere but doesn't get publicized:

*AW: Very poor. Very bad reputation by anyone who you talk to. Poor reputation based probably on the crime, the drugs and the prostitutes. I would base probably my own opinion on the few things that I've just mentioned as being very poor. I mean you have anything like that anywhere. But I think the only thing that may be different is all this stuff may go on in other areas, it probably does, but it's more discreet.*

While some individuals accept the discrediting reputation, many more truly like living in the North End and find its reputation to be annoying, demoralizing and even laughable at times. One long-time resident, who loves the North End, described how she had become defensive about protecting the reputation of the area:

*GS1: People were absolutely horrified when they heard we were going to move to the North End. I mean you must have heard this before – The North End and all its horrors. Maybe I've become a little aggressive about that. I don't know...maybe...defensive certainly on behalf of the North End...but I've always found it a wonderful place to live. It's very interesting. Every sort and condition of person lives here. You can be*

*whatever you want to be. So, from that point of view, I think it's a wonderful place to live and I find it a stimulating place to live.*

This woman also remarked that *“Living here and looking at the escarpment and the harbour. It's marvelous. I think we're incredibly lucky here. Oh I do think that”* (GSI).

While one of the younger participants who is on Family Benefits Assistance commented, *“I think it's a privilege to have such nice surroundings being on the kind of assistance that we're on”* (BD).

The majority of women I interviewed believe that the negative stereotypes associated with the North End are untenable and created by people who live outside of the area. One participant who has lived in the North End off and on for a number years observed, *“I think people fear this area without knowing it”* (VC). Outsiders tend to believe the stories they hear and the articles they read without ever setting foot in the area. For example, a young woman who recently moved to the North End when she married a local man admitted that she had a very poor image of the North End until she moved down here:

*AC: ...I think I came in with some preconceived ideas of what it would be like to live down here and, it's just a regular neighbourhood. Things are a little bit more obvious than in other neighbourhoods.*

When I asked her what she expected the neighbourhood to be like, she said:

*AC: Just really loud all the time. People beating each other up in the middle of the streets. Things like that. People always drinking and screaming and yelling. And I do see some of that but you see the good parts in it as well and, some of these things can go on in other neighbourhoods just as much as they can go on here.*

When asked about its positive features, she replied:

*AC: I think because it is such a 'porch community', everyone's sitting outside all the time and you see a lot of people actually talking to each other and becoming friends that way. Our landlord, who owns our house, owns several homes, she lives up on the Mountain now and wants to move back to the North End because she feels she hasn't met any of her neighbours and nobody's ever outside. That's one thing I do appreciate about the North End, people actually do get out and get to know each other.*

One woman suggested that outsiders who had a poor opinion of the North End should “*start looking in their own backyards before they look here*”(ED), suggesting again that what happens in the North End also happens in other neighbourhoods. Another woman, one who has been involved in environmental and community health projects, recognizes that while there are some problems in the neighbourhood, most of what she hears about the North End is not true. Whether or not participants agree or disagree with the neighbourhood's stigmatized reputation, it is still an aspect of living in the North End that residents have to deal with on a daily basis.

#### **Where would you most like to live in Hamilton?**

Given that a wide variety of negative local attributes were mentioned and that a number of participants revealed that they did not want to live in the North End, I asked participants if they could live anywhere in the City of Hamilton, where would it be and why? Out of the 36 women I interviewed, more than one third (38.9%) preferred to remain in the North End neighbourhood:

*AG: Here. I know a lot of people would find that shocking but I look at the rest of Hamilton as an absolute wasteland. You know, I know that people up on the Mountain, we have friends up there, and they just “how can you live down there?”. And I just thought, “I'd shoot myself if I lived up on the Mountain”. I just could not cope with that. It's all about preference. I*

*mean, I'm not really happy being here anymore but this is the only place in Hamilton I'd want to be. It's a great neighbourhood. The people are nice and you know everybody...*

Another woman indicated that as much as she hates the air pollution in the North End, she's here for the sense of community. She went on to explain that while her sisters, who live in Oakville, Stoney Creek and up on the Mountain, don't know any of their neighbours, she knows many of hers. Although both of these respondents dislike certain aspects of the North End (environmental pollution), the positive attributes (the sense of community and the diverse community make-up) outweigh the negative.

Those who preferred to live in other areas of the City of Hamilton, mentioned locations such as the West End, the South End and the Mountain. The primary reasons for choosing these areas were quite similar: a cleaner environment; open spaces; bigger and nicer homes; friendlier people; and proximity to amenities. The following examples typify participants' responses:

***EDB:** In Hamilton? (laughter) Well, there's a couple of neighbourhoods that I kind of like. I like working on the Mountain but I don't want to live on the Mountain, it's too boring for me. I always admired the West End of the city and I like the neighbourhood on Delaware, Delaware between Sherman and Gage. There's beautiful old Victorian homes there. [Why would you like to live there?] The houses look beautiful. I like houses that reflect a little bit of heritage. And proximity to a lot of things. I like to be close to the highway, the access, the stores. Just proximity to a lot of things.*

***CS:** West Mountain. Far away from the pollution. The houses are beautiful. It's a great area. Everyone is so friendly on the Mountain. I used to live on the Mountain for six months. Everyone is so friendly that you feel like you're in the country when you walk by. You look at somebody the wrong way downtown and you know you're going to get punched out.*

*MC: The Mountain. It's more cleaner up there. What would you say... a nicer environment for the kids and that. [So when you say environment there what do you mean?] I see clean. I don't see garbage all over the place and kids running around the neighbourhood going nuts. I don't see that stuff up there like I would see it down here. You find a bunch of drunks down here. Like around every bar.*

Another group of women preferred not to live in the City of Hamilton at all but rather, had their sights set on the outskirts of the city or in the country:

*LB: Oh man. There's couple of places. I like the West of Hamilton, it's a nice area. Up on the Mountain is a nice area. Further back, more closer to Caledonia, is nice. Out around Stoney Creek is nice. It's a toss up really because for us our life is more revolved around getting out of Hamilton. I say that as if it's a bad thing but it's just we've lived in the city for 5 years and we want to get at least an acre of land and a house and room to breathe. That's where our goals are right now, to have a place of our own. [Why would you like to live in these areas?] They're greener. They do have more greenery...*

It is interesting that while some residents feel that certain features are not accessible to them in the North End (e.g., close proximity to amenities, friendly neighbours, lots of parks), others believe that they are available. These responses may reflect either an individual's ability to choose their place of residence or their actual geographic location within the North End (i.e., some areas may be considered nicer with more accessible local services).

### **Summary**

From the diversity of responses given in this chapter, it is evident that not every North Ender perceives or is affected by their shared environment in the same way. While some women are happy and content to live in the North End, others detest the neighbourhood and cannot wait to leave; some women really like the people living in the North End and the sense of community, others feel their neighbours are too nosy and lack

respect for themselves and their surroundings; some think that the air pollution is at its worst in the North End, others feel that it is the same throughout Hamilton; and, while some strongly agree with the negative reputation associated with the area, many others refuse to accept the stigmatization they believe has been imposed by outsiders who have no personal knowledge of the North End.

It appears from participants' responses that issues of personal agency - the capacity to choose and the ability to control situations around them - may play an important role in how residents react to their surroundings. Women who have the power to choose where they live appear to be more satisfied with the North End and more willing to overlook some of the less positive attributes than those who do not. Residents' perceptions of their neighbourhood may also reflect their socio-demographic positions, area-level expectations, and time spent within the neighbourhood.

Identifying the neighbourhood characteristics that both satisfy and fail to satisfy residents can help researchers successfully focus in on the primary assets and liabilities of a community. These characteristics may vary substantially from those identified by outsiders with no personal knowledge of the community. Since residents are most affected by the features of their surroundings, it only makes sense to consider their points of view.

The following chapter continues with the theme of considering lay perceptions, concentrating on the health conditions, health concerns and experiences of North End women.

**CHAPTER SIX:  
NORTH END WOMEN'S PERCEPTIONS OF THEIR HEALTH STATUS AND  
HEALTH PRIORITIES**

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Health researchers are slowly beginning to acknowledge that incorporating women's voices into women's health research has the potential to improve the effectiveness and direction of health programming and health policy (Walters 1991, 1992). In recognition of this, this chapter presents the diversity of health concerns and priorities at the personal, neighbourhood and national levels identified by women in this study. This section begins with a discussion of how North End women conceptualize the term 'health'. It carries on to document participants' self perceived health status and health problems and then compares their health experiences to that of Canadian women in general. The chapter continues on to explore the health of women living in the North End and the factors they believe influence their health. It ends with a discussion of local health priorities identified by North End women.

**Lay definitions of health**

One of the difficulties associated with this research centres on the problem of "what is health?". Over the years, the definition of health has undergone significant changes as international and national agencies and researchers have come to recognize that health is more than just the absence of disease. Probably the most frequently cited definition of health is that put forth by the World Health Organization (WHO 1948):

Health is a state of complete physical, mental and social well-being and not merely the absence of disease. The enjoyment of the highest attainable

standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economic or social condition.

Supporters of this definition applaud its comprehensive, holistic interpretation and for moving beyond the traditional biomedical explanation of health that focuses on negative aspects such as disease, disability, death, discomfort and dissatisfaction (Young 1998). Critics of the definition argue that it is utopian, too broad (carrying with it the danger of subsuming all human life and happiness under this label), and impossible to operationalize. As such, it has been "...honoured in repetition but rarely in application" (Evans and Stoddart 1994:28).

The apparent difficulty involved in creating a mutually agreeable definition of health highlights the obvious complexity inherent in fully understanding and appreciating human health. It has been suggested that because health is fundamentally subjective, the only truly acceptable measure is an individual's own assessment of his/her health. However, as Blaxter (1990) points out, in order to consider this personal judgment it is imperative that we understand what individuals mean by the term 'health'. Accordingly, study participants were asked to define or explain their idea(s) of health.

Most women who were interviewed defined health as being more than just the absence of disease and incorporating more than just physical health. In keeping with Blaxter's (1990) findings, most participants in this study believe that health is a multidimensional phenomenon:

*SS: I think of it as something more than just the absence of disease...it encompasses...more than just physical but also spiritual and psychological, mental.*

Building on this idea, several women felt that the various factors that comprised health were interrelated, part of a larger whole that involved an element of balance:

***LB:** I define it as well-being. The health of my mind and my body and my emotions. I guess because they're all connected...when one of them is off balance, they're all off balance.*

***CDB:** Well, health would mean...wow, that's a big question. I would say it means your overall, oh geez, like your mental, physical and spiritual health. I think it is all together. And I think that the basic thing for overall health would be to consider your body as a whole being, not to forget that everything is interrelated. Like whatever you put into your body is going to affect your body. Everything you breathe, it is all affected. You can't think of your body as a separate unit.*

Interestingly enough, although most women did discuss health in a holistic way, no one specifically mentioned social factors as a component of health, although this is an important consideration in the WHO definition.

It is important to point out, nevertheless, that some women focused on only one factor in their definition. For instance, some respondents defined health in totally physical and/or functional terms, compatible with the deeply entrenched western biomedical model:

***GSI:** I'd say physical health primarily. The degree to which one feels well or ill, I suppose.*

***CM:** I guess if you don't have many illnesses. Like I always figured I was very healthy, came from a long line of healthy people. Well pretty much you know, as long as you're feeling good and you don't have aches and pains...*

***SF:** State of preservation that your body is in. The ability to function.*

A couple of participants, however, defined health in purely environmental terms which appears to reflect the concerns that many North End residents have with pollution levels in the area:

*MB: At least you can breathe. Good health. And you don't get any rashes or anything like that if you're doing something, like working outside. That you don't feel sick to your stomach when you smell too much pollution.*

*PBI: Well, its about...I don't even know how to start. It's about people living in the environment and having to put up with the air and the pollution. Pollution most definitely down in this End. And you know, different things are in the air, like little bacterias and all this here stuff. So it's really...this End is really not a good End to live at. So, that's my definition of health.*

Overall, women had a broad conceptualization of health that went beyond the physical to include emotional and/or spiritual components. Their definitions revealed that most women are intensely aware that health is determined by a complex set of interrelated factors.

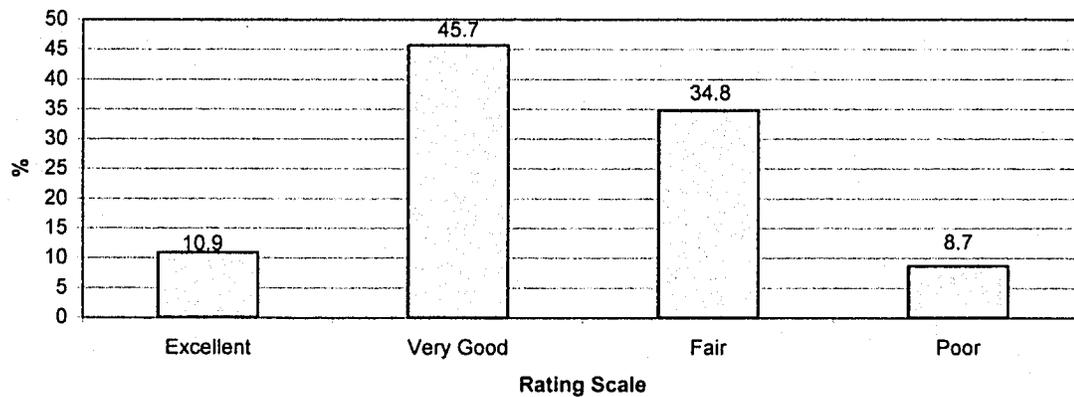
### **Self rated health status**

Self rated health is a common measurement used in population health studies (Heistaro et al 2001). Self perceived health status has proven to be an accurate and valid predictor of health risks and mortality (Yu et al 1997), and a non-biased assessment of both male and female health problems (Ross and Bird 1994). Ross and Bird (1994:162-163) also observe that self rated health is

*...highly correlated with more objective measures such as physicians' assessments, and with measures of morbidity and mortality, and it predicts mortality over and above measures of chronic and acute disease, physician assessment made by clinical exam, physical disability, and health behaviors like smoking.*

Self-rated health is typically considered an expression of physical and medical conditions/symptoms, although other determinants of health (i.e., lifestyle practices, socio-cultural constructs) may play a role (Bailis et al 2003). Consequently, one might expect to see an improvement or decline in self-rated health in response to increasing or decreasing levels of physical distress or functional limitations (Bailis et al 2003:204).

**Figure 6.1 Self rated health status of study participants (n=46)**



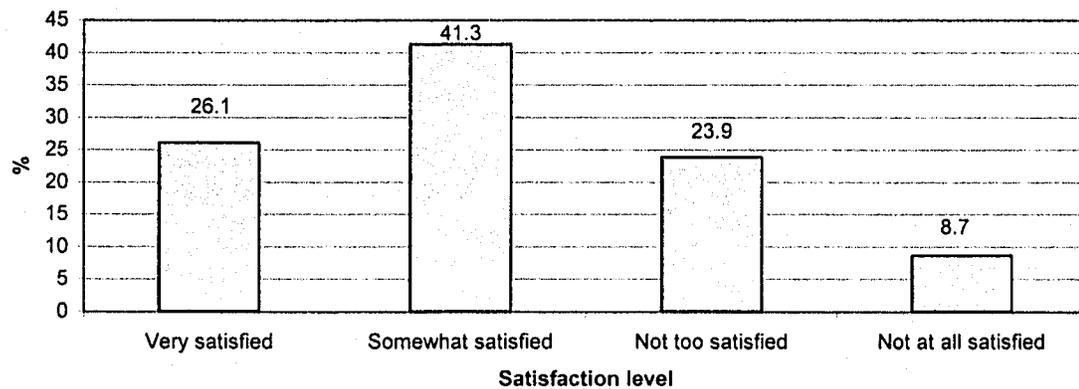
In this study, Figure 6.1 reveals that more than half of the women interviewed (56.6%) reported their health to be either excellent or very good<sup>18</sup>. When women were asked to compare their health to the health of women they know who are the same age, one-third stated that their own health is better, 45.6% said it is comparable to that of other women and one-fifth of participants felt that their own health is worse.

When asked to comment on how satisfied they are with their present level of health (Figure 6.2), more than two-thirds (67.4%) indicated they are very satisfied or somewhat satisfied with their health. As one might expect, there is a strong relationship between self-rated health and level of health satisfaction. Of those women who reported

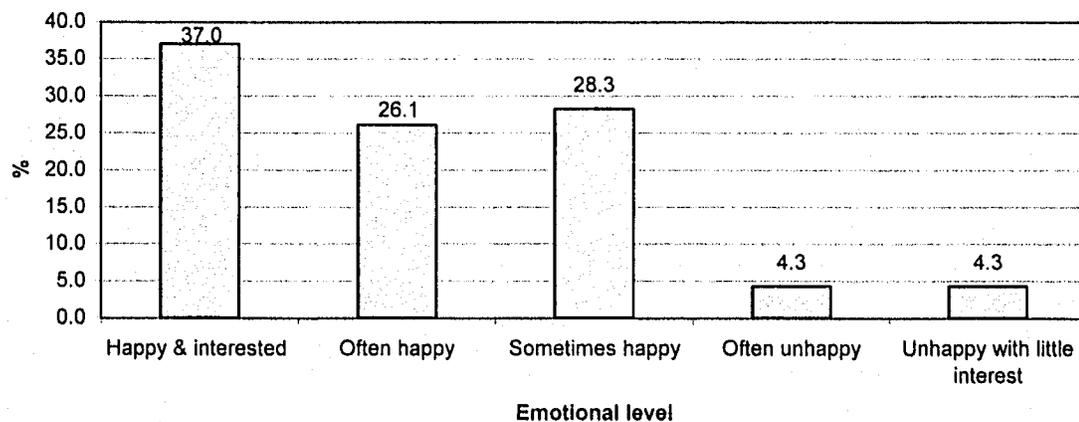
<sup>18</sup> Women were asked to rate their health on a four point scale: excellent, very good, fair or poor.

excellent or very good health, almost all (25/26) indicated that they were very or somewhat satisfied with their health. On the other hand, all the women who reported poor health (n=4) revealed that they were not too satisfied or not at all satisfied with their present level of health. Participants who reported fair health (n=16) showed significant variation in their satisfaction level with six women being somewhat satisfied and the remainder being unsatisfied with their present level of health.

**Figure 6.2: Study participants' level of satisfaction with present health (n=46)**

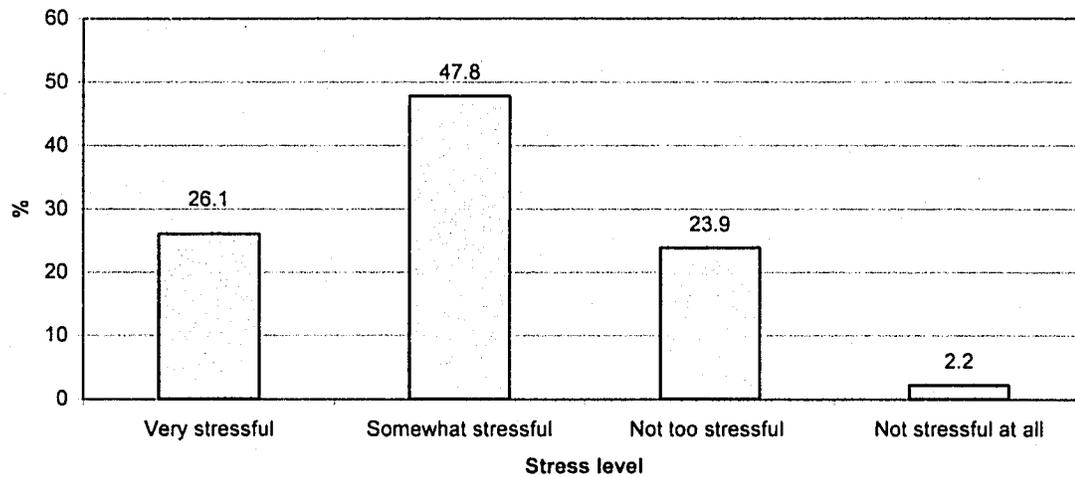


**Figure 6.3: Self rated mental health status of study participants (n=46)**



Given that self-rated health typically measures physical health, women were asked to comment on their mental health status (Figure 6.3). When asked to rate their level of happiness, almost two-thirds (63.1%) reported that they are happy and interested in life or often happy, while only 8.6% said that they are often unhappy or unhappy with little interest in life.

**Figure 6.4: Study participants' self perceived stress level (n=46)**



Because stress is known to affect both physical and mental health (Williams and Umberson 2000), women were asked to comment on their level of stress. Figure 6.4 reveals that more than one-quarter of all study participants (26.1%) indicated that their lives are very stressful while only one individual reported that her life is not at all stressful.

When interview participants were presented with a list of potentially stressful situations and asked to identify the ones that cause them stress (Table 6.1), the top five responses in decreasing order were: air pollution (66.7%), their own health (66.7%), money issues (63.9%), relationship with other family members (58.3%) and water

pollution (55.6%). When asked if other situations cause them stress, participants identified the following: loud music, going to school, children running around, pets dying, crime, life in general, people judging others, and people hurting their children.

**Table 6.1: Stressful situations perceived by study participants (n=36)\***

Situations	Stressful Situations					Totals
	Yes	%	No	%	Not Applicable	
Parenting	12	33.3	7	19.4	17	36
Child's health	13	36.1	6	16.7	17	36
Own health	24	66.7	12	33.3	-	36
Relationship with partner	10	27.8	15	41.7	11	36
Relationship with other family members	21	58.3	14	38.9	1	36
Job	8	22.2	12	33.3	16	36
Money	23	63.9	13	36.1	-	36
Personal safety	16	44.4	20	55.6	-	36
Air pollution	24	66.7	12	33.3	-	36
Water pollution	20	55.6	16	44.4	-	36

\* This question was added at a later date and, as such, only 36 women were asked this question.

When women were asked if they think there is a relationship between their health and their level of stress the majority of women (83%) perceived a link between the two. Participants identified a wide range of health problems brought on, or exacerbated, by stress: high blood pressure; lowered resistance and increased illness load; increased tiredness; poor sleep patterns; stomach pains; nausea; irritability; migraines; headaches; decreased general feelings of well-being; difficulty losing weight; and contribution to bad feelings you already have. Their responses are not surprising given that stress has been identified as a risk factor for a number of chronic, non-infectious diseases and disorders. While moderate amounts of stress can be benign or even beneficial, stress that persists for too long or becomes too severe, can produce negative feelings such as depression or

anxiety which in turn, result in hormonal changes that challenge the immune system and increase an individual's susceptibility to disease (Williams and Umberson 2000:560).

### **Personal health problems**

Traditionally, women's health has been conceptualized through the biomedical perspective, a framework that has tended to view women exclusively in terms of reproduction, ignoring other aspects of a woman's body, including her mental and social welfare. This fragmentary approach has led women's health to be narrowly defined, resulting in a limited range of inquiry and a restricted range of acceptable explanations (Dan 1994). Kielmann (2002:170) argues that because longstanding national and international women's health policies have been driven by women's health definitions that are intimately tied to issues of reproduction, attention has been drawn away from women's personal experiences of health and illness.

Such a limited perspective on health must be dismissed for omitting "...less specific dimensions of health that many people would judge to be important to their own evaluation of their own circumstances" (Evans and Stoddart 1994:29). Fortunately, the concept of women's health has broadened in recent times (Larosa 1994), allowing more sophisticated definitions to emerge:

Women's health involves women's emotional, social, cultural, spiritual and physical well-being, and is determined by the social, political and economic context of women's lives as well as by biology. This broad definition recognizes the validity of women's life experiences and women's own beliefs about and experiences of health. Every woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by that woman herself, to her full potential (Phillips 1995:507-8).

Analysis of the most important personal health problems reported (without prompting) by women in this study revealed a wide variety of health concerns that varied in scope and level of severity. A number of women identified more than one significant health problem. Table 6.2 reveals that the five most commonly reported health problems were smoking (10.1%), being overweight (10.1%), asthma (7.6%), 'bad back' (6.3%), and thyroid problems (5.1%). When related responses were grouped together, joint/back troubles and respiratory problems accounted for the greatest proportion of personal health concerns, 16.5% and 11.4% respectively. These responses represent individuals' interpretations of their own health conditions and may not coincide with diagnoses made by a doctor; individuals may misconstrue, misrepresent or be unaware of their true medical conditions (Blaxter 1990). Kielmann (2002:163) comments that there has been a tendency to reject perceived morbidity as a measure because unlike physician identified illness, which is considered to be objective and 'real', individual identified morbidity is considered to be subjective, less tangible and less 'real'. Irrespective of this, we must remember that "...individuals have information about their symptoms and their feeling states which only they can give" (Blaxter 1990:37).

**Table 6.2: Main health problems reported by North End women (n=46)\***

Health Concern Mentioned	Number of Responses	Percentage of Total Responses
<b>Physical Health Problems (chronic/acute)</b>	<b>44</b>	<b>55.7</b>
Joint/Back Problems		
Bad back	5	
Bad knees	3	
Arthritis	1	
Carpel tunnel syndrome	1	
Adhesive capsulitis	1	
Bad ankles	1	
Bad neck	1	
Respiratory Problems		
Asthma	6	
Bronchitis	3	
Thyroid problems	4	
Allergies	3	
High blood pressure	2	
Heart disease	1	
Diabetes	1	
Epilepsy	1	
Stomach ulcer	1	
Lupus	1	
Fibromyalgia	1	
Colitis	1	
Sight impaired	1	
Hearing impaired	1	
Narcolepsy	1	
Low iron levels	1	
Migraines	1	
Medication side effects	1	
<b>Health Risks</b>	<b>23</b>	<b>29.1</b>
Smoking	8	
Overweight	8	
Lack of exercise	2	
Diet/nutrition	2	
Pollution	1	
Exposure to germs	1	
Exposure to environmental allergens	1	
<b>Mental Health/Psychological Problems</b>	<b>11</b>	<b>13.9</b>
Depression	3	
Anxiety	2	
Tiredness	2	
Delusions	1	
Seasonal Affective Disorder	1	
Stress	1	
Mental health	1	
<b>Reproductive Concerns</b>	<b>1</b>	<b>1.3</b>
Menopause	1	
<b>Total</b>	<b>79</b>	<b>100</b>

\*Many women identified more than one important health problem.

Grouping responses revealed that most women identify physical health problems as their primary health concerns (55.7% of total responses). This stands in sharp contrast to the holistic WHO definition, the newly created women's health definitions and their own broad definitions of health, expressing instead a more physically-oriented medical model. In other words, although most women in this study define and accept the concept of health as incorporating numerous components, when asked about their own personal health conditions, they tended to focus primarily on the physical aspect. This may reflect the fact that

The concepts and logic of these [health and illness] ideas are not those of science or medicine, although they may be borrowed, accurately or inaccurately, from those formal systems of knowledge. Rather, they are concepts and logic of ordinary people whose experience, socialization, cultural background, and immediate social network shape and continually develop their notions of health (Freund and McGuire 1999:143).

It is interesting to note that only one woman mentioned reproductive problems (menopause) as her primary health concern. This is particularly significant given that most participants fall into the reproductive age range (18-49 years). While this omission may reflect an unwillingness to discuss very personal reproductive issues, it may also be viewed as support for the argument that reproductive problems, which have traditionally been emphasized, should not be considered the primary focus of women's health research in the future.

In order to get a sense of whether or not there were other health troubles that were of concern to my study group, participants were read a list of health problems and asked to identify which problems they were personally worried about and which problems they had actually experienced. Table 6.3 reveals that being overweight was the most

frequently mentioned concern (74.3%) followed by breast cancer (71.4%), depression (65.7%), respiratory illness (64.7%) and heart disease (62.9%). When women were asked to comment on why they worried about certain health problems their primary reasons were: (1) having personally experienced the problem (e.g., overweight); (2) it runs in the family (e.g., cancer, heart disease, diabetes, osteoporosis); (3) having seen friends and/or family members suffer the ravages of these illnesses (e.g., cancer); (4) media advertisements (e.g., breast cancer, depression); (5) smoking (e.g., lung cancer); (6) poor diet (e.g., osteoporosis, diabetes); and (7) because of the environment (poor air quality, Plastimet fire) we live in (e.g., lung cancer, respiratory illness). The three health problems that women were least concerned about were being underweight (0%), having a miscarriage (8.6%), and pregnancy problems (14.3%). Given that being overweight was the most frequently identified health concern and being underweight the least identified, it is clear that women are dissatisfied with their body image (a finding supported by Walters 1992) and strongly affected by societal pressures to be thin. Their responses also appear to reflect once again the lack of concern women have with the reproductive aspects of their lives or their non-medicalization of reproductive events.

Table 6.3 shows that women have experienced health problems such as being overweight (77.1%), respiratory illness (58.8%), migraines (54.3%), depression (51.4%), and allergies (40%). These responses reconfirm many of the health problems women identified at the personal level (without prompting) (e.g. overweight, asthma, depression, allergies). Moreover, the health problems that women identified as actually having experienced are similar to those they worry about. For instance, being overweight and

suffering from respiratory illnesses, migraines, depression and allergies are all health problems that women have personally experienced and continue to worry about. These findings seem to indicate that women's personal experiences are an important component to their assessment of what constitutes a genuine health concern.

Participants were asked if they felt that their present level of health could be enhanced and, if so, how. Most women felt that they could do something to improve their current level of health. For a large number of participants this involved lifestyle changes such as improving their diet, losing weight, increasing their level of exercise and/or quitting their smoking habit. These lifestyle factors, referred to as "the language of health promotion", were also reported extensively by young women in Charles and Walters' (1998:338) study of the effects of age and gender on women's accounts of their health in South Wales. Other participants in my study felt their health could be enhanced in more biomedical/physical ways by continuing with their physiotherapy sessions, by going to the doctor and, by continuing to take their medication(s). Another group felt their health could be improved by focusing more on emotional/mental aspects of their lives such as decreasing stress and improving self worth. A small cluster of women, however, did not believe that their health could be improved. A couple of these women were in their 70s and I believe had resigned themselves to the fact that they were growing older and experiencing the natural and uncontrollable processes of ageing. The rest of this group reported no real problems with their overall health and, as such, thought there was nothing to improve upon.

**Table 6.3: Self identified health concerns and experiences (n=35)**

Health Problem	Concerned About Occurring		Actually Experienced	
	Yes	(%)	Yes	(%)
Overweight	26	74.3	27	77.1
Breast cancer	25	71.4	2	5.7
Depression	23	65.7	18	51.4
Respiratory illness	22	64.7	2	58.8
Heart disease	22	62.9	4	11.4
Arthritis	21	60.0	12	34.3
Lung cancer	19	54.3	0	0
Migraines	17	48.6	19	54.3
Cervical cancer	17	48.6	2	5.7
Osteoporosis	16	45.7	1	2.9
Diabetes	15	42.9	3	8.6
Allergies	15	42.9	14	40.0
HIV/AIDS	7	20.0	0	0
STDs	6	17.1	3	8.6
Pregnancy Problems	5	14.3	5	14.3
Miscarriage	3	8.6	6	17.1
Underweight	0	0	6	17.1

**Women’s perceptions of health problems experienced in general**

When asked to identify what they thought were the most important health problems experienced by women in general (i.e., at the national level), once again, the majority of participants mentioned physical problems (47.6%). However, their responses to this question highlighted quite a different set of problems compared to those identified as their personal health problems (Table 6.4).

**Table 6.4: Participants' perceptions of the most important health problems experienced by women in general/Canada (n=35)\***

Health Concern Mentioned	Number of Responses	Percentage of Total Responses
<b>Physical Health Problems</b>	<b>39</b>	<b>47.6</b>
Cancer		
Cancer (in general)	8	
Breast	14	
Uterine	3	
Lung	2	
Cervical	1	
Osteoporosis	4	
Heart disease	4	
Arthritis	1	
Diabetes	1	
Scoliosis	1	
<b>Mental Health Problems</b>	<b>17</b>	<b>20.7</b>
Stress	10	
Depression	4	
Mental health (in general)	2	
Self esteem	1	
<b>Health Risks</b>	<b>14</b>	<b>18.3</b>
Overweight	4	
Diet/Nutrition	3	
Food safety	2	
Pollution	2	
Lack of exercise	1	
Dependence on medications	1	
Lack of health coverage	1	
<b>Social Problems</b>	<b>8</b>	<b>8.5</b>
Indifference to own health	3	
Lack of money/poverty	3	
Family life	1	
Male doctor bias	1	
<b>Reproductive Concerns</b>	<b>4</b>	<b>4.9</b>
Menopause	2	
PMS	1	
Birth control issues	1	
<b>Totals</b>	<b>82</b>	<b>100</b>

\*Many women identified more than one important health problem.

Table 6.4 reveals that cancer, which was not identified as a personal health problem by any of the respondents (although one woman identified herself as a cancer survivor), was considered to be the most important health concern for women in general, accounting for 34.2% of all responses. Breast cancer was considered the most important type of cancer accounting for half of all cancer responses:

*EK: Breast cancer I think is very important. Every woman can get it. It's been tackled a lot.*

*EDB: In general, just from what you hear from the media there seems to be an increase in breast cancer, uterine problems. We're concerned about what we're eating and what's in the food that we're eating and cancerous causing agents...*

After cancer, stress was the most frequently identified health problem, accounting for 12.2% of all responses:

*PTW: Stress. There never seems to be enough time – get caught up in the merry-go-round. Two people have to work in order to have things. Our busy lifestyle – you can only spread yourself so thin. I'm trying to lead a stress-free life.*

Some respondents felt that the increase in stress was due to the fact that women were too busy working and taking care of their families (being “super-moms”) to take time out to look after themselves:

*RC: And I think that our lives have become a lot more stress filled for women you know. Now they are expected to work, and keep the house and get the kids to school and...And then you know, the kids are doing so many more activities you're just going around like a whirlwind all the time. It's not a very relaxing culture I don't think anymore. There's more pressure on you to be super-mom, super-everything.*

*JA: Taking the time and being self aware. Women have a tendency to put significant others and children ahead of themselves. It's just the way it goes. You have to look after other people. So because of that lack of self awareness or lack of time or lack of feeling that you have the time to focus*

*on yourself can set women up...by the time they do get around to realizing there's something wrong, it's probably gotten to the point where it's serious...*

In addition to various types of cancers and stress, health problems such as depression, being overweight, osteoporosis, and heart disease were identified most often by women in this study (each accounting for 4.9% of all responses). Consistent with Redman's findings, most of the main health problems identified for women in general represent health education campaigns publicized in the mass media (Redman et al 1988) (i.e., breast cancer and heart disease), as well as television commercials advertising pharmaceutical products (i.e., osteoporosis, overweight, stress and depression). Redman and colleagues (1988:127) point out that these campaigns (and pharmaceutical advertisements) may create an artificial view of the "health needs of women". This is problematic. If 'ordinary' women do not perceive a relationship between their own health problems and those of women in general, this calls into question the usefulness and effectiveness of women's health promotion campaigns targeted at the national level. It also calls attention to the possibility that women have a number of health needs that are not being met by our current system of health care.

In the case of the study participants, although most of the advertised health concerns (with the exception of weight and depression) do not match personally identified health problems reported by women in this study, they do correspond closely with the health problems that women are worried about developing. As noted earlier, while their worries are based in part on media messages and personal experiences, they

are also rooted in the experiences of family and friends, and lifestyle and environmental risks.

### **North End women's health problems**

When asked to specify the most important health concerns facing women who live in the North End, the majority of responses provided by participants fell into the health risks category (63.9%) (Figure 6.5). Women expressed much greater concern about place-based/environmental risks than about lifestyle risks. It is quite obvious that residents perceive the North End's industrial setting as affecting community health:

*CDB: Oh definitely environment depending where you live. You know, I do believe that the more industrialized areas are obviously at more risk for developing diseases to the body.*

A considerable number of women (41.7%) felt that respiratory conditions related to air pollution were the most important health problems facing women living in the North End:

*RC: ...I think there must be more breathing problems around here because every time you look down the street you can see a haze of pollution around. There seems to be a lot of dust around here. There seems to be a lot of construction all the time on these streets. And noise! It can be pretty noisy some of the time... You can hear the factory whistles and a lot of big trucks around here going up and down. Well, I still wonder about that Plastimet<sup>19</sup> fire. What effect that had.*

*SF: In this area I think I would be worried about getting some type of lung thing happening. You know I wasn't born in the North End or anything so it's not like I've been here for thirty-five years and I know of a lot of*

---

<sup>19</sup> On July 9, 1997 a fire broke out at a plastics recycling plant, Plastimet Inc., located in the North End of Hamilton in an industrial site adjacent to a heavily populated residential area. The industrial site was filled with off-quality auto parts, consisting mostly of polyvinyl chloride plastic and polyurethane foam (Upshur, 1997). The fire burned for four days releasing dioxin and other toxic chemicals into the air and water. Nearby residents were temporarily evacuated (on the second day) from their homes and told not to eat the produce from their gardens which was by then, covered with a black soot.

*people who have. Some of them are kind of scratchy, gravelly and they hack and stuff but some of them smoke so it's hard to say.*

One participant felt that air pollution made her family sick when they first moved into the area:

*MC: The pollution. It's disgusting. It's affecting everybody. Just the smog. It's in Hamilton partly. I lived in Winnipeg all my life and I moved out here and...I was really sick when I first moved here. For about a couple of weeks I was really sick. I think it was due to the pollution. I lived in clean air and then I come here and it was like...you can't see nothing and...it smells...like so gross. All my kids were sick too when we moved here.*

In addition, a couple of women felt that the onset of reproductive problems were intimately linked to the area's perceived poor air and water quality. For example:

*AG: I would have to say environmental. It's the exposures, the daily exposures. I think respiratory and I think the reproductive thing which was a shocker for me. But you get talking and you discover you know...when I had my miscarriages they weren't eight weeks, they were sixteen weeks which was quite traumatic and then you're finding out that this is not that uncommon...*

These women's perceptions reflect worries about local pollution levels as well as its ensuing impact on the community's health. Their worries certainly have merit in view of the increasingly acknowledged association between air pollution and human health (Elliott et al 1999).

**Table 6.5: Participants' perceptions of the most important health problems for women living in the North End (n=26)\***

Health Concern Mentioned	Number of Responses	Percentage of Total Responses
<b>Health Risks</b>	<b>23</b>	<b>63.9</b>
Air pollution/respiratory problems	15	
Diet/nutrition	4	
Smoking	1	
Water pollution	1	
Area stigma	2	
<b>Social Problems</b>	<b>6</b>	<b>16.7</b>
Lack of money/poverty	3	
Lack of education	2	
Lack of support	1	
<b>Physical Health Problems</b>	<b>3</b>	<b>8.3</b>
Cancer	1	
Arthritis	1	
Dental	1	
<b>Mental Health Problems</b>	<b>2</b>	<b>5.6</b>
Depression	1	
Stress	1	
<b>Reproductive Concerns</b>	<b>2</b>	<b>5.6</b>
Reproductive problems	2	
<b>Total</b>	<b>36</b>	<b>100.1</b>

\*Many women identified more than one important health problem.

While the quality of the physical environment is of grave concern for women in this study, the North End neighbourhood also contains emotional and socio-economic risks that can influence overall well-being. As Fitzpatrick and LaGory (2000:14) state: "Individual choices and actions take place in space, which in turn shape and structure those choices and actions". Although the North End is extremely diverse, the area is characterized by a higher proportion of less well educated, unemployed and low income individuals than the City of Hamilton as a whole (Statistics Canada 1999). Not surprisingly then, participants in this study identified social concerns such as lack of money, education and support as significant problems for women living in this area

(16.7% of all responses). Two women discussed how important money and education are to getting on in life:

*GS2: Well usually, the North End is mostly people on the system. And if you don't have enough money or a support group it's hard to do anything.*

*JDS: Lack of education. Lack of finances. Lack of education. Because of the lack of it, it prevents them from finding the right programs that would enable them.*

Still another described the constraints and marginalization imposed by poverty:

*HS: There's more poverty. I mean, you know, if you're poor that goes a long way. It's not just that you're poor but you know, you can't participate in other things like other people do. You can't belong to the same function groups that other people do. Like I know a friend of mine, like so many times, like the odd time even, if we have simple things like with our church, I mean even a church function usually you know you still have to spend some, even if it's a little minor money. There's so many times that I just treat her because she always says she's broke and she feels like, you know how it feels when you really don't have even though it doesn't cost an awful lot. If you don't have even that little bit whatever it is, even to buy that coffee, to be like the other people, like it just keeps you away.*

The lack of financial resources and educational background is perceived as seriously limiting the life choices and subsequently, life chances of North End women.

#### **North End health program priorities**

There is an increasing realization that community members themselves can provide a "unique" perspective on health care needs. Redman et al (1988) note that the opinions of women are not well represented or understood by either the medical community or health researchers. To gain a sense of the health benefits and burdens associated with the North End, participants were asked to identify the health issues they felt a newly created women's health program should focus on so that it would be beneficial to women living in their neighbourhood. The majority of program ideas put

forth centred around issues of improving personal appearance, self worth, skill levels and social contacts (Table 6.6). The top five ideas mentioned were: programs concentrating on food and diet (14.3%), increasing social contact for women (11.7%), creating exercise programs (that were free or did not cost a lot of money) (7.8%), increasing educational levels (5.2%) and improving parenting skills (5.2%).

Although a number of women felt that the program should provide information on physical health (e.g., cancer information, illness signs and symptoms) very few women were advocating a traditional health care program. Overall, they visualized the health program as a resource centre, a place that would facilitate the sharing of ideas and information and provide them with both a social support network and the opportunity to socialize more freely with other women in the neighbourhood:

*BE: I think there should be a women's group and that would benefit in all three ways - mental, physically, emotional...A sharing circle. Meet once a week to discuss whatever's on their mind that you can't feel comfortable with even discussing with your spouse.*

*LB: I'd like to get like a facility for swimming, exercise with treadmills as well as dealing with women's everyday problems, and men's for that matter, because men have problems too. Health issues, mental issues, social issues, you know, talking things out, allowing women to get out their fears and all that into the open so that they don't feel so alone. You know, allowing people to grow and get healthier because it makes it really hard on people when the government is always saying get healthier, do this, do that...well it's really easy to say but trying to do it is a different matter altogether.*

*CM: I would say ... a drop in centre or baby sitting service to let them out. Something to let them relax a little bit. That helps a lot when you're stressed. Of course not everybody's like me but, I find crafts and just social gatherings, talking to people. I used to belong to a lady's auxiliary too but everybody's gone now. If they have somewhere where people could say have a cup of coffee, meet other people, maybe play a game of cards or even just sit and have somebody mind their kids for a couple of hours*

*give them a breathing spell. Cause nothing gets you down or uptight more than little kids.*

Even though participants had not focused on social support when they defined health, it is clear that they place a great deal of importance on the relationship between good health and the opportunity for North End women to interact with other community members.

Some women envisaged the health program as an instrument of change, one that would act to unite neighbourhood women and ultimately empower them through the creation of a collective voice.

*ED: I think that empowering women is a really big issue. Giving them something small to do that they can have control...*

*AG: I don't know if it's...I'd have to say again, to give a collective voice to women...I mean again, you're looking at such diverse issues because of economic problems and the fact that women...you know you have recent immigrants...you have women who don't speak English as a first language. But for someone to listen to that concern...listen to these women's concerns and to act as a...I guess, a common voice for them. To help them be empowered to take care of themselves.*

The responses given by participants suggest that women believe that factors such as economics, ethnic/language differences and the presence of children, acting alone or in concert, isolate women from the community at large and from each other. While some women in this study have overcome this segregation by forming women's groups (e.g., the women's group that participated in the focus group discussion), most have not.

**Table 6.6: Women's perceptions of North End health program priority areas (n=45)\***

<b>Issues Mentioned</b>	<b>Number of Responses</b>	<b>Percentage of Total Responses</b>
<b>Diet and Nutrition</b>	<b>19</b>	<b>24.4</b>
Food/diet	11	
Exercise program	6	
Weight control	1	
Breakfast program for low income parents with preschoolers	1	
<b>Women's Needs</b>	<b>18</b>	<b>23.1</b>
Increase social contact	9	
Increase community involvement	3	
Encourage the development of collective empowerment/voice	2	
Separation/divorce help	1	
Learn how to take care of one's self	1	
Abuse information	1	
Free birth control	1	
<b>Physical Health</b>	<b>16</b>	<b>20.5</b>
Cancer information	3	
Smoking cessation	2	
Illness signs and symptoms	2	
STDs/AIDS information	2	
Heart disease information	2	
Promoting natural medications	1	
Dental health	1	
Disability information	1	
Free clinic	1	
Promote healthy lifestyle	1	
<b>Personal Progress/Improvement</b>	<b>8</b>	<b>10.3</b>
Increase education level	4	
Money management	2	
Job training	1	
Book club	1	
<b>Mental Health</b>	<b>7</b>	<b>9.0</b>
Stress	3	
Mental health (in general)	3	
Self esteem	1	
<b>Parenting</b>	<b>5</b>	<b>6.4</b>
Improve parenting skills	4	
Daycare facility	1	
<b>Other</b>	<b>5</b>	<b>6.4</b>
Improve local environment	2	
Resource centre	1	
Help with landlord	1	
Work to eradicate are stigma	1	
<b>Total</b>	<b>78</b>	<b>100.1</b>

\*Many women identified more than one potential health program idea.

With the exception of diet/weight/exercise responses, the health program priorities raised by the women in this study show a fairly low level of agreement with the health problems they identified at the personal, general and neighbourhood level. The personal and general women's health problems they identified were very strongly centred on physical health issues, whereas the neighbourhood problems they described were focused on environmental issues; the health program priorities highlighted here collectively capture the physical, social, economic and mental aspects of health. Close examination of the health priorities identified by participants reveals that many of the initiatives they feel would positively influence North End women's health typically fall outside of conventionally accepted health interventions. Their ideas for health improvement instead target less traditional determinants of health (e.g. improved self esteem, increased social contact, increased education levels) that are difficult to evaluate and to address. Evans and Stoddart (1994:31) contend that "...it is not at all obvious how one should even think about the causal connections between "stress" or "low self esteem," and illness or death – much less what would be the appropriate policy responses".

The extent of the discrepancy between neighbourhood health problems and health program priorities is striking. One might have expected more women to identify environmental improvement as the centerpiece for a newly created program, given the concerns they expressed about air pollution and respiratory-related problems. Yet, only a couple of women mentioned improving the environment as a health priority area and only a few reported taking any action to help decrease pollution levels (e.g., involvement in

environmental associations). While surprising, these results are consistent with those of Elliott and colleagues who found that “despite high levels of concern and health concern reported by the respondent group [in the North End], very few respondents reported having taken any civic action regarding their concerns [about air pollution]” (Elliott et al 1999:631).

This lack of commitment to improving the environment appears to reflect an assumed lack of control or powerlessness over the primary industrial polluters. When asked whether or not they felt they had control over their own health, quite a few participants replied with a rather ambivalent “yes and no”. While they felt they could control what they were eating and how much they were exercising, many felt that they had no control over their surroundings:

*JM2: Somewhat. Well, I can't control my environment, things like pollutants in the air. But I can control it in terms of like exercising, eating health and being good in mind and stuff.*

*LB: But, the health and all that, there's nothing I can really do about the air pollution and all that. I understand that the industries, they have to make money and do their thing...*

Many women assume that they won't be able to do anything to stop the pollution because the industries are just too influential, have too much money and too much government support. However, one participant who *is* a strong environmental advocate and who *was* deeply involved in discussions pertaining to the Plastimet fire situation, spoke first hand about how the fire and its potential health effects propelled North Enders to overcome their fears and rally together for the well-being of the community:

*AG: The Plastimet fire was one issue where people did stand up in huge numbers and say “no”... I found it especially heartbreaking that you*

*would see people who would come out to these meetings you know initially and this was when it was fairly volatile and they don't speak English as a first language and you could tell that some of them are obviously so uncomfortable getting up in front of a crowd but it was such an important thing to them that they would force themselves to get up and...people were very frightened and people were very upset, people were crying and I mean to put themselves through that because yes they did care and I think it was an empowering sort of situation where it was like the domino effect. One person gets up, then another person gets up, then everybody realizes that we do have a voice.*

In fact, it seems that when a group of supposedly powerless, North End people get together to voice their opinions, they can exact local change:

“Following the fire [Plastimet fire], a number of health and environmental concerns emerged which led the residents to organize themselves and collectively pressure government to arrange for a full public inquiry into the various aspects related to the Plastimet site and to make physical improvements in the neighbourhood” (Kikulwe 1998:1).

Although most women feel they have very little ability to change policies affecting local air pollution, it does appear that positive outcomes can emerge when individuals rally together.

### **Summary**

This chapter has presented the health problems and priorities at the individual, national, and neighbourhood level as identified by a group of women living in the North End of Hamilton, Ontario. Although there is growing interest in acknowledging women's perspectives in health research, few studies have actually gone so far as to incorporate 'ordinary' women's voices. Consequently, we still know very little about women's own health priorities (Walters 1991). The results of this study highlight the fact that not only are women cognizant of the diverse and complex health issues affecting the female population, both locally and nationally, but they also recognize that women do not

represent a single homogeneous group of individuals all experiencing the same health problems and requiring the same type of health care. Moreover, their responses lend further credence to the notion that women's health is about much more than reproduction and motherhood.

In this study, women's main health concerns show very little similarity between the three levels of analysis (Table 6.7). At the personal level, the most important health problems mentioned were smoking and being overweight, two problems typically considered to reflect lifestyle choices. However, when responses were categorized<sup>20</sup>, it was revealed that most women identified physical health problems (e.g., joint/back problems, respiratory problems) as their primary health concerns followed by health risks such as those noted above (smoking and weight). The focus on physical health problems stands in sharp contrast to most participants' conceptualizations of health as broad and multidimensional. None of the women identified social problems and only one woman mentioned reproductive problems as major health concerns.

**Table 6.7: Summary of the main health concerns identified by women at the three levels of analysis**

<b>Personal</b>	<b>General/national</b>	<b>Neighbourhood</b>
Smoking	Breast cancer	Air pollution/ respiratory disorders
Overweight	Cancer	Diet/nutrition
Asthma	Stress	Lack of money/poverty
Bad back	Osteoporosis	Lack of education
Thyroid problems	Heart disease	Reproductive problems
	Depression	Area stigma

<sup>20</sup> In order to facilitate comparison responses were grouped into categories such as physical health problems, mental health problems, health risks, social problems, and reproductive concerns.

When speaking about Canadian women in general, cancer and more specifically breast cancer, were by far the most frequently identified health problems, followed by stress associated with daily living. Once again, when problems were categorized, physical health concerns (e.g., cancer, osteoporosis and heart disease) were identified most often but, they were followed by mental health problems and health risks. Social and reproductive problems were mentioned at this level.

The identification of cancer and heart disease as national level health concerns reflects the success that health agency media campaigns have had in informing women about the leading causes of female mortality. However, it does not appear that these health campaigns have been equally successful in educating women about the risk factors associated with these diseases. Smoking and being overweight, which were identified as the leading personal health concerns, are two very important risk factors associated with both cancer and heart disease.

Having said this, however, it is important to point out that when asked to comment on why they were worried about developing certain ailments, some women identified their smoking habit and their poor diet as risk factors for the development of lung cancer, diabetes and osteoporosis. Moreover, many women recognized that they could improve their present level of health by improving their diet, losing weight, increasing their exercise level and by quitting their smoking habit. Thus, it appears that these women are well aware of the health risks but that they choose to (or have little choice but to) engage in risky behaviours nonetheless. Possible reasons for, or barriers to, their decisions may be that: (1) they don't have the money or the know how to eat a

healthy diet; (2) they don't have the money or the facilities to take part in organized exercise; (3) they don't have the support, the will power or the money to purchase pharmaceutical aids that will help them quit smoking; (4) their fears of crime and air pollution limit participation in outdoor exercise; (5) the negative consequences of their actions are too far in the future; (6) compared to other problems in their lives, addressing these concerns is a low priority; and/or (7) they just don't care. The disparity between what women know about their health and how they choose to act reinforces the need for health researchers to explore in more depth the relationship between women's health knowledge, perceptions and day-to-day behaviours.

Respiratory ailments resulting from local air pollution were overwhelmingly identified as the primary health concern for North End women. At the level of the neighbourhood, when responses were grouped, environmental and lifestyle health risks (e.g., air pollution, diet/nutrition) were identified as the most important health problems followed by social problems (e.g., poverty, lack of education). Participants' focus on place-based health risks highlights the importance of considering the lived environment in program and policy development since it is perceived, and has been shown, to be a significant determinant of health outcomes (refer to Macintyre et al. 1993). Physical and mental health problems were not considered as important to women's overall well-being at this level.

Although the physical environment and its respiratory ramifications were considered the dominant health problem for North End women, participants identified diet and nutrition, exercise, and increased social networks as the most important health

program priorities to be addressed by a newly created North End women's health program. The study participants' lack of commitment to improving the North End environment appears to reflect their belief that they have no control or power over the principal industrial polluters. However, it was shown that local residents do have the power to exact local change if they rally together. Consequently, funding and promoting health programs, such as the ones identified by North End women, that facilitate the sharing of ideas and information, that promote increased self esteem, and that provide women with the opportunity to socialize with other community members, will help to unite and empower women.

The fact that 'ordinary' women identified a wide range of health concerns at the three levels of analysis (individual, national and neighbourhood) and that these concerns lack congruence, should not be considered a reason to devalue the health opinions of women. Rather, these viewpoints should be celebrated for illustrating that women's health problems and priorities are deeply embedded in their daily environment. They reflect personal experiences, the experiences of family and friends, media messages and the characteristics of the physical and social environment in which they live. Women's opinions offer some direction to health programming, funding and policy decisions that may not have occurred without their voices being heard (e.g., resource centre to promote self esteem and social interaction). In light of this, it is important to involve women in the identification and prioritization of women's health concerns.

The following chapter builds on this idea by exploring North End women's beliefs about the relationships between their health and their place of residence.

## **CHAPTER SEVEN: WOMEN'S HEALTH AND PLACE**

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The preceding two chapters explored women's perceptions of their environment and of their health and drew attention to the interrelatedness of place and health as perceived by participants themselves. Both chapters reveal that women who live in the North End identify very different health concerns and experience their neighbourhood in very different ways. This chapter considers the relationship between place and health as it is understood by the women in this study. It also presents the environmental factors that these participants believe promote and/or damage their health. To better understand the personal circumstances that contribute to diversity in women's perceptions about the neighbourhood, the life stories of six women residing in the North End are highlighted. The chapter ends with an overall discussion of the complex interaction between the participants, their health, and the North End environment.

### **Health and place**

Ask any real estate appraiser about the most important aspects of real estate sales and s/he will say "location, location, location". A vital component of buying and selling a house, location or place, is also the stage upon which life-influencing and life-altering experiences are constructed and played out. Place is

...a product of risks and opportunities, the nature of the social organization attached to the locale, its political, social, and economic relationships with other places, the psychosocial characteristics of the individuals occupying the space, and the local cultural milieu (Fitzpatrick and LaGory 2000:17).

Consequently, place plays a role in shaping our behaviour, attitudes, values and opportunities (Brooks-Gunn et al., 1993) and ultimately, it plays a pivotal role in our identity (Fitzpatrick & LaGory, 2000). In fact, place has such significant social meaning that people tend to define who they are based on where they reside (Crang, 1998). As Krase (1979:255) notes, "Our home is part of our identity. It attests to, or belies, our claims of particular social status and prestige". Individuals who reside in affluent communities may be positively labeled as educated, employed (in high-paying jobs), wealthy and powerful members of society. On the other hand, people who live in less-privileged neighbourhoods may be stereotyped as uneducated, unemployed, poor, and powerless (Weinroth et al., 1996). Our self image and the image of our community are interrelated. Our identity is tied to our place of residence and thus, we can be celebrated or discredited for our address (Krase, 1979).

Since people often evaluate themselves based on the perceived value of their communities (Krase, 1979), it is not hard to imagine that their perception of community quality carries with it the potential to contribute to better or worse overall health. As Fitzpatrick and LaGory (2000:12) note,

We are who we are, and we experience what we do on a daily basis in part because of where we find ourselves. Our physical and mental health is a product of not only how we live, but also where we live.

The place in which an individual resides is therefore an important determinant of health, acting to positively and/or negatively influence total well-being. Certain places expose residents to specific physical, social and psychological risks such as pollution, chemical contamination, loud noises, and crime while others may expose residents to positive

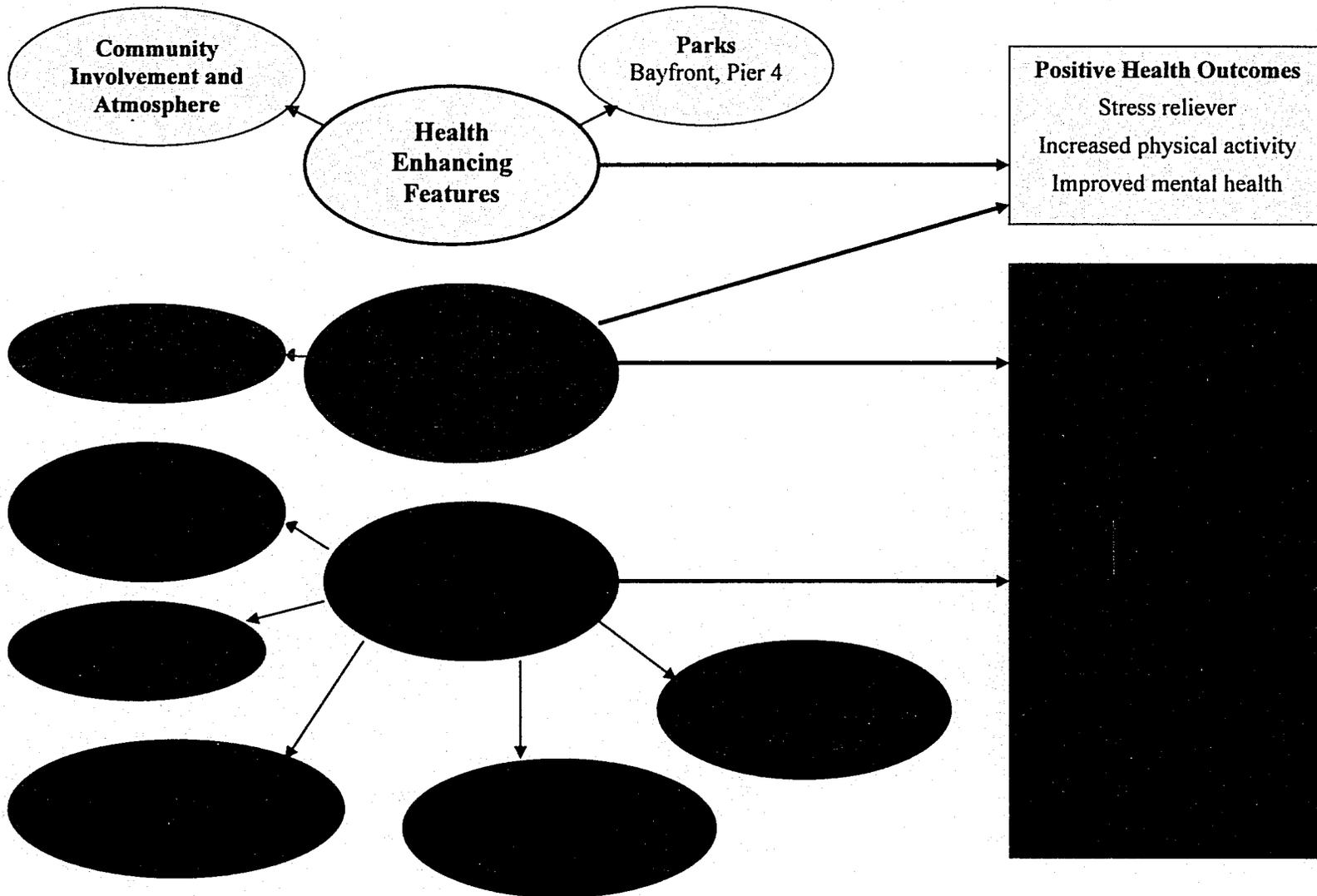
physical, social and psychological place characteristics such as green space, friendly neighbours, local amenities, and a safe environment.

**Perceptions of the relationship between health and place**

Early on in the interview process, participants were asked whether or not they thought there was a relationship – positive, negative or both - between health and the environment/place in which they live. Respondents overwhelmingly agreed that such a relationship exists (94.4%). When I asked them to provide me with examples of how their health had been, and continued to be, affected by the North End environment, participants identified a wide range of health-influencing characteristics. In some instances, these features are perceived to have a positive effect on health while in others, they are believed to negatively influence overall feelings of well-being.

Figure 7.1 provides an overview of the North End's health-influencing features and the perceived health outcomes associated with them, as revealed by respondents themselves. Health enhancing features are shown in yellow, health compromising features in blue, and features that were identified as being both health enhancing and health compromising in green. The positive and negative health outcomes associated with these neighbourhood features are also included in Figure 7.1.

**Figure 7.1: Health enhancing and health compromising features of the North End**



Availability of parks, community composition, and neighbourhood involvement and atmosphere were all identified as health enhancing features of the North End while crime, pollution, the area's sullied reputation, the cost and location of recreation facilities, and the existence of individuals caught up in the welfare cycle and evidence of what that cycle can do were considered to be health compromising features. The North End's landscape was identified as having both positive and negative health outcomes.

The following sections explore the study participants' perceived relationship between health and the North End neighbourhood by focusing on the various health enhancing and health compromising features displayed in Figure 7.1. In order to facilitate discussion of the health influencing features of the North End, participants' responses are organized into five broad categories – physical environment, locational characteristics, local services/facilities, reputation and socio-cultural environment – specified by Macintyre and colleagues (1993) and Basolo and Strong (2002).

#### **Perceived relationship between health and place**

Women in this study identified a number of environmental features they felt affected their health, but attributes of the physical environment were mentioned most often. In most cases, however, respondents expressed a negative association between the two. Environments are risk spaces and the most apparent place-based health risks are related to the physical characteristics of a place (Fitzpatrick and LaGory 2000:12). These risks may include both seen and unseen hazards such as toxic chemicals, pollutants and, the quality and arrangement of built and natural physical features in a place. In the North

End, air pollution, noise pollution, water pollution and smells were identified as serious place-based health risks.

## **Physical Environment**

### *Air pollution*

Most women believe that air pollution in the North End is much worse than elsewhere in Hamilton and is responsible for an elevated number of respiratory-related ailments such as breathing difficulties, asthma, allergies, pneumonia and bronchitis. For instance,

*PBI: Well, down here a lot of people they get asthma, bronchitis, like all different kinds of different diseases that make it hard for them to breathe and it's caused from the air. I know sometimes I have to use puffers because I can't breathe from the air or walking up too many stairs or something like that. Down here in this End, I find it's really, like I really have to use my puffers more than what I did when I was in Ottawa or when I lived down in Stoney Creek. So, it's really caused from the air down in this End.*

After talking with friends and acquaintances in the neighbourhood, a couple of participants are convinced that local pollution levels may also be responsible for high rates of spontaneous abortion. A few women also felt that high pollution levels underlie a higher level of general ill health in North End residents and an increased vulnerability to certain diseases:

*HS: Well, I believe that a lot of the people that live down here that they probably get more sick than the average person due to the pollution. Heavily polluted. Maybe more, I don't know. I don't know if it's really serious sickness but well eventually sure...probably more susceptible to cancer and okay, even if you don't go that far, you could still be sick on a daily basis more than the average person.*

As is evident in this quotation, some women also believe that exposure to air pollution may not only affect health now, but may lead to serious health problems, such as cancer, in the future. A lifetime resident of the North End, who remains in the area to care for her aging parents, expressed concern about the potential health ramifications associated with her longtime residence in the area and the Plastimet fire:

*EDB: Well. I've lived in the North End all of my life. I've been exposed to polluted air all my life so who knows, I might have some cancer in my body that I'm not aware of. I'm very worried about the Plastimet situation. I live one kilometer away from that. I went to see the fire not knowing what was there. I went cycling the day after just to check the site out and it was a hot hazy day like today and I remember my eyes were watering. I felt irritation when I was breathing. I thought geez, I better stay home. I better stay in. Definitely, definitely that's going to be a concern. Maybe not now. Maybe five, ten years down the road we're going to see there's going to be something happening. Definitely something will be happening.*

A number of other participants also mentioned the Plastimet fire incident as a local source of health concerns:

*PTW: Prior to Plastimet everything was positive, although pollution was still a problem. Since Plastimet little niggley things bother me. I open the curtains and look at things more closely.*

Another woman describes how seriously affected her family and home were by the fire:

*SF: And like I said, we got Plastimeted out of our house. We got pollutioned right out of a place to live basically. The Ministry of the Environment came and did backyard testing and we also had Green Peace doing testing. Our particular backyard was off the same alleyway as the Victoria Pharmacy so, we were behind it. Well, the way the cloud funneled around that building, it rolled right through our house. The two houses on either side of us, the tests on their backyards were fine. Ours was so toxic that we all got sick and my doctor at the time who was up on the Mountain – she'd been taking care of all three of us – and she said... "move". She told us definitely, move. My daughter who was an extremely healthy kid was throwing up and having headaches every single day. And I mean, little kids don't get headaches that often. I had headaches for about 5 months even after we moved out of there. Just breathing it. It came in our*

*house when we weren't home so there was all this gritty orange gritty stuff all through our whole house. The rugs were so toxified they were ripped up and thrown out. The roof had to be replaced. I mean, unfortunately because of the way the wind blew our house really, really got battered...It's a really toxified house. A really toxified house.*

In addition to the immediate health ramifications associated with the fire, this participant also noted serious negative financial consequences when they attempted to sell their property after the event.

Most participants singled out industries such as Stelco and Dofasco, stating that they were primarily responsible for the high levels of air pollution and the subsequent negative health outcomes. One woman, who has lived in the North End most of her life, believes that although the steel industries play an important role in employing local residents, their emissions are responsible for people's breathing problems:

*JMI: Well, I live really not too far from Stelco and Dofasco. Sucking in unhealthy air is not good for you no matter where you live but the closer you are to it the worse it is....Dofasco and Stelco they put a lot of pollutants into the air and it's not good. Some days worse than others. They, although employ a lot of people, still mess up the environment pretty good. Like I said, I live near Stelco and Dofasco. Not that I have necessarily breathing problems, but depending upon what the temperature is like, some days can be worse than others. Like you don't even want to go outside because it is harder to breathe. Lung problems can be caused a lot by those two places too...whether they employ a lot of people or not.*

One woman mentioned the stress associated with worrying about what the factories are discharging not only into the air but also into the water.

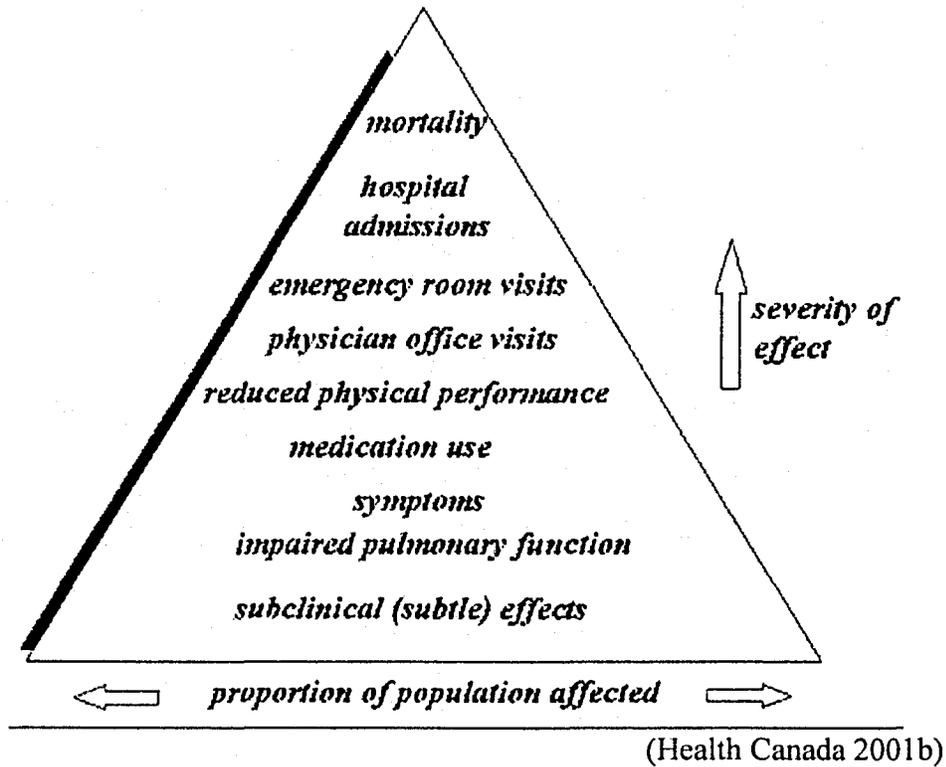
*JA: With the factories...Stelco and Dofasco...I don't have any physical proof but I know on a very real level. The fact that I'm aware of the stuff that's spewed into the air, into the water, it's part of my conscious awareness. So, it is a stressor knowing that this is the way that it is, it's part of the environment in which I live. I'm breathing it in or, even though the view is wonderful, you wouldn't catch me in that water, you know. I sail and hopefully don't dump the boat so I wind up in the water but it*

*happened and my first initial response when I was going under was 'oh my God don't breathe or open your mouth because if you swallow this stuff, I mean it's awful'. Yeah. I've seen the dead fish you know. It's too bad because it's beautiful. I have a wonderful view. That compensates somewhat but still, it would be nice to just jump in sometime and a cool off in the summer but I'm very well aware that it would not be a healthy thing to do.*

Many stated that the worry associated with wondering what is going to happen to their health in the future because of air pollution in the North End contributes to much higher levels of personal stress.

Participants' concerns about the negative relationship between air pollution and their health are certainly justified. There is a strong connection between air pollution and health problems, particularly for the elderly, children, and for those who suffer from respiratory and cardiac problems (Environment Canada 2002). Health risks associated with air pollution have emerged as an important public health issue (Sahsuvaroglu and Jerrett 2003). McLafferty (1992:568) remarks that: "Air pollution is one of the most obvious environmental problems in cities and one with potentially serious health effects". The manner and degree to which an individual's health is affected by urban air pollution depends on the type of pollutant, the degree of exposure, the individual's health status and their genetic make up (Health Canada 2001a). Exposure to air pollution can cause a wide range of health and health-related effects ranging from increased absenteeism to wheezing and premature death. Health Canada has compiled a pyramid of health effects associated with increasing levels of air pollution (Figure 7.2); the mildest and most common health endpoints are located at the bottom of the pyramid, and the least common but most severe at the top.

**Figure 7.2: Pyramid of health effects associated with increasing levels of air pollution**



There is considerable public interest about the potential negative links between air pollution and human health in the City of Hamilton. This is not surprising given that presently, Hamilton experiences some of the highest ambient air pollution levels in Canada, and that it exceeds government objectives by approximately twenty days per year (Sahsuvaroglu and Jerrett 2003:D-3). These high levels of air pollution are the result of a combination of pollution from outside the region (e.g., coal-fired generating stations in Nanticoke and the Ohio River Valley), industrial emissions (e.g., Stelco), transportation sources (increased automobile and truck emissions) and local meteorology and topography (Sahsuvaroglu and Jerrett 2003:D-3).

Residents of the North End of Hamilton are particularly concerned about air pollution levels because of the high concentration of heavy industry in this area, their close proximity to steel companies and their related manufacturing businesses, and the 1997 Plastimet fire. Their concerns are well founded. The Aesthetics, Odours and Economic Workgroup indicates that although all residents of Hamilton are exposed to industrial air pollution on a daily basis, individuals residing in areas located close to industry have a higher exposure rate (HAQI 1997). A study comparing the ambient concentration of selected air pollutants<sup>21</sup> in three areas of Hamilton – the downtown, the industrial zone and the mountain – to the downtown of four Ontario cities<sup>22</sup> found that even though Hamilton's downtown core and mountain area had similar if not lower levels than these other cities, the industrial area typically had higher levels of ambient air pollution (HAQI 1997:2).

A more recent study comparison of levels of sulphur dioxide and total suspended particulates in the Hamilton-Burlington area discovered similar results: levels of both pollutants were found to decrease as one moved away from the heavy industrial zones of north-central and northeastern Hamilton (Finkelstein et al 2003). This study also found that: (1) individuals residing in lower income neighbourhoods tended to have higher mean levels of pollution exposure than those living in higher income neighbourhoods; and (2) individuals residing in neighbourhoods with above median levels of total suspended particulates and sulphur dioxide had higher mortality rates than those living in

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<sup>21</sup> These air pollutants included sulphur dioxide, inhalable particulates, total reduced sulphur compounds, ozone, lead and suspended particulates.

<sup>22</sup> These downtown cities included Sudbury, Windsor, Toronto and St. Catharine's.

neighbourhoods with below median levels of these pollutants (Finkelstein et al 2003:401). Consequently, individuals living in the economically and “environmentally disadvantaged” North End neighbourhood (Elliott et al 1999) are at an increased risk for mortality associated with ambient air pollution.

### *Noises and smells*

For some women, the noise and the smells and fumes associated with the North End raise fears of negative health outcomes. Participants commented that noxious smells emitted by local industries such as CanAmera, Stelco and Dofasco and by car and truck fumes make them feel sick and sometimes make it hard to breathe. On almost every occasion that I was in the North End, I could smell the heavy, cloying fumes coming from the CanAmera factory. The odour really does make one feel ill.

A report put out by the Aesthetics, Odours and Economic Workgroup (HAQI 1997) underscores that there is a strong psychological component to air pollution odours. Individual responses to industrial odours are influenced by our preferences, opinions, experiences, and the sensitivity of our olfactory system. People tend to be more tolerant of an odour if the source of that odour is understood or if they believe they can do something about it. People also seem to react as much to the context of the odour as to the odour itself. In addition, over time people can become habituated to an odour and as a result of growing accustomed to a smell, are less likely to complain about it (HAQI 1997:7). The report also mentions that industrial odour can negatively affect people’s mental and physical well-being. Many people worry about the possible health effects of

the odours; they assume that if a person can smell the air, then it must be polluted (HAQI 1997:7).

Quite a few women in this study also remarked that noise levels were a significant problem in the neighbourhood. They pointed to a variety of noise sources such as local events (Aquafest), traffic (local and industrial), loud music played by local residents, children screaming, families fighting, and the sirens from nearby ambulance and fire departments. The constant noise caused them to feel “stressed out”. Noise has been known to cause hearing impairment, interfere with communication, disturb sleep, cause cardiovascular and psycho-physiological effects, reduce performance, and provoke annoyance responses and changes in social behaviour (WHO 2001). Community level studies conducted on adults have found that noise does lead to negative physical health outcomes. For instance, acute noise produces short term elevations in cardiovascular and neuroendocrine functioning. Although many adults appear to be able to adapt to chronic noise, some studies have demonstrated a relationship between chronic noise and the development of hypertension (Taylor et al 1997). The stress associated with noise has also been linked to an increase in health compromising habits such as smoking and the use of illicit drugs (Taylor et al 1997).

### *The landscape*

The surrounding view offered to residents of the North End was identified as both a negative and positive feature influencing health. A few women felt that the lack of greenery was disheartening:

*RC: It's not attractive to look at either. [Do you think that affects you?]  
Yeah, when you go out it's kind of depressing looking sometimes around*

*here. It's gray, especially the winter it's so gray and all the traffic around here. There's very little trees growing around here.*

Another participant remarked that she would like to start walking more often but that she needs something other than buildings to observe if she is going to keep it up. A number of respondents commented that the North End was filthy to look at; that people don't make an effort to keep their properties tidy and, they just throw their garbage anywhere. This lack of regard for the environment was seen as a lack of regard for themselves. A couple of women felt that if people had more respect for where they lived then in turn, they would have more respect for themselves and consequently take better care of themselves and their children. This would ultimately translate into better overall health and well-being for local residents.

On the other hand, a number of women noted that certain physical features within the North End have a positive affect on their health. One woman remarked that she felt her mental health was "*greatly stimulated*" by the view of the water and the escarpment. Another noted that her health was enhanced by the proximity of the water and resulting wildlife:

*JA: Yes. I'd say positive...I'd say positive because of the water, the view. It's definitely for me personally a stress-reliever being close to the water and there is an abundance of wildlife that's connected with that; the birds. Yeah, definitely.*

Quite a number of participants find the close proximity of Hamilton Harbour has a soothing calming influence that enhances their mental well-being.

## **Locational features**

### ***Parks***

Local parks (in particular, Pier 4 and Bayfront Parks) were identified as conferring health benefits:

*BD: ...number of parks so I can take my dog for a walk and get a little bit of exercise.*

*SS: Yes. I would say it's positive in some ways...just again going back to the thing that I have really easy access to some place to be physically active.*

The accessibility of these waterfront parks has led to an increase in physical activity as more and more people have begun to take advantage of the waterfront trails. This is significant given that physical activity is known to promote good physical and mental health. Powell et al (2003:1519) note that “[t]he availability and accessibility of places conducive to physical activity are associated with higher levels of physical activity”. Neighbourhood streets and sidewalks and public parks are the most commonly reported safe and convenient places for walking (Powell et al 2003:1520).

In my capacity as program co-coordinator for the Sunny Strollers walking group, I also took advantage of the close proximity of the waterfront parks. This is where the group went on most of its bi-weekly walks. The group met at the community health centre and from there we made our way toward the water. Not only were the parks close by, which was an important factor for some of the older participants, but the view on the way was pleasant as we meandered through a quiet section of the North End neighbourhood and past the boat and yacht clubs. On one occasion we ventured to Eastwood Park (located on Burlington Street East) but the walk to the park was off-

putting; there was a lot of traffic, a lot of noise and not much to look at. Although this park offers a great play area for children and a wonderful place to run one's dog, it provides a poor atmosphere for those intent on simply walking.

### **Local services/facilities**

#### ***Recreation centres***

Access to nearby, safe places to exercise and socialize are an important component of a healthy neighbourhood. A few women in this study mentioned that there are not enough local recreation centres, while a few more mentioned that the recreation centres available are too expensive for them and their families to use on a regular basis:

*RC: There's not even a gym around here. There's a recreation centre but it's pretty expensive even to go there. The city subsidizes some of it for people on government assistance but that doesn't help a low income person that's got a minimum wage job or you know around that level. It would cost them [low income people living in the North End] quite a bit of money and it's not really a gym. It's like swimming programs and it's not a gym to go use and exercise and stuff. I don't think there's anything like that around here at all.*

There are two recreation centres (Bennetto and Norman Pinky Lewis), both with pools, within the study area. One is located in the north-west section (Bennetto) while the other is in the north-central region of the study area. These recreation centres are certainly convenient for people living within walking distance of them, but many residents need to use public transportation (an additional cost) or drive there themselves in order to use the facilities. This is problematic because as Powell et al (2003) have discovered, there is an association between convenience/proximity (time and means of getting to a place) and physical activity. If participating in physical activity at a recreation centre is too time consuming, too inconvenient or too expensive, not only will people

choose not to take part in physical activity but, they will also experience a loss of social interaction. In fact, a qualitative study carried out by Thomson et al (2003) on the health impacts of local public swimming facilities in two deprived neighbourhoods in south Glasgow found that the most profound health effects came not from physical activity but rather, from social contact. Their study revealed that use of the local facility was linked to reports of relief of stress and isolation and improved mental health (Thomson et al 2003:666).

Moreover, because some women in the North End are afraid to walk outside alone (i.e., fear of crime), problems accessing indoor exercise facilities further restricts their ability to get in shape and meet people. For instance, when asked if her health was affected by living in the North End, one woman stated:

*JDS: I'd like to say no, but because I'm restricted really in how much I can do and how far I can walk and whatever, it does. I mean if there's an activity at Pinky Lewis at 9:00 o'clock, which involves swimming and it's a woman's swim, and you're the only one going, chances are I won't go.*

Given that regular physical activity is described as "today's best buy in public health" (Morris 1994 cited in Powell et al 2003:1519), circumstances that restrict an individual's ability to be physically active must be addressed and remedied immediately.

### **North End reputation**

Area reputation is another, more subtle, place characteristic that affects health. As mentioned earlier, a place can become stigmatized as a result of a number of associated factors (social, cultural, historical, demographic, environmental and/or health) that work together or independently. At the same time as the stigma of certain individuals or groups can be transferred to the place in which they reside, people can be stigmatized by the

reputation of the place in which they live (Krase, 1979). Although this is a relatively new area of inquiry, studies conducted by Bush et al. (2001) on the heavily industrialized area of Teeside in north-east England, Evans and Cattell (2001) on the East London neighbourhoods of Trowbridge and Kier Hardie, Hayden (2000) on the coastal community of Seabrook in Southern New England, U.S.A. and Nadel (1984) on the Scottish "fishing village" of Ferryden, all reveal to some extent how individuals can be negatively labeled by their place of residence. People who live in a spoiled place seem to be discredited by the same attributes ascribed to their place of residence (Hayden 2000). Krase (1979:252) points out that the physical appearance of an area is often closely associated with certain moral characters such that: "Physical order is seen as reflecting moral order; cleanliness marks the godliness of a neighborhood; good taste indicates the superior upbringing of residents".

Since people often measure themselves based on the perceived value of their communities (Krase, 1979), it is likely that their perception of community quality will contribute to better or worse overall health. In fact, Gregory and colleagues (1996:213) point out that stigma is an increasingly important factor in influencing how individuals perceive their health. It is not difficult to imagine that deeply entrenched negative place stereotypes may have the potential to reinforce or create negative personal images that may in turn be detrimental to an individual's overall health.

As such, the manner in which a neighbourhood/community is perceived by residents, outsiders, local politicians, and service planners and providers may have positive or negative health implications for the people who live in these areas (Sooman

and Macintyre 1995). A constant barrage of negative neighbourhood or community portrayals can be detrimental to the mental health, self-esteem, morale, and well-being of community members (Weinroth et al., 1996), and may affect who moves into or out of an area (Macintyre et al., 1993). These poor health outcomes may be the result of chronic stress, anxiety, depression and/or hostility (Taylor et al 1997) associated with the discredited reputation of a neighbourhood. Negative stereotypes can work directly or in interaction with individual attributes by reinforcing negative personal images.

Even residents who contest the negative stereotypes are affected by them in a harmful manner. For instance, a number of women described themselves as being 'sick' and 'tired' of feeling as though they had to constantly defend themselves and/or apologize for living in the North End. One woman said that she found it very stressful being judged by people and "*...being labelled as undesirable*" because she lives in the North End and is considered poor. Another woman commented that her health was affected by "*...labeling an area and I think sometimes how you're treated because of that*". It is this constant need to justify one's place of residence and the potentially harmful mental and physical health effects it can have on a person who actually likes living in her neighbourhood, which really speaks to the need for insiders, outsiders, politicians and health promoters to fight against "neighbourhoodism".

### **Socio-cultural environment**

#### ***Dependency***

Unemployment, poverty and dependence on social services were identified as serious North End concerns. Many respondents viewed the neighbourhood's

overwhelming reliance on social service as having a negative influence on their health.

One woman who loves living in the North End discusses how that type of dependency can pull you down:

*VC: But I do feel that there are some drawbacks to living in areas like the North End in that it can tend to draw people down because it's kind of a dependent [area]. Social dependency is more here than what it is in an upper class [area]... There are people that love the North End and the community itself. And I love being part of that community. We just see many people that are struggling with it. In general struggling with mental health.*

A young woman who just moved into the area because she married a local pastor expressed similar sentiments. She reflected in some detail on the frustration and stress many residents feel as a result of being unemployed and having little money and, on the types of negative behaviours these circumstances lead to. She also discussed not only how that cycle affects the health of people hindered by it but also, how the mental health of non-dependent individuals can be influenced by being constantly exposed to such negativity:

*AC: I think especially for the North End there's a big...just the effect on women who live down here. It's not...I think the North End does sometimes get a bad rap but it is a difficult place to live in. You look around and you hear people screaming at their kids and yelling and just...I think that does have an effect on how you're going to handle yourself and how you're going to raise your kids as well. Like some people you would expect them to...well people in our church especially women who live down here, a lot of people from our church who are really strong Christians who moved down here and they'll hear other people in their neighbourhood just yelling at their kids constantly and they almost start doing it to their kids as well. And that's something that they've really had to work on because it's just...you know you're in that environment constantly where you hear people yelling and you know smacking their kids and things like that. That really affects them I find, in just in how they're going to raise their kids. You know some people in this neighbourhood wouldn't necessarily be abusive physically or verbally but*

*because of the environment I find they're in they just get so frustrated, they hear the people dealing with it this way and they don't know how to deal with it themselves so they choose the way they're seeing.*

When I asked her what she thought starts this cycle, she said:

*AC: Well, it doesn't just start in the welfare community but it is very common in this community as well I think. I think a lot of it has to do with the social and economic frustrations that people down here just you know, losing their job, out of work, don't have enough money. You know a lot of them resort to drinking and you can walk down here and smell the pot coming out of their houses sometimes. I think that when you combine all those frustrations a person has to deal with, they don't know how to handle this child they're supposed to be raising and that they're entrusted to so a lot of times they take out their frustrations on them.*

When asked how this affected her own health she noted:

*AC: I think for living down here in that one sense, just feeling kind of down sometimes when you're listening to the yelling outside and that can really get me down sometimes so that's one thing that's really affected me, hearing everything that is going on around me and just knowing the frustrations that people have to deal with when people are out of work. Two of my neighbours don't have work right now so they're really short of money. And just things like that where it's really...just kind of makes you feel bad for them. You don't want to pity them but you don't know what to do to really help.*

Although almost everyone who mentioned dependency and health commented on the negative aspects of this relationship, it is interesting to note that one young woman felt that her health was influenced in a positive way by the dependency she sees in her neighbourhood:

*JM2: Like I said before, in a positive way because it makes you want to go to university, get a job, get an education and have something to fall back on so that you don't end up like people who live here...I see myself and I go "I don't want to be like that". So don't be like that. Don't consume massive amounts of alcohol. Don't smoke around your children.*

A couple of women were quite adamant about communicating their belief that the North End suffers from an over abundance of social services which they feel tends to attract less desirable people to the area. One participant felt that the over-representation of social services in the North End may be negatively affecting non-dependent residents' sense of freedom and mobility because they are afraid of some of the recipients of those social services:

*ED: If you're surrounded by such negativity. If you're surrounded by so many people who need so much help and you as an individual cannot help them. If you feel that your own freedom of mobility may be curtailed because you don't know who you may meet on the street [making reference to the 17 people with serious mental illnesses that she knows of who live in a nearby apartment building] there's a certain level of fear. See, I don't feel that so much but people who are smaller than me feel that. They withdraw and become less social.*

The other participant believes that the profusion of social services has an effect on the health of residents because it results in the negative labelling of everyone who resides in the North End regardless of economic status:

*SS: And also, I think other things in the environment are also...sort of the way certain areas are pegged or labelled and so what happens with that. So traditionally the North End has been thought of as a low income area so...things like... around that will affect us...so for example, there's a lot of social services in the area and so personally for us we've had people knocking on our door or as I'm gardening outside asking me where the detox centre or whatever is. So I mean, that's going to affect me.*

Although there are social services located throughout the entire "New" City of Hamilton<sup>23</sup>, they are certainly not, as indicated above, evenly distributed. A discussion paper published in 2000 entitled, "Residential Care Facilities, Long Term Care Facilities

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<sup>23</sup> January 1, 2001 the Cities of Hamilton, Dundas, Stoney Creek, Flamborough, Ancaster and Glanbrook amalgamated to form the "New" City of Hamilton.

and Correctional Facilities – The Past Present and Future Planning Policies in the City of Hamilton”, noted that 66.9% of all licensed residential care facility<sup>24</sup> beds are located in Wards 2 and 3 (Community Planning and Development Division 2000:6). The North End neighbourhood, defined in this thesis as being bounded on the west by Queen Street, on the east by Gage Avenue, on the south by Cannon Street and on the north by Hamilton Harbour, is contained within these two electoral wards. The concentration of residential care facility beds in these wards has not diminished since the late 1970s when the first facility inventory was undertaken (Community Planning and Development Division 2000).

**Table 7.1: Distribution of residential care facility beds in Hamilton neighbourhoods**

Neighbourhood	Number of Beds	Percentage of Total Beds
Stinson	403	15.5
Durand	255	9.8
Gibson	230	8.8
Landsdale	222	8.5
Beasley	205	8.0
Kennedy West	150	5.8
Jerome	108	4.2
Stipley	100	3.8
Delta West	74	2.9
St. Clair	70	2.7
Central	65	2.5
Blakely	63	2.5
Raleigh	53	2.1

(Community Planning and Development Division 2000:26)

<sup>24</sup> Residential care facilities refer to emergency shelters/hostels (short term care), second level lodging homes, retirement homes, groups homes and halfway houses (corrections groups homes) (Community Planning and Development Division 2000:3)

Table 7.1 shows the distribution of residential care facility beds in Hamilton neighbourhoods. Of the thirteen highest neighbourhoods listed, ten are located within Wards 2 and 3 and five within the North End neighbourhood (Gibson, Landsdale, Beasley, Stipley and Central). Moreover, the Hamilton-Wentworth Detention Centre (the city's primary correctional care facility) is also located within the North End neighbourhood, on Barton Street East.

One of the consequences of concentrating care facilities in particular areas is that more individuals with needs gravitate there, creating a larger social service-dependent population (ghettoization). In addition to these facilities, the existence of low cost housing in the North End attracts low income individuals who cannot afford to live elsewhere. The high concentration of low income and government dependent individuals can become problematic for people who, while part of the North End community, are not part of the low income, social service community. The supposed homogeneity of the North End community masks the diverse needs of other members of the population (independent and of higher income).

### *Crime/safety*

Crime was identified by numerous participants as a significant problem in the North End. As a result of high levels of real and perceived crime (muggings, burglaries, prostitution, drugs) many women feel that their personal safety is threatened. Although some participants are of the opinion that crime is a problem everywhere these days, others suggested that it is more serious in the North End because it is a low income, high transient area with a number of abandoned buildings.

Several women commented that their fears affect their physical and/or mental well-being:

*MC: I don't get out much so...I don't want to go nowhere here. I really don't like living in this neighbourhood at all. So, I won't even go for a long walk especially even at night. And I'm scared of meeting people, a lot of people are like that...they don't want to meet a lot of people so they don't.*

*RC: I don't like to walk around at nighttime. Safety is something that affects your mental and emotional status too. It seems to be a pretty high crime area with break-ins and things which again is your emotional well-being. You know, you're worried for yourself and your children.*

Many participants describe being seriously distressed by the crime in the area and convey how worried they are about their personal safety. One older woman said she had to stop worrying about “*the drugs, the alcohol and the crime*” in the area because she was frightened that she was going to give herself a heart attack. Another woman commented that she is always worrying about something happening to her home or to her dogs (who had been poisoned a few years earlier). A lifetime resident also commented that her health is being negatively affected by the fear of crime:

*EDB: I feel the stress. I feel stress not knowing, like if I'm out a little bit later in the evening I hope I get a parking spot close to the house or once I find a parking spot I look around, have my keys ready. You know the usual. It's something I've learned to live with all of my life.*

Other women discussed becoming paranoid because they were worrying so much about their personal safety. One woman stated that although she wasn't worried about her own safety, she could understand how someone may become overly fearful and begin to isolate themselves from other residents:

*ED: ...for me it's not an issue because I managed to work through it, but I'm sure that if people were that concerned, paranoia could start and they*

*could start to isolate themselves from other people. They wouldn't go out as much. They wouldn't feel safe to go out. And then all of a sudden they...some level of paranoia has to set in. Yeah, I would think that there would be some...it couldn't help but manifest itself somehow.*

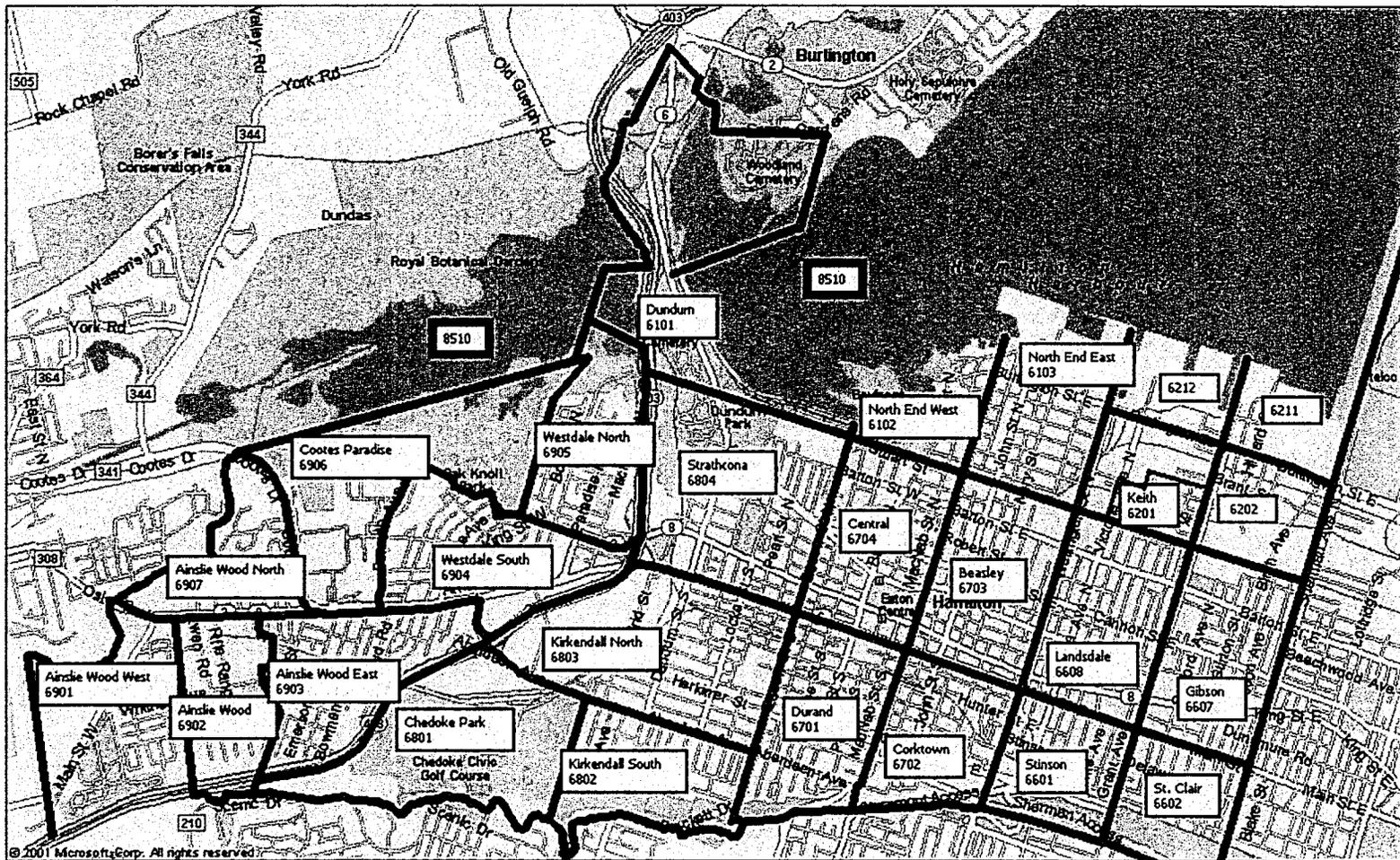
Although recent studies on crime have revealed that the fear of crime is more prevalent than the problem of crime itself (Bannister & Fyfe, 2001), in the North End of Hamilton it appears that the reverse may be true. In chapter 5, I provided a number of detailed examples of both minor (vandalism) and major (mugging) criminal events that had been committed against the study participants, their family members or their neighbours. When I first enquired about the prevalence of crime in the North End, I was told by a representative from the local police department that it was not a serious problem. However, more recent enquires have revealed that crime is in fact a significant problem in the North End neighbourhood. Crack cocaine is considered the leading motivator when it comes to of all types of crime but this is particularly true in the case of thefts, break and entries, and robberies (McKinlay, personal communication).

Crime statistics obtained from divisional analyst, Bob McKinlay, of the Hamilton Police Services (Appendix 6) indicate that the police beats located within the study area report some of the highest rates of crime in the City of Hamilton (McKinlay 2002). The highest crime rates for the City are in beats 671 and 672 (Beasley and Central), both of which are partially contained within the study boundaries (Figure 7.3). The high rate of crime in these areas is due in part both to the location of the Barton Street Jail<sup>25</sup> and the presence of commercial property. Yet, even when accounting for this inflation in crime

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<sup>25</sup> The jail exaggerates the actual drug and assault statistics by a considerable margin (Bob McKinlay, personal communication)

Figure 7.3: Division One – 2002 Neighbourhood Watch Report Geocodes



(McKinlay 2002)

rate, when beat 672 was compared to the other 42 beats within the City of Hamilton it still had the highest overall crime rate. With the exception of some of the very rural Flamborough beats, beat 681 (the West End) was the lowest (McKinlay, personal communication).

Bannister and Fyfe (2001:809) argue that

...the key to understanding fear of crime lies not in direct experiences of crime, or with control *per se*, but rather in how people experience and interpret urban space. Fear is embedded in the physical and social characteristics of place and the familiarity of that space to the individual. People effectively read the environment as a barometer of risk and protective factors. In other words, the environment provides an individual with visual evidence (when other knowledge is limited) of the likelihood of criminal risk and the likelihood that others will intervene on their behalf.

A number of studies have found a strong relationship between physical characteristics of an area - such as abandoned buildings, vandalism, illegal drug use and teenagers hanging around - and the fear of crime (Baba and Austin 1989:764). Baba and Austin (1989) found in their own study that improving the environmental features of a neighbourhood results in higher perceived levels of neighbourhood safety and thus, a decrease in the fear of crime. Moreover, Glassner (1999) notes that the media's focus on the high prevalence of crime and violence creates what he refers to as a "culture of fear". He also points out, however, that reporters tend to exaggerate the actual threat of crime in order to boost newspaper sales or television ratings. In other words, the actual reality of these crime statistics is never quite as bad as they are portrayed in the media (cited in Low 2001:47).

If fear of crime is truly associated with a neighbourhood's physical and social features, it is not hard to believe then, that the North End - with its rather dubious history,

negative media portrayal, proximity to polluting industry, and copious brownfields and abandoned warehouses – would lead people to believe it was home to a serious crime problem. However, in the case of the North End it appears that in addition to these negative characteristics creating a “culture of fear” in the neighbourhood, the personal experiences of female residents (refer back to chapter 5, pages 126-131) with criminal events such as vandalism, robbery, break and enter, and assault confirms their fears of crime and worries about personal safety.

Fear intensifies personal vulnerabilities and creates a constant or intermittent state of anxiety or stress (Bannister & Fyfe, 2001), which may in turn, have negative consequences on the overall health and well-being of an individual. Macintyre and colleagues (1993:221) found that:

A generalized sense of a threatening environment – one with high noise levels and traffic density, dirty and poor lit streets, high rates of crime, vandalism, litter and graffiti, and an ugly or uncared for built environment – may demoralize people and effect their mental health, as well as directly threatening their physical health.

Fear of crime reduces overall feelings of well-being by contributing to perceptions of the environment as less secure and less satisfying. Lower levels of housing and neighbourhood satisfaction and lower overall morale are, in turn, associated with fear of crime (Ward et al 1986:328).

Concerns about neighbourhood safety have also been identified as potential barriers to physical activity. Several studies have shown that people who perceive their neighbourhood to be unsafe are less likely to participate in physical activity (CDC 1999). This is a serious problem because it has been established that physical inactivity is a

significant risk factor for premature morbidity and mortality particularly for high risk groups such as the elderly, women and ethnic minorities (CDC 1999).

It is important to point out, however, that not all residents believe the North End is unsafe. A number of female residents stated that they felt as safe, or safer, in the North End than elsewhere. They base their feelings of safety on the belief that there is less crime in the area and that because the North End is a “porch community”, there are always people around.

### *Community involvement and atmosphere*

Although features of the socio-cultural environment have been identified thus far as having primarily health compromising effects on women’s health, it is imperative to point out that women also recognize its capacity to promote the overall well-being of residents. A number of participants expressed the belief that a strong community atmosphere coupled with pleasant neighbours, whom one could trust, increased the level of social interaction in the North End which in turn improved people’s mental health.

*VC: I think in a positive way the community atmosphere is one that keeps me going mentally. Like, I like it. I think the people’s involvement down here is...I think people are involved a lot more with their community down here than you see in other areas.*

*HS: ...you know the sense of community that we have I mean it’s good. I don’t know if it’s good to your health, but it is. And the support you have.*

One young woman who has lived in the North End almost all her life feels that she has better coping strategies than individuals in other neighbourhoods because of the experiences she had while growing up:

*CDB: The positive aspect I would say is that it’s a lot more lively than a lot of other neighbourhoods, a lot of other areas that I’ve seen anyway*

*from my experience. So, I would say positive is it's given me a lot of character for having lived in this area. For having had to deal with things that I don't think a lot of people have to deal with. Like getting things done and stuff like that.*

A participant with two young children feels that her ability to trust her neighbours in times of need has a positive influence on her health as does the diversity of individuals in the North End:

*AG: ...I'm exposed to a greater variety of people and think that always makes for a better life experience. The fact that I have great neighbours...not people who I can't depend on. I mean again, we're not socializing to the point where people are coming over for dinner but again, if something happened, if there was an emergency, I know I can count on them and that is important.*

Another woman feels that getting to know her neighbours and contributing to the neighbourhood by being involved in local decision making, has had a positive influence on her health:

*SS: A lot of my neighbours are...that I've got to know are very nice and easy to get along with. Also I've joined the neighbourhood association so that's been sort of a good social part that's been very good to living around here. In terms of feeling like I'm contributing to the neighbourhood*

The ability of community members to socialize and take part in community activities provides them with the opportunity to make contacts that may promote personal empowerment and encourage local level networking and collective action. This is the ultimate goal of social capital. Social capital, a term coined by Robert Putnam, is defined as: "features of social organization such as networks, norms and social trust, that facilitate coordination and cooperation for mutual benefit" (Putnam 1995:67). The central premise of social capital is that social networks have value (benefits) that flows from the

trust, reciprocity, information, and cooperation associated with social networks. Popay (2000:401) comments that social capital should not be mistaken for a static concept; rather, it is a dynamic process with a past as well as a present and future. Social capital changes over time and space.

Despite some debate, the primary indicators or core concepts of social capital are generally accepted to be mutual trust, civic engagement and social networks (World Bank Group 2003). Having faith in the “goodwill and benign intent” of local people and institutions (e.g., police, politicians, journalists) promotes group action and mutual cooperation (Kawachi et al 1997:1492). Civic engagement refers to the degree to which individuals belong to, or participate in, organizations or associations (e.g., sports clubs, neighbourhood or parent associations, church groups, and advocacy groups). It also refers to the extent to which individuals are involved in political life (e.g., participating in elections and signing petitions) (Kawachi et al 1997:1492). Social networks refer to the immediate (e.g., interactions with family, friends and neighbours) and secondary (e.g., relationships established in the workplace and recreational environments) networks that provide constant contact and social support (World Bank Group 2003).

Responses given by study participants reveal that social capital is present in the North End (although it is not referred to as such). Many women said that they know many of their neighbours and find them to be friendly. While some women have more in-depth interactions with their neighbours (e.g., go out for coffee together or visit one another at their homes), others just say “hello” over the fence or when they are walking their children to school. It appears, however, that regardless of the number and depth of

interactions most women in this study trust their fellow residents and feel they can turn to them in times of need. Having reliable neighbours was identified as an extremely important facet of neighbourhood life. Participants also mentioned being engaged in a number of local (civic) groups or community activities: neighbourhood associations, church group, volunteering, mom's groups (focus group participants), walking club (Sunny Strollers), environmental associations, and block parties. The advertisements for this study were printed in a little neighbourhood paper that runs weekly and announces local events.

Social capital has been shown to be an important place-based determinant of health. The link between social capital and health was established over a century ago when Emile Durkheim identified a relationship between suicide rates and levels of social integration (Kawachi et al 1997). Despite some theoretical and measurement limitations (refer to Kawachi et al 1997; Popay 2000) the concept of social capital has been embraced by health researchers because of its potential to integrate complex, community-level socio-economic processes in ways that may help explain variations in the health status of communities across time and space (Sherman et al 2001:166).

The World Bank (2003) notes that social capital can influence health and nutrition in a number of positive ways: (1) through access to health education and information; (2) through the design of better health care delivery systems; (3) by acting collectively to build and improve infrastructure; (4) through advancing prevention efforts and; (5) by addressing cultural norms which may be detrimental to health. The presence of social capital/ties is associated with lower mortality rates and improved mental health (Kawachi

et al 1997; Kawachi and Berkman 2001). The absence of social capital on the other hand, has been linked to a number of negative health-related outcomes, such as high rates of child abuse, high levels of adolescent aggression and delinquency, high levels of adult crime, higher rates of teen pregnancy, increased mobility, increased fear of crime and social isolation (Taylor et al 1997:421-2).

Kawachi et al (1997:1496) note that social capital is a resource available to everyone living within a particular community and that access to it cannot be restricted. Thus, even a socially isolated resident stands to benefit from living in a community with plenty of social capital. On the other hand, however, Campbell (2000:193) suggests that "...social capital is not a homogeneous resource that is equally created, sustained, and accessed by all members of a particular community. People are embedded in local networks in different degrees and in different ways". Campbell (2000) found that age and gender differences were responsible for varying community perceptions and experiences.

In keeping with Campbell's (2000) findings that social capital is not uniformly distributed in a community, my study revealed that while some women are deeply involved with community members and community life, others are much more isolated. When participants were asked to identify priority areas they thought a newly created health program should focus on, increased social contact was mentioned as one of the most important women's health needs along with increased community involvement. The fact that some North End residents experience a wealth of social capital while others experience very little, suggests a definite lack of consistency in social capital within the neighbourhood boundaries.

In this study, there was a small group of women who mentioned that they *wanted* to interact more with other residents but said that their neighbours keep to themselves. One woman feels that this reflects the transient nature of the North End; people don't make the effort to get to know one another because they don't think they will be staying there for a long time. Regrettably, this type of thinking sets up the beginning of an unfortunate cycle in which people keep wanting to move out of the neighbourhood because little, or no, social capital is generated.

The results of this North End study also suggest that the capacity to choose residential location has a significant effect on North Enders' willingness to participate actively with other community members. Women who did not want to live in the North End but were forced to for financial reasons were often quick to point out that their neighbours were unfriendly and that they didn't trust them. As a result of their beliefs, they struggle to distance themselves from people around them, waiting impatiently for the day when they can afford to leave the North End and move into a "better neighbourhood with better people". Many of these women subtly expressed the belief that they are superior to their neighbours whom they view as lacking respect for themselves or for their surroundings. Their anger and frustration at having to live in an area they don't like, and that outsiders look down upon, prevents them from getting to know their neighbours and from participating in local activities. Their unwillingness to interact with local residents, thereby excluding themselves from the positive effects of social capital, makes them and their family members more vulnerable to a variety of

negative health and health-related outcomes (e.g., increased stress, higher rates of child abuse, social isolation).

Furthermore, because they have isolated themselves from their neighbours, they may not have anyone outside of their immediate family to turn to for companionship or support in times of need. This lack of social support can have serious implications for their overall health and well-being. As Williams and Umberson (2000:559) state: “[s]ocial support provides a buffer that protects individuals from the negative health effects of stress exposure, largely by reducing the likelihood that undesirable events and life conditions will be appraised as stressful”. In chapter 6 (pages 151), it was revealed that almost three-quarters of all participants view their lives as very stressful or somewhat stressful. Thus, although women encounter stress in many dimensions of their lives (e.g., family relationships, economic situation, environmental conditions, health), those who engage in social relationships are at an advantage relative to those who have little or no social and emotional support systems in place.

### **Health influencing features**

It is quite evident that women who participated in this study believe that there is a relationship between their health and features of their lived environment. Although some women did identify aspects of the North End that they feel positively influences their overall health, Figure 7.1 and the ensuing discussion clearly revealed that many more participants believe their health is adversely affected by various features in their neighbourhood.

In the North End, the most prominent negative health outcomes reported were respiratory-related ailments associated with air pollution. High levels of localized pollution are perceived by female residents to be linked to acute illnesses (e.g., bronchitis; pneumonia), chronic illnesses (e.g., asthma, heart and lung problems), and potential future ailments (e.g. lung cancer). As noted earlier in this chapter, chronic exposure to elevated levels of ambient air pollution have been linked to higher incidences of respiratory-related morbidity and mortality in Hamilton's industrial areas (Finkelstein et al 2003).

Chronic stress was the next most frequently mentioned adverse health effect associated with living in the North End. Stress is defined as a state of both physiological and emotional stimulation which develops in response to circumstances that challenge an individual's ability to adapt or cope (Janzen 1998). Elevated levels of stress in North End participants were linked to a number of local features such as the pollution (air, water and noise), actual and perceived crime, lack of personal safety, the area's stigmatized reputation, and the over-representation of social service dependent individuals. According to Thoits (1995:54), as stressors accumulate, "individuals' abilities to cope or readjust can be overtaxed, depleting their physical or psychological resources, in turn increasing the probability that illness, injury, or disease or that psychological distress will follow". In this study (chapter 6, page 152), women identified a broad array of physical and mental health problems brought on, or exacerbated, by stress: high blood pressure; lowered resistance and increased illness load; increased tiredness; poor sleep patterns;

stomach pains; nausea; irritability; migraines; headaches; decreased general feelings of well-being; difficulty losing weight; and contribution to bad feelings you already have.

The third most frequently reported negative health consequence associated with residing in the North End was a decrease in physical activity as a result of factors such as the air pollution, fear of crime/personal safety, combination of cost and proximity of local recreation facilities and an unappealing visual landscape. As was noted earlier, limited physical activity can result in a decline in both physical and mental health as well as a decrease in social interaction and an increase in social isolation.

The presence of more health compromising than health enhancing features in the North End is not all that surprising given the overall low economic status of the neighbourhood. Taylor et al (1997:419) point out that neighborhoods of lower socio-economic status have been linked to higher levels of exposure to physical dangers such as air, water and noise pollution, hazardous wastes, pesticides, industrial chemicals, and crowding. In addition to these physical risks, low income neighbourhoods tend to contain more social and psychological stressors such as higher rates of perceived and documented crime, more refused services, limited transportation and inferior recreation facilities, than do higher income areas (Macintyre et al 1993; Sooman and Macintyre 1995).

Taylor and colleagues (1997:411) view neighbourhoods that threaten safety, challenge the establishment of social networks, and that are conflictual, abusive or violent as unhealthy. They believe that these unhealthy neighbourhoods actually get “under the skin” and lead to the creation of health disorders. Taylor et al (1997:414-417) suggest that negative environments get under the skin through a number of different routes



relationship is so complex. One reason for this complexity is that the outcomes associated with area features may differ: (1) certain features may produce physical health outcomes, while others may result in mental health outcomes; and (2) certain features of the lived environment may be associated with negative health outcomes, while others may be associated with beneficial health effects. For instance, while stress levels can be increased, physical activity decreased, and mental health diminished as a result of characteristics in the North End such as crime, limited access to recreation centres, air pollution, and area reputation, stress levels can also be decreased, physical activity levels increased and mental health improved by others features in the North End, such as the presence of parks and neighbourhood spirit. A further complication is the interrelatedness between area level attributes that makes it particularly difficult to investigate specific features while ignoring others (Diez Roux 2001). Another reason for the difficulty is that the same environmental feature may be identified as positive by one individual and negative by another. For example, the North End landscape is considered by some to stimulate mental health and relieve stress while to others, it is depressing and discouraging. A further reason for the complexity is that not all individuals may consider certain local features to influence their health. For instance, not all participants believe that the proximity of the waterfront parks is salutary; not all respondents feel that the North End's reputation adversely affects their health; not all women feel that the limited number and cost of recreation centres unfavourably influences their health; not all women believe that the community atmosphere and composition enriches their overall mental well-being.

Why don't all women living in the North End experience their surroundings in a similar fashion? Why can't all women living in the North End agree upon which attributes affect their overall health and well-being? It is evident in this chapter and elsewhere in this thesis, that although people share the same residential location, they occupy different life spaces and react differently to the conditions and circumstances existing in their lived area (Kearns & Parkinson, 2001) and have different ideas about what constitutes 'health'. Thus, it appears that in order to appreciate the reasons for this variability, it is necessary to consider more closely the characteristics of the women themselves – their socio-demographic profile, their personal histories, their pre-existing level of health and, their experiences and perceptions of the North End. The diversity of responses and reactions to the local environment, even in a small study such as this, attests to the fact that people interact differently with their lived space.

### **Life Stories**

In order to better understand the diversity in women's perceptions and perspectives of the North End neighbourhood, the life stories of six women residing in the area are sketched out here. Situating women in their lived environment provides some much needed context for their reactions to, and their beliefs about, the North End.

#### ***Sally***

Sally is a 38 year old woman of Irish descent who is married and has two children, one boy and one girl. Sally has a college degree. She and her husband both work - part-time and full-time, respectively – and together earn more than \$50,000. The family lives in the west half of the North End in a house that she and her husband own.

She has lived in the North End for 12 years and has a strong network of both family and friends that she can turn to in times of need. In addition, she identifies her religion as an important component of her life, bringing to it a strong sense of right and wrong that has propelled her to stand up for people and volunteer in the community.

Sally considers herself to be in excellent overall health. She describes herself as 'happy and interested in life' and says that her life is 'not too stressful'. Her primary health concern is environmental exposures which exacerbate her asthma and that of one of her children. She attributes their asthma to living in the City of Hamilton (not the North End specifically). Sally is very concerned about the air she breathes and the food she eats. These daily exposures cause Sally serious stress because she worries about the long term effects on her children's health. She feels that she could improve her overall health by decreasing the amount of artificial foods she eats and increasing the amount of organic foods in her family's diet. She also feels her present level of health could be improved by losing some weight and toning up. Sally has begun working out and aims to be at her optimum health by the age of 40.

Sally feels that the most important health concern facing women today is their tendency to ignore their own health. She believes that women have a responsibility to take control of their own health and listen to their bodies. Sally feels that the most important health concerns facing women in the North End are related to daily environmental exposures. She believes that these exposures are related to resulting respiratory ailments, severe allergic reactions, and reproductive problems such as

miscarriage. While Sally knows a number of female North Enders who have experienced these problems, she too has personally experienced all of these problems.

Sally and her husband moved to the North End because they had lived in the neighbourhood when they first got married and liked the area and, because they could not afford to purchase a house in Toronto. She states that the people who live in her neighbourhood are very friendly and helpful and even though they don't all speak the same language, they still manage to interact. What she likes most about living in the North End is its convenience, the NHCHC and the diversity of people. Sally doesn't believe that the reputation associated with the North End is fair. She thinks that outsiders view it as a scary place to live with bikers but that in reality the people who live here feel safe and they never feel threatened. However, although Sally is 'very satisfied' with the North End and would rather live in this area than anywhere else in Hamilton, she would 'very strongly like to move' out of the neighbourhood. She attributes this decision primarily to poor governmental representation (although she notes that the representation has changed for the better) but also to the environmental exposures and to incidents of violent crime.

Sally believes that there is a relationship between health and the place that one lives. She feels her health has been positively affected by being exposed to greater variety of people in the North End which has led to a better life experience and, by having great neighbours that she can count in the event of an emergency. Sally also believes that residents have the power to alter the place-health relationship if they are not happy with the outcome(s) (e.g., Plastimet fire). She feels that heavy industry will keep pushing the

envelope (e.g., pollution levels) and in response, residents have to adopt a stronger political will and begin to (and then continue to) stand up against big business. Sally is a strong environmental advocate, both creating and joining neighbourhood committees and speaking out against environmental injustice.

*Lucy*

Lucy is a 42 year old woman who is single and childless. She lives in the east half of the study location in a home that is owned by her parents. Lucy is a full-time elementary school teacher with a Bachelor of Arts and a Bachelor of Education. Although she now teaches at a school on the Mountain, she did at one time teach in the North End. She earns over \$50,000 per year. Lucy has lived in the North End all of her life. Her parents immigrated to Canada from Italy before she was born. They chose to live in the North End of Hamilton because it was cheaper, there were other immigrants already living there (who spoke the same language and shared the same customs), they were close to the industries that offered work and they were close to their church. Aware of the challenges that new immigrants face, Lucy is currently helping some Kosovo refugees who recently moved into the neighbourhood. Lucy says that she comes from a loving, supportive family.

Lucy is very satisfied with her present level of health and rates it as excellent. She describes herself as 'happy and interested in life' but says that her life is 'somewhat stressful'. She considers her personal safety in the neighbourhood to be a source of serious stress in her life. She worries about crime. Lucy identifies her constant exposure to children's germs as her most important health concern because she is always catching

colds. She feels that the only way she could improve her present level of health would be to lose a few extra pounds.

Lucy believes that the most important health problems affecting women today are breast cancer, uterine problems and a concern about the foods we're eating (the cancer causing agents they may contain). In the North End, Lucy believes the most important health problem is the poor air quality that is the result of local industry and the recent Plastimet fire disaster. She is concerned about the development of lung cancer and respiratory disease because of the air pollution. She believes that the Plastimet fire may have led to the development of serious allergies in the area. She cites the development of new allergies (sneezing and eye irritation) in her cousin and mother as evidence.

Lucy is not very satisfied with living in North End. Although she does like the multicultural make-up of the North End and its proximity to a number of amenities, she doesn't like the crime – the vandalism and robberies – and some of the people who live in the area. Lucy would rather move to the Mountain, the West End of the city or to the Delaware neighbourhood because she likes the houses better (the architecture) and feels that these areas are more convenient. The only reason she remains in the North End is because she lives with her parents in a care-taking capacity. Lucy notes that her parents stayed in the area for financial reasons but also because of the convenience and accessibility it afforded.

Although Lucy likes what the city has done to the harbour (Pier 4 and Harbour Front Parks) and takes advantage of the new park pathways every morning during her daily walk, she believes that a lot of the changes that have occurred have not been for the

best. For example, Lucy has observed a shift from permanent homeowners, especially those of European descent who took pride in their homes, to transient renters who neglect their properties. Lucy is also concerned about a number of other neighbourhood issues such as unemployment, noise, traffic, drugs and alcohol and youth gangs. Lucy believes that there is a strong relationship between health and the environment in which you live. In particular, she feels that her health is being negatively influenced by air pollution. She thinks that living in the North End all of her life and being constantly exposed to the air pollution may have led to the development of some type of cancer in her body that she is not yet aware of. Lucy also feels that her health and the health of her parents is being negatively affected by the crime in the area. Lucy comments that when she was a student at McMaster University she would walk very fast and carry a hat pin with her when she had to walk home at night. Although she never had to use the hat pin, it was always there and she was always ready. Lucy also tells the story of when her father had a stroke and the ambulance came to take him to the hospital. While the family was away from the home, the house was broken into and ransacked from the basement to the attic by juveniles who were later caught. Not long after her father returned home from the hospital, he was robbed as he went for his daily walk (something he had to do because of his stroke). Lucy believes that the stress associated with worrying about the possibility of other criminal incidents occurring, has a harmful effect on her health.

***Carol***

Carol is a 28 years old woman who is married and has three young children aged 5, 7, and 8 years. She identifies her ethnic origin as "Heinz 57" meaning that she's got a

bit of everything: French, Aboriginal and Canadian. Her highest level of education is grade 11. She and her husband rent a home in the east half of the study site. They have resided in the North End for four years. Carol spends her days caring for her family. The primary source of income for her family comes from social assistance with the total household income being less than \$10,000 per year. Carol does not believe that her household brings in enough money to meet all of the family's basic needs. As a result, sometimes they cannot afford to buy enough food. Carol uses the local food banks about once a month but complains that they don't provide healthy food items. She remarks that her children need fresh fruit, vegetables, milk and bread not a package of pasta and a can of sauce. Carol attends to the needs of her children before she takes care of herself and as a result, she notes that she has nothing. The family's limited finances also mean that Carol and her children cannot afford to take advantage of the activities offered (e.g., after school clubs, swimming) at the local recreation centre (Norman Pinky Lewis Recreation Centre). Consequently, Carol has to have her kids with her at all times.

Carol rates her own health as poor, in part, because of the injuries she sustained in a car accident that occurred a couple of years earlier. Although she is receiving physical therapy for the injury (a bad back and neck), she has gained almost 40 pounds. Carol is supposed to go for therapy three times a week but sometimes she cannot get a babysitter to watch her children. Carol feels that her overall health could be improved if she was to lose some weight and stop smoking. Prior to the accident, Carol felt that she was quite healthy but now, she is not nearly as active and is suffering from depression. Carol describes herself as being 'often unhappy' and says her life is 'very stressful'. She

identified a number of factors that she finds stressful such as parenting, relationship with partner, relationship with other family members, lack of employment, money issues, personal safety, and air pollution.

Carol believes that the most important health problems facing women are breast cancer and weight gain as a result of limited daily activity. She believes that the most important health concern facing women living in the North End is the pollution. Carol used to live in Winnipeg where she feels the air is very clean. When she first moved to the North End Carol says she and her children were all sick for a couple of weeks. She attributes this illness to the high level of air pollution in the North End.

Carol and her family moved to the North End because the rent was cheaper and because she has extended family members living in the area. Her house is located near a number of large factories and she now questions her decision to move into this neighbourhood. She remarks that she is 'not at all satisfied' with the area and 'very strongly wants to move' away from the North End. Although Carol cannot afford to move away at this time, if she had the opportunity she would move to the Mountain. She believes that the Mountain is cleaner and offers a better environment for her children.

Carol describes the North End as a ghetto and feels that the negative reputation associated with it is more than fair. There is nothing that she likes about her neighbourhood. What she dislikes most about North End are the kids. Carol says that there are a lot of bad kids around that throw things at her house and van and that their parents don't do anything to stop them. She believes that these parents have no authority over their children, letting them run wild. She reveals that local kids have beaten up her

children because they go to church and abide by her rules. Carol also worries about her personal safety and that of her children because of the prostitutes that hang out in front of the local library. Carol has called the police on a number of occasions to report vandalism and incidents involving alcohol (e.g., fights).

Carol believes that there is a relationship between health and the place that you live. She explains that living in the North End and dealing with the bad kids and all of the other neighbourhood problems causes her a lot of stress that leads to migraine headaches. Carol says that she gets very upset and feels overwhelmed because she doesn't know what to do. Carol also remarks that because she dislikes the North End neighbourhood so much and is scared of the people living in the area, she is uncomfortable going outside. As a result, Carol does not get the exercise she needs in order to lose the weight she has gained.

### *Jane*

Jane is a 42 year old Canadian woman with no children. Although she is single, she has a boyfriend at the present time. She rents an apartment in a high rise building in the west half of the study locale. Jane has completed some university courses but has not graduated with a degree. She spends the majority of her days volunteering at a local church run organization and the NHCHC. Jane's only source of income is a disability pension that brings in less than \$10,000 per year. She says that she has enough money to meet all of her basic needs because she has learned to live within her limited budget.

Jane describes her own health as very good but feels that it could be improved if she stopped smoking and adopted a more structured exercise program. Six years ago Jane

was diagnosed with fibromyalgia, a chronic disorder characterized by widespread musculoskeletal pain, fatigue and localized tenderness that occurs in areas such as the neck, spine, shoulders, and hips. Jane also experiences sleep disturbances and irritable bowel syndrome associated with the disorder. Many of the pharmaceutical medications prescribed for her fibromyalgia produced severe side effects in Jane. She is now working with a specialist to determine the best medications for her to take. Jane mentions that the local pharmacist has been very helpful and supportive, explaining the possible side effects associated with each of the medications prescribed. Jane describes herself as 'happy and interested in life' and says that her life is 'not too stressful'.

Jane believes that the most important health problem facing women is their tendency to put their significant others and their children ahead of themselves. She feels that this inclination to look after others first means that women's own health is often ignored until something serious turns up. In keeping with this, she also feels that women with children need stronger support networks so that they can take time out to look after themselves.

Jane moved into the North End six years ago because she liked the view and having the water so close. She is 'very satisfied' with living in the North End and doesn't want to live anywhere else in Hamilton. She likes the fact that it is a tight knit community where people care a great deal about one another. Jane also likes the NHCHC and all of the innovative and up-to-date services that it offers to community members. Jane notes that she has used about every service that the NHCHC has to offer. In particular she has taken advantage of their physiotherapy department and, she volunteers with the garden

program. The only thing that she doesn't like about the North End is that it is located so close to the factories that are polluting the air. Jane is aware of studies that have linked higher incidence of asthma and respiratory problems in North End children to the poor air quality caused by the factories. Aside from the problem of pollution, she does not think that the neighbourhood suffers from any other troubles. Jane believes that there is a strong negative and positive relationship between health and place. She considers the air and water pollution in North Hamilton to be serious personal stressors. At the same time, however, she considers the water, the view and the wildlife to be important stress relievers.

Jane really loves living in the North End. She believes that anything a North Ender needs – whether the needs are physical, emotional, spiritual or medical – can be easily attained in the neighbourhood. Jane says that it's just a matter of reaching out and the help is there. She states that everyone in the North End community knows everyone else and because of that, there are incredible social support networks available.

### *Teresa*

Teresa is a 40 year old, Canadian woman. She is the divorced mother of three girls. She lives in the east half of the study locale in a house that she rents. She has a Bachelor of Arts degree and a Bachelor of Education. She spends most of her days caring for her family and volunteering. Teresa's primary source of income is social assistance (government work fair in which she must volunteer for 70 hours per month) which brings in between \$10,000 and \$20,000 per year. She does not feel that she has enough money to meet the basic needs of her family. Teresa feels that her diet would be much better if

she could afford to buy more fresh fruits and vegetables. To alleviate that problem she would like to plant a garden in her back yard but believes that the soil is too polluted. Teresa also notes that the lack of money means that she cannot afford to buy her family new clothes and that she and her girls cannot afford to participate in social activities such as eating out or going to the movies. She says that she always looks for food sales and walks as much as she can to cut out the cost of transportation.

Teresa rates her health as 'very good' but believes that it could be improved through exercise and through a decrease in environmental pollutants. She states that her primary health concerns are allergies and a mild form of asthma. Teresa believes the development of these ailments may be linked to her being born in the North End and having remained here most of her life. Although Teresa believes that she has some control over her own health she does not feel she has control over situations, such as the air pollution, that occur in the larger environment. Teresa describes herself as 'sometimes happy' and her life as 'somewhat stressful'. Her major source of stress is her ex-husband but she also notes that parenting, her children's health, money issues and personal safety cause her some anxiety. Teresa believes that her health is affected by her level of stress; causing her to become irritable, lose sleep and not eat properly. When the need arises, Teresa utilizes the community health centre located in the downtown core. However, she remarks that this is not very convenient for her and would prefer a place more centrally located.

Teresa thinks that the most important health concerns facing women today are menopause, cancer causing agents in food, heart disease and the stress associated with

being a modern day mother who has no time to relax. In the North End, Teresa feels that the most important health concerns are: breathing difficulties associated with the high levels of pollution and the Plastimet fire; safety, because it is a high crime area; lack of recreational facilities that allow individuals the opportunity to exercise and socialize; and poor eating habits because it is a low income, transient area. Teresa believes that her health is negatively affected by living in the North End.

Teresa has lived in the North End on and off for most of her life. She decided to remain in the area because of the cheaper rent and because she grew up in the neighbourhood. What Teresa likes most about the North End is the familiarity she feels with the area, that the buses are easily accessible, and that the library is nearby. Although she is 'somewhat happy' with living here, she says that she would 'very strongly like to move'. Teresa has seen a number of changes occur in the neighbourhood over her lifetime. She says that the area is more run down and there are a lot more empty buildings. She doesn't like the loud noises, the lack of parks, or looking at the factories. Teresa thinks that unemployment, smells and fumes, and incidents of vandalism and burglary are serious problems in her neighbourhood. She notes that her home has been vandalized and that there have been seven or eight break-ins on her street. Although Teresa doesn't believe everything she hears about the North End's sullied reputation, she does acknowledge that the area is dirty, poor and crime ridden. She feels that city does not invest as much money here as they do elsewhere, in part, because North Enders are not vocal enough about their needs.

It is Teresa's dream to move out of the area; she considers the North End as her family's first step on their journey of life. If Teresa had the opportunity, she would move her family to the West End of the city, near Dundas, because this area is more residential with less factories.

*Helen*

Helen is a 78 year old widow of Scottish descent who has four grown children. She lives with her sister in a central area of the study locale in a house that she owns and has been paid off. Helen's highest level of education is grade 8. She receives an old age pension that amounts to approximately \$13,000 per year. She feels that this is enough money for her to meet all of her basic needs. Although Helen does not have a lot of friends remaining (most of them have died over the years), she says that she has her family to turn to in times of need.

Helen rates her overall health as 'very good' and does not feel that there is anything that she could do to improve it. She identifies her main health concerns as her lack of eye sight (a hereditary form of macular degeneration), a stomach ulcer and arthritis that comes and goes. Helen believes that everyone has control over their own health; that it is a frame of mind. If you keep busy and don't dwell on things then you don't feel sick. Helen appears to be a testament to this type of thinking. She is involved with a number of activities offered by the "Y": pottery; swimming; weight classes; chair exercises; bowling; and a seniors group. Helen describes herself as 'often happy' and feels that her life is 'not too stressful'. The only things that she really worries about are

her own health and the health of her children. Helen receives the majority of her health care from a physician located outside of the North End.

Helen thinks that the main health problems facing women today are nerves and tension caused by financial stresses and the need to work both at home and outside the home. She feels that the primary health concerns in the North End are related to the factories, the dirt, the smells and particularly to money problems. Helen says that most families in her neighbourhood have children and because of that, the mother cannot work. Consequently, the family must exist on one income which means they have limited funds for buying food. Although Helen believes that there is a relationship between health and place, she thinks that the social circumstances are far more important to overall health and well-being than the physical conditions of the environment: if you're not happy then you don't feel good.

Helen has lived in the North End for 58 years and in her present home for 50 years. She decided to move to the North End because a house became available next to where her mother lived. Helen is 'not too satisfied' with the neighbourhood and she 'very strongly wants to move'. She has tried to sell her home but because the asking price is so low, she would end up losing too much money on the deal. Helen says that it is an old house that never got the repairs it needed because her husband died. She says that there is nothing about living in the North End that she likes anymore. Helen says that the North End used to be very nice with everything close at hand (e.g., shops) but now everything has faded way to nothing and the neighbourhood has become rough. She identifies personal safety as a serious problem in the North End. Helen knows of a number of house

break-ins in the area. She doesn't go out at night anymore. Although Helen thinks that her neighbours are generally quite friendly and not a problem, she says that she doesn't interact with them very much because she can't speak their language (there are many Portuguese and Asian people living in the neighbourhood) and because there is a constant turn over of residents. Helen knows the people who live on either side of her and comments that it is important to her to have friendly neighbours that she gets along with because it makes her feel better to know that there is someone close by to call if she needs help.

Helen is not sure if the North End's tarnished reputation is justified or not; people have told her that it is valid. She thinks that although the neighbourhood is a little poorer and has a few more immigrants, the problems experienced by North Enders are also experienced elsewhere.

### **Discussion**

Although there has been a tendency to think of individuals living within the same community as being homogeneous - having shared socio-demographic characteristics and similar interests, values and aspirations - communities are in fact composed of a heterogenous group of people. Comparing the demographic profile, health conditions, and personal histories of these six women reveals significant variations in their age, ethnicity, marital status, family size (number of children, no children), education level, employment status, income level, health status, tenancy (owner versus renter), length of time spent in the North End, personal interests, social support networks, degree of community involvement and level of vulnerability. The high degree of variability, even in

this small subset of the study sample, helps explain the inconsistency in women's responses to the health and place questions. It also provides further support for the notion that human health does not take place in a vacuum but rather is the result of individuals reacting with their lived environment. It furthermore highlights the need for researchers to consider the characteristics of both the place and the people living there when they investigate the relationship between health and place.

Because this study was qualitative in nature (i.e., generates an extensive amount of detailed information from a much smaller number of individuals), it is not possible to make statistical generalizations about which personal characteristic(s) is responsible for specific perceptions and experiences of the North End neighbourhood. For example, not all low income women are forced to live in the North End because of financial constraints (e.g., Jane), not all homeowners are satisfied with the neighbourhood (e.g., Sally), and not all high income women have a choice about whether they remain in the area (e.g., Lucy). Other quantitative studies, however, have found significant differences in how individuals living in the same place perceive their residence. For instance, a study conducted by Ellaway et al (2001:2304) on four contrasting neighbourhoods in Glasgow found that:

1. females reported significantly higher levels of perceived neighbourhood problems than males;
2. middle aged people reported more problems than younger and older people (but this was not statistically significant);
3. lower socio-economic status individuals had significantly more negative perceptions;

4. individuals who worked outside the home reported the lowest perceived neighbourhood problems while those who worked in the home reported the highest;
5. and, home owners tended to have a more positive neighbourhood outlook than those that rented.

Ellaway and colleagues (2001:2306) also found that: (1) the older the resident the more likely s/he was to report high neighbourhood cohesion; (2) individuals who owned their homes reported high social cohesion; (3) retired residents had the most positive assessment of neighbourhood cohesion; and (4) those working outside the home had the most negative appraisal of neighbourhood interaction.

Although my study of the North End of Hamilton only focused on women, there is a growing belief that men and women are affected by their lived environment in different ways. Kettel (1996:1376), for example, argues that because men and women lead “gender-differentiated lives”, they occupy and use different life spaces which make them susceptible to different environmental risks. Kettel’s findings are strongly supported by Cornwell (1984) who’s study based on life in East End London revealed that even a husband and wife do not experience community in the same manner because of the different social and geographical spaces they occupy. Moreover, Molinari and colleagues (1998) found that women’s health was more greatly affected by the social quality of the community, while men’s health was influenced more by its physical features.

As noted earlier in this thesis, it appears that choice plays an important role in how residents perceive their surroundings and may account for some of the variability. From this small number of life stories, we see that living in the North End is a matter of

constraint rather than choice for a number of women. Although financial limitations are the primary barriers to choice of neighbourhood location (e.g. Carol and Helen), familial obligations can also play a role (e.g., Lucy). Individuals who have no alternative but to live in the North End tend to be less satisfied and more likely to focus on the negative attributes associated with the area and the people who reside there. These individuals are also more inclined to believe that their health is being negatively affected by the neighbourhood in which they are forced to live.

The variability in residents' perceptions may also reflect the amount of time that individuals spend in their neighbourhood. For example, it has been suggested that women, older people and socio-economically disadvantaged individuals may be more constrained to their local areas than other residents and consequently, may be affected more extensively by their lived environment (Macintyre and Ellaway 1998:91). For example, because Theresa does not own a vehicle, she walks most places because she cannot afford to take public transportation. Consequently, her financial situation restricts her ability to leave the area. Takano and Nakamura (2001) suggest that because women spend more time in their lived environment than do men, they are influenced to a greater extent by their residential locale. Accordingly, these researchers point out that projects aimed at improving urban life should respond mainly to the identified needs and demands of the female population.

In addition to differences in the socio-demographic characteristics and the amount of time that individuals are confined to their neighbourhood locale, varying expectations of residents about their neighbourhood may influence their overall perceptions. For

example, Sooman and Macintyre (1995) found that although public transportation was not as good in poorer neighbourhoods, respondents from these areas did not report it as so, indicating potentially lower expectations in the poorer areas. Their findings suggest that middle class residents have higher expectations of their living space than do working class residents. In the North End study, women may have lower expectations of the neighbourhood because of its sullied reputation and because of the negative messages they hear about it from the media and from individuals living both within and outside the community.

The inconsistency in women's interpretations of, and experiences with, the North End neighbourhood implies that participants are uniquely affected by the attributes of their place of residence. The variability in their perceptions about the features of the North End and about how they affect their health, suggests that factors such as socio-demographic characteristics (e.g., age, income level, tenancy), choice of residential location, time spent in the neighbourhood on a daily basis and preconceived expectations of the neighbourhood may influence women's interaction with their surroundings and residents who live there.

### **Summary**

Research conducted during the last decade has revealed that human health can be affected by a variety of neighbourhood characteristics. Women in this study overwhelmingly indicated that they believe there is a relationship between their health and certain features of the North End neighbourhood. Participants pointed out a number of place-based characteristics – physical environment, locational characteristics, local

services/facilities, area reputation and the socio-cultural environment – that they feel enhance and/or compromise their overall well-being.

The majority of participants feel that their physical health has been adversely affected by the air pollution emanating from nearby steel companies and from the 1997 Plastimet fire incident. Air pollution was by far the most significant negative attribute associated with the North End. Poor air quality was thought to contribute to current levels of poor respiratory and general health and to carry with it the potential to adversely affect future health outcomes. Women also felt that their mental health was negatively influenced by high levels of stress and fear associated with a wide range of neighbourhood features such as crime/personal safety, over-representation of social service dependent individuals, the area's reputation, noise levels and future ramifications of being exposed to high levels of air pollution. Many of these stressful situations, in addition to the cost, proximity and number of local recreation facilities, were also identified as potential barriers to physical activity and social interaction.

Although many outsiders, and some local residents, may question the existence of any health promoting North End attributes, participants stated that features such as the parks, the view and the community involvement and atmosphere were responsible for improving their physical and mental health. The parks were viewed as promoting physical activity and increasing social interaction while the view of the water and the wildlife was felt to relieve stress. Contact with neighborhood residents, the strong sense of community and the diversity of the North End population were viewed by a number of women as having a positive and “stimulating” effect on residents’ mental health. Many

women commented on how much they liked their neighbours and how they trusted them to be there in times of personal and/or familial need. Several participants also indicated that they were involved in community level associations and events which increased their level of social interaction.

While there was some consensus among residents about which place-based features have a health promoting and/or health damaging effect on health (e.g., air pollution), there was also some variation in women's perceptions (e.g., not all women identified the availability of parks in the North End as health enhancing features, not all women thought the prevalence of neighbourhood crime negatively influenced their well-being). The variable way in which women living in the same neighbourhood perceive their environment suggests that people are differentially affected by the characteristics of their place of residence. Since women are being exposed to the same environment, it follows that an individual's personal characteristics must play a role in how they interact, experience and interpret their lived surroundings. The six life stories presented in this chapter clearly highlight the heterogeneity at the community level and emphasize the need to consider both the attributes of the place and the characteristics of the people who reside there.

In other words, people and places are interrelated. This view is upheld by Relph (1976:34) who states:

In short, people are their place and a place is its people, and however readily these may be separated in conceptual terms, in experience they are not easily differentiated. In this context places are 'public' – they are created and known through common experiences and involvement in common symbols and meanings.

This is also an opinion supported by Popay (2000), who unlike most health and place researchers, believes that compositional and contextual effects are related and cannot be separated. Popay (2000:401) challenges area researchers that concern themselves with what she believes is the “artificial pursuit of separation between the composition and context of an area”. Consequently, when investigating area effects on health, it is important that researchers consider the characteristics of both places and people.

## **CHAPTER EIGHT: CONCLUSIONS**

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This thesis documents North End women's health concerns and experiences and contextualizes their perspectives and perceptions within their every day lives. Although there is a strong tendency for researchers to think of people living in a neighbourhood as having common backgrounds, shared circumstances and similar interests, values and aspirations, the results of this study have shown a significant amount of heterogeneity at the local level. The women of Hamilton's North End represent a diverse group of individuals who vary with respect to their demographic characteristics, personal experiences, perceptions of life in the North End, and their health needs and concerns.

Women's health has traditionally been defined biomedically with a focus on reproductive attributes while other components of women's health, such as their social and psychological well-being, have been neglected. Definitions of health provided by participants in this study clearly reflect their awareness of the multidimensional nature of health. The term 'health' was broadly conceptualized as incorporating physical, emotional/mental and spiritual components.

More than half of the women in this study (56.6%) identified their physical health as excellent or very good, while 63.1% of participants stated that they were happy and interested in life or often happy. However, almost three-quarters of all women indicated that their lives were quite stressful as a result of factors such as air pollution, their own health, money issues and unrealistic expectations placed on them by other family

members and by society in general (i.e., pressure to be “super-moms”). They associated their stress with a wide range of negative health outcomes such as migraines, increased blood pressure, nausea and poor sleep patterns.

At the personal level, the most important health problems mentioned were smoking and being overweight (each representing 10.1% of all responses). When responses were grouped into categories, physical health problems (55.7%) such as back/joint problems and respiratory ailments were identified most frequently followed by health risks (29.1%). For Canadian women generally, participants identified cancer (in particular breast cancer) (34.2%) and stress (12.2%) as the most important health problems. Once again, when the health problems were categorized, physical health concerns (47.6%) (e.g., cancer, osteoporosis and heart disease) were mentioned most often followed by mental health problems (20.7%), such as depression and stress. When asked to identify the primary health concerns for North End women, respiratory problems associated with local levels of air pollution were overwhelmingly identified (41.7%). Not surprisingly, when responses were grouped, health risks (both environmental and lifestyle) were identified most often (63.9%) followed by social problems (16.7%) such as poverty and lack of education.

When asked to identify priority areas that should be addressed if a new women’s health program were to be created in the North End, most participants identified programs that focus on improving personal appearance, self worth, skill levels and social contacts. Women did not, as one might have expected given the perceived associated respiratory consequences, focus on the physical environment. This lack of congruence is

interpreted to reflect issues of control and power; most North End women do not believe they have any influence over the primary polluters (e.g., Stelco and Dofasco).

Asking participants to openly discuss their own health concerns and those of women at the national and local levels revealed that not only are North End women aware of the multifaceted health issues facing the female population, but they also recognize that women do not represent a uniform group of individuals all experiencing the same health problems and requiring the same health care. The inconsistencies identified between the three levels of analysis (personal, general/national and neighbourhood) reflect women's personal life experiences, the experiences of their family and friends, and the quality of life in the North End neighbourhood. Their responses reveal that women's health problems and priorities are deeply entrenched in their everyday lives. Women's personal, day-to-day experiences were also found to have a profound effect on their assessment of the North End neighbourhood.

The North End represents a neighbourhood that has been, and continues to be, marginalized. Initially, the social, economic and ethnic segregation, along with the physical topography of the area, acted to isolate North Enders from the rest of the City of Hamilton. North End residents were and still are perceived to be different from other members of society and, as a result, a number of negative myths evolved that highlight demoralizing features of the area and of those who reside there. The negative reputation associated with the North End continues even though positive changes have occurred. Factors such as the history of the area, rumour, negative media portrayals, lack of

political concern and the socio-demographic composition of the neighbourhood facilitated the creation and maintenance of the North End's stigmatized image.

Though there is no longer a physical separation between the North End and the rest of the City of Hamilton, there still remains a definite disconnection between North Enders and other Hamiltonians. Many outsiders still consider everyone in the North End to be different from themselves; they view them as poor, drunk and rough. Outsiders believe that only people without financial resources live in the North End and that given the choice and economic means, everyone would leave the area immediately. In reality, the North End is an eclectic and colourful place to live with a diverse population representing people from all walks of life.

While many non-North Enders believe there is nothing positive associated with living in the neighbourhood, the North End actually exhibits both positive *and* negative attributes. Participants stated that what they like best about the North End is its accessibility to local amenities, the people who live there, the strong sense of community, and its proximity to Hamilton Harbour. What women like least about the North End is the air pollution (and proximity to polluters), some of the people, noise, garbage strewn around, lack of property upkeep, evidence of poverty and neglect, and the area's reputation. When women were asked to comment further on the quality of the North End by indicating the existence or absence of certain neighbourhood problems, they overwhelmingly identified smells and fumes, unemployment, air pollution, water pollution and poverty as serious problems. Crime and issues surrounding personal safety also emerged as significant concerns for women in the North End. Moreover, participants

indicated that the North End's sullied reputation has negative consequences for its residents because the stigma associated with the area is projected onto the people who live there. Accordingly, women are discredited by the same attributes that are ascribed to the North End neighbourhood.

It appears that personal agency plays a central role in determining how women perceive their surroundings. Those individuals who had the capacity to choose where they resided were more satisfied with the North End and more willing to overlook some of its faults than those women who were forced ("placed") into the neighbourhood because of financial reasons or because of familial obligations. In order for people to be happy with their place of residence it is important that they believe that: (1) they have a choice of location (i.e., they chose to live in this neighbourhood and they can choose to stay or leave if they wish) and; (2) others would also wish to live in their neighbourhood (Kearns and Parkinson 2001). Considering that most study participants live in the North End for financial reasons and that most outsiders wouldn't dream of moving to the area, it is not hard to understand why many women are dissatisfied with the North End neighbourhood and unable to see any of its positive qualities.

Women in this study strongly believe that place matters to health. Their overwhelming acknowledgement of a relationship between the North End neighbourhood and their health supports a more holistic, community-based framework for conceptualizing health. North End women indicated a variety of place-based characteristics – physical environment, locational characteristics, local services/facilities,

reputation and socio-cultural environment – that compromised and/or enhanced their overall health and well-being.

The most important negative attribute identified was air pollution. Most residents believe that local air pollution compromises their present level of health causing a wide range of respiratory illnesses such as asthma and bronchitis. Participants also believe that the air pollution may lead to serious health problems, such as cancer, in the future. The noise and the smells and fumes associated with the North End also raise fears of negative health outcomes. Women indicated that the noise levels cause them to feel “stressed out” and the smells and fumes make them feel sick and sometimes make it difficult to breathe. High levels of local crime and feelings of personal peril are additional negative place-based features that are thought to unfavourably affect health by leading to outcomes such as increased levels of stress, decreased physical activity and increased social isolation. The neighbourhood’s sullied reputation was also identified as having a negative effect on women’s health. A constant onslaught of negative community portrayals can be detrimental to the mental health, self-esteem, morale and well-being of community members. Even women who contest the negative reputation describe being “sick” and “tired” of having to defend their decision to move into the North End. The high cost of, and distance to, community recreation centres is believed to adversely affect both physical and mental health as women are restricted from taking part in organized physical activity and from interacting with other individuals.

On the other hand, the availability and accessibility of neighbourhood parks (e.g., Pier 4 and Bayfront) are believed to confer health benefits such as increased physical

activity and improved mental health. Moreover, the strong community atmosphere coupled with pleasant neighbours whom one can trust is believed to increase the level of social interaction, promote personal empowerment and encourage local level networking and collective action (i.e., social capital). The existence of social capital in a neighbourhood is associated with lower mortality rates and improved mental health (Kawachi et al 1997; Kawachi and Berkman 2001). The absence of social capital on the other hand, has been linked to a number of negative health related outcomes such as high rates of child abuse and higher rates of teen pregnancy (Taylor et al 1997).

However, not all women identified the same health-influencing attributes and not all women concurred about which North End characteristics contribute positively and negatively to their health. While some women identified air pollution as negatively affecting their health, others identified the community atmosphere as having a positive influence, and while some women think the people of the North End make their health better, others think that they lead to a decrease in residents' health because women are afraid to socialize with their neighbours.

It became evident quite early on in this study that although women occupy the same neighbourhood, they interact and experience the North End in radically different ways. What accounts for these differences in perceptions and perspectives? Fitzpatrick and LaGory (2000:9) suggest that,

We live in personal worlds, so that the very same places may be understood and defined very differently by persons with different sociocultural backgrounds and personal experiences. One person's heaven may be another's hell.

The differences in North Enders' perceptions about the neighbourhood and the effects that neighbourhood attributes have on their health appears to reflect variations in participants' health status, needs and priorities, socio-demographic profile, feelings of personal agency, satisfaction levels, time spent in the neighbourhood on a daily basis, and area expectations. For example, women who chose to move into the area because of its multicultural make up, proximity to the waterfront and colourful history, are more satisfied with the neighbourhood and perceive it as having a positive influence on their health. On the other hand, women forced into the North End because of financial constraints are more likely to perceive the neighbourhood as having only negative effects on their health. Thus, it appears from the diverse way in which women living in the same place perceive their environment and its potential health effects, that the characteristics of people and places are closely interrelated. The process of trying to sort out the contextual and compositional effects on health is an "artificial" endeavour (Popay 2000).

Given the relationship between compositional and contextual features, it is important that we consider the opinions of 'ordinary' women because their viewpoints represent contextually appropriate information that may uncover previously unrecognized or insufficiently understood health issues. The narratives of lay people represent a diverse and 'privileged' form of knowledge about the places in which they live, their health concerns, and the dynamic relationship between health and place. The unique perspectives presented by 'ordinary' citizens symbolizes a subjective understanding that differs significantly from the "objective", sanitized facts put forth by 'experts' who have no personal, lived connection with the place and the people they study. Instead of

underestimating the importance of personal experiences and observations and regarding them as biased and unscientific, researchers should begin using them to enhance their understanding of women's health. We need to acknowledge that expert opinions about women's health, and about the relationship between health and place, may lie not only in the academic community but also in the lived community. Information provided by local residents may actually challenge the way in which the media, health researcher or policy 'experts' portray a neighbourhood (Popay et al 1998).

Surprisingly, most research on health and place to date has been conducted using quantitative methodologies that tend to represent neighbourhoods as homogenous entities. Ethnographic (qualitative) methods, though rarely used in this type of research, reveal that neighbourhood populations can be composed of diverse groups of individuals (Sampson et al 2002) who vary significantly in their responses to place. This study, which sought out the opinions and knowledge of North End women, was able to clearly illustrate the heterogeneity inherent at the local level. Quantitative approaches to data gathering and analysis often mask individual variability and thereby conceal important information that may alter research outcomes. Employing qualitative techniques, such as interviewing and focus groups, allows researchers to address the issue of variability at the local level while at the same time providing richer interpretations of the lived environment. Frumkin (2003:1451) maintains that in order for researchers to gain a full understanding of the effects of places on people, it is necessary to acknowledge the existence of human variability. The analysis of narrative accounts improves our

understanding of place effects, lay perceptions and the mechanisms underlying the relationship between health and place (Thomson et al 2003).

The gaps in our understanding of women's health and the lack of solid research on women's health issues prevent us from correctly identifying appropriate policy and program initiatives, and useful intervention strategies (Health Canada 1999b). Walters (1991:33) supports this notion:

It is only when women's concern are documented that there is the possibility of taking them into account in policy making. No longer can physicians and other key informants and experts claim the unchallenged right to define women's health.

'Ordinary' women have the knowledge to help fill some of these gaps and in doing so may strategically refocus and redirect decision-makers. Incorporating lay women's own health ideas into priority setting is essential to the design of sustainable women's health promotion programs (Denton et al 1994:1).

The present study has several implications for future research on women's health and for program and policy development. First, it appears that more resources are needed in the area of weight control, since the women in this study consistently indicated that this health risk was important to them. Given that the majority of women in this study are dissatisfied with their body image, and the epidemic of obesity in North America, issues surrounding weight, nutrition and body image must be dealt with immediately. One way to address this problem is through the increased convenience and affordability (decreased costs or subsidies for low income families) of local recreation centres which would allow many more North End women to participate in organized physical activity in a safe environment. Better availability carries with it the potential to improve women's physical

fitness level, facilitate weight loss, decrease stress levels that may allow women to quit smoking, and increase their social networks. Not only will these changes improve their mental well-being, but they will also decrease their risk of developing cancer, heart disease, osteoporosis and diabetes (diseases that women stated they were worried about developing).

Second, it seems that the creation of a women's resource centre that focuses on non-medicalized, health-related problems such as increased social interaction, nutrition, increased education levels and improved parenting skills, is a high priority for North End women. It is thought that the establishment of such a centre would help unite and empower neighbourhood women. Women's identification and prioritization of less conventional means of improving their health calls attention to the need for health agencies and governmental decision-makers to employ a very broad based framework in their understanding of health. Although there is an increasing awareness of the multidimensional factors involved in health, most industrialized nations still continue to allocate a large majority of their scarce resources to health care approaches (Renaud 1994) and to focus health policy on traditional health/medical care interventions (Marmor et al 1994). Consequently, funding allocation and policy formulation are being directed toward less effective health interventions, and away from more useful strategies for health promotion and illness prevention (Health Canada 1999b).

Third, it appears from participants' focus on place-based health risks, such as pollution (air, water, noise), crime levels, and the neighbourhood's negative reputation, that characteristics of the lived environment must be addressed in health program

development. Decreasing pollution levels in the North End, and in Hamilton in general, requires a commitment from provincial (Ministry of the Environment) and national (Environment Canada) level government agencies to create and enforce more stringent emission guidelines; municipal governments to monitor daily emissions; industry's themselves to remain within or below government guidelines; and residents to be consistently vocal about their unhappiness with pollution levels and the associated negative health outcomes.

Decreasing crime levels in the North End and improving women's feelings of personal safety necessitates an increase in police presence in the North End. Establishing community policing centres and programs such as Neighbourhood Watch and Block Parents may help North End residents to feel more secure in their neighbourhood.

Changing the image of the North End means dispelling many deeply entrenched myths; "cleaning out' the inappropriate images and installing new ones..." (Shields 1991:256). Having more neighbourhood events that build on local assets such as the parks and the sense of community, and that will attract non-North Enders to participate in them, may help to promote more positive feelings about the North End community as a whole. Improving the reputation of the North End will improve the mental health, self esteem, morale, and well being of community members thereby decreasing the chronic stress, anxiety, depression and/or hostility associated with discredited neighbourhoods (Taylor et al 1997).

The results of this study have shown that women's health must be approached in a much more holistic manner that emphasizes the socio-environmental determinants of

health. Policies and programs aimed at promoting women's health should take into account both the characteristics of the people and the attributes of the places in which they live. Gathering in-depth information from women residing in this place allows researchers and local politicians to make more informed decisions about future neighbourhood plans.

This project is a case study of one neighbourhood in Hamilton and represents the perspectives, at one point in time, of a small group of female North End residents. Consequently, generalizing the results is inappropriate. However, the findings from this study do contribute to the overall scholarship on health and place as they reveal ways to improve the quality of future research endeavours. For example, future studies into the effects of area characteristics on health should include a comparison of male and female viewpoints since these may differ. Research conducted by Molinari and her counterparts (1998) revealed that men's health tended to be affected more by the physical features of the environment while women's health appeared to be influenced more by a community's social characteristics.

Future projects should also strive to incorporate qualitative approaches into the research process because aggregate level, quantitative data tends to portray neighbourhood populations as fairly homogeneous; ethnographic methods unmask the diversity at the local level. Surprisingly, many recent studies on health and place (e.g., work done by Macintyre) have used mainly quantitative techniques to gather and analyze place-based data. As Jones and Moon (1993:520) so aptly remark: "People should not be reduced to statistical aggregates, and places should not be reduced to generalizations".

The study conducted in this target neighbourhood should be replicated across neighbourhoods throughout the City of Hamilton since residents' needs and perceptions will vary across space. In addition, I would recommend that upcoming research attempt to carry out longitudinal studies so that changes in the lived environment can be examined over time because as Diez Roux (2001:1790) notes, "People change neighborhoods over their life course, and neighborhoods themselves may also change over time". It is important that researchers be aware of past circumstances, understand current conditions and be attentive to the future vision of the neighbourhood from the perspective of the residents. In so doing, a researcher can help develop strategies, policies, and services that serve the needs of the residents in a particular neighbourhood. Recent studies on place and health have focused primarily on neighborhoods at one point in time (Diez Roux 2001). Although this study similarly captured only a moment in time, it is quite clear from background information gathered on the North End that the history of this neighbourhood plays a significant role in how the area is perceived today by insiders and outsiders.

A review of the anthropology literature revealed that place is an under theorized concept in the field as a whole. Rodman (1992) believes that it is time for anthropologists to acknowledge that places, like voices, are local and multiple and can be represented and interpreted in many different ways. In re-conceptualizing place in anthropological studies, it is important that we bring individuals' voices into the analysis so that we can represent their perceptions and perspectives.

While sociologists, medical geographers and environmental researchers have begun to integrate the concept of place into their health studies, medical anthropologists are still viewing place as merely a backdrop (an “inert container”) for their research. The findings from this study alone support the notion that place is an important health determinant that deserves serious consideration by medical anthropologists who have the methodological expertise to carry out the type of local level analysis required. Medical anthropologists, moreover, have the theoretical frameworks to evaluate the relationship between health and place. Employing paradigms such as the biocultural model and the critical interpretive approach that build on the personal knowledge and interpretations that individuals themselves assign to health concerns in their communities, allows anthropologists to obtain a comprehensive and meaningful understanding of an individual’s lived experiences. The discipline’s failure to incorporate place into its theoretical frameworks is a critical oversight given that place can enhance or compromise overall health and well-being. As geographer, Gatrell (1997:141) notes: “There is a very real sense that health needs to be put in its place”.

Appendix 1: Poster Advertising the Study

# NORTH HAMILTON WOMEN'S HEALTH STUDY

*WOMEN OF ALL AGES NEEDED  
TO TAKE PART IN A SHORT INTERVIEW  
SESSION*

*This study focuses on the health needs of women living in the North End of Hamilton. In the interview I will be asking you to discuss the ways in which you think your health may be affected by the environment in which you live.*

## \$10.00

given to all individuals who participate

*If you are interested in participating or would like more information please call the Anthropology Department at McMaster University at 525-9140 (extension 24423) and ask for Tracy.*

Appendix 2: Consent Form

**Appendix 2: Consent Form**

Dear Participant,

My name is Tracy Farmer. I am a PhD student in McMaster University's Department of Anthropology. I am doing research on the health needs of women in the North End of Hamilton. I will be asking your opinion about the way you think your health may be affected by the environment in which you live, work and socialize with your family and friends. I am exploring this issue because very few studies have examined the way in which women think city living affects their health. The results of my study will be given to health care providers and community-based organizations in Hamilton to inform them of your experiences and concerns. It is my hope, that the information will be used to create better health-related programs for women that will improve the overall quality of their lives.

This interview takes about one hour to complete. There are no right or wrong answers. You are free to decline answering any questions that make you feel uncomfortable. You can withdraw from the interview at any time. With your permission, the interview will be tape recorded. If at any time you decide you don't want your answers to be recorded, let me know and I will turn off the tape and take notes instead. If you wish, I will provide you with a written copy of your interview and a report of my study findings. I promise to keep your identity confidential.

I sincerely appreciate your participation. If you would like more information about the study you can reach me at McMaster University at 525-9140, ext. 24423.

Thank you,

Tracy Farmer  
Department of Anthropology  
McMaster University

Participant's Name \_\_\_\_\_

Participant's Signature \_\_\_\_\_

### Appendix 3: Interview Questionnaire

Code: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Participant: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Birth/Age: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Do you have any children? \_\_\_\_\_

Are you presently working? Where? \_\_\_\_\_

Interview Location: \_\_\_\_\_

Interview Start Time: \_\_\_\_\_

Interview End Time: \_\_\_\_\_

Tape Number: \_\_\_\_\_

Can you tell me how you heard about this study? \_\_\_\_\_

#### PERSONAL HEALTH

Can you tell me what the word "health" means to you? (Can you define the word health? What do you think of when you hear the word "health"?)

How would you rate your own health? Would you say it is:

- Excellent \_\_\_\_\_
- Very good \_\_\_\_\_
- Fair \_\_\_\_\_
- Poor \_\_\_\_\_

In general, compared to other women you know that are your age, would you say that your health is:

- Better than theirs \_\_\_\_\_
- Same as theirs \_\_\_\_\_
- Worse than theirs \_\_\_\_\_

How satisfied are you with your present level of health? Would you say that you are:

- Very satisfied \_\_\_\_\_
- Somewhat satisfied \_\_\_\_\_
- Not too satisfied \_\_\_\_\_
- Not at all satisfied \_\_\_\_\_

Do you think that your present level of health could be improved?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

**YES** - How do you think you could improve your present level of health? (In ways could you improve your current state of health?)

Do you feel that you have control over your own health? (what happens to your health, how healthy you feel)

- Yes \_\_\_\_\_
- No \_\_\_\_\_

**NO** – What makes you feel that you have no control over your own health?

What do you consider to be your most important health problems (health concerns)?

Are you now, or have you, been receiving treatment for these problems?

What do you think brought on/caused these health problems?

Do you think that these problems affect the way you live your life? (How?)

Looking back, say since your teen years, would you say generally that you have experienced good health?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

**YES** - Do you contribute your good health to anything in particular? (for example, anything that you did, anything that you didn't do, any food that you ate etc..)

**NO** - Would you mind telling me a little about your past health problems?

Do you think that your present level of health is affected by your past state of health?

- Yes \_\_\_\_\_
- No \_\_\_\_\_
- Don't know \_\_\_\_\_

**YES** - How do you think it has been affected?

What do you think are the most important health concerns facing women today?

What do you think are the most important health concerns facing women living in the North End of Hamilton?

Are you personally concerned about these health problems?

Do you think that there is relationship between health and the environment (place) in which you live, work and interact

- Yes \_\_\_\_\_
- No \_\_\_\_\_

Can you give me an example of how you think the two are related? How your own health has been affected by the environment in which you live?( can be a positive experience or negative one)

Which of the following best describes how you usually feel?

- Happy and interested in life \_\_\_\_\_
- Often happy \_\_\_\_\_
- Sometimes happy \_\_\_\_\_
- Often unhappy \_\_\_\_\_
- Unhappy with little interest in life \_\_\_\_\_

Would you describe your life as:

- Very stressful \_\_\_\_\_
- Somewhat stressful \_\_\_\_\_
- Not too stressful \_\_\_\_\_
- Not stressful at all \_\_\_\_\_

Can you tell me if any of the following situations make you feel stressed or anxious?

**Situation**

**Yes      No      Don't Know      No Answer**

- Parenting
- Your child's health
- Your own health
- Relationship with your partner
- Relationship with other family member(s)
- Your job
- Combining work and parenting
- Money issues
- Personal safety
- Air pollution
- Water pollution

Can you think of anything else that causes you stress?

Do you think that your health is affected by your level of stress ?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

**YES** - How do you think that it affects it? In what way(s)

Do you feel that you have a lot of friends? How many close friends do you think that you have?

Do you have friends or family that you can turn to in times of need?

Is the church, your religion, or your spirituality an important component of your life?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

What does it bring to your life?

Do you think that this association has any affect on your health? In what ways?



**HEALTH CARE**

During the past 12 months, was there ever a time when you needed health care but did not receive it?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

YES - Thinking of the most recent time that this happened, what type of care that was needed?

YES - Why were you not able to receive the health care you needed?

Thinking about your last contact with a health care professional (i.e. family doctor, specialist), do you feel that you were treated fairly and with respect?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

NO--Can you tell me what happened?

Do you use the services available at the NHCHC?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

YES--What particular services do you use there (the NHCHC)?

NO, where do you go for health care? (where is your doctor?)

In the last 12 months how often do you think that you have visited the NHCHC or your family doctor for health care?

Have you visited a hospital emergency department in the last year?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

YES - Do you mind telling me what the problem was?

Do you think that you seek out medical attention every time that you feel sick?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

When you need information on health where do you get the information from?

During the past 12 months, was there ever a time when you needed dental care but did not receive it?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

YES - Can you tell me what happened?

**NORTH END NEIGHBOURHOOD**

How would you define the term "environment"? (What does the word environment mean to you?)

If someone asked you to draw a map of the North End, what would you draw as the boundaries of this area? So, to the north, south, east and west, what streets define the boundaries of the North End?  
If you could live anywhere in Hamilton, where would it be?

Not the North End - Why would you like to live there?

If you had to rate how much you would like to move from the North End of Hamilton? Would you say that

- Very strongly like to move \_\_\_
- Prefer to move \_\_\_
- Don't mind either way \_\_\_
- Prefer not to move \_\_\_
- Very strongly want to stay \_\_\_

What made you decide to live in the North End of Hamilton?

How long have you lived in the North End?

How long have you lived at your present address?

Do you own/rent/lease your present home?

Who lives with you in your home?

How friendly are the people who live in your neighbourhood? Are they

- Very friendly \_\_\_
- Quite friendly \_\_\_
- Not very friendly \_\_\_
- Quite unfriendly \_\_\_

Is it important to you to have friendly neighbours that you get along with? Why yes?

- Yes \_\_\_
- No \_\_\_

Do you know any of neighbours? How well do you know them?

If you were to move, would you stay in the same area? Why?

Have you lived anywhere else in the North End?

- Yes \_\_\_
- No \_\_\_

YES - Where else in the North End have you lived?

Do you feel that your health is affected ( in either a positive or negative way) by living in the North End?

- Yes \_\_\_
- No \_\_\_
- Don't know \_\_\_

YES - Can you tell me in what way you think your health is affected?

Have you lived anywhere else in Hamilton besides the North End? Where?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

YES - How did it compare to the North End neighbourhood? (was it better or worse, cleaner, quieter , etc.)

Have you seen any changes in the North End neighbourhood since you first moved here?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

YES - Can you tell me what those changes are? (good, bad)

What do you like most about living in the North End of Hamilton? (try to get 3 things)

In general, how satisfied are you with the North End of Hamilton as a place to live? Are you

- Very satisfied \_\_\_\_\_
- Somewhat satisfied \_\_\_\_\_
- Not too satisfied \_\_\_\_\_
- Not at all satisfied \_\_\_\_\_

What type of reputation do you think that the North End of Hamilton has? (Do you think outsiders (people who do not live here) think of the North End as a place that they would like to live?) Why is that? Do you think that this reputation is a fair one?

What do you like least about living in the North End of Hamilton?

Do you think that any of the things you have mentioned affected your health? In what way?

*Can you please tell me whether or not you consider any of the following to be a serious problem, a minor problem or no problem at all in your neighbourhood?*

**Situation**

**Problem**

**No Problem**

**Don't Know**

Unemployment

Affordable housing

Available housing

Availability of health services

Access to recreation facilities

Access to transportation services

Personal safety

Health of children

Neighbourhood homes in disrepair

Smells & fumes

Air pollution

Water pollution

Noise levels

Traffic

Drugs

Alcohol

Youth Gangs

Vandalism

Burglaries  
Assaults & muggings  
Poverty

Can you think of any other concerns you might have about the North End neighbourhood?

Have you ever taken action to address any of the problems you have identified?

Do you feel that any of the problems you have identified affect your health in any way? Identify which ones.

- Yes \_\_\_\_\_
- No \_\_\_\_\_

YES - In what way(s) is your health affected by these problems?

### Demographics

What nationality are you?

What is the highest level of education that have attained?

What do you consider to be your main activity on a day-to-day basis? (don't read out)

Caring for family (stay at home) \_\_\_\_\_  
Working full-time for pay/profit \_\_\_\_\_  
Working part-time for pay/profit \_\_\_\_\_  
Caring for family and working full-time for pay/profit \_\_\_\_\_  
Caring for family and working part-time for pay/profit \_\_\_\_\_  
Volunteering \_\_\_\_\_  
Going to school \_\_\_\_\_  
Going to school and working for pay/profit \_\_\_\_\_  
Recovering from illness/disability \_\_\_\_\_  
Looking for work \_\_\_\_\_  
Retired \_\_\_\_\_  
Other \_\_\_\_\_

In the past year, what was your primary source of income?

Wage/salary from job \_\_\_\_\_  
Social assistance \_\_\_\_\_  
Unemployment insurance \_\_\_\_\_  
Old age pension \_\_\_\_\_  
Disability pension \_\_\_\_\_  
Mothers allowance \_\_\_\_\_  
Self employed \_\_\_\_\_  
Other \_\_\_\_\_

In the past year, what was the primary source of income for your household?

Wage/salary from job \_\_\_\_\_  
Social assistance \_\_\_\_\_  
Unemployment insurance \_\_\_\_\_  
Old age pension \_\_\_\_\_  
Disability pension \_\_\_\_\_  
Mothers allowance \_\_\_\_\_  
Self employed \_\_\_\_\_

Other \_\_\_\_\_

Can you tell me which of the following categories best describes your own total income earned from all sources?

- Less than \$10000 \_\_\_\_\_
- \$10000 – less than \$20000 \_\_\_\_\_
- \$20000 – less than \$30000 \_\_\_\_\_
- \$30000 – less than \$50000 \_\_\_\_\_
- More than \$50000 \_\_\_\_\_

Can you tell me which of the following categories best describes the total household income from all sources?

- Less than \$10000 \_\_\_\_\_
- \$10000 – less than \$20000 \_\_\_\_\_
- \$20000 – less than \$30000 \_\_\_\_\_
- \$30000 – less than \$50000 \_\_\_\_\_
- More than \$50000 \_\_\_\_\_

Do you feel that your household brings in enough money to meet all your basic needs?

- Yes \_\_\_\_\_
- No \_\_\_\_\_

**NO** - What gets left out if you run out of money?

Can you tell me why you agreed to participate in this interview?

Is there anything that you would like to add?

#### Appendix 4: Focus Group - Self Administered Questions

This questionnaire will only take about 5-10 minutes to complete. There are no right or wrong answers. You are free to decline answering any questions that make you feel uncomfortable. I promise to keep your identity confidential by ensuring that the answers you provide me with are not connected to your name at any time.

**Please answer the following questions:**

- 1) Name: \_\_\_\_\_
- 2) Address: \_\_\_\_\_
- 3) Phone Number: \_\_\_\_\_
- 4) Date of Birth: \_\_\_\_\_
- 5) What is your present marital status?  
Single \_\_\_ Married \_\_\_ Common Law \_\_\_ Divorced \_\_\_ Widowed \_\_\_
- 6) Do you have any children:  
Yes \_\_\_ No \_\_\_
- 7) If you have children, please indicate their age(s) and sex:
- 8) Are you presently working?  
Yes \_\_\_ No \_\_\_
- 9) If you are presently working, please indicate where you work and what type of work that you do:

#### **Health Questions:**

- 10) How would you rate your own health? Would you say it is:  
Excellent \_\_\_ Very good \_\_\_ Fair \_\_\_ Poor \_\_\_
- 11) In general, compared to other women you know that are your age, would you say that your health is:  
Better than theirs \_\_\_ The same as theirs \_\_\_ Worse than theirs \_\_\_
- 12) How satisfied are you with your present level of health? Would you say that you are:  
Very satisfied \_\_\_ Somewhat satisfied \_\_\_ Not too satisfied \_\_\_ Not at all satisfied \_\_\_
- 13) Do you think that your present level of health could be improved?  
Yes \_\_\_ No \_\_\_
- 14) If you think that your present level of health could be improved, please indicate ways in which you feel you could improve your present state of health?
- 15) What do you consider to be your most important health problems?
- 16) What do you think caused these health problems?

17) Which of the following best describes how you usually feel?  
Happy and interested in life \_\_\_ Often happy \_\_\_ Sometimes happy \_\_\_  
Often unhappy \_\_\_ Unhappy with little interest in life \_\_\_

18) Would you describe your life as:  
Very stressful \_\_\_ Somewhat stressful \_\_\_ Not too stressful \_\_\_ Not stressful at all \_\_\_

19) Do you think that there is relationship between your health and the environment (place) in which you live?  
Yes \_\_\_ No \_\_\_ Don't know \_\_\_

**Neighbourhood Questions:**

20) If someone asked you to draw a map of the North End, what would you draw as the boundaries of this area? In other words, what streets do you feel define the boundaries of the North End to the north, south, east and west?

21) If you had to rate how much you would like to move from the North End of Hamilton, would you say that:  
Very strongly you would like to move \_\_\_ You prefer to move \_\_\_ You don't mind either way \_\_\_  
You prefer not to move \_\_\_ Very strongly you want to stay \_\_\_

22) How long have you lived in the North End of Hamilton?

23) Do you feel part of the community?  
Yes \_\_\_ No \_\_\_ Don't know \_\_\_

24) How friendly are the people who live in your neighbourhood? Are they:  
Very friendly \_\_\_ Quite friendly \_\_\_ Not very friendly \_\_\_ Quite unfriendly \_\_\_

25) In general, how satisfied are you with the North End of Hamilton as a place to live? Are you:  
Very satisfied \_\_\_ Somewhat satisfied \_\_\_ Not too satisfied \_\_\_ Not at all satisfied \_\_\_

**Background Information:**

26) What is the highest level of education that you have attained?

27) What do you consider to be your main activity on a day-to-day basis?  
Caring for family (stay at home) \_\_\_ Working full-time for pay/profit \_\_\_  
Working part-time for pay/profit \_\_\_ Caring for family and working full-time for pay/profit \_\_\_  
Caring for family and working part-time for pay/profit \_\_\_  
Volunteering \_\_\_ Going to school \_\_\_ Going to school and working for pay/profit \_\_\_  
Recovering from illness/disability \_\_\_ Looking for work \_\_\_ Retired \_\_\_  
Other \_\_\_

28) In the past year, what was your own primary source of income?  
Wage/salary from job \_\_\_ Social assistance \_\_\_ Unemployment insurance \_\_\_  
Old age pension \_\_\_ Disability pension \_\_\_ Family benefit \_\_\_ Self employed \_\_\_  
Other \_\_\_

29) In the past year, what was the primary source of income for your household?

Wage/salary from job \_\_\_\_ Social assistance \_\_\_\_ Unemployment insurance \_\_\_\_  
Old age pension \_\_\_\_ Disability pension \_\_\_\_ Family benefit \_\_\_\_ Self employed \_\_\_\_  
Other \_\_\_\_

30) Can you tell me which of the following categories best describes your own total income earned from all sources?

Less than \$10000 \_\_\_\_ \$10000 – less than \$20000 \_\_\_\_ \$20000 – less than \$30000 \_\_\_\_  
\$30000 – less than \$50000 \_\_\_\_ More than \$50000 \_\_\_\_

31) Can you tell me which of the following categories best describes the total household income from all sources?

Less than \$10000 \_\_\_\_ \$10000 – less than \$20000 \_\_\_\_ \$20000 – less than \$30000 \_\_\_\_  
\$30000 – less than \$50000 \_\_\_\_ More than \$50000 \_\_\_\_

32) Do you feel that your household brings in enough money to meet all your basic needs?

Yes \_\_\_\_ No \_\_\_\_ Don't know \_\_\_\_

**Thank you for taking the time to complete this questionnaire.**

### **Appendix 5: Focus Group - Discussion Questions**

1. Can you tell me a little about the women's group:
  - when it started
  - why it started?
  - who started it?
  - how long each of you have been part of this women's group?
  - can anyone give me examples of how the group has been useful to
    - 1) you personally?
    - 2) to the community as a whole?

#### **Community Questions:**

- 1) What made you decide to live in the North End of Hamilton? If you could live anywhere else in Hamilton where would it have been and why?
- 2) What do you like most about living in the North End of Hamilton?
- 3) What do you like least about living in the North End of Hamilton?
- 4) What are the most important issues currently facing your community? The North End?
- 5) Do you feel that your health is affected by living in the North End?
- 6) Can you give me an example of how you think your own health has been affected by the North End environment in which you live? Positive? Negative?
- 7) Do you think that the North End of Hamilton has reputation? What type of reputation do you think it has? Is that a fair judgment of the area?

#### **Health Questions:**

- 8) What do you think are the most important concerns facing women living in the North End of Hamilton?
- 9) If the money was available to create a women's program in the North End of Hamilton, what issues do you think that the program should focus on so as to be beneficial as possible to women living in this area? Why?

<b>Appendix 6: Neighbourhood Watch Reports - Division One Crime Statistics (year ended 2002) continued</b>								
	<b>Beasley</b>		<b>Central</b>		<b>Kirkendall North</b>		<b>West Neighbourhoods</b>	
	<b>Neighbourhood - 6703</b>		<b>Neighbourhood - 6704</b>		<b>Neighbourhood - 6803</b>		<b>6901 to 6907</b>	
	<b>Beats 671 &amp; 672</b>		<b>Beats 671, 672 &amp; 682</b>		<b>Beat 681</b>		<b>Beat 691</b>	
	<b>2001</b>	<b>2002</b>	<b>2001</b>	<b>2002</b>	<b>2001</b>	<b>2002</b>	<b>2001</b>	<b>2002</b>
<b>Violent Crime</b>								
Homicide	1	0	0	0	0	0	0	1
Attempted Murder	0	0	0	0	0	0	0	0
Robbery	48	55	10	31	9	9	9	5
Assault (including Sexual Assault)	899	706	108	120	39	52	90	100
Abduction	0	0	0	0	0	0	1	0
<b>Total</b>	<b>948</b>	<b>761</b>	<b>118</b>	<b>151</b>	<b>48</b>	<b>61</b>	<b>100</b>	<b>106</b>
Prostitution	2	2	1	0	0	0	0	0
<b>Property Crime</b>								
B&E-Residential	63	64	37	36	54	58	97	73
B&E-Non-Residential	92	71	44	43	18	22	37	49
Theft of Motor Vehicle	200	139	80	84	33	65	63	127
Theft Over \$5000	14	15	11	10	5	13	24	21
Theft Under \$5000	733	703	365	388	147	184	321	397
Fraud	64	73	24	24	3	6	5	14
<b>Total</b>	<b>1166</b>	<b>1065</b>	<b>561</b>	<b>585</b>	<b>260</b>	<b>348</b>	<b>547</b>	<b>681</b>
Drugs	229	135	37	40	3	7	22	47
<b>Statistical Comparisons 2001 to 2002</b>								
<b>Violent Crime</b>	<b>decreased 20%</b>		<b>increased 28%</b>		<b>increased 27%</b>		<b>increased 6%</b>	
<b>Property Crime</b>	<b>decreased 9%</b>		<b>increased 4%</b>		<b>increased 34%</b>		<b>increased 25%</b>	

Appendix 6: Neighbourhood Watch Reports - Division One Crime Statistics (year ended 2002) continued								
	Gibson		Landsdale		Durand		Corktown	
	Neighbourhood - 6607		Neighbourhood - 6608		Neighbourhood - 6701		Neighbourhood - 6702	
	Beats 661 & 663		Beats 661 & 662		Beat 673		Beat 674	
	2001	2002	2001	2002	2001	2002	2001	2002
<b>Violent Crime</b>								
Homicide	0	1	1	0	0	0	0	0
Attempted Murder	0	0	0	0	0	0	0	0
Robbery	23	24	30	28	11	13	25	28
Assault (including Sexual Assault)	167	164	200	205	107	114	152	128
Abduction	2	0	0	1	1	0	0	0
<b>Total</b>	<b>192</b>	<b>189</b>	<b>231</b>	<b>234</b>	<b>119</b>	<b>127</b>	<b>177</b>	<b>156</b>
Prostitution	42	4	24	19	0	0	0	0
<b>Property Crime</b>								
B&E-Residential	128	124	117	121	109	67	86	78
B&E-Non-Residential	58	32	44	18	52	29	68	45
Theft of Motor Vehicle	85	104	97	87	137	93	100	131
Theft Over \$5000	14	15	7	12	20	11	19	9
Theft Under \$5000	351	330	472	421	433	390	405	418
Fraud	19	7	23	18	26	18	22	21
<b>Total</b>	<b>655</b>	<b>612</b>	<b>760</b>	<b>677</b>	<b>777</b>	<b>608</b>	<b>700</b>	<b>702</b>
Drugs	60	39	51	44	35	17	76	53
<b>Statistical Comparisons 2001 to 2002</b>								
<b>Violent Crime</b>	<b>decreased 2%</b>		<b>increased 1%</b>		<b>increased 7%</b>		<b>decreased 12%</b>	
<b>Property Crime</b>	<b>decreased 7%</b>		<b>decreased 11%</b>		<b>decreased 22%</b>		<b>no change</b>	

Appendix 6: Neighbourhood Watch Reports - Division One Crime Statistics (year ended 2002)								
	North End Neighbourhood		Keith Neighbourhood		Stinson		St. Clair	
	East - 6101		6201		Neighbourhood - 6601		Neighbourhood - 6602	
	Beat 611		Beat 611		Beats 661 & 674		Beat 661	
	2001	2002	2001	2002	2001	2002	2001	2002
<b>Violent Crime</b>								
Homicide	0	0	0	0	0	0	0	0
Attempted Murder	0	0	0	0	0	0	0	0
Robbery	2	21	1	8	26	21	5	19
Assault (including Sexual Assault)	51	51	11	24	13	124	47	91
Abduction	0	0	0	0	0	1	0	0
<b>Total</b>	<b>53</b>	<b>72</b>	<b>12</b>	<b>32</b>	<b>129</b>	<b>146</b>	<b>52</b>	<b>110</b>
Prostitution	1	2	0	0	5	8	5	3
<b>Property Crime</b>								
B&E-Residential	30	26	1	9	82	56	44	63
B&E-Non-Residential	42	24	11	8	14	13	20	13
Theft of Motor Vehicle	37	25	11	12	69	70	41	42
Theft Over \$5000	11	5	3	1	7	2	2	8
Theft Under \$5000	121	106	25	48	199	208	112	151
Fraud	3	2	2	0	13	8	7	4
<b>Total</b>	<b>244</b>	<b>188</b>	<b>53</b>	<b>78</b>	<b>384</b>	<b>357</b>	<b>226</b>	<b>281</b>
Drugs	8	2	0	1	20	29	20	14
<b>Statistical Comparisons 2001 to 2002</b>								
<b>Violent Crime</b>	increased 36%		increased 166%		increased 13%		increased 112%	
<b>Property Crime</b>	decreased 23%		increased 47%		decreased 7%		increased 24%	

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