

**MEETING THE HEALTH AND HEALTH CARE NEEDS
OF LOW-INCOME WOMEN**

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OF LOW-INCOME WOMEN

By

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ABSTRACT

There is a growing body of evidence that suggests that the prevailing public discourse around improving the health of Canadians has failed to provide any meaningful results. Despite universal access to a publicly funded system of health care delivery, the research clearly demonstrates that persons with low incomes can expect to be less healthy, suffer more and die earlier than their wealthier neighbours, simply because they are poor. In particular, women marginalized by poverty are at much higher risk for inequitable health care treatment as well as the gamut of health related concerns. As poverty becomes increasingly feminized and medicalized as a result of shifting socio-political priorities, the consequences for women may be particularly dire.

This paper focuses on the health and health care needs of low-income women living in an urban setting. Based on the findings of a qualitative study, it explores the relationship between health, poverty and gender and discusses how those most impacted view their own health and the health care they receive. The results indicate that the traditional biomedical discourse that individualizes health matters does not adequately reflect the complex and multidimensional health needs of low-income women that are often rooted in their social locations. As a result, current health care responses offer only limited solutions to women's health problems. Further, based on participants' narrative accounts, women who experience poverty also experience significant marginalization when accessing mainstream health services. Using an institutional ethnographic analysis to frame the findings, this paper concludes that the health care of low-income women is largely structurally determined as a product of dominant ruling relations that reinforce and perpetuate the feminization and medicalization of women's poverty. Poor health is a product of societal injustices and, therefore, requires responses beyond the individual including policy, practice and research initiatives.

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CHAPTER I

INTRODUCTION

The impetus for this research stems from the growing body of evidence that suggests that the prevailing public discourse around improving the health of Canadians has failed to provide any meaningful results. Despite universal access to a publicly funded system of health care delivery, the literature strongly indicates that people in Canada experience their health and health care differentially as a consequence of structural inequities associated with their social locations. In particular, there is a wealth of supporting evidence to suggest that Canadians who experience poverty also experience compromised health and health care simply because they are poor. Studies further suggest that these health inequities do not result solely from differential treatment based on socio-economic status. Gender also seems to play a significant role in people's health and health care experiences. Combined, this interplay of factors appear to render women who are poor at much higher risk for inequitable health care treatment as well as the gamut of health related concerns. With poverty becoming increasingly feminized, the health of low-income women is becoming proportionately compromised. In a country that values good health, this is unacceptable.

A review of the available literature suggests that prevailing discourse around inequities within health and health care tends to predominantly revolve around access barriers to traditional health care services, particularly with regard

to marginalized communities. While there is no consensus around how accessibility is defined (Brotman, 2000, p.19), the discourse tends to fall along two streams depending on the context within which it is discussed (Goddard & Smith, 2001, p.1151). The first, financial barriers to access, typically refers to people's ability to secure and provide proof of health insurance like OHIP (Butters & Erickson, 2003, p.15) and/or an ability to purchase necessary treatments like dental care and medication (IGH, 2003, p.7) for example. Others broaden the definition to include financial barriers like transportation and childcare, both of which may also impede health care access.

The second, non-financial barriers to access, usually involves an individual's ability to enter and navigate the health care system, including the ability to understand and receive services in a way that meets the needs of the individual within the context of the particular service delivery system. These include practical concerns around how and where services are delivered, as in service hours, appointment set-up, wait lists and geographical locations. Some barriers are relational like professional and client attitudes toward care (Brotman, 2000, p.19) while others involve care with particular communities (Butters & Erickson, 2003, p.11). Increasingly moving to the forefront of equitable access discourse however are the non-financial barriers associated with diversity like language, culture, socio-economic status, gender and race (Ballem, 1998, p.336; Williams, 2001, p.232; Andrulis, 2000, p.859; Crump, Gaston & Ferguson, 1999, p.219).

Yet, in reviewing the literature, it became apparent that with only a few exceptions, the underlying motivation for discourse about accessibility was not so much about client care, but rather, economics and the parameters of service utilization from the perspective of resource allocation and cost effectiveness (Crump et al., 1999, p.219; Andrulis, 2000, p.862; Brotman, 2000, p.21). To that end, measures like the appropriate use of services (Brotman, p.16), rates of hospitalizations, frequency of emergency contacts and length of hospital stays (Andrulis, p.859; Butters & Erickson, p.10; Crump et al., p.220) surround the discourse around health care. Implicitly, identifying and removing such barriers to access by virtue of reducing costs and improving health, is according to most research, an economically and humanely sound endeavour that addresses systemic inequities.

The sparse research from the perspective of those most impacted challenges this notion however. Professional and political priorities are often very different from those of the people they serve, particularly as it relates to women's health (Ballem, 1998, p.337). In one comparative study exploring women's health and health care experiences in Israel and the United States, perceived accessibility was not so much linked to their ability to pay but rather, was more associated with education and income levels and their subsequent ability to understand the system, their rights and to self-advocate (Schoen et al., 2003, p.67). In another study, Ballem (1998) found that in developing a women's health clinic, the women involved in her study identified "safety, respect, comfort and

empowerment” as key elements of access with the elaborate spectrum of health services as offered secondary (p.337). Similarly, in Butters & Erickson’s study (2003) with substance using women, the participants chose definitions of desired access completely outside the realm of medicine (p.13). Clearly, differences exist between women’s actual health needs and the prevailing rhetoric.

Personally and professionally situated near the Toronto downtown core, I am becoming increasingly aware of the vast and intricate ways poverty gets woven into the fabric of people’s lives. As a social worker in a Community Health Centre and as a member of an Urban Health Team, nowhere are these intricacies more apparent to me than within the delivery of health care services. ‘Managing’ factors related to poverty are increasingly becoming the mainstay of our services as a reflection of changing community demographics, shifting governmental priorities as well as growing health care demands. Less and less within the realm of the welfare system, responses to poverty tend to be manufactured through a medical lens, despite the human and economic costs.

Yet, in spite of the costs, few studies have attended to these more deeply embedded structural barriers like gender and class and how these barriers gets manifested in health, for example, through internalized oppression, self-blame and deservedness (Butters & Erickson, 2003, p.12). Even fewer researchers have attempted to gain knowledge and understanding from the perspective of those most impacted by poverty on a personal and a political level.

This paper presents a qualitative study that describes the state of the health of Canadian women marginalized by poverty and explores their health care needs from their perspective, using their voices. It also attempts to disrupt the dominant discourse that serves to maintain and perpetuate the particular socio-political arrangements that marginalize low-income women and that subsequently compromise their ability to attain health and access health care in meaningful ways. Using Institutional Ethnography (IE) filtered through an anti-oppressive lens as the analytic framework, the ruling relations and practices that foster medicalization within this community are explored. By examining whose interests are being served by this marriage between health and poverty, new opportunities for resistance emerge.

THE LINK BETWEEN HEALTH AND HEALTH CARE

To frame the pursuant discussion, it is important to differentiate conceptualizations of ‘health’ and ‘health care’ as unique, but related entities. While no agreement or consensus exists around how to fashion universally operational definitions for these concepts, an exploration of mainstream or dominant discourse reveals certain consistencies worth discussing.

Statistics Canada (2003), for example, conceptualizes health as health status, well-being and satisfaction and defines this concept as referring to “the self-assessed or self-reported perception of a person with respect to his or her health condition” (Canada, p.1). Health is subsequently measured along three dimensions: health problems, health satisfaction and health status. Of these

variables, health satisfaction and health status are self-assessed, meaning they are based on personal perceptions. Health problems, on the other hand, are self-reported, meaning they are based on a person's reporting of a long-term or chronic medical condition as diagnosed by a health professional (p.1). It is an important distinction in that health problems, unlike health status and satisfaction, are, for Statistics Canada, based on external, objective medical assessments.

Expanding the definition beyond a purely medical or disease model of health, the Dictionary of Epidemiology offers several definitions, including “a state of equilibrium between humans and the physical, biologic and social environment, compatible with full functional activity” (Canada, PHA, 2002, p.1). Similarly inclusive, the World Health Organization (WHO), in 1947, defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2003, p.1). Rootman and Raeburn (1994) provide a particularly comprehensive definition:

Health...has to do with the bodily, mental, and social quality of life of people as determined in particular by psychological, societal, cultural, and policy dimensions. Health is...to be enhanced by sensible lifestyles and the equitable use of public and private resources to permit people to use their initiative individually and collectively to maintain and improve their own well-being, however they may define it. (p.69)

However, despite the apparent breadth of variation and scope of definitions of *health*, definitions of *health care* prove to be much more limited and very much reflect the dominant medical model of health as a response to emerging health needs. To demonstrate how pervasive the medical model is in

health care literature, a simple web search listed a total of fifteen possible sources for health care definitions. Of those fifteen, only two provided a health care definition beyond the scope of medicine: one was a website that focused on First Nations health care and the other, extended the definition to “sometimes” include self-care. Indeed, the definition of health care given by the Public Health Agency of Canada (2003) describes health care in Canada as a “publically-financed, privately-delivered health care system” that provides “access to universal, comprehensive coverage for medically necessary hospital, inpatient and outpatient physician services” (p.1).

As will later be discussed, such discourse around health care is very meaningful in that, by virtue of excluding alternative definitions, it implies that medical health care is the primary and preferred response to health related issues and therefore, inherently links health to health care along medical lines. By association then, it also infers that health care necessarily improves health, a notion that has been heavily contested of late. Because these concepts are often used simultaneously and/or interchangeably, the terms health and health care will therefore be distinguished as separate entities for the purposes of this research for, just as this melding of concepts is arguably both deliberate and purposeful, so too is their distinction.

THE LINK BETWEEN HEALTH AND POVERTY

To locate this discussion as a point of growing interest and concern, a review of current research around the health of Canadians proves helpful.

Portrayed as among our nation's greatest humanitarian achievements, the Canadian health care system has increasingly become fraught with contentions and concerns. In response, the Government of Canada set in motion a Commission on the Future of Health Care in Canada to investigate the state of our current system and to make recommendations for future directions (Canada, 2002, p.4). This endeavour resulted in the release of the 'Romanow Report' (2002) which reaffirmed a renewed commitment to the principles outlined in the Canada Health Act (1985); to wit, a health care system that would be publicly administered, comprehensive, universal, portable, accessible (p.5) and now, accountable (Canada, p.25).

Reflecting these promises, the literature describes Canada as an “egalitarian society committed to accessible and comprehensive health care” (Butters & Erickson, 2003, p.1). Indeed, Schafer (2002) asserts that equality of access is “*the* defining value” of our system, a value to which we are most committed (p.4). Yet, while applicable to all in principle, these commitments are not applicable to all equally in practice (CRIA W, 2006, p.14). Herein lays the importance of conceptually differentiating health and health care: equal access to health care as defined does not mean access to equity in health.

Despite the rhetoric of universality, accessibility, accountability and comprehensiveness, our comparative record for health equality is worse than anticipated (Butters & Erickson, p.1; Humphries & van Doorslaer, 2000, p.663). According to the literature, Canada, like the United Kingdom, more closely

resembles the United States than other European countries studied in terms of related health inequality (Humphries & van Doorslaer, p.670). Other comparative studies similarly suggest that, while Canadians fare better than their American neighbours along measures of income and health inequities, we do not perform as well as other countries like Norway and Sweden (Phipps, 2003, p.ii; Raphael, 2004, p.12) as well as Belgium, France and the Netherlands (OWHN, p.2). Despite touting universal access to a publicly funded system of health care delivery, the research clearly indicates that persons with low incomes in Canada can expect to be less healthy, suffer more and die earlier than their wealthier neighbour simply because they are poor.

The research is clear: by all accounts, poverty and health are inextricably linked. People living with poverty experience a higher incidence of adverse health and health related conditions (Andrulis, 2000, p.859; Butters & Erickson, 2003, p.2; Phipps, 2003, p.13), a relationship that has been replicated across the world regardless of chosen measure (Humphries & van Doorslaer, 2000, p.663). Citing research in the United Kingdom, Raphael (2002) demonstrates that for low-income groups, the risk of suffering from a range of diseases was greater as were the chances of dying or becoming injured throughout the life span (p.4). Research in Canada coincides with this finding. The most economically disadvantaged of our society have higher mortality rates for all life-threatening diseases than their wealthier counterparts (Raphael, p.4). According to the Ontario Women's Health Network (OWHN), the timing and duration of one's experience of poverty also

impacts health: longer periods of impoverishment, earlier in the lifespan, means more compromised health throughout the life span (OWHN, 2005, p.2; Phipps, 2003, p.14). Social and economic positioning, it seems, is directly connected to a range of social conditions as well as issues of access that negatively impact the health of those most poor (OWHN, p.3). Importantly, this relationship between poverty and poor health is reciprocal and self-perpetuating in that poor health is both a cause and effect of poverty. In this way, poor health is not only costly to individuals; it is also an economic liability for the larger society.

Raphael (2002) directly attributes the fact that people with low incomes have poorer health to poverty (p.vi). Importantly, health inequalities based on income occur not just in cases of extreme poverty, but rather across all socio-economic strata and tends to be even more pronounced in studies using more subjective measures like self-assessed health (Humphries & van Doorslaer, p.663, 688, respectively). According to Raphael, it is the distribution rather than the level of wealth that is key to determining mortality and health: more equitable distribution means better health (Raphael, p.9; Phipps, 2003, p.2). As the gap between the rich and the poor widens and as the prevailing discourse around sustainability and privatization looms, the rhetoric of equitable access to health care becomes increasingly more elusive.

THE LINK BETWEEN HEALTH, POVERTY AND GENDER

Beyond the well-documented link between health and poverty, evidence also exists that strongly suggests that differential treatment occurs universally

within the health care system along the basis of gender. For women, the prospects may be particularly dire, for, not only does gender influence how people are treated within the health care system but also influences their health (IGH, 2003, p.4). Canadian women are also more likely than men to experience poverty (Raphael, 2004, p.9; Brodie, 2002, p.105; Donner, 2002, p.1).

Based on studies quoted by the OWHN (2005), these gender differences are true in every age group studied, with women experiencing not only higher rates, but also, deeper levels of poverty compared to men (p.3). When other factors associated with oppression, such as race, disability or age, are introduced, the impacts of gender specific poverty are even more pronounced (OWHN, p.3; Donner, 2002, p.2).

Even more troubling, single parent, female-led families remain among the poorest in Ontario (OWHN, p.3) with women and children disproportionately represented among those most poor (CRIAW, 2006, p.4). In one report, the rate of poverty for this group had been assessed at 51.6%. For mothers under the age of 25, this figure rose to an astounding 85.4% (OWHN, p.5). In a time of growing poverty, the potential fallout is unimaginable when the lifelong implications for children's health are considered.

In a country with eight consecutive years of budget surpluses (CRIAW, 2006, p.1), these trends are simply unconscionable. In a later discussion around the current political context, this issue will be explored further. Suffice to say, as

poverty becomes much more feminized through shifting governmental priorities, women's health will be concomitantly impacted.

POLICY RESPONSES

How this knowledge translates into health care policy, practice and research has been intriguing. Despite the wealth of literature linking poverty with health and gender, a review of policy responses to health rarely links structural influences like government in creating poverty and its subsequent impact on the health of low-income persons. Raphael (2002) agrees, noting that the government's role in the economic and health related plight of the poor is noticeably absent from both health related discourse and practice (p.10). Similarly, just as issues of poverty have disappeared off the political agenda over the last several years, so too have issues of gender and gender equality (CRIAW, 2006, p.10).

According to the Canadian Research Institute for the Advancement of Women (CRIAW), governments have limited their perspective to think of individuals and markets, "rather than complicated webs of social power and peoples' lives" and therefore policies reflect this disconnect (2006, p.14). While others, such as the Public Health Agency of Canada (PHAC) suggest that the absence of such discourse may be a product of other concerns.

In a working paper on population health for example, the PHAC (2002) suggest that policy makers, concerned with program and policy outcomes, rely heavily on 'scientific' research and as such, require clear, measurable variables.

They argue that with no consensus around how to conceptualize social determinants of health and to measure outcomes, sound evidence-based research is not as yet feasible. They add that this lack of consensus around how to define and measure alternative health concepts became problematic in British Columbia for example, when key stakeholders within the business community found great difficulty in accepting the legitimacy of social determinants of health like poverty or education as a health sector concern (p.2).

Whatever the offered rationale, poverty, and therefore health, has increasingly become a matter of individual responsibility, the policy responses aimed at fixing the individual rather than the broader socio-political context in which health inequities evolve.

What is particularly troubling for me is that, despite very clear links between poverty, health and gender, the proposed remedies for these trends almost always lie within the realm of medicine. Even more unsettling is that this linkage between health, poverty and medicine is not new, nor is the link between gender and the medicalization of poverty. In one article located in the *Journal of Women's History*, Blackwell (1999) finds evidence of the gender-based application of medical solutions to poverty dating back to 1907 and describes how even then, medical services and providers were increased as a means to alleviate poverty (p.57). Today, almost a hundred years later, the preponderance of public discourse around opportunities to address these health inequities overwhelmingly revolves around bolstering an already taxed health care system and applying

medical solutions to the most marginalized. Schram (2000), in discussing the medicalization of welfare, supports this view, stating that poverty is increasingly being reframed from an economic problem to a medicalized problem (p.81); hence the phrase, the *medicalization of poverty*.

Yet, interestingly, studies consistently demonstrate that medicine is not the answer to improving the health of low-income people and that, more than ever, we need to rethink our financial priorities; for, as our health care spending steadily increases and in spite of medical advancements, women are not becoming healthier and, based on the fact that low-income women continue to experience a disproportionate amount of health and health related concerns, it is also apparent that their health needs are not being met (Ontario, 1993, p.4). In fact, one study presented by Dunn (2005) demonstrates that total public expenditures, particularly for education and welfare, are the most strongly related factors associated with improved mortality rates, whereas expenditures on health care and hospitals are virtually unrelated to changes in mortality. Others agree. For example, Donner (2002) claims that economic security, social support and a more equitable distribution of income are more influential health-wise than medical care (p.3). In another article, Murphy (2002), in response to the international AIDS epidemic, argues that the poor are more vulnerable to poor health and disease because of material conditions and therefore, that their problems stem more from social rather than medical roots (p.2). Rather poignantly, he asserts:

The most profound predictor of health status is a secure livelihood in a cohesive, safe and dynamic social environment...Put another

way, the most pervasive causes of illness and premature death are injustice, violence, and corporate crime; the most profound factors in health are justice, peace, and citizen and consumer rights (p.1).

It stands to reason that rather than focussing on health care per se, these failings could be addressed, if not eradicated, by a heightened socio-political focus on those areas that *produce* poverty and poor health, areas like hunger, unemployment, low minimum wage and inadequate housing (OWHN, 2005, p.6). This is not to devalue medicine; most people would concede that medicine has made a positive contribution to the health of Canadians over the past century. What I am saying however is that, if our goal is to improve the health and health care of low-income women, for example, improvements to social determinants of health like nutrition, housing and hygiene would be even more fruitful, as other studies demonstrate (OWHN, p.6).

PRACTICE RESPONSES

As with policy, practice responses to the health and health care needs of low-income women similarly ignore the role of governments in creating poverty and its impact, focussing instead on the “delivery of ameliorative programs to those living in poverty” (Raphael, 2002, p.10). Brotman (2000) offers similar criticisms, arguing that such discourse rarely challenges the systems at an organizational or institutional level and instead focuses on the “fixable” matters at a front-line level (p.20). For low-income women, this means framing women’s health problems as personal deficiencies warranting medical responses. Nowhere is this deliberate medicalization of poverty more pronounced than within the

mental health system, a system where problems can remain contained, individualized and feminized. This individualization helps society keep the locus of responsibility and therefore control in terms of treatment within the individual and helps in disempowering women by constructing their reality as among the dependent and ‘sick’ in need of a medical cure. As medicalization becomes more entrenched, the social and economic factors associated with poor mental health become increasingly lost (Mechanic, 1999, p.91; CMHA, 2003, Shera, 1996, p.18; Aviram, 2002, p.623). The medical model effectively removes ‘illness’ from its social context, and therefore, fails to consider other factors such as income security, housing and employment that need to be addressed in the provision of a more responsive and holistic approach. The result is that the health care system becomes the favoured avenue to address the needs of low-income women, irrespective of other factors including the social determinants of health. Medicine becomes the place to situate and address social problems.

Naming those factors and their impact on women’s health will be an important piece of this research as will be how this growing trend toward the medicalization of women’s poverty effectively neglects their health and health care needs. More broadly, everyday practices will be explored in an effort to understand how women’s health is socially organized and why these inequities persist.

THE ROLE OF GOVERNMENT

Any discourse around low-income women's health and health care needs would be remiss if the political context of women's poverty and health poverty went without comment. Policies and their subsequent practices are deeply connected and therefore directly related to the political responses, or lack thereof, of our federal and provincial governments.

A closer analysis of these trends reveals a much grander, more insidious socio-political arrangement demonstrated by gradual, yet significant shifts in governmental priorities, as a product of what Fabricant & Burghardt (1992) would argue is the divestment of state responsibility and the reinforcement of the 'New Right's agenda (p.72). Over the past two decades in particular, Canadians have witnessed a steady dismantling of the welfare state and an increased thrust toward a neoliberal economic model that emphasizes globalization and privatization over the human condition and issues of social justice (CRIA W, 2006, p.6). It is an agenda that is no less tenacious today. This fundamental shift in how we view our social responsibilities is reflected the significant cuts to social programs both provincially and federally which in turn has impacted of the delivery of those services. "Profits have taken priority over people" (CRIA W, 2006, p.11).

Provincially, particularly since the "Harris days"¹, we have also seen a steady divestment of state responsibility and the reinforcement of the 'New

¹ Refers to the provincial government of Michael Harris in power from 1995 to 2002 and best known for his "Common Sense Revolution", a government program that emphasized deficit reductions, lower taxes and reduced government spending on social programs.

Right's agenda. Two concrete examples of this divestment come to mind. Since 1995, recipients of Ontario Works (OW) and the Ontario Disability Support Program (ODSP), those already living well below the poverty line, have endured financial losses in income support by 35% and 12%, respectively (OWHN, p.5). At around the same time, public surveillance of welfare recipients also intensified through various watchdog programs and strategies such as the welfare 'snitch line', reinforcing the socially constructed undesirability of receiving financial assistance.

As expected, women are among those hardest hit. Through the reduction of social programs and services involving housing, social security, home care, childcare and the labour market for example, poverty is increasingly and systematically becoming feminized. According to the CRIAW (2006), "when social services are cut to fund debt reduction programs, women often bear the brunt of these cuts" (p.7). So, while we continue to enjoy the fruits of budget surpluses over the past several years, poverty in Canada has deepened, social programs have been eroded and women have become increasingly poor. According to recent figures, one in seven or 2.4 million women live in poverty (CRIAW, 2006, p.4). For children, it is no less devastating; child poverty has increased by 41% since 1989 in Ontario (OWHN, p.5). Given what we know about the link between health and poverty, these figures are particularly unsettling. As poverty becomes more feminized, we can expect that women's health and health care will be concomitantly impacted.

Based on the current political climate, the situation is becoming much more urgent for those of us concerned with the present and future health of low-income women. Aside from the immediate health ramifications, the concern is that, with a heightened focus on the market economy, policy changes will increasingly serve the interests of those who hold economic and social power, not the marginalized and therefore, not low-income women. The CRIAW (2006) points out that when the ideals of the market and of the citizen intersect, norms tend to get established that position those who do not 'fit' with those ideals as targets for moral judgments and discrimination which in turn, results in even more discriminatory practices and judgments (p.6-7). In terms of future prospects, these trends therefore tend to have a reinforcing tendency. With the recent election of a federal Conservative leadership, it is apparent that neoliberalism clearly meets with the Canadian public's approval, at least at the national level, and we are well positioned for continued health inequities.

RECENT INITIATIVES

Policy and research initiatives

There are however several organized bodies that have been challenging the cause and embracing the need for policies that respond to the specific and unique needs of women including women marginalized by poverty. For example, the Institute of Gender and Health (IGH) was created in 2000 as one of 13 institutes within the Canadian Institute of Health Research (CIHR), albeit in response to a very strong lobbying effort on the part of Canadian women's health research and

activists (Williams & Garvin, 2004, p.29). Among their key research priorities is the “Improved Access and Equity for Marginalized Populations and Vulnerable Groups” with an emphasis on gender, health equity and access (IGH, 2002, p.15).

Also on a national level, as a part of federal government’s Health Canada, the Bureau of Women’s Health and Gender Analysis continues to focus on policy issues relating to gender and health. According to their website (Canada, 2005), the Bureau oversees a variety of Health Canada initiatives such as the Women’s Health Strategy and through their ongoing connections with various women’s organizations like the Canadian Women’s Health Network and the Centres of Excellence for Women’s Health, strives to promote women’s health and health research in a variety of forums. Because they are considered to be relatively innovative in their focus on the social and economic determinants of health, the Centres of Excellence for Women’s Health has emerged as being a leading force within women’s research within the last ten years. Initiatives in Ontario, Manitoba, Saskatchewan and British Columbia have also recently started to explore women’s health beyond the biomedical to include gender and other social determinants as being profoundly influential in how we conceptualize and respond to women’s health and health care needs.

On a broader scale, a review of abstracts from recent dissertations in Canada and the United States also indicates some recent interest in this field of study, particularly as it relates to the health of economically disadvantaged women (Baranowski, 1999; Reid, 2003; Paul, 2004). Internationally, similar work

is currently being conducted in the form of questionnaires issued by the UK government's Social Exclusion Unit for the purposes of improving service delivery for, and from the perspective of, disadvantage adults (UK, 2005, p.3).

While I do believe that such new and innovative initiatives offer tremendous possibilities for both policy and practice, they require that knowledge be used in meaningful and relevant ways. For example, I am very aware that research funding can often be very political and distributed in ways that create the illusion that this issues are being attended to when really it is about de-politicizing 'leaky issues'. Bearing this in mind, I approach these endeavours with guarded optimism.

Government funding initiatives

Recent funding announcements within Ontario have also generated some optimism, particularly within health care circles. Increased funding for Community Health Centres (CHC's) and Family Health Teams suggest there may be some political will to promote a more socially inclined political agenda that respects the role of social determinants of health and therefore may provide some opportunities to address inequities in low-income women's health and health care.

The same provincial government also recently unveiled a new, and in some ways promising, approach to health care delivery through the development of Local Health Integration Networks (LHINs) intended to direct the provision of health care locally and to put decision-making, including the allocation of institutional and community health care resources in the hands of local

communities. Both of these initiatives, while important, are only mildly encouraging in that they continue to support a medicalized response to the management of poverty and gender.

ROLE OF SOCIAL WORK

The role of social work in addressing the health needs of low-income women has been, and continues to be, rather precarious at best. For some time, social work as a profession has undergone its own challenges and has also, as a result of cutbacks and organization restructuring, been floundering to find its place within Canadian society.

Over the last several years, social workers have been increasingly brought into the health care fold to field and contain the ‘messy’ work for medical institutions and medical professionals (Heimer & Stevens, 1997, p.139; Watt, 1977, p.3). Given its historical roots within health care, this recurring trend presents an interesting dilemma for social work. Having a long-standing tradition of working with the poor and the unwell within other contexts, social work found a legitimate place in health care in 1950 when it was formally introduced to the hospital setting by Dr. Richard Cabot. Since then, physicians have taken the helm in defining the work of medical social workers (Watt, 1977, p.1; Erickson & Erickson, 1989, p.13). Often considered to be ‘handmaidens’ to physicians (Watt, 3; Erickson & Erickson, p.10), social workers working in health care continue to experience tensions in their work as they posture for professional recognition and

independence while simultaneously assuming the roles and responsibilities assigned to them by physicians.

Indeed, recent trends suggest that social work's role is becoming much more complex and even more precarious within health care as medicine usurps authority over the management of the social determinants of health including gender and poverty. For example, social workers are currently being used inconsistently within primary health care contexts, i.e. CHC's and Family Health Team models where nurse practitioners and family physicians are more formally assuming a great deal of the work previously associated with traditional social work. At the same time however, social workers have recently been given professional authority to complete ODSP applications, which, as later will be discussed, is a highly organized system of medicalizing poverty.

With the increasing focus on the social determinants of health and with the emergence of multidisciplinary teams as a valued entity within health care, it seems it is a critical time to strategically inform and organize our practice within the health care system, not only for the benefit of the profession but also, for those with whom we work. Rather than being co-opted as a profession into the dominant agenda where poverty is feminized and its role on the medicalization of women's health, social workers ought to be strategically positioning the profession within the health care system to better meet the health care needs of women marginalized by poverty. A later discussion on opportunities for resistance

will explore some of the ways social work might become better positioned in the fight toward equity and social justice in women's health.

RESEARCH STATEMENT

The literature demonstrates conclusively that the medicalization and feminization of poverty has resulted in a health care system that increasingly fails to respond to the health needs of low-income women. Further, current solutions put forth at the policy and practice levels do not appear to provide the essential elements to rectify the social injustices low-income women face to become and remain healthy. If Canadians value universal, comprehensive and accessible health care, it is imperative that these systemic inequalities be identified and addressed.

Understanding that improvements in women's health requires a fundamental shift in how we view health care, this research study aims to better understand health from a perspective much broader than the dominant biomedical approach. By integrating of the broader socio-political context with the everyday experiences of women's lives, the purpose of this study is therefore, two-fold:

- To investigate women's perception of their own health, including the impact of key social determinants of health such as gender and income; and,
- To explore the extent to which the health care system is perceived to meet the health needs of low-income women living in Toronto.

CHAPTER II

METHODOLOGY

OVERVIEW

For more than a century, the positivist or scientific paradigm has been heavily endorsed as the chosen and preferred location from where to conduct the gamut of research. Operating from a framework that values neutrality, objectivity and truth (Beresford & Evans, 1999, p.673), the scientific approach suggests that there exists a universal reality that could be explained and measured through logical, deductive observation and exploration (Neuman, 1997, p.63). Given that medicine, professionally and institutionally, is well versed in this tradition at all levels (policy, practice and research), it stands to reason that health related research also predominantly adheres to this paradigm. As the literature attests, research surrounding the health and health care needs of women is typically grounded within this framework.

While it has endured with some tenacity within health circles, the positivist paradigm has not gone uncontested however. For example, critics of the positivist stance such as those adhering to an interpretative approach would argue, among other things, that no objective reality but rather that reality is created, or socially constructed, based on the meaning individuals assign to their everyday experiences and interactions (Neuman, 1997, p.33). Proponents of the critical approach similarly find fault with the notion of an objective, scientific truth,

suggesting instead that reality is a product of more deeply embedded structural arrangements that are driven and maintained by the social, cultural and political values and influences of the dominant class (Neuman, p.39). Social order is therefore created in such a way so as to maintain the status quo for the benefit of the privileged, in other words, those in positions of power and influence. Importantly, it means then that social order is transformable. For the critical researcher, this transformation is the essence of research: social justice is the ultimate goal. This study of the health and health care needs of low-income women is located within this framework.

THEORETICAL INFLUENCES

Methodology refers to the marriage between what we know (theory) and how we know it (method) (Neysmith, 1995, p.101). Methodologically positioning research is therefore critical to understanding its epistemological value. A number of theoretical perspectives fall within the broader critical framework, some of which were particularly influential to this work.

Feminist theories

To date, much of the research about women's health has been based on positivist tradition and more specifically on the hegemony of medicine, an institution and profession known for its patriarchal roots. According to feminist theories, society is both influenced and structured along gender lines. By viewing women's lives, and therefore health, through this patriarchal lens, women's health and health care is very much influenced by socially ascribed male power and

privilege and therefore, subject to misperceptions and injustices that ought to be rectified. For feminist theorists then, gender ought to be a critical focus of analysis (Baber, 2004, p.980; Reinharz & Chase, 2003, p.74-65; Canada, 2003, p.1, Krumer-Nevo, 2005, p.99).

Consistent with this viewpoint, feminist researchers typically select methodologies that not only value women's voices and experiences as a place of knowledge building, they also seek out women's expertise as a means to understand and improve the lives of those experiencing oppression on the basis of gender (Moosa-Mitha, 2005, p.51). Knowledge production is therefore not only important in terms of improved understanding; it is also an important site in the fight for social justice (Moosa-Mitha, p.56). For me, inequities in health reflect social injustices. Thus, any research about women's health needs to be subject to feminist analysis and pay very close attention to gender as a significant mediating factor in women's lives. One very appealing aspect of feminism is its ability to view women's lives through various theoretical lens and analyses (Moosa-Mitha, p.52; Baber, 2004, p.981), which in turn, reflects the complexities associated with women's lives. It was this evolving idea of complexity that led me to extend my theoretical positioning within my own research to explore anti-oppressive theories as a complimentary approach to this research.

Anti-oppressive theories

As the literature reveals, low-income women experience inequities in health and health care as a result of deeply embedded social structures that

discriminate on the basis of both gender and income. As the data from this study will attest, women's lived experiences are not easily categorized or explained in simple terms however and must be considered along various social dimensions (Reinharz & Chase, 2003, p.73). Risking reductionism, analysis of gender alone neither explains the intricacies and complexities associated the lives of women who are marginalized along several variables nor does it explain the interconnectedness among those variables. Indeed, one limitation associated with feminist theories and therefore a source of criticism, is their failure to be inclusive of differences, such as those linked to sexual orientation, race, disability and so on (Moosa-Mitha, 2005, p.53).

Anti-oppressive theory, on the other hand, is unique in that it offers a blending of what are referred to as difference-centred theories with that of the critical approach (Moosa-Mitha, 2005, p.37). Emerging in the mid-1990's, anti-oppressive theories rely heavily on the theoretical perspectives of social identity theories for their roots. In particular, social identity theorists challenged the notion of oppression based on one identity location, focussing instead on "the analysis of multiple and intersectionality of identity locations" (Moosa-Mitha, p.61). As with anti-oppressive theories, social identity theories are grounded in the critical stance and therefore, challenge negative notions of difference supported by other mainstream theories and embrace social action as a place of resistance to dominant structures and ideologies (Moosa-Mitha, p.61).

While adhering to these underlying principles, anti-oppressive theorists have recently focused on this idea of ‘difference’ in a more concentrated way and have begun to consider the implications of a ‘difference-centred’ society. To this end, assumptions around what is ‘normal’ are contested, as are practices that result in social exclusion based on these normative assumptions. For anti-oppressive theorists then, social justice means a society in which difference is not only embraced, but it is also expected (Moosa-Mitha, 2005, p.63).

One particular methodology that falls within this category by definition is the Intersectional Feminist Frameworks (IFFs). As described by the CRIAW (2006), IFFs “attempt to understand how multiple forces work together and interact to reinforce conditions of inequality and social exclusion” (p.3). The intersecting of such factors as income, gender, class, and ability are therefore the focus of analysis. While this particular study had always retained a feminist bias in its approach, the opportunity for praxis during its course generated a need to explore a theoretical perspective that would more clearly account for the complexities associated with the multiple oppressions experienced by these particular women. As a result, the IFF’s with its anti-oppressive theoretical stance seemed most befitting and was adopted as one of the key approaches to this research.

Institutional Ethnography

Institutional Ethnography (IE) was another approach deemed particularly relevant to this study on the health and health care needs of low-income women.

Consistent with my own theoretical positioning as a critical, anti-oppressive practitioner, IE asserts that people and their everyday lives are influenced by the broader socio-political context of their lives. These influences, such as power, knowledge and patriarchy, can be understood, according to proponents of IE, through an institutional analysis that explores the often hidden relational aspects of people and their world (Campbell & Gregor, 2002, p.17).

Institutional Ethnography was developed by a Canadian feminist sociologist, Dorothy Smith (Mykhalovskiy & McCoy, 2002, p.19; DeVault & McCoy, 2003, p.369) whose work on the social organization of knowledge profoundly influenced how women were epistemologically positioned (Campbell & Gregor, 2002, p.14). For Smith and other feminists, there was a disconnect between dominant discourse and women's actual experiences that required an alternative approach to knowledge building which led to this research methodology. In particular, they would resist any attempts to objectify women's lives (Mykhalovskiy & McCoy, p.19) and instead remained focussed on their personal everyday experiences.

According to IE, people's lives are carefully and purposefully orchestrated through the "interplay of social interactions" that define everyday life (Campbell & Gregor, p.27). Mykhalovskiy & McCoy (2002) provided a very clear definition of IE when they stated, "Institutional Ethnographers are primarily concerned with exploring and describing the various social and institutional forces that shape, limit and otherwise organize people's actual, everyday/night worlds"

(p.19). Using IE to explore the health and health care needs of women within the context of this research therefore means closely looking at, and listening to, the verbal and written text to uncover how power, or ‘ruling relations’, are purposefully implicated in the everyday lives of low-income women.

RESEARCH DESIGN

As discussed, the health and health care experiences of economically disadvantaged women are inextricably linked to, and socially organized by, the socio-political and economic structures embedded within their lives. Using applied research, as defined by Patton (2002, p.213), as a tool to better understand women’s health and health needs requires that the research be positioned accordingly. For these purposes, critical social science was subsequently chosen as the broad theoretical framework within which to locate this research, as a place for exploring the human experience and as a means for social change. Within that broader framework, feminist theory, anti-oppressive theories and institutional ethnography were chosen as the foundation of the research design.

To effectively use a critical approach with its feminist traditions toward an improved understanding of the health and health care needs of this particular population and concomitantly, to explore the broader socio-political context that impacts their ability to achieve health and to access relevant health care, a qualitative approach using the women’s own voices was recommended and therefore utilized (Finch, 1991, p.195; Ballem, 1998, p.337; Patton, 2002, p.129;

IGH, 2003, p.1). This approach also coincides with the preferred methodology of institutional ethnographers (DeVault & McCoy, 2003, p.373).

Subsequently, data for this research was collected through the use of taped, in-depth, face-to-face, semi-structured interviews with women who experience low socio-economic status. As suggested in the literature (Babbie, 2001, p.298; Goodwin & Horowitz, 2002, p.44), this method of data collection not only afforded heightened data validity, it also, perhaps more importantly, allowed me to capture the richness, texture and depth of participants' experiences and knowledge.

To frame this qualitative inquiry, a semi-structured interview guide was used (see section on instrumentation) offering a number of advantages. Firstly, interview guides are time and organizationally efficient, particularly in terms of data analysis (Patton, 2002, p.349). Secondly, while topics of interest were broadly identified at the onset, the conversational, collaborative style associated with this narrative method invited elaboration and flexibility on the part of both parties, generating a more authentic dialogue outside of the ruling discourse, that was both sensitive to "local language" (Patton, p.363) and that challenged the "expert needs interpretation" which usually favours dominant groups (Fraser, 1989, p.164). Institutional Ethnographers also recommend this conversational style and refer to the interview as being more simply, "talking with people" (DeVault & McCoy, 2003, p.374). For this reason, conceptualization in this study was not pre-determined, but instead, evolved through the interviews, as did the

questions. Apart from loosely following an interview guide, the conversations were, for all intents and purposes, iterative processes meaning that the participants' responses directed and informed future questions and discussions in a reflexive manner, creating space for new information and learning. Consistent with the study's theoretical underpinnings, this method of co-constructing knowledge was both empowering and relationship building. Not only does it respectfully position the participant as her own expert, but it also shifts the balance of power within the research relationship (Finch, 1991, p.200) and demonstrates both self-awareness and humility on the part of the researcher (Ballem, 1998, p.336-337).

Sampling

In hopes of achieving theoretical redundancy (Patton, 2002, p.246), a total of eleven (11) individuals were selected and interviewed for this study. Since the goal of qualitative inquiry is to gain insight rather than generalizability (Patton, p.40; Babbie, 2001, p.212; Goodwin & Horowitz, 2002, p. 44), this seemed to be an acceptable compromise. While 12-26 participants are usually recommended to achieve saturation (Luborsky & Rubinstein, p.105), time and financial limitations essentially restricted numbers.

A non-probability sampling strategy known as purposive sampling (Babbie, 2001, p.179; Luborsky & Rubinstein, 1995, p.104) determined who would participate in this study. The desired sample included only those women who were likely to experience compromised health because of their low-income

status as indicated by their primary source of income. The selection criteria therefore included only those women who are in receipt of Ontario Works (OW) or the Ontario Disability Support Program (ODSP) for a minimum of one year². Time restrictions were introduced to denote the expected experiential differences between transitory and non-transitory poverty.

Other inclusionary/exclusionary criteria were also included for the sample selection process. Sensitive to the potentially unique health and health care needs as well as the socio-political implications for the transgender community within this urban setting, this study was limited to only those individuals who were biologically female. Similarly, as it relates to factors associated with age and ageism, the women selected for this study were required to be between 25 and 60 years of age. The requirement that the women live in an urban setting reflects the demonstrated differences in rural and urban health and health needs. For example, differences associated with cost of living, access to resources, geographical challenges and so on (OWHN, 2005, p.4). For ease and accuracy of data collection based on my own language limitations, all participants were also required to be fluent in English. For ethical reasons and to help ensure the trustworthiness of data, individuals with whom I have previously worked in a counselling capacity would be excluded, as would individuals associated with the

² In Canada, the poverty line or low income usually refers to the low-income cut-offs (LICOs) (OWHN, 2005, p.4). Figures provided by the OWHN in 2005 place recipients of OW and ODSP within that category: the total amount of income available to single person on OW is \$6,838 (35% of the amount needed to reach the poverty line and the total amount of income available to single person on ODSP \$11,765 (59% of the amount needed to reach the poverty line) (p.6).

local community health centre where I am now currently employed. The ability to give informed consent was deemed essential.

The participants for this research were recruited from a community centre in downtown Toronto known to me through my previous work. It is a place where I have facilitated focus groups involving consumer based systemic advocacy and where women marginalized by low income are plentiful. Nonetheless, to avoid a perceived sense of obligation and therefore, possible coercion, third parties were used to mediate the sampling recruitment. As a complimentary strategy consistent with purposive sampling, the technique of snowball sampling was also employed.

Instrumentation

Participants in this study were asked open-ended questions loosely based on a semi-structured interview guide (see Appendix A-1). To ensure depth of data and to inform the wording and nature of questioning in future interviews reflexively, probes were used judiciously but generously. Where appropriate, illustrative examples were used (Patton, 2002, p.366), particularly when participant responses appeared ‘thin’ and/or seemed likely to be impacted by issues of “social desirability” (Babbie, 2001, p.245). For example, on at least one occasion, I mentioned that sex trade involvement had been mentioned by other participants as being a relevant health matter, not to bias the data but rather, to set the stage for a more open dialogue.

True to iterative fashion, interview questions evolved experientially as a product of the knowledge exchange and while maintaining the essential flavour of

the suggested interview guide, those occurring previously would inform each subsequent conversation. In hopes they might help guide future interviews, all participants were asked for suggestions around the content and nature of the questioning to ensure areas of import were not missed or minimized. At the end of each interview, participants were asked a series of standardized questions relating to group demographics (see Table I). Participants were advised at the onset that these questions were optional and that responses could be declined without consequence.

Prior to implementation, the interview guide and potential probes were reviewed by a women's advocate and educator well versed in the feminist/critical traditions to check for oppressive, ruling influences based on my place of privilege and professional location, particularly as it relates to the medicalization of needs, biases associated with my professional position and, since medicine tends to be a male dominated enterprise, any male biases that might be contaminating the process (Finch, 1991, p.196).

Procedures

Approval

Prior to research commencement, approval for this study was obtained sequentially at three levels. As per program requirements, a proposal was reviewed and approved by my Research Supervisor outlining the research plan, including the proposed research objectives and methodology, for submission to the School of Social Work. Based on this approval, application to involve human

Table I. Demographics of Research Participants*

	<i>N</i>	(%)		<i>N</i>	(%)
Age			Living Situation		
25-35	2	18%	Alone	8	73%
36-45	3	27%	Other	3	27%
46-60	6	55%			
Primary Source of Income			Financial Assistance for Accommodation		
OW	2	18%	Subsidy	6	55%
ODSP	9	82%	Other	2	18%
			No	3	27%
Cultural/Ethnic Background			Housing Status		
Canadian	2	18%	At Risk of Homelessness	2	18%
Native/French	1	9%	Neither	9	82%
English/Newfie	1	9%			
Caucasian	2	18%	Disability		
Hungarian/French	1	9%	Yes	10	91%
South African	1	9%	No	1	9%
English	1	9%			
French Canadian/British	1	9%	Nature of Disability (not mutually exclusive)		
Native Canadian/European	1	9%	Fibromyalgia	1	9%
Citizenship			Angina	1	9%
Canadian	9	82%	Depression	2	18%
Landed Immigrant	1	9%	Numerous broken bones	2	18%
Other (dual British/Canadian)	1	9%	Back problem	1	9%
Sexual Orientation			Epilepsy	1	9%
Straight	7	64%	Arthritis	3	27%
Bisexual	2	18%	ADD	1	9%
Other – Normal	2	18%	Bipolar	1	9%
Housing Situation			Hep C	1	9%
Apartment	10	91%	Obesity	1	9%
Rooming house	1	9%	Mental health	1	9%
			Physical	1	9%

*Responses recorded as self-described

participants in this research was subsequently made to the McMaster University Research Ethics Board (MREB) for consideration and eventual approval. The latter would respectfully guide all subsequent activities related to this study (see section on ethical considerations).

The last step involved obtaining approval from the community centre from where the sample would be drawn and the interviews would be conducted. This written submission, which took the form of request for assistance (see Appendix B-1), was forwarded along with copied proof of the MREB approval to two key Program Managers as recommended, for organizational approval during two separate, scheduled meetings. During these meetings, both managers were introduced to the research, oriented to recruitment strategies and formal arrangements were made to use this venue as a neutral facility in which to conduct the research. Both managers were offered verbal and written reassurances that community centre would be relinquished of all responsibility for the project and its participation would not be revealed in any subsequent formal research writings. As agreed, the role of the community centre would be limited to providing interviewing space as well as authorizing respective staff to engage in recruitment strategies as follows.

Recruitment

Being known and trusted by the community by virtue of my work history within the community centre, would, in principle, ease my entry within the research setting and produce better quality data. However, to avoid a perceived

sense of obligation and therefore, possible coercion, third party mediators from the community centre were used for participant recruitment. In addition to, and in consultation with, the two program managers, key program staff members were identified to invite service users to participate in the research as well as to distribute flyers centre-wide (see Appendix C-1). Staff members were selected based on their anticipated contact with the selected population as well as any expressed interest in assisting with this research process. Each participating staff person received an orientation to the research as well as to the recruitment process, in particular alerting them to concerns relating to participant coercion and/or inducements. Interested parties who self-identified as low-income women and who expressed an interest in participating in the research were then connected to me to discuss their participation further, either through direct contact or through bridged contact which included both the exchange of telephone numbers and personal meetings arranged through the respective staff person involved.

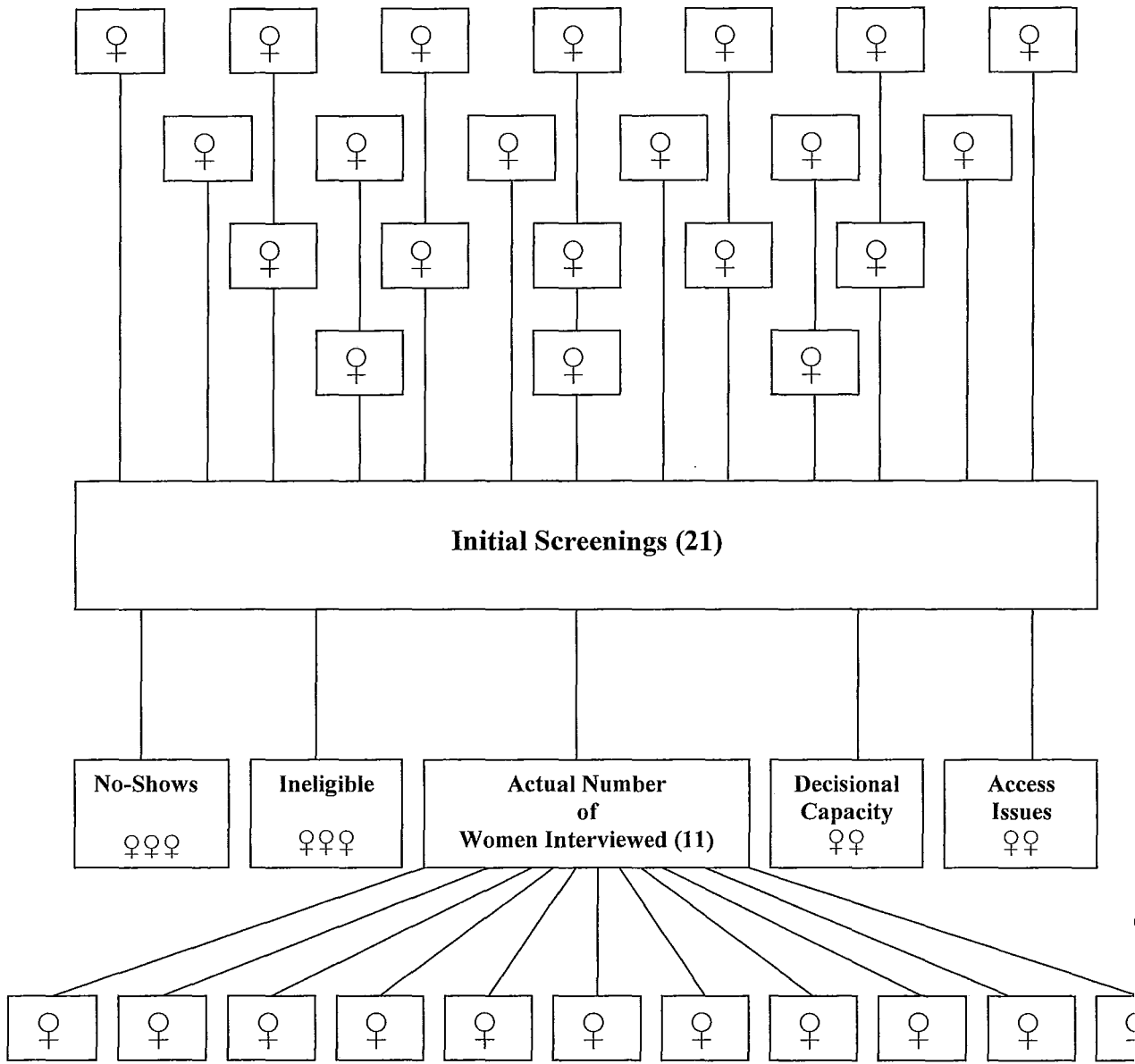
A preliminary screening was conducted with each interested party, usually a telephone screening however, for those individuals without telephone access, a face-to-face screening was conducted. The screenings provided an opportunity to provide an overview of the research study including its purpose and procedures, to discuss mutual expectations around the research process, as well as to ensure that each participant met the inclusionary/exclusionary criteria as outlined (see section on sampling). Based on the outcome of this initially screening process, interviews were then scheduled at mutually agreed upon times.

During this process, a total of seven individuals were respectfully declined participation. Two individuals who volunteered for this study were declined based on questionable decisional capacity and therefore their inability to provide informed consent due to challenges in comprehension about the nature and purpose of the research process. Two individuals were declined based on their association with my place of employ. Two individuals were homebound for mental health reasons and therefore not eligible due to perceived liability issues associated with home visits. Lastly, one individual did not meet the age requirements. Three women did not show for the interview. For a visual presentation of the recruitment process, see Chart I.

A number of issues arose during the recruitment phase, a few worthy of comment. Firstly, reliance on third parties for recruitment led to significant time and energy challenges as well as sampling consequences. In particular, varying levels of commitment and support to this type of research inevitably led to a narrowing in sample selection with mixed effects. What was lost in potential generalizability however, was gained in increased understanding and expertise about particular communities that would tap into analytic variables extending beyond gender and income. White, Russ & Travis (2001) would argue that the development of “diversity mindful” expertise, consistent with anti-oppressive theories, is indeed an asset to any forthcoming research (p.271).

Secondly, eliciting participant interest was more challenging than anticipated and may, in part, reflect my own underestimation of the impact of

Chart I. Recruitment Process



poverty related issues on the recruitment process. Aside from unforeseen issues related to flyer dispersion, the advertising for participants, in hindsight, ought to have included a provision for compensation, at the very least for transportation reimbursement. Initial concerns about inducements proved to be an unnecessary barrier toward access. Another factor not considered was that several participants experienced limited social contact and in some cases, virtual isolation as a product of their circumstances, thereby limiting the success of snowball sampling as a recruitment strategy.

A final comment about recruitment relates to perspective about the value of research, the manageability of the process and its level of import in the broader context of these women's lives. As one woman so eloquently put, in reference to challenges associated with poverty, maybe it was about having "bigger fish to fry". Reinharz & Chase (2003) speak to this challenge when they state that persistence and flexibility is required when choosing to participate in research with individuals with complex social locations (p.82). As my experiences in this regard attest, tenacity, time and commitment were all essential components of the recruitment process: no-shows and the need to repeatedly reschedule interviews came to be expected. One woman who showed up needed to leave to attend court. Other women 'were lost' in the process despite repeated attempts to connect. It is mentioned not as a complaint but rather, as one of my many learning experiences in this process.

Data collection

Each interview was conducted in a private office space at the community centre located in downtown Toronto and lasted approximately one to one and a half hours in length. Before proceeding to the interview proper, several areas were covered with each of the women. A verbal review of the letter of information (see Appendix D-1) as well as a letter of consent (see Appendix D-2) would orient each participant to the research and the research process. Each participant received a copy of each of these letters. Any emerging questions about the research or the research process were fielded at this time and written consent was obtained before proceeding.

As part of this orientation process, the research was situated within my personal and professional biases, consistent with the feminist approach. All participants were told that I currently work in a local Community Health Centre, that I am a community advocate, that I am using this academic research to build knowledge about the health and health care needs of low-income women from their perspective and that my theoretical biases reflect the belief that social structures influence how we experience our health and health care needs.

With the participants' permission, all interviews were subsequently taped and written notes were taken as needed during the interviews. Participants were informed that a very broad interview guide would help frame the interview but that a conversational style was very much desired. The women were strongly encouraged to answer any questions in their own words and in their own ways and

were advised that all questions were optional. Confidentiality was assured throughout the process in terms of data management as well as the use of identifying information, barring any legal requirements associated with disclosed information, i.e. danger to self or others. Following the interview proper, participants were asked to provide some personal demographic data including age cohort, ethnicity, immigration status, disability, sexual orientation, housing status and living arrangements for group description purposes (see section on instrumentation).

Follow up interviews were also offered at this time. Participants were given the option to attend a follow-up meeting for a few reasons: to obtain any missed information from the first interview and to conduct member checks in order to clarify and assess the accuracy of data analyzed to date. This discussion would also permit dialogue should any unsought consequences arise based on the analysis. For example, this may include any negative impacts the study may have had on their self-concept by virtue of being identified as among those disempowered. While it was an offer that several women would request at the time of the interview, only one woman has attended a follow up meeting to date.

Additional ethical considerations

Throughout this study, ethical considerations were attended to in accordance with my personal and professional responsibilities to the MREB and College of Social Workers and Social Service Workers. The issue of decisional capacity and informed consent as discussed by Kayser-Jones & Koenig (1994,

p.19) was taken very seriously given the possible vulnerabilities associated with this research. Issues around literacy and comprehension came to mind, as did the possibility of mental or physical disabilities since some participants were in receipt of ODSP. Written information sheets were subsequently reviewed verbally and distributed. To ensure understanding and therefore informed consent, participants were asked to confirm their understanding of the information provided prior to signing the written consent. Questionable decisional capacity was handled by erring on the side of caution.

The issue of reciprocity was addressed in a few ways. Aside from the secondary benefits of being heard and validated as an expert in building knowledge, participants were financially recompensed as a token of my appreciation for their time and expertise. Each participant received financial compensation that included a food voucher and transportation assistance along with a letter of appreciation for his or her participation (see Appendix E-1). As promised, they will also be provided with summaries of the research when available.

Analysis

Data was interpreted through a critical feminist lens throughout the interview process as well as throughout the analysis phase of this research, in accordance with the guiding principles and assumptions associated with institutional ethnography and anti-oppressive theories. Once transcribed verbatim, each interview was reviewed, word for word, and the data was systematically

coded (Strauss, 1987, p.20) according to relevant themes and categories, searching for patterns and interrelationships among the concepts (Patton, 2002, p.41). Through this process, I was seeking out information that might suggest oppressive forces in operation and that specifically spoke to issues of gender and income as key variables for analysis. I was also interested in better understanding how these women's lives were socially organized as a result these factors. As the findings suggest, the analysis centred on describing key themes in women's perceived health and health care needs, exploring the influences and interconnectedness of factors like gender, class, income, disability and race in relation to their health and explicating the ruling relations that institutionally and socially organize their health and health care. These women's words were also carefully considered in an effort to ensure clarity and accuracy in understanding the information, to examine my participation in the research process and to reflect on the research process as a place for social change.

Understanding the profound influence of text by virtue of my Institutional Ethnographic groundings, particular care was taken, in the writing of the findings and the conclusions, to locate these women's experiences as being a function of social context and social organization and not as deficiencies within the women themselves.

CHAPTER III

FINDINGS

DEFINING HEALTH AND HEALTH CARE

Introduction

As the literature review suggests, definitions of health and health care vary based largely on the personal, professional and political locations of the defining parties and as noted, these definitions are not without implications. A sizeable portion of this research therefore included a discussion of how women marginalized by low-income define health and health care, based on their own lived experiences. This exploration served several purposes. It was an opportunity to gain a mutual understanding of these concepts to guide and inform the interview process: an effort in ‘getting on the same page’, if you will. Consistent with the feminist and anti-oppressive approaches, this discussion also provided a venue to hear from low-income women firsthand how they define health and health care³. By not defining concepts on behalf of the women interviewed in advance, it created opportunities to engage in discourse beyond that of the dominant as well as to locate and understand their own definitions of health and health care within a feminist and anti-oppressive framework. Lastly, it was hoped that, based on any alternative discourse that may emerge, new and/or less traveled

³ For confidentiality purposes, all of the women’s names have been replaced by pseudonyms.

paths might surface that could begin to address women's health and health care needs, at the policy and practice level, in a more meaningful and relevant manner. Further, by talking with these women about their health and health care needs, possible avenues for future research beyond the traditional biomedical framework, may be generated, or at least supported. According to the Maritime Centre of Excellence for Women's Health (MCEWH) (2001), this conversation is both necessary and timely, stating that women's health research has, thus far, been much too limited in focus and therefore, fails to take into consideration the complexity and diversity of women's lives or their perceptions of health (p.1).

Defining health

In order to access this information, the women were asked not only to provide information around how they might conceptualize health, they were also asked to share their perceptions around being healthy and being sick, particularly when responses seemed thin. This latter prompting tended to elicit more personal responses based on their own life experiences. The following responses to questions about health therefore range from being more generic to the very personal and were, as will later be discussed, compiled over the course of the interview.

When asked about their definitions of health specifically, a significant portion of the women interviewed defined health beyond the very restricted and narrow biomedical framework, consistent with the view of the MCEWH (2001, p.1). Some of the responses included:

Physical, emotional, mental, spiritual well-being. (Leslie, p.1);

Mind, body and soul and spirit. It's like a holistic kind of approach. (Tanya, p.1);

My organs...my body...my mental state...my physical being my body right. (Karen, p.1); and,

Well there are all kinds of aspects of health. There's health of mind, body and spirit. (Jackie, p.16).

Other women in this study described their definitions of health in more specific terms and often in combination. In categorizing the responses from these participants, a framework that emerged from similar research in the United Kingdom, and used by MCEWH, proved most helpful (2001, p.1). Using this framework as a guideline, the responses from the women in this study could be similarly categorized into the following areas:

- i) Absence of disease;
- ii) Physical fitness or energy level;
- iii) The ability to perform roles or functions;
- iv) Psychological fitness or mental health; and,
- v) Lifestyle factors/health maintenance

Absence of disease

For some women, being healthy, or experiencing health meant the absence of disease and was subsequently framed within the biomedical model. For example, they spoke of having “pain”, “a tickle”, “poor colour”; in other words, some physical indicator that might suggest a physical concern. One participant

described that, in the absence of health problems, “I would not feel ill like nauseous, headachy, tired...achy” (Cathy, p.2). Sickness for her, on the other hand, would mean that “generally there is the chest pains, there’s the nauseous feeling, there’s the muscle spasms, really hot with high blood pressure kinda thing” (Cathy, p.2).

During the course of the interviews, each woman disclosed a number of past and present physical health problems that included, but were not limited to, the following⁴:

- Arthritis
- Fibromyalgia
- Chronic fatigue syndrome
- Angina/heart attack
- Bad legs
- History of bone fractures
- Migraines
- Diabetes
- Gynaecological problems
- Hepatitis C
- Possible lung cancer
- Chronic pain
- Collapsed lung
- Emphysema
- Asthma
- Sleep problems
- Unable to walk without assistance
- Bone disease
- Bad back

Several described physical health complications that were life threatening and continue to live with the residual effects of those events. Not all were however considered to be disabilities by the women (see Table I for a comparative analysis). As one woman so eloquently put, “My lungs are a health issue, not a disability.” (Jane, p.35)

It is also important to note with this particular group of women that there was a range of physical health circumstances that self-reportedly ranged from

⁴ While a quantitative analysis of this data was tempting for description purposes, I felt strongly, by virtue of my theoretical positioning, that this data be considered qualitatively for none other than to reveal the physical health experiences as self-defined and so have been listed in no particular priority or frequency. Any health concerns that might demonstrate import as part of the data analysis will be discussed accordingly with these concerns in mind.

“good” to “poor”. However, several described complex medical problems, often involving multiple diagnoses.

Physical fitness or energy level

Physical fitness or energy level as a marker for health was also a common response to how health was conceptualized by this study’s participants. The phrase “feeling run down” surfaced with considerable frequency as a sickness indicator as did “feeling tired”, albeit less often. For these woman, health was subsequently measured by energy level: they would “keep busy”, have “more stamina” and would feel more like “getting exercise”, “walking, riding a bike or swimming”, for example. Along this line, one woman stated she would be “able to do things I wouldn’t normally be able to do.” (Tanya, p.1)

Ability to perform roles or functions

The third category, the ability to perform roles or functions primarily referred to the woman’s ability and/or willingness to socialize with others, although capacity to parent as a result of health concerns was also placed within this category. One participant spoke of having difficulty getting up and going out (Susan, p.4). In describing what healthy might look like, one woman stated that she “might get up and do housework” (Cathy, p.7) as an indicator of wellness. I have respectfully taken the liberty of interpreting her response to imply a gender-related role and therefore, have incorporated it also within this category.

Psychological fitness or mental health

Psychological fitness, or mental health for the sake of consistency, proved to be a particularly interesting area that was borne with tensions as a site for discourse for some of the women. Some of these tensions will be discussed later. For others, mental health was considered to be an integral part in defining health. One participant describes in her list of elements of health, “Mental is as much health as anything so, good mental standing.” (Kate, p.29)

A few women declared at the onset that they experienced mental health issues; while for others mental health would be discussed in more descriptive terms. For example, mental health might be inferred by such descriptions like being in “good mood” or “good spirits” or in a “happy go lucky” frame of mind. Similarly, for some, being healthy meant “better concentration”, “better memory”, improved understanding, more patience and more tolerance for noise. When asked if these descriptors were linked to mental health, the respective women confirmed my interpretation.

As the interviews unfolded, most of the women spoke of their personal experiences in this area. Family histories of mental health challenges as well as personal struggles were brought to the forefront. Anxiety, ADD/ADHD, PTSD, Bipolar Disorder, Seasonal Affective Disorder, suicidality and depression were all mentioned without probing, the latter two in significant proportions. In fact, almost half of the women talked about their struggles with depression and more than a quarter of them spoke personally about suicidal ideations, suicide attempts

or both. I raise these figures not to be alarmist or to place judgment on the mental health of these women but rather to suggest the degree to which social determinants of health like income and gender may be linked to the mental health of low-income women.

Lifestyle factors/health maintenance

Some responses to the question about defining health focused on specific strategies that promote health from a more preventative stance. One woman spoke of good exercising, good eating, the environment, fresh air and not smoking as being important to her definition of health. When probed, she described environment as including not only nature and our surroundings but also, people and how you communication with those people (Mary, p.2). Another participant stated that health to her, involved a “daily routine for starters, which includes health eating and exercise” (Kate, p.29). She went on to declare that nutrition and exercise were *the* most important elements of health. This focus on health promotion also included knowledge, having the knowledge around how to improve one’s health as well as the knowledge to know what to do and where to go should you become unwell.

One of the areas not covered by the categories but worthy of comment is the idea of spiritual health. When asked to elaborate on this concept as it related to her definition of health, one woman stated that spiritual health was “anything approaching self-actualization...even just peace of mind and the ability to cope and just feeling good about oneself and the world and how to interact with other

people.” (Jackie, p.17) It was a concept that seemed so fundamental to health, yet so profound.

While categories are useful for description purposes, they tend to be neither mutually exclusive nor mutually independent, as is the case here. Indeed, there is considerable overlap and interconnectedness within and between all of these categories as the following explanations attest:

Say I have a sore back and I'm walkin' around and it's really hurting and it starts aggravating me and...I have things to do and I have no choice but I have to do them. So...I get cranky and I get frustrated and then, I give up and go home because I can't do it.
(Tanya, p.2)

Similarly, one participant simply said in reference to her own health status, “ I am not sitting at home depressed and waiting for my lung to collapse again” (Jane, 2006). Yet another woman spoke to the interconnectedness of these categories when she said,

I was also told that I had chronic fatigue syndrome so I'm always tired, not tired to sleep but body tired...the brain feels dead most times. It's really hard to concentrate. You don't sleep...You have nightmares...Sometimes you think of suicide...and when I am in constant (sic) pain all the time, I don't always show it. So, because I don't show it physically, people don't believe that there is something wrong. (Cathy, p.2-3)

She went on to say...

When I'm not feeling good, for example, when my blood pressure goes up to the 200 or higher...I...feel sick. I get extremely hot where it's like I've come out of a shower...I get dizzy. I will get lots of chest pains...It's almost like you are having a stroke, is what it like...and it is a very scary, frightening feeling...I won't get up. I will stay laying down...I won't eat cause, cause I'm not hungry. Or if I eat, I'll feel sick...I could end up crying...sometimes it could be because of the way I feel. You

know...gees, why is this happening kinda thing...and then I would have scary nightmares about my mother for example...Cause when I don't feel good...I don't want to be around people...I can't stand the noise. I can't stand the arguments...I just don't want to be anywhere...I just want to lay down in a little ball for example and just stay there. I don't want to get up. I don't want to do anything. I won't have showers. Nothing. Do absolutely nothing. (Cathy, p.7)

This example demonstrates, with all its complexity, that defining health along any singular dimension would be much too simplistic and would fail to take into consideration the multifaceted health issues of low-income women.

Defining health care services

Initial discourse around how to define health care services was very much limited to key medical services for most of the women. In particular, family doctors and hospitals were offered by the participants as the primary services associated with health care. Through dialogue and probing however, these women revealed knowledge about a vast array of services and programs that they consider being under the health services umbrella. These can be distributed among four (4) groupings: i) Medical health care; ii) Non-medical care; iii) Community and outreach initiatives; and, iv) Other.

Medical health care

As discussed, family doctors stood out as being the defining health care service for these women regardless of stated health needs or patterns of service utilization. To quote one participant, "I think everybody should be able to have a family doctor." (Jane, p.20) In terms of other health professionals, nurses, psychiatrists, and medical specialists including methadone doctors, pain doctors,

gynaecologists and surgeons were all mentioned as were as specific models of care like hospitals, Community Health Centres (CHCs) and walk-in clinics.

Non-medical health care

In addition to medical health care, participants in this study spoke of other professionals they considered to be within the realm of health care services including social workers, counsellors and addictions workers as well as non-medical programs like support groups. Dental care, dieticians, occupational therapists and physiotherapists were mentioned as were sleep disorders clinics, diabetes clinics and crisis services, all of which fall under the non-medical category of health care services.

Community and outreach initiatives

Several of the participants in this study are, or were, heavily street involved and brought with them a wealth of expertise in terms of various medical and non-medical outreach initiatives providing health care services in downtown Toronto. The Sherbourne Health Bus and harm reduction programs like The Works and COUNTERfit (also known as “Raffi” or the “Drug Awareness Program”) were cited as health care services as were various initiatives that involved workers and nurses doing health outreach on the streets, in CHCs, in people’s homes and within places like the Scott Mission.

Other

Interestingly and unexpectedly, church and volunteer work were both cited as health care services, the latter mentioned by at least one other woman when

they were asked specifically about their health care definitions. Both women talked about the personal health value associated with helping others and an increased sense of purpose as a result of volunteer work. One of the women stated,

I did drugs at one time. I did a lot of drugs...I needed something to come back to, like I wanted to quit...but I needed to get back into society and it's hard. When you're used to doing something, it's hard to get back and communicate...just like I'm doing now, it's sort of...it's hard to speak to somebody because I haven't in a long time...I needed to do something so like volunteer work and working with other people and helping people. That was, I found, was good...made me feel good and helped me. You know, it was good for my health. (Mary, p.4)

Keeping in mind that these responses were elicited for the purposes of defining health care services, it is important to differentiate between what constitutes health care and what promotes health. As will later be discussed, the participants did identify several programs and services not under the auspices of health care services from their perspectives but that nonetheless, impact health in significant ways.

Descriptions around use of health care services

While a deeper understanding around the nature and quality of service utilization among these particular women can best be gleaned in the forthcoming discussion around health care experiences, it is nonetheless important to comment on a couple of areas related to health care service use. Most of the women interviewed spoke of history of service access beyond traditional family medicine and hospital care that often included a multiple providers located in multiple

settings. For some women, this was especially problematic. The other area worth commenting on is that the nature of women's actual service use decidedly differs from their desired use. For the low-income women in this study for example, patterns of health care service use were directly linked to the personal financial costs associated with those services. Women tended to access non-fee services and tended not to access those services for which fees would be incurred, regardless of perceived personal value or preference.

FACTORS THAT IMPACT WOMEN'S HEALTH

As discussed, the existing literature demonstrates convincingly that a number of factors, extending well beyond the traditional medical or disease model of health are associated with the health of low-income women. By exploring this area more deliberately, particularly as it relates to gender and income, this study created space for alternative discourse around health-related matters beyond dominant medical discourse to include the lived experiences of low-income women. Based on these conversations, several common themes emerged that suggest that a number of factors, acting independently and in concert, are implicated and therefore ought to be considered as part of any analysis of the health needs of low-income women.

Impact of income

Not surprisingly, the consensus among all of the study's participants was that the income provided by Ontario Works (OW) and the Ontario Disability

Support Program (ODSP) is insufficient as a sole source of income and prevents women from meeting their basic needs. To use the words of one participant,

Well, on ODSP you don't get a lot of money, a lot of extra money. You don't get hardly anything. They don't even give you the cost of living. I mean that is dreadful. (Cathy, p.10)

From their perspective, low-income is not only influential in their lives; it is also profoundly detrimental to their health.

Low-income and access to food

An inability to access decent food was cited with considerable frequency as one of the biggest health barriers facing these low-income women. In fact, one woman disclosed that she agreed to participate in this interview specifically because she was in need food at the time. Another woman simply stated, "Hell yeah. Income has...everything to do with diet." (Jane, p.24). For some participants, the use of meal programs and food banks seemed to be common practice in order to help bridge the gap between their lack of income and their need for an adequate supply of food. To quote one participant,

Because I don't get a hell of a lot of money so I still have to access food banks and that's a big thing to do with diet...people still don't get near enough money to live on...and I am one of them. (Jane, p.24)

For Tanya and others, lack of income means buying inexpensive, non-perishable food at the beginning of the month to ensure access to some food, however poor in quality, until their next cheque arrives. To use her words, "I eat to stop from feeling my blood sugar go down. That's it...I eat a lot of sugar. I eat

a lot of pasta. A lot of stuff that's cheap.” (Tanya, p.13) Cathy spoke of similar compromises. When asked how more income might impact her life she stated,

So I mean, there's so many simple little things...you wouldn't have to eat Kraft dinner all the time...maybe you'd be able to buy yourself a nice...couple pork chops, some nice potatoes, and get yourself some really fresh fruit and vegetables...that's healthy for you. (Cathy, p.18)

For many of the women in this study, access to a healthy diet meant access to health. According to Cathy, “if you're not getting healthy food, you know, you're not healthy” (p.18). Susan, a mother of three and a sole provider, talked about what the importance of a healthy diet for her family's health when she said in reference to her youngest child,

My little one, being ADHD, it's important that he has, you know, good nutrition because the pills that he takes does suppress his appetite. So when he does eat, I make sure he gets, you know, fresh fruit, fresh vegetables, stuff like that. (Susan, p.12)

One of the women spoke passionately about this issue and was able to contextualize how her own lack of income has affected her health from a much broader perspective. In response to queries about how low-income and health impacts her everyday life, she replied,

Well definitely malnourishment...which leads to the mental problems...I never realized it but half of my problems all through school and all through work is food. I never realized it until this last few years that one of the reasons that I was always so scattered and way out there and weird and screwed up and strange, wasn't necessarily because I was ill and needed medication, I mean yes that was the truth, but I was bloody hungry and I was ignoring that hunger trying to function in the world...being hungry made me worse up here (pointing to her head)...If I had just been eating something...just the routine of having a breakfast in the morning

is, is so fundamental for maintaining a personality...cause you have to be a personality when you are in a job. (Kate, p.14-15)

This link between mental health and food insufficiency as a result of low-income finds supports in the literature as well. In one recent study by Wu & Schimmele (2006) for example, food insufficiency and its related stressors were directly linked to increased risk of depression. They argue that, based on the significance of their data, 1.3 million Canadians who are impacted by food insufficiency may be at risk for depression (p.499).

Low-income and mental health

The idea that poverty impacts mental health has been well established in other studies (Wu & Schimmele, 2006, p.498) and surfaced with considerable frequency in this study as well. For example, several participants spoke about financial hardship as a source of great stress. The stress associated with being “broke” for most of the month and having to wait until the next cheque arrived was a familiar theme. According to one woman, “You are always worried because you don’t have a lot of money.” (Cathy, p.11)

Other women specifically used the word ‘depression’ to describe how poverty impacts their mental health. In reference to the recent \$1100 cut to her family’s OW cheque as a result of changes to the special diet allowance, Susan stated,

So the last month was just pure hell and this month is not much better, you know. I’m not looking forward to my cheque on Tuesday. It’s \$450. What do they want me to do with that...I sat there and cried when they said I was cut off...It’s just, it was awful. (Susan, p.19)

Another woman stated that she too gets depressed a lot since illness reduced her income level. She described her thoughts,

You know, since I'm on OW, what can I do? You don't get enough money to do anything. Like I say, I used to be able to travel all the time. I had a good job. (Jane, p.12)

Low-income and social isolation

In this study, social isolation, in particular the ability to participate in society in a meaningful way and to maintain social connectedness proved to be another health related challenge linked to lack of income. Other studies have similarly linked social contact and support as important determinants of health (Denton et al., 2004, p.2587). For some of these participants this had implications for their mental health and their physical health. Not having the 'extra' money to connect with friends and family or to engage in pleasurable activities impacted not only on a women's ability to socially connect, but also on their support network and self-esteem. Cathy, for example, spoke of being unable to spend time with family because of her financial situation and of the embarrassment she faces as a result. Even to go for a coffee, "unless you put that dollar aside and save for that, you're not gonna get it. You know, you can't afford to get it." (Cathy, p.12-13) The result is that her social and familial contact is limited and therefore, so too are opportunities for support. High transportation costs presented similar challenges and also contributed to the social isolation experienced by some of these low-income women.

For others, the idea of social inclusion presented itself in rather unexpected ways. In noteworthy proportions, participants in this study commented on the importance of access to cable television and a telephone. For some, it was about enjoyment. For others, it meant social inclusion as well as access to improved mental and physical health, particularly for those experiencing complicated health problems. One of the participants talked about her concerns about not having a telephone in the event of an emergency and went on to discuss what having a telephone has subsequently meant for her. Initially because of health concerns she thought, “I need a home phone now and I didn’t have a phone so I really felt cut off too...what a difference that just made, just having a phone.” (Jane, p.14) She talked about the disconnection she felt with her family previously and how the regular contact afforded by telephone access has improved her mental health and her experiences with depression in particular.

Capacity for self-care

Another factor mentioned by some women that was outside of usual health discourse but nonetheless identified as a health related concern was their limited ability to engage in self-care practices because of their limited income. Cathy for example talked about not being able to have “any joys in life” (Cathy, p.10) and the impact certain limitations have on her overall mental health. She explained,

If I want to go get my hair done for something different to make me feel good and happy...it is literally impossible to do it, even to go get a haircut. It is literally impossible because there is not enough money. It’s frustrating you know. Then you start to look like crap. (Cathy, p.11)

Later she added,

Because I find you know, if you can go get a haircut, get a new hairdo or something like that, you know, a lot of times it makes you feel good about yourself...you get to a point that you, you don't feel good about yourself in any shape or form, you can't stand the way you look, you're startin' to look older than you are...you become a nervous wreck. (Cathy, p.12)

Physical dress, appearance and cleanliness were raised in various conversations as matters of importance and were certainly related to some women's self-esteem and mental health. However, as the later discussion around health care experiences will explore, the capacity for self-care also carries much deeper meaning for these women in that physical appearance often visually marks people along class lines and can therefore be a catalyst for marginalization based on income. Given differential experiences of men and women around issues of age, sexuality and physical attractiveness, whether or not this is a gender-based phenomenon is an area worth pursuing.

Impact of gender

As already discussed, the link between gender and inequities in health has been well established within the existing literature from a variety of perspectives. Denton et al. (2003) for example, questioned whether gender-based health inequities were the product of differential exposure to determinants of health or differential vulnerability when exposed to those determinants (p.2585), which explores gender beyond the broader structural explanations like access to income. The findings from this study suggest that women's views around the place of

gender in their health vary widely and that numerous factors may in fact be uniquely implicated in their health based on their own lived experiences.

It needs to be said that, for a sizeable proportion of women in this study, the notion that gender might be somehow implicated in their health was new and was simply something they had not previously considered. When Susan was asked about how gender influenced her health for example, she simply stated that given her social isolation she lacked a frame of reference from which to answer that question. For other women, a number of health-related factors were identified as being influential but were not necessarily framed as a gender issue. The forthcoming discussion identifies some of those factors that emerged with significance within this study and, where appropriate, situates those factors within a feminist framework.

Biological factors

In this study, gender in the biological sense played a very limited role in participants' discourse surrounding gender and health aside from occasional discussions around female reproductive issues and concerns like puberty, menopause and child-bearing. Although one woman did suggest that women tend to be sicker and have more problems than men for physiological reasons.

Gender roles and stereotypes

More pronounced than biological factors were the health issues associated with gender roles and stereotypes, particularly as they relate to increased stress and demands within these women's lives. Referring to her own experience

transitioning from a girl to a woman, Karen commented, “I got married. I was being a woman. I just...cooked dinner, ironed, cleaned. I didn’t like that woman part.”(p.16). Cathy had a similar response to queries about gender and health. She stated,

Women are not treated equally anyway. You know, we’re looked upon like oh, we’re made to stay home, have babies, take care of the house and you know, just be a molly maid kinda thing...the man, you know, he’s free as a bird. He can do exactly what he wants, anytime he wants. (Karen, p.15)

On some level, women’s needs were viewed as being somehow different from men’s needs as a result of gender roles. As Cathy stated rather poignantly, “as far as men are concerned, they don’t think we have any needs anyway” (p.16). Mary, on the other hand, felt that men were stronger than women and therefore, could more easily assume the role of breadwinner and supporter within women’s lives. So, just as some women in this study resisted traditional gender roles, they also accepted and sometimes even embraced these roles within their lives to varying degrees.

However viewed, performing caregiving functions within the home, within relationships and within the context of volunteer work was commonplace among all of these participants and provided a source of added stress and responsibility, even if welcomed. One woman described her solitary role in the failing health and eventual death of her long-term partner: “At the end there I was the caregiver right so...I was the one lookin’ after him. It was a responsibility.” (Helen, p.10) Within this study, such caregiving functions would include various

homemaking activities as well as those activities that involved the nurturing, helping and serving of others, all of which might fall under the rubric of traditional gender-based roles. Literature from the National Coordinating Group on Health Care Reform and Women (NCGHRW) (2005) supports this finding, noting that the vast majority of paid and unpaid health care is done by women (p.3) and therefore, is very much a gender issue. Later, the impact of these gender-based stereotypes and roles will be explored further as part of the discussion around women's health care experiences.

Trauma⁵

A substantial number of women in this study spoke candidly about significant life experiences that they felt were relevant to this research about health. Within these shared stories, a number of trauma related themes⁶ emerged, including but not limited to the following:

- Multiple deaths (single event)
- Accidents causing severe and permanent injuries
- Childhood and adult sexual abuse
- Death of partners
- Death of best friend
- Witnessing the death of partners
- Loss of children
- Personal near-death experiences
- Childhood and adult physical abuse
- Childhood and adult psychological/emotional abuse
- Parental substance abuse

⁵ While sensitive to the issues surrounding the social construction of 'trauma', particularly as it relates to women's experiences, I have chosen to use this word for comparative ease and for descriptive reasons only. It is not intended to indicate support for present day trauma constructs or to "psychiatrize" women's life experiences.

⁶ This list is, by no means, intended to minimize these women's experiences but rather, is meant to demonstrate the depth and pervasiveness of these often hidden aspects of low-income women's health. These items have been listed randomly without quantification or prioritization.

- Personal/partner substance abuse
- Homelessness
- Suicide

While simply not able to include all of these women's stories, it is imperative that these women's lives are somehow located within the often unspoken or hidden life experiences that they deemed to be life altering and that they believed help set the trajectories of their lives, at least health-wise. For most of these women, multiple traumatic experiences were the norm and speak to the importance of looking at the cumulative and interrelated effects of these experiences over time. The following examples offer some narrative to their experiences.

Patty shared, "I just lost my husband...He died beside me in bed...I called 911. I said he is dead." (p.12) Patty went on to describe the subsequent chain of events.

You know what? They taped my door up that night when he died at 10:30. 7 o'clock in the morning the coroner showed up. I had to stay in the apartment...the whole time...with him. (Patty, p.12)

It was a bachelor apartment and she described being there with the police, the coroner, the fire department, and ambulance attendants. Personal supports were not permitted. Patty said,

And even the ambulance said, you can't leave her in there like that, she's gonna go nuts. They knew me from the hospital...she's gonna lose it. I lost it. They took me out on a stretcher. (Patty, p.13)

Patty conceded that the police did apologize the next day that they were just following procedures, but if they had just called the hospital she said, they would

have known that her partner was released that day, albeit willingly, with no supports knowing that he had only twelve hours to live. She said, “See I’m strong eh. I wasn’t strong for that. Nobody is for death.” (p.13) Ever since, Patty has struggled with depression and suicidal thoughts. She is not new to death however. At age 16, she was permanently disabled as a result of car accident that claimed the lives of her three best friends.

Jackie, a registered nurse by training, talked about the critical events or traumas that set in motion her life path. She relayed,

I had a very serious accident. I was actually hit by a GO train when I was in my car...I was lucky to be alive and lucky to actually be able to walk because it was...doubtful at one time that I’d be able to walk again. The accident put a hole in my life.
(Jackie, p.2)

Jackie had just had a baby three weeks prior she says, a baby that needed to be placed in foster care because of her own injuries. Shortly afterward, her husband died. She summed it up when she said, “All within a period of three months, have a child, get hit by a train, lose your husband...I kind of had my little version of a nervous breakdown.” (p.2) For Jackie, this meant a problem with substance use. Despite efforts to address her substance use, or perhaps because of her efforts she would argue, she eventually lost custody of her newborn child permanently. Jackie never returned to nursing. Instead she has moved about trying to secure a life for herself, a portion of which would be spent homeless and living on the streets.

Leslie also experienced severe physical injuries as a result of an accident that has left her disabled and in chronic pain. In addition to the accident, she described her struggles as a result of lifelong sexual abuse. According to Leslie,

Some of the doctors I've seen think I still have PTSD because of that (childhood sexual abuse) and also because of the physical and emotional trauma of the accident, so I'm not really sure...I think I actually have it...from a series of rapes I went through. So yeah, I guess I have it for God knows what. All of them I think. (Leslie, p.6)

I respectfully share some of these stories to demonstrate not what we know about the lives of low-income women but rather to remind us of what we often do not know.

Trauma and substance use

Within the existing literature, the link between women's experiences with trauma and substance use is well established (Najavits, Weiss & Shaw, 1997, p.274; Bollerud, 1990, p.83) and, as these findings attest, speaks to the importance of gender specific research within women's health. In their work on trauma, PTSD and substance use, Najavits, Weiss & Shaw assert that childhood physical and sexual abuse is highly implicated in substance abuse among women, particularly when occurring repeatedly or in combination (p.276) and often presents additional co-occurring challenges like homelessness (p.278). One participant spoke openly about this issue:

Well I mean sexual assault in its own way can...make us poor and sick too because we have no self-esteem, no drive to life. So we just wallow in self-pity and you know, some women yeah, turn to hooking and drugs...I've had my times with drugs and...I don't know, it just doesn't set you up for a good life. (Leslie, p.8)

Leslie was not the only woman in this study to talk about substance abuse and sex trade involvement. Other women would share similar experiences.

Substance use

Repeatedly, substance use emerged as a significant factor impacting the health and health care of these low-income women. Indeed, several participants in this study spoke with much candour about their past and present use of substances including alcohol as well as prescription and illicit drugs. Mary for example acknowledged the consequences of her lengthy history of crack and heroine use when she said, “I really, did a lot of...put my body through a lot of...damage and stuff.” (p.11) Another woman, Patty spoke of having a “wet brain” (p.12) from chronic alcohol use and of being a “heroin junkie for ten years” (p.24). All of the women who disclosed using substances also talked about quitting, most of them “cold turkey”, although relapses seemed to be common. Kate, who described her experiences with crack cocaine, muscle relaxants, codeine and alcohol, addressed these challenges from her perspective when she said,

So I think if you're predisposed to being addicted, an addict at some level, I think. Unless you fall into AA or something that...you may still find yourself in the path of an addict. (Kate, p.25)

This same woman would later reveal that she acquired Hepatitis C from her father who first “turned (her) onto crack” (p.25).

In significant proportions, they described “living the lifestyle of a drug addict”, to use Kate’s words (p.25) and talked about the health impacts of long-

term substance abuse and its concomitant lifestyle factors, all of which would in various ways contribute to their compromised health or the health of those around them.

Sex trade work

The extent to which the research participants engaged in sex trade work was less clear; unsurprisingly, it seems that the women were less forthcoming in this regard. However, true to the iterative style of interviewing, gentle prompting as a result of previous disclosures did result in increased discourse around this issue. For those women who did disclose, sex trade involvement was cited both as a precipitant and as a response to their substance use. Kate for example described her involvement in the sex trade:

Back when I was a teenager, I was poor. I've been dirt poor and I've been dirt poor until now... With ODSP, I'm rich considering what I've been living on the rest of my life...except I did get into escorting and stuff. But that was not related to drugs, that was related to trying to make a better life, trying to make money.
(Kate, p.4)

She went on to educate me about the business, how single mothers and students were often escorting to supplement their income, and how her own involvement would eventually lead to problematic substance use for her. She shared that she eventually stopped escorting, "I didn't even get ahead...plus I started drinking because of the fact of what I was doing" (p.5). This finding, the idea that marginalization due to gender and income can be catalyst for sex trade work and substance use, has been replicated in other studies as well (Sharpe,

2005, p.91). Like others in the study, Kate now is working the streets, “hooking for drugs” specifically to support her drug use.

By doing so, these women engage in behaviours that may be particularly compromising in terms of both mental health and physical health. For example, in addition to the associated health risks in terms of sexually and intravenously transmitted diseases and complications associated with drug use, these women are also at much higher risk of exposure to violence. One woman recalled that she was working on the streets of Vancouver when “Mr. Pig farmer was putting those women into...grinding machines”(Jackie, p.18). Another woman, sympathetic to the plight of sex trade workers declared with outrage, “For her services, they abuse her.” (Karen, p.25) Such exposure to violence and abuse was not however limited to sex trade work.

Violence/abuse

A number of participants identified having first hand experiences with violence and/or abuse at some point in their lives and framed their lived experiences in gender-based terms. Leslie, for example, declared, “I don’t really know any women who haven’t been abused. Hardly any.” (p.11) From their perspective, simply being a woman increased their vulnerability in this area. For example, when asked if being a woman increased her likelihood to exposure to violence, Leslie confirmed, “Well statistics bear it out so...absolutely. We’re more vulnerable to most crimes. Most violent crimes anyway.” (p.11) Other women agreed. Karen shared her experience with an abusive partner,

The violence became so unbearable that I had to make him leave. The police were in there so many times. This man had abused me so badly okay. Just because I was a woman. (Karen, p.23)

In addition to being subjected to physical violence, she talked about being verbally degraded and being called names like “fat whore”. She described becoming very depressed as a direct result of these experiences: “My health was so bad, so depressed that my doctor gave me anti-depressants because I couldn’t stand it no more...My health went right down the drain and after he left, I was good.” (p.24) Karen knew his treatment of her was unacceptable and stated very clearly upon reflection, “you have no right to call a woman that” (p.23-24).

Multiple and repeated experiences with abuse were neither uncommon in the study sample, nor were their experiences limited to abuse within intimate relationships. In reference to the childhood abuse she endured at the hands of her mother’s boyfriend, Kate disclosed, “That’s the first person that was violent with me. She’s (mother) still with him” (p.11). She believes that her subsequent “dysfunctions” originated from these early experiences with abuse and have led to “many, many bad relationship choices”, the majority of which have involved violence, at times severe.

In their study, Butters & Erickson (2003) find that street-involvement⁷ presents additional risks to women in terms of heightened exposure to violence (p.9). It is a finding that would be replicated in this study as well; the women who

⁷ For the purposes of this research, the term ‘street-involved’ is used specifically to denote women who are homeless and who may or may not be accessing homeless shelters periodically.

had been heavily street-involved and sex trade involved identified violence as a constant threat in their lives, the fear for their safety an ever-present reality.

Impact of living situation

Significant relationships

For the women in this study, living situations varied, although there were some common features. For example, most participants described living alone without any financial contribution from any personal sources (see Table I). In speaking about intimate relationships, participants tended to speak about past relationships primarily. A few women described having current partners who live separately however discourse around such relationships was limited. As far as ‘important others’ were concerned, participants’ feedback suggested that their perceived import to their health varied and ranged from significant partner, family and friend involvement to virtual isolation. Helen for example spoke to her need for social connection when she stated that, “I’m not a person to be by myself” (p.8). She also stated, “When I get sick I can’t take care of myself” (p.1), suggesting that her health concerns may be related to her need for constant companionship. Differently, Mary talked about her selectivity in this area and directly links her health situation to her social circle; who she spends time with is very much connected to her substance use and therefore, impacts her health as well as how she engages socially. Susan, on the other hand, described her significant relationships or lack thereof, “It’s just me and my kids...pretty much. I

have an abusive partner but I just, I don't have any friends. I just stay at home. I do my own thing.” (p.3). Later she would reflect,

I'll look out the window and I'll see people walking. They've got someone to talk to or...they're holding hands or you know, they have a partner and...I've always pretty much had nobody. (Susan, p.11)

Housing

In summarizing the data obtained, access to housing emerged as one, if not *the* most crucial factor associated with the health of these women. In some cases, safe, affordable housing was considered to be even more influential than income. Kate provided some insight into why she viewed subsidized housing to be so fundamental to her health and well-being, even more so than income:

I'll always be able to afford my rent. It doesn't matter if I lose ODSP, it doesn't matter if I get a part-time job and go to school now. I'll always be able to afford my rent. It's only ever gonna be 33% of my wages. It's never going to be to 98% of them again. (Kate, p.28)

Later she added,

Housing is the biggest...even bigger than ODSP because ODSP is just a matter of \$300 a month for food. There's food banks and stuff...But housing, affordable housing is the biggest barrier to education, to working, to everything. Housing, affordable housing, is I think the most important thing. If I had that when I was a teenager, I would have completed school in some way, shape or form. (Kate, p.29)

Another woman vowed, “even if I had to pay my whole check to my apartment, I'd stay...I'd starve....I couldn't go back to the streets” (Patty, p.26).

While all of the women preferred housing to homelessness, many had experienced living under less than ideal conditions that they believed had

negatively impacted their health in a variety of ways. Some of these health related challenges included compromised personal safety, excessive noise, poorly maintained apartments, unaffordable rent and exposure to infestations. Mary for example finds her \$600 monthly rent for a room simply unmanageable.

I'll pay my rent and I'll pay some bills... because I...borrow for food to get through the month. So, I'll end up paying that off, and then all I have left for food is \$50 which will last me two weeks maybe right, and that's not eating well. (Mary, p.6)

She is on the multiyear waitlist for subsidized housing.

Cathy, in talking about her living situation within subsidized housing, stated that problems in her last apartment led to her recent transfer to another building. She described being unable to sleep due to excessive noise and said,

Ah, there was just no peace and it was...kinda frightening in other ways because...a lot of times you felt...you didn't feel safe...because of the kind of people that were coming in, uh, guests for example. Or even tenants...weren't the best kind of people to be around...because of the drug situation and stuff. (Cathy, p.19-20)

Her move, intended to be an improvement, brought new challenges. She described having an apartment so heavily infested with cockroaches that her mental and physical health was seriously compromised following days of fumigation: "I was sick as a dog. I was having trouble getting up. I was totally...exhausted. I was totally stressed, frustrated and at the same time, I am killing these bloody bugs." (Cathy, p.23)

The data received in this particular study was particularly rich in that, while currently housed, a significant proportion of the sample also had extensive

experience, and therefore expertise, in being street-involved. One of the women revealed a remarkable thirty years of experience with homelessness to draw from. Usual discourse about homelessness typically surrounds exposure to the elements as the most pressing health concern. In openly sharing some of their experiences however, other health related factors surfaced: exposure to violence, stress induced mental health challenges and problematic substance use were factors all named. From the words of one woman, “homelessness is a very...hard life...I’m forty. I look sixty. So it takes a lot of years out of ya.” (Patty, p.11) When asked what it was about street life that was so compromising, she replied, “It’s just the life we choose. Drugs, booze, you’re living on the streets, sleepin’ here, sleepin’ there on the sidewalk. It’s a hard life.” (Patty, p.11)

Amidst their bouts of homelessness, several women also had experiences with shelter life, the offered alternative to street life. Through their eyes, shelter living presented a number of other challenges that they felt were even more compromising to their health. The transmission of disease due to cramped living quarters, poor sanitation and inadequate hygiene was cited as a health risk with considerable frequency among those who had stayed in the shelter system along with exposure to violence and other safety related concerns. Shelter living presents several health concerns:

Look at those places. They can do better than that okay...People getting lice, bedbugs, you name it. TB, the whole thing, because the environment is not sanitary okay. (Karen, p.21)

Helen described the fate of one of her friends residing in a local shelter,

There's another friend of mine, died a couple years ago...died at Seaton House. Told him, oh we got you all set for housing and...he ended up killing himself before he got housing...Thirty-seven years old. Dead. (Helen, p.16)

Even those most seasoned to the street life no longer felt able to manage its lifestyle and the concomitant health risks. "I couldn't handle the streets...I know I can't...I stayed downtown one night...on the streets and I was in the hospital. My health's really bad so I can't do it." (Patty, p.5)

A few years back, an innovative housing project was developed in response to the dismantling of Toronto's tent city, an impromptu community of self-defined street people. Some of the participants in this study were housed as part of this project and spoke about the subsequent changes to their life as a result of being housed. Reduced substance use was one benefit:

When you are on the street you drink, you do whatever. But I was drunk everyday. See I don't no more so there is a big difference. I quit drinking since I got housed. (Patty, p.5)

Other participants spoke of similar benefits as well as other improvements to their mental and physical health.

My health has gone up. Well come on. We were sleepin' in tents, in rain whatever, you know...and you never really knew where your next meal was coming from and hygiene was a hard thing...You never, ever knew what the next turn was going to take. (p.27)

For Jane, access to respectable housing has meant, "I can come and go as I please. I don't answer to nobody. I don't have restrictions around what I can and I can't do" (p.27). Having personal freedom and control translated into personal mastery. She declared, "I am more sure of myself than I ever was" (p.27). Other

women described similar personal transformations. In reference to the dismantling of tent city, Jackie stated, it was “a blessing in disguise”, “a wonderful stroke of luck...I am very, very grateful for that” (p.6). When asked about the impact of housing on her health, Karen responded that housing “makes people feel, oh my god, independent” (p.21) and much safer.

While studying the health impacts of low income and gender initially drove this aspect of the research, housing emerged to the forefront as an important area for study within this population. Among all of the women studied, access to decent housing was one factor deemed indisputably vital to their physical and mental health. Two other areas also garnered some unexpected interest: access to education and the impact of governmental shifts.

Education

In some cases, queries about income led to discourse about education. In thinking about the lifelong economic impact of her childhood sexual abuse, Leslie described her adolescence as being rather tumultuous and the consequences of the abuse impeding her ability to acquire an education. She shared,

Well, it can screw up your education...like when I was fifteen, well even before that, the closer you get to puberty, the more fucked up you get...it screws up your education which can screw up your prospects. You know if you come from a non-well-to-do family to begin with, you're lucky if you're gonna do college or university you know, and if...like socially I couldn't handle high school. I quit when I was sixteen...as soon as I could...previous, I was a straight A student. I was a gifted student. I had tons of potential but my grades started to, started slipping and you know I could have had a scholarship or something if things had gone differently...so it was years later that I finally got my GED and then years after that, that I finally tried to go to university. And

then my hip started dying so I had to drop out of U of T. (Leslie, p.12)

Kate's rendition was similarly poignant and also pointed to how intricately connected and complex the social determinants of health can be. She talked sequentially about the chain of life events within her life as a result of not managing in school because of her earlier challenges. "Just the fact that I didn't get to complete high school alone is, is the barrier. That's the barrier right there between getting help and not getting help." (p.24) From Kate's perspective, having had an education would have meant having "a normal job", "a normal apartment" and earlier treatment. She also believes she would not have "fallen into drugs" or the sex trade (p.24). She concedes that her mental health may still be problematic but because she would be more respected by virtue of being employed, she would have received better treatment. She explained,

Being a...crack head and a street hooker, psychiatrists look at you different but if, if I was a 9 to 5'er with a drinking problem, they might have given me my Zyprexa and my Ritalin and all that...So my mental health...still would have been an issue but it would have been a *treated* issue. My health problems, physical health problems wouldn't be bad...my sex trade and psychological problems would probably be less because I'd be in society, so I'd be less likely to waiver from the norms because...your psychological outlook would be different because you're in the mainstream. (Kate, p.25-26)

Her subsequent efforts to obtain an education have been equally challenging.

After repeated attempts to obtain her GED despite her chaotic life situation, she was eventually told she was not "university material" (p.31). She stated that she

wanted to get on to ODSP so that she would be sufficiently supported to go back to school but now feels like her opportunity has passed. She stated,

Once I finally got on to ODSP and housing, I (took) a turn for the worse and become a worse drug addict...it's almost like...because the psychological aspects and my self-esteem like...by the time I was thirty, it's fuck it. It's just beaten out of me. (Kate, p.26)

Both of these women, like others in the study, believed in their academic and therefore, economic potential at one time. Life circumstances changed that.

Governmental shifts

Lastly, it is important to mention that some of the women in this study understood and positioned their health needs within the broader socio-political context and in particular to shift in government priorities and funding. For example, cutbacks to the nutritional allowance and medical transportation were cited as being barriers to health as were government agendas dating back to the “Harris days” up to the present. Contextualizing women’s health in this way is very much consistent with the pursuant analysis.

This study sought to explore those factors that impact how low-income women experience health, with a particular focus on the health related influences of income, gender and living situations. This discussion explored the perspectives of the women around these issues and from their responses, other related but distinct factors were also identified and deemed to be relevant to their health as a result of their own lived experiences. The next section focuses specifically on the experiences of low-income women in achieving health and accessing health care.

EXPERIENCES ACCESSING HEALTH CARE

Research participants were asked about the nature and quality of their experiences accessing health care with several intentions:

- 1) To acquire information based on lived experiences that may be useful in understanding and therefore, improving the health and health care of low-income women;
- 2) To explore the meaning of various dimensions such as income and gender and how they differentially affect women's health and health care experiences;
- 3) To create space for alternative health and health care discourse; and
- 4) To locate places of oppression and therefore also, places of resistance.

As hoped, the data obtained was both incredibly rich and informative. The following section describes the health and health care experiences of these low-income women and through alternative discourse moves beyond mere description to include both explorations and explanations around their lived experiences.

Nature of health care access

Reasons for accessing health care

The following list provides a basic description of reasons provided by participants for accessing health care, arranged in no particular order in terms of priority or frequency:

- Medical attention for general ailments
- Medication (physiological and psychotropic)
- Mental health counselling
- Basic preventative care (annual check-ups)

- Access to specialized medical and psychiatric care
- Access to other programs/services including access to mobility devices, income support (ODSP), income support benefits (special diet allowance, transportation allowance, drug card, dental and eye care)
- Completion of paperwork

Reasons for not accessing health care

A similar list was created to describe the participants' stated reasons for not accessing health care:

- Self-management of health
- Substance use barriers
- Organizational/systemic barriers (waitlists, insufficient resources)
- Transportation barriers
- Personal dislike for health care providers
- Fear/Avoidance of health problems, health care and health care providers
- Health complications
- Difficulties navigating health care system
- Lack of information
- Multiple/complicated referrals
- Multiple locations (too tired, confusing)

General impressions

General impressions from participants around their health and health care varied dramatically and true to their definitions, focused primarily on medically based health care services. For those accessing traditional medical services, the reviews were mixed. Some women had experienced positive long-term relationships with providers, usually physicians, although other providers such as psychiatrists, counsellors and social workers were on occasion included in these discussions. Other women described much less positive experiences. Susan stated very bluntly in reference to her dissatisfaction with her current family doctor, "It's like she doesn't like me" (p.4). When asked to elaborate she said, "She doesn't treat me like my other doctor would have or other doctors treat their patients I

find.” (p.6) Helen expressed similar concerns in relating her past experiences, “I usually have to have someone with me when I get sick because of the way I been treated with the doctors and stuff. I don’t like going to doctors.” (p.2) Instead she would access health care through hospital emergencies and only when absolutely necessary, a pattern that changed, she said, when she got linked to a downtown CHC.

Of those participants who viewed their health care in the most positive terms were those individuals who accessed their health care through various outreach initiatives and/or Community Health Centres (CHC) and who, based on their own experiences, viewed their particular satisfactions as being somehow exceptional. Very clearly, CHC and outreach involvement tended to elicit more positive responses, the reasons for which will be explored in a more integrated way within the context of a forthcoming exploration of their specific health care experiences.

To generate some meaningful discourse around these women’s experiences and to provide a framework from which to organize their vast range of experiences, the findings were first categorized based on their natural division within two particular streams: i) service delivery and ii) interrelational factors.

Service delivery

Outreach

As mentioned, outreach initiatives were highly valued and respected forms of service delivery for many of the women in this study based on firsthand

experiences as well as hearsay. One of the reasons identified was their provision of minor medical care and supplies in conjunction with the distribution of items that might be otherwise unaffordable like food, socks, vitamins, ‘clean works’ and personal hygiene products, for example. “Everything helps.” (Helen, p.14)

People going out to people as an access strategy was also held in high regard, particularly for individuals experiencing problematic substance use. Helen declared, “you wouldn’t have seen me even eat in a drop-in” (p.15), let alone access health care. Jackie talked about her experiences with outreach services during her bout with homelessness and stated the agencies that engaged with her “were just wonderful” (p.8). She noted how comforting it was to know “there were recognized social agencies keeping an eye on people’s welfare” (p.9) that would somewhat ensure the presence of health care in their lives.

Service structure

In this study, services that made active attempts to reduce the usual service barriers were also highly regarded. For many low-income, street-involved women, access to health care can be problematic in that they often find themselves without OHIP coverage or health cards due to such things as lost identification, chaotic lifestyles, homelessness, systemic and institutional barriers. Community health centres are mandated to provide health services to the non-insured and were therefore considered to be more accessible. According to one woman, “I could come off the street without a health card and they’ll take us” (Patty, p.3).

Reduced wait times for medical and counselling services was also appreciated, in particular having immediate access to providers when in crisis which requires a certain amount of flexibility of service delivery. Kate for instance expressed appreciation for such flexibility and responsiveness when she described her own access needs:

It is only because she (her counsellor) stood by me and was understanding and when I missed three appointments in a row, would still schedule me. When I was half an hour late, would still see me. That's the only reason why I am here today...getting better is because this one person...cause a lot of psychiatrists, oh if you're late, we're gonna charge you. (Kate, p. 6)

Service approach

Some of the women who spoke positively about their health care experiences also remarked about the importance of a holistic, comprehensive approach to their health and health care. While some women welcomed referrals to specialists, often as a perceived indicator of receiving 'good care', others were frustrated by having multiple providers and preferred to have one medical provider with more generic capabilities or at least having one service location rather than be shuffled around from provider to provider in various locations.

Being thorough and looking at the whole person were assets to services and so was a warm, comfortable environment in which to access these services. They appreciated not feeling like "a number or a statistic" (Helen, p.10) and having attention paid to those small personal touches that foster comfort, like offering coffee and a welcoming and friendly atmosphere. Bordering on the

interpersonal or interrelational aspects of health care, these comments provide an appropriate segue to the next section.

Interrelational aspects

Being known

This idea of being known seemed to add value to the participants' relationships with providers and created a more positive view toward services for some of the women. "They get to know ya and then they have respect for you as long as you have respect for them", said one woman (Helen, p.5). Jane also talked about the importance of familiarity. Being known by name meant that "after a while, people, I guess, seem to see you for yourself too" (p.20). Repeatedly in her interview, Jane talked about the exemplary treatment she received at one Toronto hospital, which she attributed to having 'connections', knowing someone who works there. In reference to this particular hospital employee, she relayed, "soon as he finds out I'm in hospital, he goes right there. You know, he'll get my x-rays right away, he'll do this, do that, get them right on my case for me" (Jane, p.2). She viewed her treatment as being very much outside the norm and was quite certain that being known superseded her critical health condition as a motivating factor toward more efficient, coordinated care.

Openness and honesty

In thinking about what constitutes a positive health care relationship, a number of individuals identified open and honest communication as being one such indicator. The findings suggest that having that "patient and doctor

confidence” (Karen, p.7) and “open trust” (Kate, p.9) allows for open and honest dialogue in which information can be mutually shared within the context of the helping relationship.

Understanding and caring

The ability of a provider to demonstrate understanding and caring also warranted mention in participants’ views around what constitutes a positive helping relationship; for example, being kind, asking questions, taking an interest in their lives, conveying understanding and concern in their words and actions, all of these promoted positive helping relationships. Kate spoke about the importance of mutual caring from her perspective:

Now I know you can’t expect that because it’s bad for both parties but, they know there’s this whole big deal...you can’t get involved with your clients. But the fact of the matter is I don’t think you can do a good job unless you do! (Kate, p.8)

Non-judgment and respect

In noteworthy proportions, women in this study described their experiences being judged by health care providers and their respective institutions within a variety of contexts and circumstances. Jackie, for instance, very much rejected the “holier than thou attitude” (p.12) she encountered in favour of a harm reduction mindset which, in her eyes, is helpful and non- judgmental. Feeling judged and disrespected is an area that will be re-visited in much more depth in upcoming sections.

Being dismissed, disbelieved and discounted

Based on participant feedback, one of the most salient dynamics interrupting helping relationships across sample differences is feeling dismissed, disbelieved and discounted by health providers and institutions. As the following examples demonstrate, it is a dynamic that impacts not only how low-income women experience their health and health care but also, how they experience oppression.

Mary shared her dissatisfaction around this issue when she spoke about her desire to access a second opinion for her health concerns. She stated, “Cause sometimes it seems like that doctor just sloughs, sloughs you off, you know sort of like...no, you’re fine. Even if you’re not.” (p.9) Other women mentioned being ‘sloughed off’ as well.

Cathy voiced her struggles in this area particularly as it relates to being disbelieved.

It’s very hard to get people to believe, including doctors, psychiatrists...support workers, because a lot of times they don’t feel that there is any such thing. They don’t believe that there is fibromyalgia. They don’t understand it I guess. (Cathy, p.3)

When asked about the impact of not being believed, Cathy spoke fervently,

It’s very frustrating. It’s really frustrating. It just makes me so frustrated and so angry and I just find it so depressing...I am always having to...what’s the word...defend myself...and I shouldn’t have to defend myself. (Cathy, p.4)

She went on to say,

You are starting to feel useless because you know, nobody seems to believe that you have an illness of some sort because they can’t

see the damn thing...I'm always having to justify everything. People don't understand...they don't want to listen...it's all in your head and I'm getting tired of hearing that old story. (Cathy, p.30)

She argued, "We know our own body most of the time, at least we are supposed to." (p.29). Tanya echoed her thoughts. "I just know that I am totally being dismissed and I know my body more than anybody else does." (p.4) On some level, women clearly embraced their expertise and resisted the notion of 'other' as expert of their lives, an important concept to be discussed in upcoming sections.

This theme was replicated throughout the interviews using different language. Sometimes it took the form of being 'sloughed off' or dismissed: at other times, it was framed as not being taken seriously enough or afforded credibility.

Tanya's example was poignant. She explained that she knew for some time that she needed to see a psychiatrist but required a referral from her family doctor. One year later, still with no referral, she approached her doctor feeling desperate and suicidal. Tanya described the encounter,

I try not to take all the blame for this yet, because I am responsible for my own well-being...but as I was telling him about the situation that I'm in, he's eating a sandwich and tells me...well, we'll talk about this next week when you come back. (Tanya, p.4)

When asked what finally prompted the referral, she said that it was because she was "self-medicating" with Valium and that perhaps, he felt he could no longer manage her situation.

The converse of being dismissed and discounted is being heard and validated. Time and an attentive ear made a great deal of difference for Karen who described her experiences with previous providers.

It's a very, fifteen minute, you know, proper thing. Okay, what's wrong with you...blah, blah, blah...yes, yes, Miss ----- and that's it. Thank you very much...before you can get all those questions in, you are already dismissed, and bye. (Karen, p.5)

To be able to sit and talk with her current doctor, she admits, is not only beneficial to her physical health, it is also good for her mental health.

While these are just a few examples, the discounting of women's voices was pervasive throughout the acquired data and speaks dramatically to the marginalization of low-income women in terms of their ability to achieve health and access health care. The next section builds on these findings and more closely examines the concept of marginalization within their lived experiences by exploring how participants experience and explain their health and health care from a critical, anti-oppressive perspective. To this end, women were asked about how certain factors like income, gender and living situation impact their ability to access health and health care.

Factors related to income

When participants were asked how having a low-income affected their health and health care, the responses tended to fall among three groupings: financial barriers, marginalization related to low-income status, and differential access to treatment.

Financial barriers

As recipients of OW or ODSP, all of women in this study experienced financial limitations that would restrict their ability to access and secure medical health care. Specifically, transportation costs were cited as creating barriers to access, as were costs for medications and medical tests/procedures. As one woman stated, “Like if the doctor gives you a prescription for example and it’s not covered by ODSP...you can’t pay for it because you don’t get anything extra” (Cathy, p.11). This same woman spoke about her experience with unexpectedly incurring fees from one of her tests. “I wouldn’t have had it done, you know. I mean it wasn’t that much but because you don’t get that much, it is a lot of money to throw away.” (p.12) It was a telling comment on how health and health care gets negotiated in their daily lives.

Marginalization related to income status

Women in this study spoke passionately about this issue. Some of their comments follow:

The poor get treated like...the poor is poor. (Patty, p.7);

I guess when you’re poor, you know when you’re not middle class or higher, they kinda treat you different...society. (Susan, p.8); and,

Don’t slough people off because they’re poor and have no money. Everybody’s the same. Just you have a dollar more than I do but everybody’s the same. Everybody’s different, like in different classes but basically, we’re all human beings. (Karen, p.15)

This awareness of income-based discrimination also translated into their lived health care experiences.

Differential access to treatment

Participants commonly felt that their health care was compromised specifically because of their low-income status and that the treatment they received was somehow different from the treatment received by people with higher incomes. Karen for example, described a recent experience with an eye doctor:

Well this doctor did such a slop job that it was unbelievable...took me five minutes, wrote a prescription for a pair of glasses that I couldn't even see out of. Why? Because I am on...ODSP. And then there was a lady after me and because she had her health card and very sophisticated and you know, the whole thing. She was in there for an hour...Is that not discrimination between poor and middle class? (Karen, p.2-3)

Susan also felt that her lack of income affected her health care and that she too was treated differently. Specifically, she expressed that she was talked to differently and health matters were not explained to her as well as they should be which she attributed to “not taking the time and not thinking its necessary to, or not caring that it's necessary actually” (p.9).

Another woman, Helen reflected on the care of her loved one who died in hospital after a lengthy illness. “There's another example. He was on welfare and he got treated like shit too.” (p.8) She surmised, “the way he was treated should never have happened” (p.10).

Factors related to living situation⁸

Although directly related to low-income status, women's living situations impacted their health and health care experiences in particular ways. Participants who had experienced street-involvement or homelessness discussed the unique forms of discrimination they faced and the differential treatment they endured as a direct result of their housing status.

Marginalization Related to Living Situation

Once again, physical appearance emerged as an area that contributed to women's perceptions of marginalization. Understanding that personal care is especially compromised for the street-involved, it makes sense that some women found it would enter into their health care experiences.

If somebody's in front of me at St. Mike's okay, and they're not dressed liked us, like how I dress...I don't dress high-class. I don't. I'm not gonna every change that way. I can dress sometimes nice but...I'll go in and sometimes I might have mud or something on me okay...they'll look at me, the person in front of me, they talk nice. But when I walk in, boy it's like, that face will drop and they'll just, very ignorantly, it's because...I'm homeless, like I live the street life and they don't want to deal with the homeless. (Patty, p.8)

Similarly Susan found, "It's like their needs aren't as important as...somebody that's got more money or dress nice" (p.9). Visual indicators of poverty, which tend to be less well hidden among the homeless, were the

⁸ Initially meant to encompass a range of factors such as relationship status and tenancy arrangements, the concept of living situation evolved based on participants discourse to specifically reference housing status. For consistency sake, the original wording has however been retained.

perceived source of overt discrimination and marginalization for a significant portion for these women.

Differential access to treatment

Negative values and beliefs associated with street-involvement played a role in how some women received health care. The general consensus among women who had been street-involved was that judgments about the homeless produced differential treatment for them compared to those who were not street-involved. Helen talked about this in her interview. With regard to her experiences accessing health care, she said, “As soon as they find out that you are a street person or you are on low-income, that’s the way you get treated.” (p.2). When asked to elaborate, Helen stated that street people, to use her words, are talked to differently: “a lot of them treat you like you’re...down-grading ya cause you’re a street person or a person on an income” (p.3). Other women concurred and felt that street people generally had similar experiences. Patty, for instance, stated, “I know a lot of people on the street. Their health is really bad and they go to emergencies and they just throw ‘em out on the street anyways, so what’s the difference.” (p.1) A recent example supported her claim. “A girl went in there (hospital emergency) last night. She got slit from here to here (gesturing from her mouth to her upper cheek). She got cut. They just washed her face and threw her out the door.” (Patty, p.1)

Sometimes the marginalization is more subtle, for example having to wait longer for services. “They just have a completely different attitude toward you.

Like...you're low-class, you don't matter. You can sit and wait.”(Helen, p.2)

When this claim was tested, knowing that wait times in health care are generally problematic, she responded that she knew it was different for her: “Because when I was working, I was able to work and I went to the hospital or a doctor, I didn't get the same attitude from them.” (Helen, p.3) Everything changed she said when she went on disability.

Factors related to gender

Queries around how gender impacts women's ability to access health care generated a range of comments and perspectives among this group. The most relevant and pronounced of these findings have been captured under the following 5 headings: Marginalization Related to Gender; Differential Access to Treatment; Gender of Providers; Gender and Caregiving; and Gender and Income.

Marginalization related to gender

Again, issues of credibility and discrimination emerged, in this case around gender. Sexist stereotypes were at the forefront in at least one woman's mind when she responded with “...everybody seems to think you are stupid and don't know what you are talking about” (Cathy, p.13). She provided several everyday examples both inside and outside of the realm of health care to support her beliefs. Other women spoke directly to their gender experiences within the context of differential treatment.

Differential access to treatment

Unlike with income status and housing status, questions about differential treatment based solely on gender produced mixed results. For some women, being female was an asset when it came to accessing health care. One woman replied, “Sometimes women get better treatment.”(Jackie, p.15) Susan described being treated well by the nurses in particular when giving birth to her children. Another woman, Karen, felt that compared to men, women fared better. “Like I think doctors and nurses respect women more than men. Like I think, they’re more tender.” (Karen, p.16)

Other women reported having less favourable impressions based on their experiences. When asked whether she believed that men were treated differently within health care, Tanya exclaimed, “Oh, come on. That’s a given.” (p.14) To support her belief, she described how her pain was managed compared to that of her husband.

He (the doctor) didn’t believe I was in pain...just by experience of talking to other women, it’s the same thing for them. Their husbands are walking around with painkillers, real painkillers and the most they can get is Tylenol 3’s or antidepressants. (Tanya, p.14)

She felt it important to clarify that this incident occurred before her “drug problem”.

Some participants focused on previously addressed concerns like being dismissed specifically because they are women. According to Leslie, “I don’t think doctors take us as seriously like and that’s been well documented you know,

for a couple centuries.” (p.16) She remarked that maybe things are changing: “you know we used to have hysteria” (p.16).

Supporting evidence for the psychiatrization of women’s health concerns emerged in other interviews as well. Cathy expressed her thoughts about this and cited some striking examples of being personally dismissed along mental health lines when trying to access health care. She said,

A lot of times you get told, oh it’s all in your head. Well, you know, at one time...there wasn’t anything in my head...I would just constantly be on the go...my memory was great...I was able to work. (Cathy, p.3)

She offered an example from her own experiences. In seeking help for chest pains, she was redirected to her psychiatrist on the premise that she was suffering from anxiety. She stated, the eventual outcome, albeit only after her psychiatrist’s intervention, was that “I found out that one of my arteries was completely blocked, 100%, and that’s what was causing the chest pain. It wasn’t anxiety at all that was causing it.” (p.5) Later she offered another example, this time in relation to her body’s physiological response to stress:

If I get stressed...then I get the chest pains...and then, my whole body feels like, you know, big bricks sittin’ on it or...you’ve been run over by a truck...and he’ll say, oh it’s because of...what happened to you in your past when you were growing up. As far as he’s concerned, there is no such thing as fibromyalgia, especially fibromyalgia. (Cathy, p.6)

When medical discourse fails to account for physical symptoms, women’s health concerns can, it seems, become even more psychiatrized. Arguably, through the recipient’s lens, psychiatrization is also a form of being dismissed.

In response to being dismissed, Leslie admitted to resorting to aggression at times but noted that it does not always work to her benefit. “Sometimes they’ll dismiss you even more drastically if you fight...cause who am I. I am just some...uppity little woman coming and talking to this big doctor man.”(p.16-17) She spoke intensely about this issue noting, “I think about gender a lot.” (Leslie, p.17)

Tanya also spoke about the need to be aggressive in order to access health care in a way comparable to men and expressed her displeasure at having to do so. She described a recent incident when a man went into her doctor’s office and demanded care. It worked, while she waited much longer to have her health needs addressed. Finally, she said,

I finally made a scene but...I don’t understand why I have to make a scene before I get served properly. You know, I’ve had a good relationship with these people and now I have to be aggressive about it so that I can get what I need. (Tanya, p.15)

Other gender differences were also noted in terms of service delivery and service access. Men, for example, were viewed as having fewer restrictions within rehabilitation settings and were thought to access services less often but with more success than women. According to the NCGHRW (2005), frequency and patterns of access to health care do vary by gender, with women accessing the health care system more frequently and differently than do men (p.3).

Gender of providers

To some extent, participants in this study preferred to have access to female providers, stating they felt more comfortable and understood in their

presence. One woman was adamant about this request, stating her mother had experienced sexual abuse by her own physician. Women were viewed as being more vulnerable in this way and therefore, viewed access to gender-specific providers as a necessary option.

Gender and caregiving

Cognizant of gender-based roles within women's lives, it is important to talk about how caregiving roles also influenced women's health care experiences. At least a few women spoke about their caregiving roles with partners that very much resembled care normally provided by health care professionals and facilities. In fact, one woman described providing health related caregiving like personal care over a period of months while her partner was dying in hospital. Not only was she dealing with the fact that she was losing him, "Then I had to help take care of him too." (Helen, p.9) It was an important comment. Given recent funding trends that have seen cuts to various health services, women are increasingly becoming unpaid health care providers by default, often with little or no support (NCGHRW, 2005, p.19; Aronson & Neysmith, 1996, p.56).

Gender and income

As expected, gender and income could not easily be separated as mutually exclusive dimensions for analysis. In thinking about the consequences of such differential treatment for example,

The low-income woman...doesn't matter where you go, they're already at low self-esteem and if they get treated differently than other women, they are gonna feel that much more...rejection. (Helen, p.17)

Her comment demonstrated how marginalization could be both interconnected and layered to create unique experiences for low-income women.

Indeed, accessing research data that could be separated along particular dimensions proved challenging throughout this study and speaks to the complexities of women's health and health care needs within the broader context in which they are situated. The constant awareness of various marginalities and their interconnectedness, as described by Krumer-Nevo (2005, p.89), proved useful in attempting to sift through individuals' multi-layered oppressions. Clearly, one of the benefits of using an open and iterative interview structure was that it allowed for alternative discourse that captured other areas significant to women's health care experiences; namely, mental health and substance use.

Factors related to substance use and mental health

Mental health

In noteworthy proportions, participants spoke about how their mental health impacted their health care experiences. All of the women related to undergoing mental health challenges to varying degrees at some point during their life span and several embraced psychiatric labels, using them liberally in discourse. A few participants strongly identified with their diagnoses and viewed having a diagnosis as being essential to accessing good treatment. Kate was one of a few women who spoke openly about her extensive experience with the mental health system. Here are some of the highlights involved with her story.

Dating back to childhood, Kate's mental health needs were largely ignored despite numerous attempts on her part to secure help: "no one was giving me a diagnosis and a course of treatment". (Kate, p.6) Her early struggles eventually led to several psychiatric hospitalizations many of which proved to be unhelpful. For example, she said the hospital would release her after a week of observation, with various rationales. On at least one occasion, she said, she was prematurely released from hospital because she was unable to take the prescribed medication. Treatment was subsequently suspended. She explained that she was part of a research study, her treatment it seemed contingent on meeting the institution's research needs. Since then, she described a number of tumultuous relationships with health care providers and their respective institutions over a period of years.

For the past five years however, she has managed to attain, in conjunction with some key providers, a satisfactory level of mental health and health care. A multi-tiered approach with ample flexibility has worked best for her.

This time around, I've stuck with the counselor, I've stuck with the meds, I've stuck with the application, I've stuck with everything and now, everything is good. But it was a good 15 or so years of hell. (Kate, p.4)

She particularly appreciates that they, specifically her counsellor and her psychiatrist, work with the *individual* and not merely the label: "it's not just a cookie cutter...oh drug problem goes here...oh bipolar goes here". (Kate, p.8) Interestingly, one's desire to have a label is not the same as being treated according to one's label.

Substance use

Without prompting, a considerable number of women disclosed their challenges with substance use and spoke about how their use impeded their access to good care. Unsurprisingly, treatment received in hospital settings while under the influence was much more compromised than when not under the influence, for instance. Jane shared her experiences, “If I went into an emergency room drunk, I wouldn’t get treated near as fast or near as nice as I do today”(p.18).

In describing her access to treatment while using, Kate said,

Definitely I have things to say about being...low-income and the struggles but the more...my problem hinged on was the fact that once I got into drugs, I kept getting turned down, and turned down and turned down because I was a drug addict. (Kate, p.4)

From Jackie’s perspective, marginalization based on substance use extends beyond the realm of health care, yet impacts how she accesses health care. She described how she believes her efforts to address her substance use effectively resulted in the permanent loss of custody of her child. Referring to her involvement the Children’s Aid Society, she said, “It turned right against me...we are not going to help you find solutions to your situation. We are going to spend our little 9 to 5 working hours just finding any conceivable problem that we can with your life.” (Jane, p.6-7) Her example demonstrates how accessing health care may, under certain circumstances, in fact compromise low-income women’s health.

Mental health and substance use

Nowhere in the findings were perceptions of marginalization more evident than among low-income women who experienced mental health challenges as well as substance use challenges. As the following examples illustrate, this combination of factors presented unique challenges for women already marginalized by other factors like low-income and gender and in some cases, homelessness as well.

Having co-occurring challenges seriously limits options for care as Kate found out. She declared, “I’m bipolar...ADD...and drug problems” (p.2) and spoke about how her diagnoses resulted in being repeatedly turned away from various programs and services, including those in medical health care.

So I’ve gone through like umpteen counselors, umpteen psychiatrists and always with the same end...We can’t help you for some strange reason like either I can’t take the meds or my drug problem or this or that or you know, whatever it was, it never came to fruition. (Kate, p.3)

Tanya addressed this issue with much emotion, its impact evident. Picking up on the previously mentioned incident with her doctor, who had casually dismissed her suicidality, she confessed, “I guess part of me took...the abuse because you know, I was a drug abuser in the past and you know, I was worried that this was a behaviour that he recognized and so I just let it go” (p.4). She reminded me that she has not used drugs in five years. Clearly, the impact was lasting.

When asked specifically about these effects, she replied, “it hurt more than anything” (p.6). Concerning her history with mental health difficulties and substance use, Tanya said tellingly,

It kind of marks me as somebody who is...I don't mean to say hypochondriac but I mean...somebody who complains a lot. And so it was, it becomes harder and harder to say anything to people. (Tanya, p.7)

She further reflected on this experience, her attempts to make sense of it evident. She suggested that perhaps her doctor thought she was “drug seeking” and admitted,

Maybe sometimes I am but...one of the things the psychiatrist said to me was that part of the reason I did take drugs is because I was trying to make things feel better. So part of it validated, you know, why I was doing them...I don't know why other people do them. I was doing them...more to feel normal. (Tanya, p.5)

Responding differently to such treatment by health professionals has been a task for Tanya.

I am starting to gain a better voice about it and more confidence and in speaking up about but when I was in the midst of it I didn't have that. You know I just kept going and banging my head against the wall and kept taking the pills they were giving me. (Tanya, p.4)

Paths of resistance

Having just relayed many health care experiences of low-income women very much through a critical lens, it needs to be said that in no way is the presentation of these findings intended to portray these women as mere observers or victims. Marginalization and oppression is not synonymous with powerlessness or passivity. Indeed, as the findings also suggest, a number of avenues exist in

which women exercise power in spite, or perhaps because of, their experiences. These paths of resistance leapt out throughout the interviews.

Surviving

The findings of this study were infused with messages of survival. Many women relayed tales of strength and endurance attesting to their capacity to resist the impact of even remarkable circumstances. In some cases, this prompted questioning about the source of their tenacity in the face of such difficulties while in other cases, information would simply be offered as a matter of everyday discourse. Here is a sampling of their responses:

I've given up a few times or thought I was giving up but...when I get to the brink, something always pulls me back. (Leslie, p.18);

I am a survivor. I'm gonna do it. I'll deal with it. You know, every day ...is a hard day now and one day at a time. That's all you can do. That's it. (Patty, p.26); and,

I think I am just a survivor. I am just strong. I don't know...I chose life I guess...I wonder myself sometimes...I am just blessed. (Mary, p.11).

Managing

In describing the various strategies the women employed in order to survive, there was an undercurrent of “managing” (Aronson, 1999, p.54) in spite of lived experiences. According to Susan, managing depression means, “I don't talk much about my feelings. It's just...it's hard. I just get by day to day.”(p.3) Rather than becoming immobilized by her challenges she suggested, “You try not to think about them. Think about others things. Keep your mind busy on other things.” (p.22). Recall, Susan is sole parenting three children on a meager income.

Mary, who had an extensive and complicated history of substance use had a similar strategy, “Some people don’t like me cause I laugh at everything...I just take everything lightly. That’s how I am.”(p.15). When she was asked how she has survived, she said, “I just did it...I am very independent. I don’t ask. I don’t like to. I’ve never been that sort of person to ask for a lot...but I learnt that you do have to sometimes”. (p.12)

Other women also managed by engaging the help of others and have learnt, like Mary stated, that at times it is necessary to survive. In speaking about how she navigated the ODSP system, Jackie said she drew on her community supports, “people that can help me plow through all this...helped me to fill out forms but I mean, it was like wading through mud.” (p.4)

Passive resistance

That passive resistance might be operating in how women negotiate their health care needs was a novel and interesting idea. Some women spoke openly about not showing up for appointments for various reasons, ranging from managing their fear to protesting their treatment. Helen talked about how her access to health care would shift if providers treated her differently: “I’d keep my appointments and go to my appointments...the way they treat you now, it’s just a waste of my time.” (p.4) If made to wait unnecessarily, Helen would simply leave without accessing services: “Usually I just get fed up, tired of waiting and I just leave.” (p.4) Rarely does discourse approach issues of access in this manner; usually framed as non-compliance within health circles, not accessing health care

may instead be related more to women's resistance rather than passivity or complacency, as these findings suggest.

Fighting back

The women in this study participated in various activities that would constitute 'fighting back'. As previously discussed in the sections on differential access to treatment, "making demands" (Aronson, 1999, p.60) is one fighting back strategy participants used when treated poorly by health care providers and institutions. It took various forms. Cathy for example, stated her expectations firmly, "I want to be treated like an equal." (p.21) Patty's opinion was similar: "Everybody should be treated the same way, even if you are rich...or not. It should all be equal...we're all the same. We all bleed red." (p.6) Patty later assumed a much more defiant stance in seeking to get her needs met in the face of marginalization. She declared, "I just get mad and start cursin' them and then security comes." (p.8) Other women had similar approaches.

As with passive resistance, fighting back also took forms that appeared much more benign than those described above. Although not framed as resistance in the interviews, more than few women spoke about how they engaged in knowledge building as a means of engaging in informed discourse, thereby leveling the playing field. By researching their health concerns and by bringing that information to their interactions with health professionals, the women effectively positioned themselves differently. As will later be discussed, this approach was not without costs.

From a systems standpoint, participants also tackled marginalization within the broader systems that impacted their health. For instance, in trying to secure ODSP benefits, women commented on their need to fight for their entitlements. Having been turned down twice for benefits, Jane stated convincingly, “This time I’m gonna fight it if I am (declined). The other two times I didn’t fight it. But this time I am.”(p.31) Jackie felt similarly. In talking about her repeated attempts to access ODSP entitlements, she said adamantly, “You really have to fight with this government.”(p.5) From her perspective, governments do not want women to fight back and are happy when they simply accept their decisions, however unfair.

Lastly, despite the complexities of their daily struggles, social activism was also on the agendas of these women, constituting yet another avenue of resistance. Remarkably, a number of women who participated in this study also rallied their personal resources, committing both time and energy to the bigger and broader battles of resistance. They were heavily invested in social change and had participated in various public protests and media events around issues of poverty and homelessness and therefore based on the findings, asserted their rights to improved health. In justifying her participation at the front lines of social activism, Patty declared vehemently, “I’m fightin’ for the homelessness. I’m fightin’ for the street people. I’m fightin’ for the low-income people and I’ll do it til the day I die.” (p.19) They were hardly the words of the weak. Indeed, many women brought much strength to the discourse and as the following section

demonstrates, they also brought many viable and practical ideas around how to better meet the health and health care needs of low-income women.

RECOMMENDATIONS

Toward the end of each interview, participants were asked to imagine sitting across from a politician who was interested in hearing their thoughts around recommendations to improve the health and health care of low-income women. This final section represents their responses to this question and attempts to incorporate their other suggestions from elsewhere in the interview process. Their many suggestions have subsequently been condensed and organized into 6 key recommendations⁹.

1) Build on current successes

- a. Maintain and improve outreach initiatives by:
 - i. Increasing outreach services for the homeless (medical and non-medical);
 - ii. Maintaining a harm reduction philosophy;
 - iii. Engaging in creative outreach with sex trade workers;
 - iv. Promoting the use of ‘insiders’ to bridge and promote access to health care services;

⁹ Interestingly, a post-analysis discovery found that there was considerable overlap between the recommendations put forth by these women and the Framework for Women-Centred Health developed by the Vancouver Coastal Health, supporting the reliability of the data obtained in this study (NCGHCRW, 2005, p.18).

- v. Reducing visible differences between providers and the street-involved to facilitate integration like language and dress; and
- vi. Building relationships with the street-involved community.
- b. Maintain and improve Community Health Centres (CHCs) by:
 - i. Increasing access to CHCs particularly for those who have health cards; and,
 - ii. Increasing flexibility around catchment areas.

2) Build knowledge base

- a. Improve knowledge base and competency of health care providers by:
 - i. Acquiring more education and information about various health problems including improved and more timely diagnostic and treatment capabilities; and
 - ii. Increasing knowledge base through research specifically with people who are street-involved.

3) Increase access to income

- a. Increase standard of living for social assistance recipients by:
 - i. Raising rates for OW and ODSP assistance;
 - ii. Reinstating the special diet allowance; and,
 - iii. Expanding eligibility criteria for transportation allowance beyond medical appointments.

4) Improve program and services

- a. Attend to women's non-medical health needs by:
 - i. Establishing more social opportunities for low-income women;
 - ii. Increasing access to free complimentary medical health care services and facilities such as foot care, home exercise equipment, and therapeutic pools;
 - iii. Creating more specialized programs and services including combined exercise and meal programs, support groups for women, mental health facilities as well as life skills groups;
 - iv. Increasing availability of women's drug and alcohol rehabilitation services;
 - v. Designing a safe, comfortable and welcoming place with support, counselling and medical services available 24 hours per day for people experiencing mental health difficulties; and,
 - vi. Improving services for street involved women and women involved in the sex trade including facilities that dispense harm reduction materials and offer safe places to eat and shower.

5) Improvements to medical health care

- a. Improve the existing medical health care system by:

- i. Reducing waits lists;
 - ii. Preparing for pending epidemics including more planning and more resources;
 - iii. Increasing access to caring physicians; and,
 - iv. Increasing access to free health care services.
- b. Develop new and innovative health care services by:
- i. Creating women's health clinics responsive to the unique health needs of women, particularly the street involved;
 - ii. Increasing access to health care services for people with Hepatitis C;
 - iii. Establishing after hour services episodic and preventative care for women involved in sex trade work; and,
 - iv. Creating a roster of medical providers who are sorted by specialty.

6) Eliminate marginalization

- a. Offer low-income women access to health care that is equitable and non-discriminatory based on income, gender, housing status, mental health and/or substance use by:
- i. Reducing access inequities within health care settings;
 - ii. Treating women with decency, respect and kindness; and,
 - iii. Refraining from judgment and practicing compassion.

CHAPTER IV

DISCUSSION

SUMMARY OF FINDINGS

This qualitative study explored the health and health care needs of low-income women using knowledge obtained through their lived experiences. Key areas for consideration included an exploration of how health and health care was conceptualized, influenced, experienced and evaluated by low-income women, with a particular emphasis on the role of gender and poverty on their lives within the context of health.

While there was no consensus about how best to define health and health care, participants defined these concepts more broadly than the biomedical model so prevalent in dominant discourse. Consistent with other research, health involved many aspects of women's lives that extend well beyond the absence of disease. Definitions tended to be expressed both conceptually and functionally, meaning that some descriptors were presented more abstractly - "spiritual health" - while others were more tangible in nature - "energy level". Both approaches were equally useful in understanding the meaning of health for this population.

Definitions of health care were similarly broad and encompassed a range of programs and services including medical and non-medical care, community and outreach initiatives, as well as some intriguing ideas around other services such as volunteer work. Most women described a history of accessing health care

services in varying degrees and in assorted combinations. In addition to accessing medical services such as hospitals and family doctors, most women had also accessed non-medical health care services. Disparity existed between their desired and actual service use. Access decisions tended to be primarily cost-dependent, meaning that medical and non-medical services were more often used, or not used, based on expected fees, regardless of perceived value or preference. Given the sampling requirement that participants were required to be OW or ODSP recipients, this result was not surprising.

With the aim of better understanding low-income women's health and health care needs, participants were also asked to talk about how income, gender and living situations influenced their health. Within each of these areas, several common themes emerged suggesting that various factors influenced their health, in parallel and in combination. All women reported having multiple, significant factors within their lives that impacted their health.

Access to basic needs such as food and affordable housing were deemed to be fundamental to their health, yet often beyond their reach due to their meager incomes. In particular, experiences with homelessness were profoundly detrimental to the health of these women and consequently, they positioned housing as being perhaps *the* most fundamental health need. Poverty-related stress led to concerns about their mental health and contributed their sense of isolation. Presentation of self from a place of poverty proved to be challenging as well.

Discourse about gender seemed less accessible for these women; however, some pertinent factors cited within feminist literature as having gender-based roots were implicated in less direct ways. So while not framed as being gender issues per se, factors like trauma, substance use, sex trade work, violence and abuse emerged as findings of importance for these participants and were situated accordingly along with biological factors and gender roles/stereotypes as having consequences for their health.

One of the benefits of using a qualitative approach involving semi-structured interviews was the space afforded for the inclusion of discourse outside of the researcher's agenda. Some women took advantage of that space to generate additional categories for analysis. Factors like access to education and government-related shifts were subsequently added to the roll of factors impacting their health.

Exploring participants' experiences accessing health care proved to be especially illuminating in understanding how women view their health care. It also provided a venue for acquiring knowledge around how our health care system is structured and how social problems like poverty subsequently get managed and manufactured within women's lives. The women in this study generously shared the experiences they felt most relevant and worked collaboratively with me to generate an improved understanding of how factors like low-income, gender and living situation influence their health care.

To some extent, participants focused on the types of services received in health care. While some women reported their experiences favourably, by and large, mainstream medical health care was problematic for various reasons. Medical and non-medical services received through outreach initiatives and CHCs, on the other hand, were decidedly positive, due in part to the flexible and comprehensive approach to service delivery but more so, due to the characteristics of providers associated with those services.

To a much larger extent, participants concentrated on the relational aspects of health care. Seemingly, the process of receiving care took precedent over the content of care. For many of the women, services were important but service delivery was more important. For example, flexible, caring relationships with health care providers that were grounded on mutual respect and equity appeared to be valued more than those that were not. Similarly, being heard and validated was far more conducive to health, from their perspective, than being dismissed and discounted.

Irrefutably, the findings from this study support claims that women who experience poverty within the context of urban life tend to also experience differential access and treatment within our health care system, despite the prevailing rhetoric about equality. In listening to their experiences, indications of marginalization became an underlying and pervasive theme. Low-income women felt as though they were treated differently by health care facilities and providers and cited numerous encounters to support their claims. From their viewpoint,

visible indicators of poverty and homelessness generally led to less positive interactions with health care providers and their respective institutions. However, health care services that more deliberately service marginalized communities such as outreach services, were viewed to be less discriminatory and more equitable: “Everyone is on the same level.” (Karen, p.7) When it came to differential care based on gender, participants’ thoughts were mixed: some considered being female an asset in terms of care while others viewed it to be a disadvantage.

In participants’ feedback around their preferred service access, there was evidence that current patterns of service utilization are a product of medicalization. “In a perfect world”, to use the words of one woman (Tanya, p.2), alternative or non-medical health care services would have been accessed much more liberally without having to contend with the burden of costs that impede their access. Reliance on medical services, it seems, may have been more about costs than about perceived value and may help to explain women’s reliance on medical services for non-medical reasons. Women’s problems then got framed in medical terms and the perception of increasing demands for medical services was perpetually created and reinforced at the expense of securing access to services that meet their actual needs.

The findings from this study further indicated that the exclusive use of the biomedical approach was often not adequate, even inappropriate, when it came to identifying and addressing their health concerns, given the scope and plenitude of factors that negatively impact the health of low-income women as a result of their

experiences with poverty, homelessness and gender. Other studies concur (Reid, 2002, p.8) and yet, a tremendous amount of medical health care has been systematically directed toward the management of all of women's health concerns. Even if well-intentioned, medical solutions do not resolve social problems. So, it begs the question: if the battle lies in the fight against poverty and injustice, why then do we, as a society, continue to reinforce the battle against illness and disease?

THE MEDICALIZATION OF WOMEN'S POVERTY

Ruling Relations

In seeking answers to this question, Institutional Ethnography (IE) offers a useful framework to locate and explore this particular social arrangement and challenges us to uncover that "something" that creates and perpetuates, in this case, the medicalized approach to women's poverty (Campbell & Gregor, 2002, p.17). In explicating the operational ruling relations, two dominant forces emerge as being critically influential -- the institutions of government and medicine.

In her writings about women's health care, Reid (2003) stresses the importance of the broader socio-political context of women's lives including emergent political, funding and policy trends (p.3). Responses to women's health very much reflect the broader structural arrangements surrounding their lives, which tend to favour the most influential and dominant groups within our society. Some of the women made these connections within their interviews and reflected on how the *personal is political*. Jackie for instance, used the treatment of low-

income people within welfare offices as a reference point for their treatment within the health care system. She stated,

There's a lot of prejudicial (sic)...set-up against low-income groups. I mean...you just have to go into a welfare office...just the whole make-up of the place...there is a tier system in terms of how people are treated like, let's face it...like these people are poor, they're used to it so we can treat them like that. You know, that's what they've been used to. (Jackie, p.13)

She expanded on this idea,

The thing that has developed in terms of bureaucratic agencies...for example...the welfare office that has become accepted you know...that has had a tendency to spill over into the way that low-income people are, or are given access to the health care system...these blueprints...have become the norm. (Jackie, p.14)

As governmental priorities have shifted so too have these 'blueprints'. As purveyors and managers of public opinion, the state has increasingly moved poverty from the public arena to the private, thereby effectively rendering poverty a matter of individual rather than societal concern, irrespective of the profound influences of social policy in peoples' lives. Just as issues of poverty have disappeared off the political agenda over the last several years, so too have issues of gender and gender equality, particularly as they relate to the intensification and the feminization of poverty (Brodie, p.91). Not surprisingly then, with the unravelling of our income security safety net and the subsequent downloading of social services to other systems, there has been a concomitant increase in demands within the health care sector. What the welfare state relinquished, medicine usurped.

Lugones (2005) argues that medicalization is increasingly permeating all aspects of life (p. 3) and that women in particular are susceptible to its influences as a means of social control (p.1). By framing women's social problems as personal deficiencies, health matters become medicalized, individualized and feminized and are removed from portfolio of societal responsibilities. Other studies put forth similar concerns (Lugones, 2005, p.2; Mykhalovskiy & McCoy, 2002, p.21).

As medicalization becomes more entrenched, the social determinants of health like gender, income security, housing and employment become lost in the provision of health care. While increasing the responsibility on the health care system, medicalization effectively devolves social and political responsibility from other systems that ought to be at the table and could be, as Shera et al. (2002) suggest, counterproductive in the socio-political arena (p.561).

Medicalization is a double-edged sword of sorts. While it may be costly to the socio-political context of health, it may also increase the likelihood of money being spent in this area due to public acceptance of illness as being a 'just cause'. For medical institutions and professionals as well as service users, this can be good news.

The lure of funding is not the only way medicine, institutionally and professionally, benefits from this arrangement however. By framing social problems like poverty as medical problems to be diagnosed and treated, the hegemony of the medicine stays protected within health care, expert status is

maintained and the male-dominated medical profession stays well positioned to maintain its professional monopoly, in this case, over the management of poor women's social and medical needs. Evidence of expert positioning could be found in the words of various participants within this study, often in the form of asides. In reference to her care, one woman stated, "So how do you argue with the doctor, you know...if I go see another doctor, I can get in trouble for that." (Mary, p.9) A few women spoke about the tenacity of this social arrangement, especially apparent when expert status is challenged within doctor-patient relationships. Demonstrating personal knowledge or asking questions regarding a health matter was sometimes viewed as assaults on medical expertise and can lead to punitive behaviour as Kate's example illustrates:

I got chased out and yelled at by one of my psychiatrists for asking what Tryptophan (sp) was...this is a personal opinion...this isn't something you can scientifically say but, these men go to school, they learn what they learn and they figure you don't possibly know what they know because they spent ten years learning it. So for you to come up and say...I should have 700 mg. of Tryptophan a day. Who the fuck are you to tell me? I am not going to give it to you now. I am gonna give you something else." (Kate, p.23)

The stronghold on health care is not only lucrative for physicians. Medical social workers and nurses enjoy similar benefits in that, as professions, they have also successfully created niches within the system to engage in their work. Indeed, Blackwell (1999) reminds us that medical social work evolved at about the same time as the medicalization of poverty (p.58).

Just as importantly, low-income women also gain from this arrangement in spite of the costs and will therefore sometimes behave in ways that purposively

afford medical providers expert status as a means to obtain other benefits that privilege medical problems over social problems. As will later be discussed, women sometimes negotiate how their health care is defined to not only construct their access to care and resources but also, their self-concept.

Poverty among women gets medicalized as a product of the often hidden interests of those dominant interest groups who, as key stakeholders, have an investment in sustaining these relations of ruling. The evidence lies within everyday practice. According to Campbell & Gregor (2002), “ruling takes place when the interests of those who rule dominate the actions of those in local settings” (p.36). Based on Smith’s work in IE, they encourage us to closely examine written and verbal text as a place to explicate ways in which power gets embedded in organizational relations and practice (p.25) and subsequently, how these texts get constructed in ways that can be controlling and disempowering of people (p.22). In thinking about how these ruling relations were operationalized among the women in this study, some examples came to mind.

Verbal text-mediated discourse

According to proponents of IE, verbal text or discourse reinforces particular social arrangements. Often, it is about what is said and how it is said; however, absence of discourse may also be purposeful and socially organized. For example, what the presentation of findings around definitions of health and health care has not revealed is that *initial* responses from the vast majority of this study’s participants were either very limited in scope along medical lines or were, in some

cases, virtually non-existent. When asked specifically for their definitions, some participants would state that they did not know how to, or simply could not answer this question. According to one woman, “It’s something I don’t really have much um, experience with. So I don’t really have a definition for it.” (Tanya, 2006) Other women, at least initially, struggled to come up with an operational definition of health beyond the dominant medical definition of health, or the absence of disease perspective. Discussions around health care services were similarly thin at times. With the exception of one woman who happened to be extraordinarily well-versed in the gamut of mainstream and alternative health services, health care definitions were also very much limited to traditional medical services like hospitals and doctors.

Because the questions about defining health and health care were typically asked at the beginning of the interviews, it made it possible that these response patterns may have been related to the positioning or phrasing of the questions in the interview process. Further, some unanticipated tensions might have been generated that limited their responses when I situated myself as a health care provider and as a proponent of critical feminism. However, when questioned about their thin definitions, their answers were varied: one woman stated that they were unsure as to why these were difficult questions; another woman simply rejected any possible difficulty; and two of the women, attributed their challenges to being mental health related.

Using IE as the analytic framework, another possibility emerged that could help explain their responses. In their qualitative research with people living with HIV/AIDS, Mykhalovskiy & McCoy (2002) found that people who were marginalized by social location produced very different treatment discourse than those who were not marginalized, causing them to conclude that health discourse may in effect be a middle class construct (p.31). Talk about health and health care required discourse around health that may not have readily accessible for these women. Perhaps then, in the absence of alternative discourse, women who did respond resorted to more dominant discourse that narrowly defines health and health care along biomedical lines. Importantly, it became apparent that the dialogue became much richer and more edifying when invitations were extended for alternative discourse. Questions about their everyday experiences, of which they were the experts, generated very different conversations than would have otherwise been permitted.

Written text-mediated discourse

Verbal text is not the only way women's health care is socially mediated. By exploring written text, ruling relations can also be explicated. The ODSP application process provides a rich example to concretize these ideas. In order for people to qualify for ODSP, they must be poor *and* 'disabled' and they must have a doctor who is willing to complete a written standardized application form attesting to their level of debilitation in a variety of areas. Too often, as the research proves, people are 'disabled' because they are poor. However, as a result

of political will, and therefore public support, income security programs like ODSP are reserved for the most ‘deserving’, or the most ‘deficient’, if you will. Consequently, it is understood that for an application to be successful, physicians must present patients in the bleakest way possible, using the gamut of diagnostic language and labels afforded only to them as the experts (Newnes, 2005, p.3). Reliance on their physicians to secure disability income was an arrangement that generated a great deal of tension for the participants of this study.

Special diet and transportation requests work in much the same way: in order for people on OW or ODSP to afford any food or TTC assistance, they must be assigned a documented medical problem by a health care professional to show, vis á vis a letter, that they are demonstrably ‘in need’. Insufficient income leads to the medicalization of women’s problems, which in turn means generating verbal and written discourse attesting to the deficiencies of the woman rather than the system. One woman in this study relayed, “unless you have at least five appointments a month at a doctor’s, you get nothing” (Cathy, p.17). The only way to qualify for these additional benefits is to be seen, often repeatedly, by a medical professional who then assumes authority over your eligibility. In these ways, local texts demonstrate how poverty gets medicalized and how ruling relations often get sustained in obscure ways.

As socially sanctioned gatekeepers of many health and social services, physicians thereby effectively exercise their power to position patients experiencing poverty in an even more deficient role, I suspect often as “unwitting

participants”. As institutional ethnographers would argue, such power relations are often invisible to even the participants; that is, until they are challenged. For example, the recent political posturing by some medical providers that generated an influx of special diet requests to our income security programs was met with even stronger posturing by the government suggesting that more than initially thought, medical professionals are “agents of ruling relations”. Interestingly, the result of this exhibition of contested power has been to even further medicalize people’s poverty as a means to contain government spending in the social services arena.

The implications of written text in mediating women’s health care can sometimes be far reaching as Tanya’s example so poignantly demonstrates. She very emotionally described her experience.

My methadone doctor at the time, said that when he read my file and, this was very telling for me, that when he read my file, he thought, well we’ll just prescribe her methadone and you know, we can get on with it...She is just a junkie...He said he met me and I was intelligent and...I spoke well...It didn’t seem to fit with what he saw on paper...That made me think that...I’m quite a problem. (Tanya, p.8)

The importance of verbal and written text in the construction of women’s health and health care experiences ought not to be underestimated. As health care services become much more technologically advanced, and the threat of ‘e-charting’ looms, written text-mediated discourse will only become a bigger challenge (NCGHCRW, 2005, p.10). As computer programs replace traditional methods of documentation, medicalized text will become even more refined; the

multi-dimensional aspects of low-income women's health will be reduced to specific, pre-determined categories that oversimplify the complexities of their lives.

IMPLICATIONS

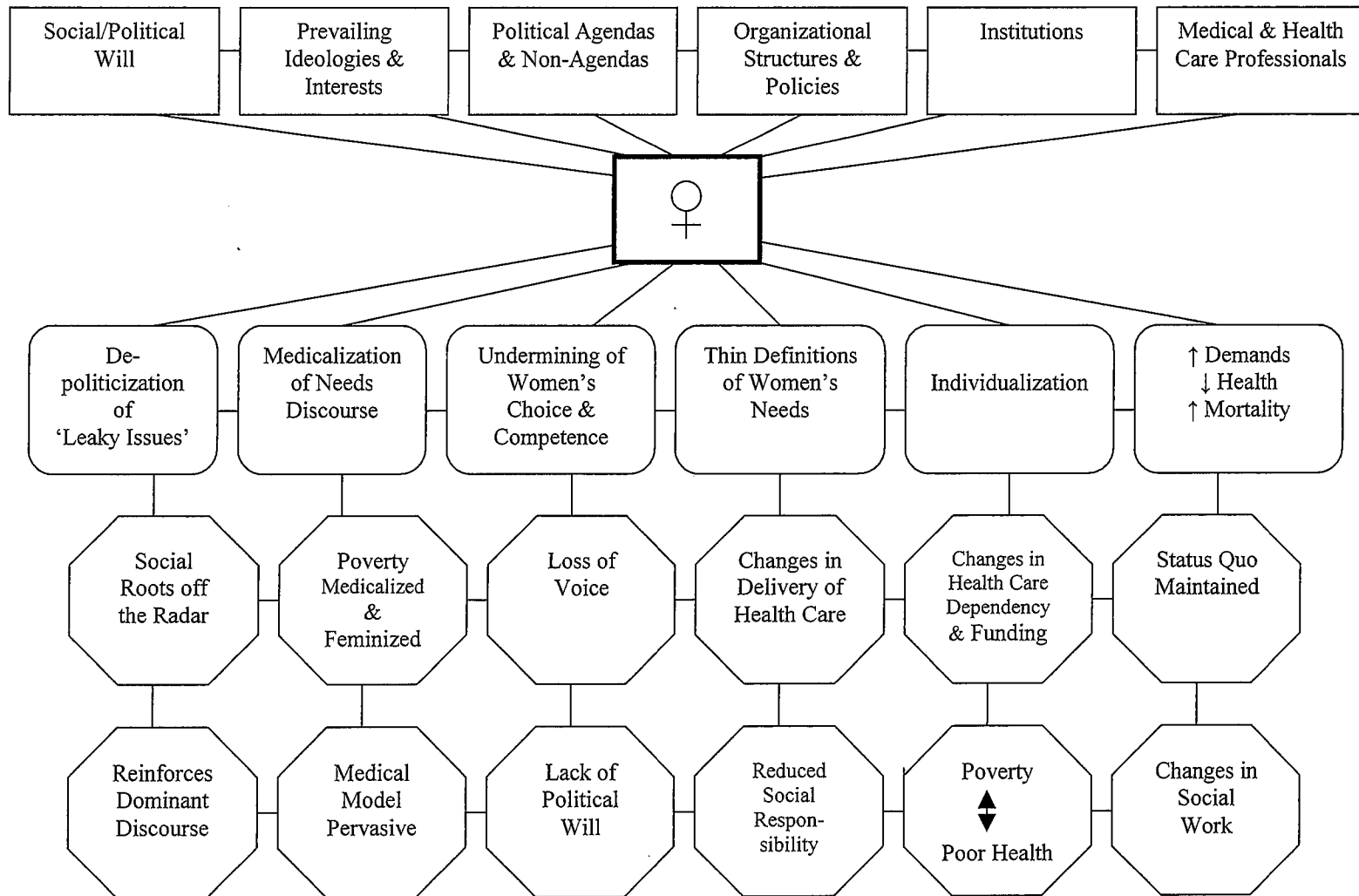
As this discussion suggests, the ruling relations that create and perpetuate the medicalization of poverty constitute a highly complex interplay of social and political agendas located within the broader context of women's lives that have tremendous implications for women's ability to attain health and access health care (see Chart II for a more in-depth analysis of these relationships).

Understanding the impact of these arrangements on women's lives, Lugones (2005) challenges feminists to "play a role in critiquing and condemning these forms of social injustice that hide behind the veil of medicine" (p.2) and of which women are victims. For me, addressing social injustices is the essence of social work.

Implications for social work

As health care professionals, it is critical that social workers explore how we too are implicated in creating and sustaining these ruling relations and practices. Newnes (2005) speaks about being "multiply identified" (p.3), meaning that we are each a mixture of many selves depending on any given situation. Based on the manifestation of these multiple selves, we can be differently positioned both as ruled and ruler, oppressed and oppressor (Potts & Brown, 2005, p.258), depending upon context and circumstance. Much like the doctors

Chart II. The Medicalization of Women's Poverty



described earlier, how we are personally and professionally implicated in ruling relations is therefore, very much a fluid and transient process.

For example, it is well known within health care circles that physicians are typically seated at the top rung of the professional hierarchy and often revered by their colleagues simply by virtue of their status. Social workers, on the other hand, tend to occupy a much lower rung on the proverbial ladder and consequently, as a result of our professional identities, we sometimes choose to assume the position of accommodating participant rather than risk challenging the status quo. Newnes (2005) might say we are “unwilling to rock the medical boat” (p.4); others might call it co-opting. Either way, it speaks to some of the challenges Fook (2000) describes when positioning one’s self with or against colleagues based on one’s position of power (p.190).

Certainly, some reluctance to challenge the status quo stems from the challenges and pressures associated with the cultural milieu of the health care setting. It is a “milieu that tends to reprivatize and individualize experience” (Brown, 1994, p.50) and therefore, would not be likely to appreciate a social analysis. The literature by Rossiter et al. (1998) about their work within the mental health field offers a great deal of insight around the pressures within institutional structures to practice in ways that perpetuate the “dominant discursive practices of mental health” that not only limit our practice but also serve to inform our reality within these systems (p.12). Pressures to conform to traditional, illness-based models of medicine and psychiatry restrict attempts to

support client's views, to advocate on their behalf or to locate their 'problems' within a social context (Rossiter et al., p.12). To position oneself on the side of the client in this way sometimes means risking one's own professional credibility and legitimacy within this context, to risk being 'written off' by colleagues.

For similar reasons, it is sometimes difficult to publicly consolidate personal and professional identities. For example, depending on the audience, at times it may feel risky to situate myself as a feminist or 'to out' my own feminist positioning. As a product of the same social structure and therefore also subject to similar gender and power related inequalities and injustices as our clients (Wise, 1991, p.238), finding that intricate balance between maintaining credibility within the system whilst engaging in social activism on behalf of our clients can be particularly challenging. At the same time I am being ruled, I am simultaneously engaged in ruling. I point out these dilemmas to illustrate how terribly messy the business of explicating ruling relations and practice is based on our own personal and professional locations.

That said, it would be profoundly irresponsible for social workers to ignore those aspects of power and privilege afforded us by virtue of our education and training. Positioned as an expert of sorts, we can exercise that power and privilege in clever and innovative ways to challenge those more oppressive ruling relations and practices for the benefit of the clients with whom, and on behalf of whom, we work. It is through this lens that I approach possibilities for resistance. Indeed, understanding that ruling relations underlie ruling practices and aware that

ruling practices serve to disempower those most marginalized, locating possibilities for resistance is essential.

Paths of Resistance

Opportunities for resistance can occur on a number of levels within the context of health care. Much more aware of text as a mediator of ruling relations, and more specifically, how poverty gets managed by dominant forces through medical text to the detriment of individuals, it seems relevant to focus on written and verbal discourse within the workplace as a point of critical analysis and action. Ill-positioned as an outsider and limited by professional location, expending energy to tackle the textual practices and tools of larger bureaucracies like ODSP seems futile, despite its well-documented flaws. At the local level however, some very concrete strategies can be implemented to challenge how social problems like poverty get formulated within a health context.

Several authors speak to the importance of discourse in perpetuating dominant views (Schram, 2000, p.99; Aronson, 1999, p.60; Fraser, 1989, p.164; Fook, 2000, p.97). Using their work as a point of reference, social workers can, more deliberately and respectfully, use their positions within their work settings to create space for alternative, non-medical discourse in conversations and in writings about clients. This may mean better contextualizing people's experiences of poverty, using less medical jargon, putting forth clients' voices and finding ways to thicken needs discourse within clinical assessments beyond the biomedical approach. Fook suggests setting the discourse agenda and reminds us

that the use of accepted discourse determines the views that dominate (p.197). It is food for thought.

To some extent, social workers already partake in forms of resistance as it relates to text, for example in navigating systems such as ODSP. As part of our work, we become well versed in the discourse required to access resources on behalf of clients and subsequently get increasingly proficient at “organizational tinkering” (Aronson & Sammon, 2000, p.176). Schram (2000) points out how the medicalization of poverty has created a “highly medicalized form of resistance” in which people are forced to construct identities of sickness in order to obtain necessary resources (p.94). Knowing this achieves the desired outcome, we need to be prepared to work with individuals around generating a text built on medical need when necessary. However, as Shemmings & Shemmings (1995, p.54) recommend, it is work that is done deliberately, thoughtfully, honestly and most of all, collaboratively. Although it is not without consequences, it is work that has been valuable to clients and, for that reason, ought to be continued.

Tremendous opportunities exist to practice resistance at the organizational level also. Instead of being more visible ‘critics of the authorized view’, which often brings both unwanted attention and conflict, social workers might heed the advice of others more adept at social activism and develop, what Smith (2005) calls, a “more nuanced skill set” to challenge ruling relations and practices. Based on her own research, Smith found that politically astute social work activists found value in more subversive strategies to influence change, strategies

like “stealth practice” and “impression management”. Sometimes this means laying low, staying patient and picking battles much more carefully to effect change within the workplace on behalf of clients. These strategies of resistance feel much more subtle, much more deliberate and, based on my own experiences, are likely to be much more productive.

That is not to say that blatant activism does not have a role in social workers’ repertoire of resistance practices. Instead, it means becoming more strategic and organized in building allies around issues of social justice. Too often I have succumbed to the “lone crusader” mentality (Fook, 2000, p.191), feeling both outraged and alone in my response to some perceived injustice. Smith (2005) suggests a more responsive, organic approach through the use of “transitory coalitions” which makes room for allies based on need rather than ongoing association. It also means keeping abreast of local social justice initiatives and staying ever respectful and encouraging toward those individuals and groups fighting the hard fight on the front-lines (Newnes, 2005, p.6).

Then there is knowledge. Understanding that knowledge is both socially constructed as well as political (Potts & Brown, 2005, p.261), another resistance strategy is to focus on how we build, integrate, resist and disseminate knowledge to impact ruling relations (Baber, 2004, p.981) and therefore, to effect social change. Anti-oppressive research, as Potts & Brown (2005) demonstrate, can be a vehicle for social justice and resistance in process and outcome through its ongoing attention to power relations throughout the research process (p.260).

Institutional ethnography similarly positions research as a political endeavour (Campbell & Gregor, 2002, p.14). What is consistent about both approaches is that they effectively challenge ruling discourse by introducing new knowledge acquired from the voices of those being ruled. That alone is an act of resistance, one that I hope I have replicated in this research around meeting the health needs of women marginalized by poverty. Such knowledge building is not however reserved for academics: it can occur through less formal means, through the everyday conversations with clients who enter the health care system from a position of poverty or with policymakers who create those policies that perpetuate women's marginalized status.

Finally, resistance is ultimately about positioning: our own positioning, the positioning of clients and the relationship between the two. Newnes (2005) recommends a "there but for the grace of God go I" position, adding that we act as though service users are somehow so very different from us (p.6). Others recommend becoming allies with the marginalized (Aronson, 1999, p.63). Both are valid strategies. However, for me, it is more complex; it is about awareness, awareness of ruling relations and how to strategically use those relations, including my own power and privilege, for the benefit of clients. To this end, it is crucial that I remain studiously aware of the broader socio-political context influencing my life as well as the lives of my clients and colleagues.

Implications for future research

While we ought to continue to strive for universal access to appropriate medical treatment and meaningful health care as a matter of human right, this research substantiates the fact that we also need to be cautious about medicalization of poverty and injustices that obscures the everyday struggles of the poor. “In the long run, these are social problems, not medical problems, and require political and social interventions.” (Murphy, 2002, p.2) Nevertheless, the major thrust of the research to date has been to focus on women’s health care needs using a biomedical approach, typically to service dominant agendas. Not bound by such constraints, this research instead provided a glimpse into alternative discourse about the health and health care needs of low-income women to sufficiently “trouble ways of thought” (Mykhalovskiy & McCoy, 2002, p.18) and in doing so, uncovered new avenues worth exploring. Indeed, the findings generated more questions than solutions and thus, offer promising areas for future research.

Bearing in mind the need for increased attention to the social determinants of health, ongoing research ought not to be limited to naming those factors but to also explore how they work in concert to influence how individuals experience their health. Measuring and evaluating responses to those factors would seem essential to effecting future policies around the health of those most marginalized. For example, this might include ongoing service evaluation by and for service users particularly around the human and economic impact of non-medical or non-

traditional approaches to health. It may also include a formal analysis of the impact of shifts in social spending on the health of Canadians.

Continued examination of the everyday experiences of low-income women would also be valuable with a particular focus on women who experience multiple oppressions. As these findings attest, sources of oppression are frequently multidimensional and their relationships often very complicated. While, gender and income were the primary focus of this study, some other areas also emerged as potential areas of interest including the impact of factors like substance use, mental health and homelessness as well as sexual orientation, race/culture and age.

With the growing trend toward multidisciplinary health care through teams such as Family Health teams and CHCs and as a member of a multidisciplinary health care team currently, I am particularly interested in research that investigates the impact of multidisciplinary and/or interdisciplinary care on the health of low-income women and how such an approach helps or hinders the medicalization of women's poverty. A related piece might include an exploration around how medical practitioners and social workers view their roles in the lives of low-income women.

This observation brings me to the idea of ruling relations. Institutional ethnography offers a unique and valuable perspective to the field of critical research in that it permits a more deliberate investigation into how ruling relations orchestrate women's health within daily life through everyday example. One area

that surfaced as a point of concern through this analysis was the designation and assumption of the dependent or ‘sick’ role and its implications for the health, well-being and social positioning of low-income women. A further exploration into how low-income women negotiate this role, using an IE approach, would be welcomed.

Lastly, this piece of research demonstrated to me, the extraordinary impact of the research process and the power of knowledge building in unison with marginalized communities as a place of social justice and social action. De-briefings at the end of interviews often led to some fascinating discourse and led me to wonder about the short and long term effects of this kind of research not only on participants, but also on researchers. As a future area of study, uncovering that ‘something’ within research might help to inform strategies for engagement with communities in the fight toward social justice.

Closing remarks

In viewing the health and health care of low-income women through an institutional ethnographic lens, I am struck by how deeply embedded gender and power relations are as result of personal, professional, organizational, social and political influences and how these relations get operationalized often unbeknownst. By understanding my workplace as both a place of dominant ruling practices as well as a place of opportunities for resistance, it is also important that I refrain from simplifying people’s lives to the observable and become more vigilant around how gender and power relations might be operating in everyday

discourse, in everyday example. Committed to the principles of access, equity, advocacy and partnerships, our CHC offers a model of service delivery that attempts to address the broader determinants of health such as poverty and to provide multidisciplinary, holistic health care in a more inclusive, responsive, client-focused, equitable way so as to improve the health of its community. As part of an Urban Health Team organized to provide outreach to those populations most likely to be impacted by poverty and as a budding researcher, I am well situated at the door of possibilities in terms of effecting change in how women's health and poverty gets understood and addressed, at least at the local level. It begins with listening intently to the voices of women like those who so graciously shared their expertise by participating in this study.

APPENDIX A-1

Interview Guide

The participants will be asked open-ended questions loosely based on the following interview guide (probes optional):

1. Define health and health care
 - Elements of health
 - Definitions of health
 - Definitions of sickness
 - Definitions of health care services
 - Descriptions around use of health care services
2. Factors that contribute to being healthy/unhealthy
 - Impact of income
 - Impact of gender
 - Impact of current living situation, i.e. relationships, housing status
 - Impact of changing these factors on health
 - Most/least helpful
3. Experiences accessing health and health care
 - Reasons for accessing services
 - Recent experiences/past experiences of importance
 - Factors related to income
 - Factors related to gender
 - Satisfactions/disappointments
4. Recommendations
 - Changes/improvements to health care system
 - Changes/improvements to health care services
 - Other

In order to describe the group of people who participated in this research study, personal information is needed to compare what you have told me to what others say.

1. Are you between the ages of 25-35, 36-45 or 46-60?
2. What is your cultural and/or ethnic background?
3. Are you a Canadian citizen? If not, what is your immigration status?
4. Do you consider yourself to have a disability? If yes, please describe?
5. How do you describe your sexual orientation – straight, lesbian, bisexual, other?

6. Where do you currently live – in a house, an apartment, a rooming house or other?
7. Do you live alone? Does anyone else help to pay for the accommodation in which you live?
8. Do you consider yourself homeless or at risk of homelessness, i.e. couch surfing, in a shelter, on the streets

APPENDIX B-1

RESEARCH STUDY: Understanding the Health and Health Care Needs of Low-Income Women Living in an Urban Setting

RESEARCHER: Leah Palmer, MSW Student, McMaster University

STUDY OVERVIEW:

My name is Leah Palmer and I am a registered social worker who is completing a Masters in Social Work at McMaster University in Hamilton Ontario. I was a previous long-term employee of (-----) Community Services who is presently working within your neighbourhood as a Case Coordinator/Social Worker at South Riverdale Community Health Centre. To fulfill my thesis requirement, I will be conducting a study about the health and health care needs of low-income women living in an urban setting. Please note that this study has received ethics clearance through the McMaster University Research Ethics Board (certificate attached).

The impetus for this research stems from the growing body of evidence that suggests that the prevailing public discourse around improving the health of Canadians has failed to provide any meaningful results. Specifically, despite universal access to a publicly funded system of health care delivery, the research clearly demonstrates that, in Canada, persons with low incomes can expect to be less healthy, suffer more and die earlier than their wealthier neighbours, simply because they are poor. Studies further suggest that these health inequities do not only result from differential treatment based on socio-economic status. Gender also seems to play a significant role in people's health and health care experiences. Combined, this interplay of factors appear to render women who are poor at much higher risk for inequitable health care treatment as well as the gamut of health related concerns. With poverty becoming increasingly feminized, the health of low-income women is becoming proportionately compromised. Understanding that these factors are inextricably linked, this research study explores the relationship between health, poverty and gender and seeks to understand how those most impacted view their own health and the health care they receive.

METHODOLOGY:

For this study, I am interested in interviewing approximately 12 women who meet specific inclusionary/exclusionary criteria: the research participants must be biologically female between the ages of 25 and 60; be residing in an urban setting; and be receiving OW or ODSP. Additionally, they must be fluent in English and be able to give informed consent. Those individuals, with whom I have entered into a past or present one-to-one counselling relationship, will be excluded from this study. A preliminary telephone screening will be conducted with each participant to ensure they meet these

criteria. The consent form and information letter will also be verbally reviewed at this time. Participants will be advised they will be asked to sign this consent at the time of the interview.

Data will be collected through the use of taped, in-depth, face-to-face semi-structured interviews, with women marginalized by low socio-economic status, each approximately one hour in length. Following the interview proper, participants will be asked to provide some personal demographic data including age cohort, ethnicity, immigration status, disability, sexual orientation, housing status and living arrangement for group description purposes. Second interviews will be offered to all participants for follow up purposes. Please note that issues around consent and confidentiality have been addressed meticulously and conscientiously within the proposed methodology to the satisfaction of the MREB. I would be completely willing to share those protocols as needed/requested.

REQUEST:

Aware that your agency provides services to women marginalized by low-income in various capacities, I would very much appreciate your assistance in recruiting eligible participants for this research study. Specifically, I would like to request the assistance of the Program Managers from both Housing and Homelessness Services and Mental Health and Developmental Services and their respective staff to invite service users to participate in the research as well as to distribute flyers centre-wide (see attached). Interested parties will be asked to contact me by phone or in person and their names will be placed on a time-limited interest list, providing they meet the stated selection criteria. If possible, but not necessary, one identified contact person at (-----) CS who could bridge interested parties would also be helpful. Because a very short turnaround time between recruitment and the interviews is anticipated, the required staff resources will be expectedly minimal.

Because of your convenient, accessible, non-medical environment and because of your physical presence within the South Riverdale community, I am also requesting that some private office space be provided on-site to conduct these interviews. Aware that space is at a premium, I am prepared that some flexibility will be necessary in making these arrangements.

In granting these requests, a summary of these research findings will be forwarded to your organization upon the study's completion. Please note that (-----) Community Services will be afforded the same respect in terms of confidentiality given to all research participants and will be referred to as a "local community centre" in all research writings.

CONCLUDING REMARKS:

As a community agency committed to ensuring access to "the essentials of life", I trust that you will see the value and importance of this research for those women marginalized by low-income who together we serve in the South Riverdale community. As I am sure you are already aware, local demographic

studies identify our neighbourhood as already having a disproportionate and growing number of individuals living in poverty.

Unlike the majority of health research to date, this study is innovative in that it provides the opportunity to hear about the understandings and health experiences of low-income women, witnessed through their eyes, expressed in their own words. It is argued that, by changing discourse, we can change agendas. This research offers a place of knowledge building to inform health care practice at the local and organizational level, consistent with local, provincial and national policy and research initiatives.

Further, because of my current work as a local health care provider on an urban health team, this research and its findings can, and will, be utilized to improve community health responses to the needs of low-income women as we continue to develop innovative programs designed specifically to address the health needs of marginalized groups. It is therefore not only an opportunity to enhance service delivery within our shared community, it is also an opportunity to once again unite in partnership at the local level to continue building the relationships needed for a coordinated, integrated system that is responsive to the health and health care needs of low-income women.

The approval and cooperation of your agency is therefore respectfully requested as outlined. Should you have any questions about this research study, please feel free to contact me at #416-461-3577 or Dr. Susan Watt at 905 525-9140 ext 27091 or wattms@mcmaster.ca.

APPENDIX C-1

**RESEARCH STUDY:
PARTICIPANTS WANTED**

*Are you a woman living on OW or ODSP?
Are you between the ages 25 & 60?*

&

*Do you have something to say about your
health? What about your experiences with
the health care system?*

I WANT TO HEAR FROM YOU!!!

*If you would like to participate in this
research study and would be willing to be
interviewed, please contact:*

OR

Leah Palmer at 416-461-1925 X297

APPENDIX D-1

MCMASTER UNIVERSITY LETTERHEAD

May 1, 2006

Letter of Information

This research project looks at the health and health care needs of low-income women who live in Toronto. It is important to study this topic because people with low-incomes are sicker and die sooner than people with higher incomes. This is not just because they have less money and therefore, fewer resources. It is also about how money and resources are spread out, meaning that the bigger the gap between people who are rich and people who are poor, the bigger the chance people who are poor will suffer more health wise. This is especially true for women who are poor.

Some people, me included, would argue that our society is set up in such a way that makes it harder for low-income women to experience good health and to receive good health care. So far, most of the research has not looked at this concern from the viewpoint of those most impacted - you. Therefore, it is important to hear from those of you directly about what you think about your health and your health care experiences so that we understand your needs better and so that hopefully, decisions will get made that are more helpful to you. Those of us who work in health care in this community could also really benefit from hearing your perspective so that our services better meet your needs. It is also important for the general public and those in government to think about how we as a society affect your health and health care.

Sometimes thinking and talking about experiences may be difficult and you may feel many emotions. For example, you may feel upset, angry, uncomfortable or embarrassed. I would really like to know if any strong feelings do arise for you at any point during this process. Throughout this research, every attempt will be made to reduce those feelings and if they do come up, to look after them hopefully in the best way possible.

Before beginning this study, you will be asked to sign a consent form, a copy of which you will keep. Your participation in this study is completely voluntary. If you decide to stop participating, you can do so at any point without any problem and all of the information you have given will be destroyed.

All of the information you provide will be kept private and confidential. Your name will not be used and your identity will be protected as best as possible throughout the study. Rarely, other people involved may recognize details of events that you talk about. Every effort will be made to avoid this throughout the study and especially in the writing of the final report. All of the information you provide will be kept in a locked filing cabinet in my home, which only I can access. After two years it will be completely destroyed.

In participating in this study, you will be asked to take part in one interview that will last about 1 hour. These interviews will normally take place at the community centre. Another suitable location may be considered, providing your privacy can be guaranteed and the request is safe and reasonable. This interview will be taped, some notes might be taken and the information will be used later in a research report. During the course of this interview, you will be asked questions about your health and health care experiences as well as some other personal information like your age, ethnic background and so on for group description purposes. It is your choice whether or not you want to answer the questions and you can make that choice at the time of the interview.

You will be invited to a follow up meeting a few weeks after the interview to cover any missed areas and to make sure that I have understood what was said to me. It is also an opportunity to address any lasting effects your participation may have had on you. It is your choice whether or not you want to attend this meeting. At the end of the study, you will be offered a summary of the research findings to keep.

This study is being done by Leah Palmer, a student at McMaster University, and is being supervised by Dr. Susan Watt, a professor at McMaster University. The Research Ethics Board at McMaster University has also reviewed and approved it. If you have any concerns or questions about your participation in this research, you can contact the Board at 905-525-9140 ext. 23142.

APPENDIX D-2

MCMASTER UNIVERSITY LETTERHEAD

Understanding the Health and Health Care Needs of Low-Income Women

Consent Form

I agree to participate in this study about the health and health care of women who have low-incomes. I have been told about this study and I understand what the study is for.

I know that Leah Palmer is a graduate student at McMaster University and she is the person who is doing this study. I know that she is being supervised by Susan Watt, who is a professor at McMaster University with the School of Social Work.

I agree to take part in one interview that will last about 1 hour. I know that the interview will be taped, some notes might be taken and the information will be used later in a research report. I understand that I will be asked questions about my health and health care experiences as well as some other personal information like my age, ethnic background and so on. It is my choice which questions I want to answer.

I know that I can decide whether or not I want to answer any of the questions at the time of the interview.

I understand that I will be invited to a follow up meeting a few weeks after the interview to cover any missed areas and to make that the interviewer has understood what was said. It is also an opportunity to talk about any feelings I might have because of my participation in this study. It is my choice whether or not I want to attend this meeting.

I understand that I can stop participating in the study at any time without a problem and that if I do, any information I have provided will be destroyed.

I have been told that my information will be kept private and confidential. My name will not be used and my identity will be protected throughout the study.

Signed: _____
Witnessed: _____
Dated: _____

APPENDIX E-1

Dear ,

Please accept this small gift as a token of my appreciation for sharing your invaluable time, input and expertise around these health and health care issues. You have made not only an important contribution to this area of research, you have also I believe, made an important contribution to the lives of other women who experience the health effects of gender and poverty everyday of their lives.

Thank you.

Leah Palmer

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