"We don't count, we're just not there":

Using feminist action research to explore the relationship between exclusion, poverty and women's health

by

Colleen J. Reid

B.PHE Queen's University at Kingston (1993)
B.A. Queen's University at Kingston (1993)
M.A. The University of British Columbia (1997)

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

in

INTERDISCIPLINARY STUDIES
(Health Promotion, Women's Studies, Educational Studies)

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

September 2002

In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of _Interdisciplinary Studies_

The University of British Columbia
Vancouver, Canada

Date _October 2, 2002._

Abstract

One of the greatest social injustices is that people who are marginalized experience more illnesses, disability, and shorter lives than those who are more affluent (Benzeval, Judge, and Whitehead, 1995). In this dissertation I critique the notion that health is affected by poverty through primarily material factors. In fact, poor women are systematically excluded from resources and opportunities to pursue their health. This feminist action research project addressed how poverty and exclusion influenced poor women's health, examined how a group of women negotiated their experiences of poverty and health, and developed action strategies to address their shared concerns.

For 1 ½ years I worked with a group of 30 poor women and gathered qualitative data from 15 meetings, 32 interviews, and 30 sets of fieldnotes. The women lived in material deprivation and could not afford the most basic living necessities. They felt stereotyped, excluded, and invisible in their every day lives. The stereotype of the "welfare recipient" fueled institutional stigmatization and surveillance. Welfare, health care, and community recreation workers were threatening, withheld important information, and limited the women's access to services through discriminatory practices and policies. The women had limited access to health-promoting resources, and their interactions with authorities were shaming which negatively influenced their psychosocial health through stress, depression, low self-esteem, and anger. Services that were meant to help them labelled them as poor and humiliated them. The women's shame, material scarcity, and limited access to resources engendered feelings of lack of control and hopelessness and influenced their health.

The women's varied discourses of poverty and health reflected attempts at finding legitimacy in a society that systematically excluded and de-legitimized them. Through their conversations and our feminist action research work together, they uncovered legitimate identities within experiences of poverty and ill-health and advocated action and social change. They cited a "livable" income, accessible health-promoting resources, and redressing stigmatizing practices and policies as changes required to improve their health. These findings confirmed that the social determinants of health must be reframed to better understand the effects of exclusion on poor women's health and that inclusion, respect, and dignity are fundamental conditions for promoting health.

Table of Contents

List of Figures and Tables

Acknowledgements

This dissertation would not have been possible without the participation of the following "WOAW women" – Alexa, Arlene, Caroline, Cassie, Christine, Cynthia, Elizabeth, Gloria, Helen, Joanne, Julie, Katharine, Kelly, Maey, Martha, Rene, Susan, Theresa, Trina, Virginia Dawn, Wanda, and Willow. I learned and grew from our work together; they taught me what it means to be truly courageous, strong, and committed. Working with them leaves me hopeful that social change is possible. I would also like to thank the WOAW organization and the community service providers who warmly welcomed me – Louise Hara, Carla Alexander, Brenda Devine, Jim LaCroix, Gwen Wong, Andrea MacDonald, Diane Lego, Pam Bailey, and Bonnie Ste. Croix. I am inspired by their tenacity and dedication to their work. I would especially like to thank Louise Hara for helping me to better articulate my research interests and determine the need for the Research Team.

Dr. Allison Tom, my research supervisor, is a remarkable mentor and friend. With her uncanny ability to get to the core of difficult research issues and think deeply and analytically she enabled me to find the clarity and direction I needed. Allison shared my enthusiasm for my research while challenging me with humility and compassion. I thank Allison for enabling me to find my voice as a feminist researcher. Dr. Wendy Frisby, my Master's advisor and Ph.D. committee member, provided me with the opportunity to work with WOAW. We have shared the ups and downs of community-based research and I have learned from her insight and commitment to the ideals of feminist action research. I would also like to thank Dr. Carol Herbert, who despite moving to London Ontario remained an invaluable and active committee member, and to Dr. Penny Gurstein, who supported and encouraged me all along the way.

There were two groups of students who greatly enhanced my doctoral work at UBC – the WOAW Working Group and Ournet. The WOAW Working Group, including Pamela Ponic, Sydney Millar, and Beth Pinnington, has been my sustenance for the last three years. Our discussions and support for one another transformed my Ph.D. from an often lonely and isolating experience to one of connectedness and sharing. I would particularly like to thank Pam for her insight and intellect. Together we have dissected challenging research issues, written papers and presentations, and openly shared our own biases and assumptions. Ournet provided a rich learning environment that stimulated me both intelllectually and emotionally. In particular I'd like to thank Marina Niks, Lynette Harper, and Johanna Kuyvenhoven for the conversations, passion, and friendships we have shared.

Finally, I thank my family. My parents, Heidi Reid and Gordon Reid, have always instilled in me a sense of confidence and possibility. They encouraged me to pursue my passions and to never compromise my interests for the sake of conventions. My sister, Heather Reid, has expanded my world vision through helping me connect authentically with my work. My life partner, Rod Tukker, has been a pillar of support and encouragement every step of the way. He has facilitated this journey in innumerous ways. I feel such gratitude having you in my life – thank you.

Prologue

When I was eighteen, a friend of mine worked for Ottawa Parks and Recreation as a wading pool lifeguard. She told me that the job was fun and social and that as a lifeguard you worked outside all day and programmed activities for children in the local area. I was hired and stationed at a pool in one of the lowest income areas in Ottawa. Over that summer I witnessed unbelievable stories of deprivation and hopelessness – a four year old child at the pool for 10 hours a day with no food, teenagers selling merchandise they had stolen the day before, a six year old girl babysitting her two year old brother, a twelve year old girl telling me that she wanted to be a "hooker" when she grew up. Almost every day someone asked me for money and my lunch. I saw parents who were so impoverished that they could not provide a secure home for their children; most of them lived in violence and scarcity in what the local residents called "the foster farm." What truly amazed me, however, was not the extent of the deprivation, but how, despite living only 10 minutes apart, we had drastically different trajectories of every day life. My security and sense of reality, that were nestled in my suburban middle-class upbringing, became unhinged; poverty and my own privilege were now visible to me.

Watching the news coverage of the Montreal Massacre in 1989 was another experience that profoundly shifted my worldview. As I watched the paramedics carry the women's bodies out of the engineering building, I saw parents and friends approach the scene, confused and panicked. I remember seeing a bewildered boyfriend learn that his girlfriend had been murdered. I was stunned that such an act of violence, injustice, and hate could occur, and realized that this event could just as easily have happened in one of my classes at Queen's University. I could have been one of the women being carried out on the stretcher.

I now recognize how these experiences – my work at the wading pool and watching the

Montreal Massacre – had a formative influence on what I am pursuing today. They led me to identify with the feminist movement and to uncover my passion for examining social injustices, reflecting on my own assumptions and privilege, and understanding women's roles and experiences. I now believe that through remaining compassionate and humble every person has a role to play in the pursuit of social justice. Fundamentally, this dissertation is my attempt at taking part in the work of social justice.

> Justice to me is a warm spirit, born of tolerance and wisdom, present everywhere, ready to serve the highest purposes of rational wo/man. To seek to create the just society must be amongst the highest of those human purposes. Because we are mortal and imperfect, it is a task we will never finish; no government or society ever will. But from our honest and ceaseless effort, we will draw strength and inspiration, we will discover new and better values, we will achieve an unprecedented level of human consciousness. On the never-ending road to perfect justice we will, in other words, succeed in creating the most humane and compassionate society possible. *Pierre Elliott Trudeau*
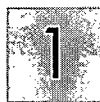
Introduction

The economy is stacked this way and the social situation is stacked this way and the problems you're having are certainly not of your own making. And when you understand what's working against you out there, you feel much stronger to face up to it.... You're a human being and you deserve dignity and you should have some rights, when you're not fully aware of what the society... it's our food, it's our politics, it's our institutions (Helen, RTM June 7, 2000).

Global Trends: Poverty and Exclusion

In the last sixty years major transformations in economic, social, and political systems have occurred. Arguments for social progress and increased economic efficiency have rationalized the deregulation of global markets, the development of supra-national institutions, and the decreasing role of government. These globalization[1] trends support a reduced role of government because of the purportedly "self-regulating" nature of global economies and the threat of government intervention to economic processes. Governments increasingly support corporate interests and sanction industry relocations to places where labour costs are lower, unions are non-existent, and state regulations are less expensive (Fine and Weis, 1998). Although corporate-centered trade has displaced jobs, capital-intensive investment remains in North America. With the reduced role of government, job displacement, and accumulation of capital, the wealthy become wealthier and income distribution widens.

Not only have globalization trends meant that fewer jobs are available to poor and working-class people, but Canada's welfare state has also been affected. "Amid globalization, the increasingly transnational activities of the private sector circumvent and even undermine the

capacity of individual countries to ensure social protection and welfare. Countries competing for foreign investment may reduce their social policy standards to be more economically attractive" (Bettcher and Lee, 2002, p.10). As a consequence of political and economic trends that favour corporate interests, in the early 1980s the welfare state entered a fiscal crisis and lost legitimacy. The principle of universality in government services was blamed for excessive spending, inordinate bureaucratization, and halted economic progress (Harvey, 2001). The diminution of manufacturing-based employment, twinned with the shredding of the public safety net, produced conditions that exacerbated the growing inequality between the rich and the poor (Fine and Weis, 1998). Indeed, "the legacy of the 20th century is the cynical defeat by capital and the state of social equality" (Fine and Weis, 1998, p.258).

An important aspect of the legacy of the 20th century is the spilling over of the self-interested individualism of the marketplace into other areas of social life (Wilkinson, 1996). At the centre of the concept of individualism is the practical separation of each person's interests and identity from those of others. According to Wilkinson (1996), individualism is most fundamentally expressed by the role of cash in a market economy as we earn and spend our "living," opposed as buyers and sellers in the marketplace. Everyone is dependent on their individual incomes, and any acknowledgement of others' needs is perceived to endanger the sufficiency of one's income and security to meet one's needs (Wilkinson, 1996). With the loss of community and rising individualism, people tend to assume that their position in society is a reflection of their innate worth and that the poor are the principal authors of their own fate (Harvey, 2001).

The logic of possessive individualism that is engendered with globalization limits some people's rights and their ability to fully function in society. The notion of participation affirms the human right of persons to contribute to decisions that affect them, and is also fundamental

to human flourishing. Those who conform to the market-driven ideals of individualism are included in society and can participate, while those who fall outside of the criteria for inclusion and participation, because they are single mothers, sick, disabled, or poor – because they are dependent – are excluded (Reason, 1998). Exclusion involves disintegration from common cultural processes, lack of participation in societal activities, alienation from decision-making and civic participation, and barriers to employment and material resources (Raphael, 2001). Individualism has changed the nature of public life such that human interaction has become dominated by the asocial values of the market (Wilkinson, 1996). These asocial and individualistic values that drive the economy and human interaction legitimize exclusion and the withholding or denial of an individual's right and need to participate equitably in society.

Women's Health and Social Justice

In almost any developed society people lower down the social scale may have death rates two to four times higher than those nearer the top; more egalitarian societies, that is societies with smaller differences in income between rich and poor, tend to have better health (Wilkinson, 1996). As health and society are closely related, learning about society can teach us about health, and learning about health can teach us about society. Increasing poverty and income inequality are mirrored by increasing health inequalities (Wilkinson, 1996; Shaw, Dorling, and Smith, 2000). The social and economic structure of society, especially low income, income inequality, discrimination, and social exclusion, can be seen as the ultimate determinants, the "causes of the causes," of disease and death (Deaton, 2002).

In Canada, there is rising poverty, inequality, and unemployment alongside reductions in social, health care, and community services. Socio-demographic changes, aging populations, and rising numbers of lone parents also contribute to social inequities and a greater proportion of people living in poverty. A purpose of this dissertation was to better understand how a group of

3

women on low income[2] understood and experienced poverty and health. The societal trends of increasing individuation, reduced social cohesion and community, and the exclusion of the poor suggest that better understanding the relationship between exclusion and women's health is relevant and timely. Social inequities' assault on health is indeed too significant to be ignored.

Health inequities are also significant because health is widely recognized as a fundamental right of citizenship "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economics, or social condition" (WHO, 1948; cited in Hankivsky, 1999). In that vein, health is a social justice issue – "it is one of the greatest of contemporary social injustices that people who live in the most disadvantaged circumstances have more illnesses, more disability, and shorter lives than those who are more affluent" (Benzeval et al., 1995, p.1). According to Young (1990), social justice concerns the degree to which a society contains and supports the conditions necessary for all individuals to exercise capacities, express experiences, and participate in determining actions. Social justice requires not the melting away of difference, but the promotion and respect for group differences without oppression (Young, 1990). If there is not a sense of social justice in society, then the legitimacy of social institutions is fundamentally weakened and the moral community which makes social life coherent is lacking (Wilkinson, 1996). Numerous international platforms explicitly focus on women's right to health as an integral component of human rights protection and promotion.[3] International conventions, documents, and platforms obligate the global community, including Canada, to take concrete action to eliminate all forms of discrimination against women. Importantly, it is not enough to state or recognize human rights, rather, conditions must exist in which they can be exercised and realized (Hankivsky, 1999).

Health can be seen as a social justice issue since social justice is concerned with creating the

opportunities for attaining full health potential and reducing health inequities (Hankivsky, 1999). Equity refers to conditions largely out of individuals' control that create unjust differentials in health.[4] Lack of power at the individual, community, and societal levels is a major risk factor for poor health. Empowering the disadvantaged – or disempowering those who use their privilege to benefit themselves at the expense of the wellbeing of the community – is an important tool for health promotion. Protecting and restoring health involves a social justice ethic based on collective action and fair play that respects individual rights and experiences (Wallerstein and Freudenberg, 1998).

The Role of Feminist Action Research

The social transformations arising from globalization, mounting rates of and concerns about exclusion, and the rise of poverty and income polarization, are reasons for rethinking how we conceptualize and study poor women's health (Harvey, 2001). Social justice is not only a way of seeing the world, it can also inform how research is conceptualized and conducted. It is possible to locate issues of social justice front and centre on research agendas through carefully appreciating the political nature of research (Poland, 1998). To develop theories and methods to examine social injustice profoundly influences how we engage with marginalized groups and conceive our role as researchers (Wilkinson, 1996).

Feminist action research (FAR) is a conceptual and methodological research framework that is fundamentally about exploring and pursuing opportunities for social justice. Feminist action researchers explicitly center women's experience and diversity in practical and explanatory frameworks (Maguire, 1987) and apply the principles of inclusion, participation, action, social change, and reflexivity throughout the research process. Feminists envision justice as according respect and participation in decision-making to those who are dependent (Young, 1990). FAR's methods aim to open horizons of discussion and to create spaces for collective reflection in

5

which new descriptions and analyses of important situations may be developed as the basis for new actions (Greenwood and Levin, 1998).

The second purpose of this dissertation was, through applying FAR principles, to examine the process of working collaboratively towards social change. As a project manager and doctoral researcher I worked with a collective organization named "Women Organizing Activities for Women" (WOAW). WOAW was a partnership between university-based researchers, community service providers, and women on low income that explored and addressed a group of marginalized women's barriers to meaningful participation in their communities. The complex structure of WOAW enabled different kinds of participation for all of the members. Most of the women on low income participated in WOAW's activities, including community recreation, workshops, and social activities. Many WOAW members were involved in WOAW's organizing, such as attending meetings, planning workshops, and coordinating activities. Research was the third component of WOAW. The Social Sciences and Humanities Research Council of Canada (SSHRC) provided three years of funding to examine women on low income's health problems and different forms of community organizing; over half of WOAW members were involved in the SSHRC research. As researchers we, a group of professors and graduate students at the University of British Columbia (UBC), conducted interviews and focus groups and recorded fieldnotes for most WOAW meetings.

For a year and a half a group of the women on low income and I worked together as the Research Team. It was with the members of the Research Team that I conducted the research for this dissertation – the one-on-one interviews, group meetings, participant observations, and fieldnotes. I posed three research questions: (1) How did a group of women on low income understand and negotiate their experiences of poverty, exclusion, and health, both individually and collectively? (2) From the perspectives of a group of women on low income, what was the

connection between poverty and health? In what ways did they believe that the experiences of exclusion, stereotyping, and invisibility affected their health? and (3) How did a group of women on low income collaboratively identify, organize, and enact action towards social change to address their shared concerns?

In framing these research questions I attempted to avoid dichotomizing individual volition and societal determinism. In other words, to entirely focus on the individual risks privatizing by rendering personal the social and economic underpinnings of poverty and powerlessness, yet focusing only on structural issues may ignore "the immediate pains and personal woundings of the powerless and people in crisis" (Labonte, 1994, p. 259). I hoped to portray the complexity of the women's personal experiences, strengths, and abilities, and the structural constraints they faced. The process of exploring the women's shared constraints and experiences of poverty and health was guided by feminist action research. An examination of ideals and realities of inclusion, participation, action, and social change underpins the third research question.

Representational Challenges: My Voice as the Researcher

For a novice feminist action researcher, working with WOAW as a project manager and doctoral researcher was a unique and formative experience for which I am deeply grateful. Importantly, the proceeding analysis reflects how I experienced WOAW and the Research Team and is by no means a complete picture of all that occurred with this complex organization and its diverse members. As Wendell (1996) wrote, "I do not imagine that my own worldview is complete or even very accurate" (p.104). My analysis is indeed only a partial picture that is conveyed through the lenses of my personal experiences, assumptions, and worldview.

In this dissertation I position myself as a feminist conducting feminist action research. In the "rendered accounts" that follow I have attempted to hold myself accountable both to the research participants and to myself for my critical analysis and responsible use of power (Ristock

and Pennell, 1996). This involved significant representational challenges. I am a white, middle-class, heterosexual, educated woman speaking about the "Other"[5] – in this case a group of marginalized, stereotyped, and poor women. Under assumptions of finding a less exploitative approach to research, feminists previously sought counter-practices of knowing such as articulating personal voices and practices of co-writing. However, no longer can feminists assume "innocence" in a desire to give the voiceless a voice. Judith Stacey (1988) interrupted this drive to innocent knowing with focusing on the inescapable power imbalances of inquiry situations, feminist or not. She suggested that by setting itself up as better intentioned, feminist research risked even greater violation of the researched than the more distanced objectivity of conventional research methods (Lather, 2001). My representational efforts did not assume a cure or a solution, nor did I wish to join "the university rescue mission in search of the voiceless" (Visweswaran, 1994, p.69; cited in Lather, 2001). It is necessary to focus on the limits of our knowing and to also acknowledge that texts are inevitably and always a site of failures of representation (Lather, 2001).

What remains from these feminist dilemmas is a necessary tension between the desire to know and the limits of representation that enabled me to question my authority without paralysis. My research was explicitly interdisciplinary and involved a blending of literatures from different voices, languages, research methodologies, and conceptual frameworks. In this text there are multiple approaches that endorse complexity, partial truths, and multiple subjectivities (Lather, 2001). Metaphorically, this dissertation can be envisioned as a crystal, with each chapter a side of the crystal that illuminates an aspect of the women's lives. In approaching each chapter as a partial story or piece of the whole crystal, I attempted to layer complexity, foreground problems, and displace the privileged fixed position from which I interrogated and wrote about the researched (Lather, 2001). Each chapter has a different perspective, voice, and body of

literature that informed it, and I positioned the women's experiences alongside my theoretical analyses. In my representational efforts I "both got in and out of the way " (Lather, 2001, p.215).

Overview

This dissertation has eight chapters. In chapter 2, I review literatures that range from social epidemiology, women's health, discourses of poverty and health, to feminist action research. I argue that a theory of cultural, institutional, and material exclusion advances understandings of poor women's health and that a feminist action research framework can facilitate such understandings while moving towards collective action. The research context, "Women Organizing Activities for Women," and the research methods are described in chapter 3. In this chapter I provide detailed descriptions of the research methods and analysis, my influence as the researcher, and the challenges of reflexivity, representation, and trustworthiness.

Chapters 4, 5, 6, and 7 comprise the analytic sides of the crystal. Chapter 4 is an overview of the women's lives and experiences. This side of the crystal is data-rich and descriptive. On chapter 5's side of the crystal, I explore how the theory of exclusion arose from the data and argue that exclusion has a serious influence on the women's health in terms of shame, material deprivation, psychosocial health conditions, and health behaviours. In chapter 6, I interpret the data on a discursive level by making the women's discourses themselves the object of study. I present the ways the women negotiated their lives and experiences and sought legitimacy and power in a society that systematically excluded and "othered" them. Chapter 7's side of the crystal provides an analysis of the Research Team through drawing on the principles of feminist action research that were described in chapter 2 – inclusion, participation, action, social change, and researcher reflexivity. I explore my role as the feminist action researcher and my emotional reactions to the research process. The exploration of my role, experiences, and emotions is at the end of this chapter because I did not want to foreground the women's experiences with my own

9

reflections. Finally, in chapter 8 I argue that health is a social justice issue and suggest policy and research recommendations.

In this dissertation I attempt to provide as complete a picture as possible of a group of poor women's exclusion and health and their experiences in a feminist action research project. Yet, "fieldwork is a morally ambiguous enterprise. The question for me is how to show respect for the people I write about, given the impossibility of complete sincerity at every moment" (Duneier, 1999, p.336). I wrote to inform rather than to impress and to openly portray the women's experiences and myself within and throughout their experiences (Duneier, 1999). In striving to write with compassion, humility, admiration, and outrage, I "practiced presence."

> Being present invites us to set aside judgement yet still retain discernment, to set aside sympathy yet hold to empathy, to set aside power yet be responsible for influence. It invites us to bring head, heart, and body into this moment (Woodman, 2001).

Notes

[1] **Globalization** can be defined as a set of processes leading to the creation of a world as a single entity, relatively undivided by national borders or other types of boundaries such as cultural or economic. Globalization contributes to intensified human interaction in a wide range of spheres (economic, political, social, environmental) and across three types of boundaries – spatial, temporal, and cognitive – that have hitherto separated individuals and societies. It also influences the timeframe of human interaction and thought processes (Bettcher and Lee, 2002).

[2] The research participants used the terms "poor women," "low-income women," "women on low income," "women with limited resources," "women facing barriers," and "isolated women" alternatively. There was tension and disagreement around the use of terms such as "poor" and "low income." Given that there was no consensus among the women, both "women on low income" and "poor women" are used throughout this dissertation.

[3] According to the United Nations Social and Economic Council (1999), "the realization by women of their right to the enjoyment of the highest attainable standard of physical and mental health is an integral part of the full realization by them of all human rights, and that the human rights of women and the girl child are an inalienable, integral, and indivisible part of universal human rights" (cited in Hankivsky, 1999).

[4] "If you live longer than I do or if you suffer from less sickness and disability, our health status is **unequal**. There is inequality between us, but not necessarily inequity. The difference may not result from our living conditions which may be essentially the same, but from accidents, genetics, and life choices. If however, the differences in our health status result from different living conditions, mine being less satisfactory than yours, a question of **inequity** arises. I may have less access to nutritious foods, difficulty in finding decent housing or high-quality health care sensitive to my particular needs. My income may be lower, and my work stressful and demoralizing, punctuated by frequent periods of prolonged unemployment. In this case, inequalities in health status are the result of inequities in life" (Draper, 1989; cited in Hankivsky, 1999).

5 The term "Other," as defined in chapter 2, is used throughout the dissertation. I distinguish it from common usages of the word other by capitalizing it – Other – and, when necessary, marking it with quotations – "Other." At times I have also used the terms "othering" and being "othered" to capture the process of being designated the Other.

2

Poverty, Exclusion, and Women's Health:
Using Feminist Action Research to Problematize and Address Poor Women's Health

> Having no money is a prison in itself. You can go nowhere. The only thing you can do is take a walk. You have no power, having no power you have no self-esteem.... I have to rebuild my life. How do you rebuild your life, how do you believe in yourself? Because we're brainwashed every day with these subliminal messages of people looking down on you 'cause you're on welfare. All this is very powerful. It's imprinted on the mind and you suffer it. Your mental plane, emotional plane, and everything suffers. So you're down (Katharine's interview, March 14, 2000).

Although lack of access to effective medical care is likely to lead to unnecessary illness and suffering, there are inequalities in the onset of new disease, which are not related to medical care, and inequalities in mortality from diseases which are not always amenable to medical intervention (Marmot, 2000). In fact "to understand health or illness one must understand the social conditions in which health and illness are created, identified, defined, and continued" (Virchow, cited in Whiteford, 1996). The poor are often in bad health not from their own negligence, but from social conditions that systematically deprive them of resources and from historical conditions that isolate them (Whiteford, 1996).

In this chapter I review literature from divergent fields of research including discourses of poverty and health, social epidemiology, women's health, feminist theory, and feminist action research. I review the dominant discourses of poverty and health in order to provide a broad landscape for locating poor women's experiences of health. I then argue that adopting a social determinants perspective is most suitable for studying poor women's health. Although the health

equity field's conceptualizations of the relationship between poverty and health have advanced understandings of the social determinants of health, they have not fully captured women on low income's lived experiences. As a consequence, I propose a theory of cultural, institutional, and material exclusion. Through proposing a theory of exclusion, I contribute to conceptualizations of poor women's health and the ways that women on low income negotiate their day-to-day lives. In the final section of this literature review I explain the genesis and principles of feminist action research (FAR), how the use of FAR can elucidate and address poor women's health, and the ways that it is a viable research framework for the work of collective action.

The Dominant Discourses of Poverty and Health

A discourse is a socially structured way of knowing that affects our subjectivity and social relations (Weedon, 1987). Discourses are sets of shared and often unconscious assumptions reflected in language that position people in relation to one another and frame knowledge (Ristock and Pennell, 1996). Discourses co-exist and compete with each other; some discourses are marginalized while others are authoritative and dominant (Fraser, 1992; Kelly, 1996; Batsleer and Humphries, 2000). Although societies contain a plurality of discourses and discursive sites and a multitude of positions and perspectives from which to speak (Fraser and Gordon, 1997), the dominant discourses of poverty and health reflect ideological agendas that are both historically specific and socially situated signifying practices.

The Dominant Discourse of Poverty

The dominant discourse of poverty is framed in terms of welfare dependency. As Fraser and Gordon (1997) argue, in the 16th and 17th centuries dependency was seen as a normal condition – a social relation associated with wage labour – and was not seen as an individual character trait. Independence was associated with privilege, superiority, increased political rights, and freedom

from labour. In the 18th and 19th centuries dependency shifted and was framed as both a social relation and an individual character trait. Positive images of independence proliferated while dependence was seen as antithetical to citizenship. Any work associated with remuneration, including wage labour, became associated with independence, while people excluded from wage labour were personified as dependent. Increasingly, as can be seen in stereotypes of the "pauper" who lived on poor relief, character defects were believed to cause poverty (Fraser and Gordon, 1997).

Currently the dominant discourse of poverty has two dimensions. The rhetoric of pauperism and the theory of the culture of poverty contend that poor and dependent people have something more than lack of money wrong with them. The flaws can be located in biology, psychology, upbringing, or neighborhood influence. The properties once ascribed to social relations become inherent character traits of individuals or groups, as if the social relations of dependency are absorbed into personality. The dominant discourse of poverty is also based on the economic premise of a "rational man" who faces choices in which welfare and work are both options. Whether poverty is a consequence of individual character flaws or notions of choosing or not choosing work, this discourse suggests that "dependents" have free will and control over their dependency (Fraser and Gordon, 1997).

Today "dependency" is an ideological term that most often refers to the condition of poor women with children who maintain their families with neither a male breadwinner nor an adequate wage and who rely for economic support on the government. Social and economic problems are blamed on women rather than on the profit-oriented decisions of business and the state (Abramovitz, 1995). Naming the problems of poor families as dependency tends to make them appear to be individual problems (Fraser and Gordon, 1997). Since welfare dependency is an individual character flaw or a consequence of bad decision-making, women on welfare "are

depicted as ...embodying the necessity for welfare reform and of sitting at the heart of moral decay" (Fine and Weis, 1998, p.1). Thus poor women are thought to have no self-control, choose poverty and dependency, and illegitimately cost hard-working taxpayers money.

The dominant discourse of poverty moralizes welfare dependency as a consequence of character flaws or irresponsible decision-making. The notion of individual "free will" that underlies the dominant discourse of poverty bolsters the assumption that equality of opportunity exists and individual merit determines outcomes (Fraser and Gordon, 1997). As individuation increases, interdependence is no longer understood as a necessary condition for autonomy and citizenship. "Dependence on welfare" is not something to expect at some point in our lives but a position to be avoided at all costs (Batsleer and Humphries, 2000). Consequently, dependency becomes increasingly illegitimate and any self-evidently "good" adult dependency in postindustrial society disappears. All dependency is suspect, and independence, which remains identified with wage labour, is enjoined upon everyone. Thus the worker becomes the universal social subject – everyone is expected to work and to be self-supporting. Any adult not perceived as a worker shoulders a heavier burden of self-justification (Fraser and Gordon, 1997).

The disappearance of "good" or legitimate dependency in our increasingly individualistic society has heightened the stereotype of those dependent on B.C. Benefits[1] and the welfare system itself. The welfare system is highly stigmatized, imbued with stereotypes, and portrayed as undermining motivation and accentuating an underclass mindset. With no legitimate dependency, welfare is questioned for promoting "out-of-wedlock" children and discouraging women from accepting jobs. Indeed, with the disappearance of "good" dependency, the stigma of poverty has reached unparalleled levels.

The Dominant Discourses of Health

"Health" provides the perfect metaphor for values that fundamentally structure our social

and cultural life (Crawford, 1984). We affirm each other and ourselves as well as allocate responsibility for failure or misfortune, through shared images of wellbeing. Just as the dominant discourse of poverty structures lived experiences for both the impoverished and the rich, the dependent and the independent, health has become a theme in day-to-day living. Thus the link between society and health not only serves to help us understand the cause of ill-health and disease, as health equity researchers[2] argue, but it enables people to understand themselves in relation to others. The link between society and health has implications for how health is defined and understood. The ways that we conceptualize, speak and write about health are never just about health; they also function as repositories and mirrors of our ideas and beliefs about human nature and the nature of reality, as well as about the kind of society we imagine creating and how best to achieve it (Robertson, 1998).

Unlike the dominant discourse of poverty, there are three dominant discourses of health – biomedical, individual responsibility, and social determinants discourses. Throughout the 19th and 20th centuries the biomedical discourse prevailed. Health was seen as the absence of disease, and managing health and preventing disease gave rise to the power and predominance of medical institutions, personnel, and texts. Increased medicalized practices dominated expenditures on health and the treatment of disease, and the provision of universal health care, which was instituted in 1968, remains the cornerstone of the Canadian welfare state.[3] As such the biomedical health discourse discredited the possibility of individual free will through locating the etiology and progression of ill-health, disease, and disability in biology and genetics and under the management of medical experts. Alongside the continued dominance of the biomedical discourse is the behavioural health discourse. Embedded within this discourse is the notion that poor health is an individual failing, inferring individual decision-making, a lack of education, and moral laxity on those who are unhealthy. Within this discourse health is an

important means for the middle class to structure its own class identity. Through manipulating this discourse the middle-class identifies itself as most capable of hard work, self-denial, asceticism, and clean living (Crawford, 1980). Everyone has free will, and the biological, structural, and systemic dimensions of health are disregarded.

The biomedical discourse is exercised through "expert" knowledge and professional practices and the concomitant passivity of the receptacles of expert knowledge, the patient. The classist behavioural health discourse is sustained by the dominant middle-class which has the resources and time to adhere to particular health expectations. While the biomedical discourse of health places individual control and choice in the authority of medical experts, the behavioural discourse shames and views them as deviant and inferior non-conformists because they are unhealthy "on purpose" and have insufficient resolve to exercise more, to quit smoking, and so on (White, Young, and Gillett, 1995). Individuals, who for reasons beyond their control have neither the time nor the resources to apply to health management, are blamed for their failure to live up to their social responsibility for their own bodies (Labonte, 1982). Being ill means being guilty, the obese have let themselves go, smokers have no will-power, and non-aerobics are lazy (Becker, 1986). These dominant health discourses blame the victim or abstracted biological processes for ill-health, thus diverting attention from systemic, social, and structural factors that compromise the health of many.

The social determinants of health discourse adopts a more ecological and sociological perspective and is tied to distal determinants of health including poverty, gender, race, ethnicity, and culture (O'Neill, Rootman, and Pederson, 1994). According to O'Neill, Rootman, and Pedersen (1994), the evolution towards a social or ecological view of health has enabled a broader conception of health to emerge. Krieger and Zierler (1995) contend that social, economic, and political conditions shape distributions and determinants of health, disease, and

wellbeing. Intervening in the public's health necessitates politics to reduce social and economic inequalities, curb environmental degradation, and increase options for social and individual action to improve health (Krieger and Zierler, 1995). Poverty's adverse effects of material deprivation and the home and workplace environment are seen to negatively affect health. As well, the social determinants of health discourse recognizes social class differences in health behaviour, and sets health behaviour alongside and in the context of the everyday circumstances in which people live and work. These factors are seen to shape and constrain what individuals can do to promote their health, setting limits on the choices they can make about their lifestyle (Graham, 1990).

The dominant health discourses differently locate the power of the individual in exercising free will. The biomedical health discourse presents genetic and biological factors as the cause of ill-health and disability, while the social determinants of health discourse argues that social, political, cultural, and economic factors cause the vast majority of disease and disability. In both discourses the notion of free will is challenged and the individual, for different reasons, has little or no control. The personal health behaviours and lifestyle discourse mirrors the dominant discourse of poverty, suggesting that most health conditions are an individual responsibility and a consequence of poor decision-making, while good health is a matter of individual choice and control.

A hegemonic middle-class perspective is evident in both dominant discourses of poverty and health, and in some cases one is adopted to support the other. Dominant poverty and health discourses present the controlled and healthy body as a symbol of moral rectitude and class association (White et al., 1995). "The ethic of health is often like the ethic of work... the Protestant world view extends to the body" (Crawford, 1984, p.67). The negative connotations of "welfare dependency" are supported by the biomedical and behavioural health discourses that

associate dependency with pathology and individual actions. Likewise, in 1987 the American Psychiatric Association newly coined "dependent personality disorder," a disorder most common in women, as an official psychopathology in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R). The stigma of dependency has escalated to such heights that both the biomedical and behavioural health discourses are used to enshrine dependency as a moral and psychological personality disorder, while undermining the possibility that dependency is a social relation of subordination or that interdependence is socially necessary (Wendell, 1996). Indeed power and domination tend to disappear (Fraser and Gordon, 1997).

Understanding Poverty, Inequity, and Women's Health

In order to explore the relationship between poverty and women's health, a social determinants of health perspective is most appropriate. This perspective acknowledges that individual change can rarely be achieved without harnessing social and environmental supports at a community level. The social determinants of health, however, have been interpreted and implemented in a variety of ways. Within this perspective, an individualistic approach often prevails – the individual is called upon to address the negative health effects of her oppression. For instance, in a recent study of 199 Canadian health care initiatives, the effects of poverty were addressed three times more often than were poverty's root causes (Williamson and Green, 1999).

Despite problems with the interpretation and implementation of a social determinants of health perspective, it remains the most fitting perspective for understanding and addressing poor women's health. The experiences of being stereotyped, excluded, and made invisible are closely connected with social, cultural, and economic circumstances. If a woman does not fit within dominant middle-class discourses because she is a single mother who lives below the poverty line, she is stereotyped, marked out as the Other, and excluded from society. Thus understanding the dominant discourses of poverty and health are important for grasping

18

hegemonic conceptions of poverty and health, how people make sense of their experiences, and how some people are excluded, stereotyped, and invisible because they do not fit dominant criteria for belonging.

Significantly, health equity researchers have advanced understandings of the relationship between poverty and health and have proposed ways to address health that do not rely on an individualistic discourse. Although the health equity field's conceptualizations of the gradient of health are useful, women's diversity and experiences remain inadequately conceptualized and measured. In this section I explore the major arguments forwarded by the health equity field and how these arguments both advance understandings of women's health and are gender-blind.

The Gradient of Health

One of the most pervasive and enduring observations in public health is the "gradient of health." This gradient can be pictured as a line on a graph that remains consistent across sex, age groups, cultural groups, countries, and diseases. The gradient of health shows that people who have the lowest socioeconomic status (SES)[4] experience the highest rates of mortality and morbidity. As people move up the socioeconomic gradient, their health improves relative to the gradient (Deaton, 2002; Reid, 2002).[5]

There have been widespread efforts directed at finding plausible explanations linking socioeconomic status and health outcomes. Hypothesized explanations for this relationship include artifacts of measurement, health-related social mobility, biological and genetic factors, health-related behaviours, access to and use of health care services, exposure to different environments at home and at work, and psychosocial factors (Adler et al., 1994). Some researchers have examined the possibility that health is "self-selecting," in that health is a major determinant of life chances. This implies that health "selects" people into different social strata and that ill health leads to lower position in the social hierarchy. Poor health selects people who

have a job with fewer opportunities for control, who are at risk of unemployment, who live in deprived neighborhoods, who have fewer social networks, and who eat worse food and indulge in addictive and sedentary behaviour (Marmot, 2000). This hypothesis suggests that people's health is mostly determined independently of the conditions in which they live, and that healthier people are more likely to move up the social pyramid while unhealthy people move down. Two large data sets that have been used to study this possibility found that poor health does affect social mobility but that the size of the effect is too small to account for very much of the overall health difference (Power et al., 1990 and Wadsworth, 1986; cited in Wilkinson, 1996).

Most evidence suggests that the economic, social, and political conditions under which people live their lives are major factors that determine whether they develop illness and disease (Raphael, 2001), and that exposure to unhealthy material circumstances is an indicator of relative income, or social position (Adler et al., 1994; Wilkinson, 2000).[6] Wilkinson (1992, 1996, 2000) suggests that differences in life expectancies between countries can be explained in the first instance by differences in material wealth (GNP). After a certain threshold of material wealth and standard of living have been achieved there is a plateau effect such that differences in life expectancy and mortality rates can be explained by the relative differences in income between the wealthy and the poor. Per capita income is not as strongly related to life expectancy as is income distribution, with longer life expectancy associated with a greater proportion of income received by the least well-off 70% of the population. These effects of socioeconomic hierarchies are most strongly shown within countries rather than across countries, particularly in terms of life satisfaction. Indeed, the relationship between income distribution and health is well supported: alongside over 20 reports of an association between measures of income inequality and population health, there are only two reports (using the same data set) suggesting that the relation is weak or non-existent (Wilkinson, 2000).

The overall health of a society is more determined by the distribution of income among its members than the overall wealth of the society (Raphael, 2001). Since health is powerfully affected by social position and by the scale of social and economic differences among the population, what matters within societies is the effect of social relativities (Wilkinson, 1992, 1996, 2000; Raphael, 2001).[7] The healthiest populations are those in societies that are prosperous and have an equitable distribution of wealth (Wilkinson, 1996; Health Canada, 1997). In the developed world, it is not the richest countries that have the best health, but the most egalitarian (Wilkinson, 1996).

Psychosocial Health and Biological Expressions of Social Inequality

Many health equity researchers argue that social position has its effect on health through psychosocial pathways, and have found that psychosocial conditions influence health and wellbeing (Wilkinson, 1996; Brunner and Marmot, 2000; Wilkinson, 2000; Raphael, 2001). Biological expressions of social inequality are how people embody and biologically express experiences of economic and social inequality and produce social inequalities in health across a wide range of outcomes (Krieger, 2001). Brunner and Marmot (2000) developed a model that links social structure to health and disease through psychosocial, material, and behavioural pathways (Figure 1). Material circumstances are related to health directly and through the social and work environment. These shape psychological factors and health-related behaviours. The psychological and biological factors are the proximal causes of disease and tend to be the main focus of medical attention. These factors are the intermediates on the pathway from the social level to wellbeing or disease in individuals. In sum, social structure influences wellbeing and health, and the effects of social organization on population health are mediated by psychological and biological processes (Brunner and Marmot, 2000).

Figure 1 – The Social Determinants of Health [8]
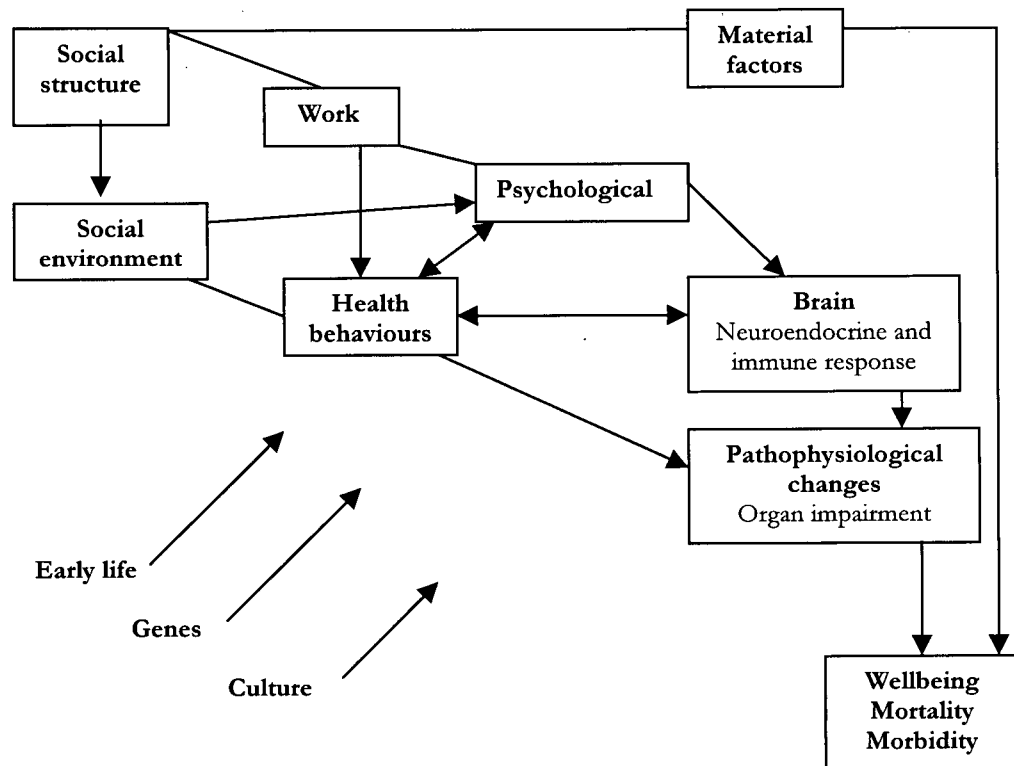
Throughout this dissertation references to psychosocial health include stress, poor social networks, low self-esteem, depression, anxiety, insecurity, and the loss of a sense of control (Wilkinson, 1996). Although stress and depression,[9] in particular, are distinct areas of research and have a number of theoretical and methodological particularities; unless differentiated they are included under the rubric "psychosocial health."

According to Brunner and Marmot (2000), the power of psychosocial factors to affect health makes biological sense. The human body has evolved to respond automatically to emergencies. This stress response activates a cascade of stress hormones that affect the cardiovascular and immune systems. The rapid reaction of our hormones and nervous system prepares the individual to deal with a brief physical threat. The heart rate rises; blood is diverted to the

muscles; anxiety and alertness increase. This response is highly adaptive and may save life in the short term. But if the biological stress response is activated too often and for too long, there may be multiple health costs. These include depression, increased susceptibility to infection, diabetes, high blood pressure, and accumulation of cholesterol in blood vessel walls, with the attendant risks of heart attack and stroke (Brunner and Marmot, 2000).[10]

To emphasize psychological pathways does not mean that the basic cause of the problem is psychological or that it can be dealt with through psychological interventions. The point of distinguishing psychosocial pathways from exclusively material ones is to distinguish the social and economic problems affecting health through various forms of worry, stress, insecurity, from those that – like air or water pollution – affect health through material pathways, even if we are totally unaware of or unconcerned by them (Wilkinson, 1996). People's social and psychological circumstances can seriously damage their health in the long term. Chronic anxiety, insecurity, low self-esteem, social isolation, and lack of control appear to undermine mental and physical health (Brunner and Marmot, 2000). A sense of desperation, anger, bitterness, learned helplessness or aggression are all wholly understandable responses to various social, economic, and material difficulties. Often, prolonged stress from any of these sources is all it takes to damage health (Wilkinson, 1996).

The Health Equity Field: Conceptual Limitations and Oversights

The health equity field and theorizations of the gradient of health have made significant strides in conceptualizing the relationship between socioeconomic status and health. This field of research has given credibility to the social determinants of health perspective and has shifted health understandings from an exclusively biological and biomedical focus towards a more societal one. However, there remain limitations within this primarily epidemiological field, in terms of gender-blind conceptualizations and measurements of socioeconomic status, narrow

explanatory frameworks, a dearth of qualitative studies, and limited conceptualizations of women's health.

<u>Gender-Blind Conceptualizations and Measurements of Socioeconomic Status</u>

Gender is both present and absent in research on the socioeconomic gradient in health – present in the sense that including women in research studies is considered "standard good practice," but absent because little systematic analysis of women's experiences or gender differences is being made (Lahelma, Martikainen, Rahkonen, and Silventoinen, 1999). Research in the inequalities field makes general statements about the shape of socioeconomic gradients in mortality or morbidity, or about causal processes, without considering whether these apply differentially to men and women (Macintyre and Hunt, 1997). Women's experiences have been subsumed into a general "human" identity with the expectation of fitting traditional socioeconomic classification systems. When women have not fit these classifications, they have been treated as an aberrant population; when women have been added, observations on women are presented as additional results only, a procedure characterized as "add-women-and-stir" (Lahelma et al., 1999). This is particularly surprising when psychosocial mechanisms are being discussed, since research in psychology, sociology, and anthropology suggest that women and men have different exposures to psychosocial threats and advantages, have different resources for dealing with threats, and may have different reference points for social comparisons (Macintyre and Hunt, 1997).

There is an inherent male bias in measures of socioeconomic status because work is defined as primarily a male activity. Assumed differential roles and meanings of work for women and men (regarding the impact of work and work as a primary versus an additional role), the gendered segregation of work, and experiences of unemployment presuppose a relatively greater importance of work for men than for women.[11] As well, the health equity field has typically

emphasized mortality data using differences between countries in terms of Gross National Product (GNP).[12] The reliance on GNP exemplifies a gender bias since the GNP does not include the contribution of unpaid work in the home, almost all of which is done by women (Love, Jackson, Edwards, and Pederson, 1997). Additionally, whether or not women or Aboriginal people or disabled people were excluded from certain sectors of the labour market, whether or not they were paid less than white, able-bodied males for work of equal value, whether or not women and others were systematically excluded from positions of political power, are often not criteria in comparisons of different countries (Love et al., 1997).

Although we understand the nature of some of the gender differences in the socioeconomic gradient in health, the extent and complexity of these differences have not yet been fully documented. In most western societies, there have been ongoing conceptualization and measurement difficulties surrounding gender differences in socioeconomic status, especially when relying on the traditional classifications of education, occupation, and income. Women cannot be simply "added in" to existing analyses – a different analytic framework is required. Further empirical comparative research that sheds light on the different mechanisms behind women's poverty and on the different combination of beginning and ending events that mark periods of poverty is needed (Ruspini, 2001). Women's evolving roles and relationships both within and outside the home heighten these challenges. Measures of women's socioeconomic status must be reviewed and revised to accurately reflect the complexity and diversity of women's lives (Reid, 2002).

Women's Poverty

The poverty rate for women is higher than for men in every age group and disparity between socioeconomic groups is growing (Health Canada, 1997). Lone-parent families headed by women have the highest incidence of poverty for all family types, a situation that has improved

very little over the past decade, and older women are still more likely to be economically disadvantaged than their male counterparts. Currently, almost 19% of adult women are living below the low income cutoffs[13] - 41% of women over 65 and 56% of single mothers are low income (Health Canada, 1997).[14]

Poverty has been defined as a relative, multi-dimensional, and dynamic phenomenon.[15] Poverty is also a gendered phenomenon – not only are more women than men likely to experience deprivation, but women's poverty is different from men's. A gender analysis of poverty is not so much about whether women suffer more from poverty than men (in numbers and/or intensity), but rather how gender differentiates the social processes leading to poverty. The trajectories leading to poverty or escape from destitution are gendered phenomena (Razavi, 1998). In North America the main causes of women's poverty are labour market inequities, domestic circumstances (marriage breakdown and motherhood), and welfare systems (National Council of Welfare, 2000; Ruspini, 2001). Recent research suggests that childbearing and society's definition of child rearing as a female activity place women and men in different structural positions with respect to the flow of information, resources in social networks, and financial compensation (Ballantyne, 1999). As well, women's poverty is highly associated with low education and the economic and social effects of racism and sexism, including housing discrimination and exposure to domestic and community violence (Schroeder and Ward, 1998).

Narrow Explanatory Frameworks

The health equity field can be criticized for failing to adequately theorize the structural and ideological origins of social inequities, especially those based on gender, race, and class. Such oversights put health promotion at risk of failing to address the root causes of social gradients in health and unwittingly reproducing these inequities in the way health promotion is conceived and implemented (Poland, 1998).

The complex associations between social class and mortality are at the heart of the health equity debate. While suggesting a broadly focused discussion of the way social divisions – of gender, race, social class, and region – are reflected in the health experience of individuals, "health inequalities" have been more narrowly defined in terms of social class differences (Graham, 1990). As previously explained, researchers are searching for plausible "biological pathways" that might provide an explanation for social gradients in health. According to Poland (1998), this has resulted in the reduction of social processes to the status of statistical variables that belie a primarily bio-psychosocial and asocial perspective. Individual cognition and psychology are thus seen as the precursor to disease (Poland, 1998).

Health is less related to people's absolute material living standards than to their position in society, as expressed by their income (Wilkinson, 2000). Income inequality has been the focus of research on health and social life because it is an attractive measure for complex political, economic, and social processes. Many societies, however, are built on overlapping patterns of oppression based on class, race, ethnicity, gender, and age, among other variables. Although health equity researchers have adopted a conceptual frame that equates these complex relationships with income (Capitman, 2001), it is problematic to rely on measures of socioeconomic status[16] as a proxy for social class. Such measures inadequately reflect theorizations of social class and the complex lived realities of both women and men. Socioeconomic status is typically measured by a single variable or small sets of variables, thus failing to examine the whole range of the SES hierarchy and how SES may function most powerfully in combinations of variables. More complex, interrelated variables are needed (Adler et al., 1994). Current conceptualizations and measurements adopted by most health equity researchers limit the analysis, preclude different or alternative findings, and fail to consider the range of experiences living in poverty and how the composite of such experiences may influence

27

health.[17]

Dearth of Qualitative Studies

Governments continue to rely almost exclusively on household surveys to generate easily quantifiable measures of poverty while case study material and other qualitative evidence are sidelined as anecdotal (Razavi, 1998). Surveys have been the primary data source informing the vast majority of health equity research. However, there are inherent limitations in such data sets. They focus purely on household income levels while making it impossible to answer questions about intra-household distribution (Razavi, 1998). As well, surveys rely on literacy and English as a first language, and are incapable of capturing the experiences of living in poverty and how these experiences may differ between different groups of people.

In order to better conceptualize and measure women's health in the context of women's lives, women's health researchers have called for more qualitative research methods. Qualitative methods are most congruent with a socio-environmental view of health and health promotion (McDonough and Walters, 2001) and may enable women's voices to be heard. Additionally, several authors have made a compelling case for the need for qualitative research on inequalities in health as a corrective to the current bias in favour of positivist social epidemiology. Poland (1998) argues that research employing qualitative methods from a critical-interpretive paradigm is needed. Through conducting qualitative research one can enter into dialogue with women about not only their perceived needs but also the structural changes they believe will lead to improved health. Additionally, qualitative participatory approaches may increase participants' awareness of social constraints and can encourage participants to challenge their health barriers.

Limited Conceptualizations and Measurements of Women's Health

Epidemiological indexes of health status that include measures of morbidity and mortality are based on the notion of health as the absence of disease. The health equity field has largely

relied on measures of morbidity and mortality[18] as a proxy for population health. These measures are most easily applied in large-scale epidemiological studies since they narrowly define health, are easily measured, and allow comparisons among populations. However, there are problems in relying solely on morbidity and mortality measures. They are implicitly deemed important and representative of health irrespective of whether or not they exist alongside unjust and inequitable social relations based on gender, race, or other forms of exploitation. For instance, morbidity data do not indicate highly significant events in women's lives, such as rape, or other problems, such as arthritis (Redman, Hennrikus, Bowman, and Sanson-Fisher, 1988). The ends, such as low mortality rates, are defined as positive and desirable regardless of the context (Love et al., 1997).

What is Women's Health? [19]

Throughout life, the human experiences of birth, death, illness, and disability are embedded in social contexts. In any gender-dichotomized society, the fact that we are born biologically female or male means that our environments will be different, we will live different lives (Lorber, 1997), and we will have different experiences with health. All cultures characterize men and women as different types of beings, suitable for different kinds of tasks and entitled to differing levels of economic, cultural and political resources (Doyal, 1995). These differences determine differential exposure to risk, access to the benefits of technology, information, resources and health care, and the realization of rights, all of which can influence health (World Health Organization, 1998). Indeed, women's everyday experiences must be understood within the context of the larger social organization and ideological structures generated from outside experience (Anderson, 1987).

For decades mortality and morbidity rates have indicated that "women are sicker but men die quicker" – women live longer, men die prematurely, and women experience more morbidity

29

than do men. The life expectancy for Canadian women compared to Canadian men is almost seven years greater (Love et al., 1997). If one equates longevity with health, then women appear to be healthier than men (Reid, 2002). However, it is generally agreed that women suffer greater burdens of morbidity, distress, and disability (Doyal, 1995), including depression, stress overload, chronic conditions such as arthritis and osteoporosis, and injuries and death resulting from family violence. In general women present more acute medical problems, are hospitalized at higher rates than men, use more prescriptive medications, and report feeling less healthy (Greaves, 2000). Research over the last decade suggests that gender differences in health are rooted in social roles against the backdrop of some male biological disadvantage. Standard explanations for why women report more ill health have included biological or genetic risks, risks acquired through social roles and behaviours (the burdens of domestic and female role responsibilities, such as child rearing and housework), illness behaviour (women appear or act more sick), health reporting behaviour (women are seen to be more verbal or "complaining"), and differential health care access, treatment, and use (Hunt and Annandale, 1999; Macintyre, Ford, and Hunt, 1999; Reid, 2002).

Women's health researchers and advocates suggest that health promotion and disease prevention activities must focus not only on diseases that are more common, more prevalent or more serious among women, but also on priority health issues identified by women themselves, women's diversity, and the determinants of health (Cohen, 1998, p.187).

> Women's health involves women's emotional, social, cultural, spiritual and physical well-being, and it is determined by the social, political and economic context of women's lives as well as by biology. This broad definition recognizes the validity of women's life experiences and women's own beliefs about and experiences of health (Phillips, 1995; cited in McComas and Carswell, 1996).

Women's health is perceived as a continuum that extends throughout the lifecycle and that is critically and intimately related to the conditions under which women live. Examinations of

women's health require a social model of health that puts women's health needs at the centre of the analysis and focuses attention on the diversity of women's health needs over the lifecycle (Ruzek, Clarke, and Olesen, 1997).[20] The traditional oppression and disempowerment of women must also be addressed at both personal and societal levels, thus broadening the approach. "Every woman should be provided with the opportunity to achieve, sustain and maintain health as defined by that woman herself to her full potential" (Ontario Women's Health Interschool Curriculum Committee; cited in Cohen, 1998, p.188).

Poor and Unhealthy Women as "Other": A Theory of Exclusion

Health equity researchers have advanced understandings of the relationship between poverty and health, and women's health researchers and advocates have built up a large body of work demonstrating the gender-blind theorizations of the health equity field with evidence of the intimate relationship between gender inequalities and health (Doyal, 1995; Stein, 1997; Annandale and Hunt, 2000; Doyal, 2000). Given the increasing rates and severity of women's poverty, the integration of these advances can further understandings of the social, economic, cultural, and political practices and institutions that are implicated in the creation and perpetuation of women's poverty (Razavi, 1998). The complex ways that societal forces affect women's opportunities for health and experiences of health and wellbeing must be explored (Ruzek and Hill, 1986).

Poor and unhealthy[21] women are stigmatized and find little place in the dominant social fabric. According to Iris Young (1990), cultural imperialism is the construction of dominant societal meanings that render the perspectives of marginalized groups invisible while simultaneously stereotyping marginalized groups and marking them as Other. In so doing, the dominant group's experience and culture are universalized and established as the norm. "Other" groups are brought under the measure of dominant norms and are constructed as non-adherent,

deviant, and inferior. Since only the dominant group's cultural expressions receive wide dissemination, they become the normal, the universal, and thereby the unremarkable. "Others" are thus on the margins or excluded altogether from the social fabric, and are forced outside the definition of full humanity and citizenship (Young, 1990). This process of othering a person and labeling them as deviant depersonalizes the offending individual, who is then treated as a mere instance of a discreditable category, rather than as a full human being. The imposition of a stigma then provides a basis for collective discrimination against them (Schur, 1980).

The selective stigmatization of Others is rationalized through the dominant means of interpretation and communication in society (Fraser, 1987). Typically, societal means of interpretation and communication are expressed through hegemonic discourses that fuel self-evident descriptions of social reality that normally go without saying and escape critical scrutiny (Fraser and Gordon, 1997). Particular interpretations of social life are enshrined as authoritative while others are de-legitimized and obscured, to the advantage of dominant groups in society and to the disadvantage of subordinate ones (Fraser and Gordon, 1997). Exclusion processes preserve poor women's multidimensional disadvantage and constructions as Other. Exclusion involves disintegration from common cultural processes, lack of participation in societal activities, alienation from decision-making and civic participation, and barriers to employment and material resources (Raphael, 2001). The explication of cultural, institutional, and material exclusion elucidates how the processes that create and perpetuate poor women as the Other influence their health.

Poor women are *culturally excluded* as a consequence of being stigmatized, stereotyped, and invisible.[22] Wendell (1996) asserts that we project rejected aspects of ourselves onto groups of people who are designated the Other. "We see 'the Other' primarily as symbolic of something else – usually something we reject and fear and project onto them" (Wendell, 1996, p.60).

Dominant cultural[23] understandings portray women on welfare as draining resources and undermining social coherence. Women on welfare are seen to create division and difference – they are Others haunting the "norm" (Batsleer and Humphries, 2000), and are viewed as non-adherents of the individualized ideals of independence and self-control. They are culturally branded with having insufficient resolve, knowledge, and will-power to conform. In contrast, members of the powerful mainstream are portrayed as possessing the will-power and resolve to be independent, healthy, and working for pay.

Cultural exclusion processes portray poor and unhealthy women in particular ways – as either in control of or at the mercy of poverty and ill-health, or, in other words, in control of or at the mercy of their "free will." In the notion of free will the origins and conditions of responsible behaviour, whether humans are free in what they do, or whether they are determined by external events beyond their control, are questioned (Audi, 1995). Thus, poor and unhealthy women, because they are poor and unhealthy, are othered because they have insufficiently harnessed their free will. Dominant discourses rarely examine social, political, or economic factors; rather, the poor and unhealthy are told to secure their free will, take control of their situations, and make better choices and decisions. The processes of cultural exclusion do not realistically portray poor women's experiences – rather such processes are generally controlled by "right-thinkers" for whom being indigent or placing demands on the state to take care of the body are signs of moral weakness (Ingham, 1985). Consequently, only partial accounts of the world that are constructed from within particular historical contexts and that serve particular economic, political, and social interests are presented (Kelly, 1996).

Institutional exclusion is fueled by the deeply held assumption that moral agency and full citizenship require that a person be autonomous and independent. Poor women on government assistance depend on bureaucratic institutions for support and services. Being a dependent in

our society implies being legitimately subjected to the often arbitrary and invasive authority of social service providers and other public and private administrators, who enforce rules with which dependents must comply. Consequently poor women are subjected to patronizing, punitive, demeaning, and arbitrary treatment by the policies and people associated with welfare bureaucracies. Paternalistic authorities[24] construct the needs of people in their service, claiming to know what is good for them. Dependency in our society implies, as it has in all liberal societies, a sufficient warrant to suspend basic rights to privacy, respect, and individual choice (Young, 1990).

While those who are more socially included have greater access to economic, educational, and social resources and support (Shaw et al., 2000), cultural and institutional exclusion processes rationalize poor women's *material exclusion*. Exclusionary processes confine poor women's material lives, including the resources they have access to and the opportunities they have or do not have to develop and exercise their capacities (Young, 1990). Poor women are economically excluded since they are expelled or retreat from equal participation in economic and social life (Young, 1990).

Metaphorically, exclusion "trickles down." It trickles from cultural assumptions and stereotypes, fuels punitive institutional policies and practices, and legitimizes material deprivation. Exclusion as a "trickle down" means that linear measures and conceptualizations of health and poverty are not enough. What matters are women's multi-faceted experiences living in poverty, how these experiences are socially isolating, and the effects on health. Cultural exclusion processes, such as stereotyping, surveillance, and threatening, shame poor women. Institutional exclusion trickles from cultural exclusion and denies people the opportunity to participate in and contribute to society and to enjoy an acceptable supply of goods and services. It functions through discriminatory practices that create barriers to accessing services and

resources. Meanwhile, poor women's material exclusion and scarcity are legitimized. Cultural, institutional, and material exclusion lead to human misery, loss of potential, and poor health (Shaw et al., 2000; Raphael, 2001b).

Unpacking the "Other": Provisional Identities and Women's Diversity

In a society that systematically excludes and devalues poor and unhealthy women, only partial and distorted understandings of ourselves and the world around us can be produced (Harding, 1987). In many instances the weight of ideology has systematically distorted people's views of their world and their own capabilities (Rahman, 1983) and the result can be shame, passivity, and a resignation to the status quo as an unchangeable and natural experience (Comstock and Fox, 1993). Some theorists believe that shame is the key to social conformity, forcing the shamed to avoid embarrassment and being thought different, inadequate, or stupid (Wilkinson, 2000). "Unacknowledged shame plays a central role in causing subjects to yield to group influence, even when it contradicts their own direct perceptions" (Scheff, Retzinger, and Ryan, 1989, p.184).

Although stereotyped and inferior images may be internalized by group members, "deviants" must also make various efforts to avoid or counteract the social and psychological impact of the stigma (Goffman, 1963). Despite the power of dominant exclusion processes, oppressed people often refuse to adhere with the dominant group's devaluing, objectifying, stereotyping visions. "Individuals make use of the discursive resources available to them while at the same time positioning themselves in ways that represent the least risk in terms of challenges to existing systems of knowledge and belief" (Croghan and Miell, 1998, p.449). Although stereotypes and shame can produce passivity, they can also facilitate a kind of agency to re-create identity (Sedgewick, 1993). According to hooks (1990), shame and marginalization can give birth to a process of politicization, become a place of action, and enable a reclamation and reinterpretation

of socially derided identities (hooks, 1990).

Though Others are seen as non-conformists and deviants, they may reclaim and reinterpret their socially derided identities. *Identity* is the social self that is named and experienced. It is a contingent and variable sense of self, both conscious and unconscious (Ristock and Pennell, 1996). Individuals inhabit different identities that may be stressed or muted depending on the situation (West and Fenstermaker, 1995). According to Fraser (1997), people's social identities are complexes of meanings and networks of interpretation. To have a social identity is to live under a set of descriptions that is drawn from the fund of interpretive possibilities available to individuals in specific societies. Since everyone acts in multiple social contexts, the different descriptions comprising any individual's social identity fade in and out of focus. People's social identities are fashioned and altered over time. Under conditions of inequality, social groups are formed and at times work towards emancipatory social change (Fraser, 1997).

Feminists grapple with the substantial theoretical challenge of how to honour and appreciate diversity, while also recognizing how difference is constructed (Hunt and Annandale, 1999). Postmodern feminists reject master narratives and suggest mini-narratives that are provisional, contingent, temporary, and relative, and that provide a basis for the actions of specific groups in particular circumstances. Feminist postmodernists stress fragmentation – of language, time, the human subject, and society itself (Batsleer and Humphries, 2000). As such, any naming or categorizing tends to call attention to similarities and to neglect differences (Acker, Barry, and Esseveld, 1991; Martin, 1994). Paradoxically, postmodern feminist attempts to unmask the differences among women have imposed false unity on their research. In overcompensating for a failure to acknowledge the differences of race, class, and ethnicity, feminists gave privileged status to a predetermined set of analytic categories and affirmed the existence of nothing but difference. In other words, in trying to avoid the pitfall of false unity, they walked straight into

the trap of false difference (Martin, 1994).

As feminists we must expose both the links and contradictions between ourselves and other citizens of the world. We must resist the temptation to mask crucial differences with the notion of universality and to deny generalities for fear of essentialism. Consequently, feminist postmodernists encourage the development of multiple discourses that are responsive to the diversity of women's experiences (Ristock and Pennell, 1996). The provisionality of identities is accepted as well as their daily solidity in the relations of power. Identities are useful and meaningful; in both political organizing and personal lives, identities are adopted because they make sense at that moment, though they are not definitive or everlasting (Spivak, 1990).

Identity is saturated with the voices of others and needs to be understood not as a unified and static entity but as constructed in order to achieve specific strategic and presentational ends (Croghan and Miell, 1998). People come into interactions by assuming situational identities that enhance their own self-conceptions or serve their own needs, which may be context specific rather than socially or culturally normative (Angrosino and Mays de Perez, 2000). What people say in interviews, in writing, or in their everyday interactions can differ from what they really think, and attitudes and behaviour may not always match each other. Language is by nature metaphorical, figurative, and context-dependent and not very successful at mirroring complex circumstances (Alvesson and Skoldberg, 2000). Language can also be used to construct individual subjectivity in ways that are historically and locally specific. Reality is continually constructed and reconstructed moment by moment through linguistic and social practices and self-conscious reflection. This multiple and changing world includes multiple and changing selves. Persons are understood to not possess a single, stable, internal identity but to have many selves which are constructed and then reconstructed depending on the context (Drew and Dobson, 1999).

In my efforts to study poor women's health, it was important to understand the cultural, institutional, and material dimensions of exclusion, how the dominant discourses of poverty and health construct poor and unhealthy women as the Other, and the ways that these multifaceted experiences of exclusion influenced women's health.

Feminist Action Research: A Response to Poor Women's Exclusion

Although health has long served as a barometer of the economic and social conditions under which people live (Walters, Lenton, and Mckeary, 1995), the development of appropriate tools to measure the impact of gender on women's health has lagged behind conceptualizations about social and structural influences (Reid, 2002). Oversights in the health equity field include the dearth of qualitative studies and the narrow gender-blind conceptualizations of women's health and poverty. Additionally, hegemonic discourses of poverty and health that favour middle-class values and experiences necessitate research efforts that explore poor women's experiences. Feminist action research (FAR) is a conceptual and methodological framework that attempts to address these needs and limitations. Feminist action researchers typically use qualitative research methods to generate in-depth understandings of women's experiences and put women's diversity at the centre of the analysis. FAR strategies attempt to be inclusive, participatory, collaborative, and to elucidate poor women's exclusion. Indeed, FAR can be seen as a research tool to address poor women's complex experiences – in terms of better understanding the factors that perpetuate their exclusion, appreciating the diverse and often disparate ways that poor women negotiate their lives, and responding to social injustices through advocating collective action and social change.

Feminist action research is a blending of participatory research and feminist theory. In this section I describe participatory research; the genesis, goals, and principles of FAR; and feminist action researchers' current struggles with academic co-optation and marginalization. Although

these challenges have not been fully rectified, I saw FAR as an appropriate and useful framework for examining the three research questions that guided this dissertation.

Participatory Research

Participatory research (PR) arose during an era of reflection and self-questioning within social research.[25] At issue were the purposes of research, definitions of objectivity, power relationships between the researcher and the researched, ownership of research results, and the ethics of data collection and reporting (Maguire, 1987; Fals-Borda, 1991; Green, George, Daniel, Frankish, Herbert, Bowie, and O'Neill, 1995). In response to these issues PR is value-driven and self-consciously not value-neutral. PR integrates subjectivity into a scientific analysis and to the work of structural and social transformation (Vio Grossi, 1981). Participatory researchers advocate methods of data collection and analysis that are grounded in the context of the community and contribute something of value to the community in which the research is conducted (Herbert, 1996). Most generally, participatory research is a process that combines three activities: research, education, and action (Hall, 1981).

PR involves a social action process that is biased in favor of dominated, exploited, poor, or otherwise ignored women, men and groups. Participatory researchers work "with" rather than "for" the researched, breaking down the distinction between researchers and the researched while legitimizing the knowledge people are capable of producing (Fals-Borda, 1991). Consequently, participatory researchers outline and utilize explicit processes to facilitate ordinary people's reflection on and analysis of their reality. They attempt to involve participants in the entire research process, including an action phase, and present people as researchers in pursuit of answers to questions of daily struggle and survival (Tandon, 1988; Fals-Borda, 1991; Nyden and Wiewel, 1992). The people studied make decisions about the study format and data analysis. This model is designed to create social and individual change by altering relationships in the

project (Reinharz, 1992).

Participatory researchers see no contradiction between goals of collective empowerment and the deepening of social knowledge (Hall, 1992), and attempt to adhere to the tenets of community empowerment, emphasizing increased power and control across multiple sites of practice. PR involves a critical problem-solving process of diagnosing, action planning, action taking, evaluating, and specifying learning (Brown and Tandon, 1983; Hall, 1992, 1993; Park, 1993; Freire, 1996). Participatory researchers espouse that through a dialectical process of collective reflection and action – "conscientization" – the community and its constituent organizations and individuals foster a sense of identification and shared fate. Through developing the skills and resources to engage in the cyclical process of diagnosing and analyzing problems, they plan, implement, and evaluate strategies aimed at meeting identified needs (Israel, Checkoway, Schulz, and Zimmerman, 1994). Community members, organizations, and the community as a whole gain increased influence and control, that is in turn associated with improved health and quality of life. Together participatory researchers and community members strive to maximize both increased knowledge and understanding of a given phenomenon and take action to change the situation (Israel et al., 1994). Action and evaluation proceed simultaneously in a fluid approach that is constantly evaluated, rather than a traditional research project where the design is thought out at the beginning, implemented in a carefully controlled way, and finally evaluated (Reinharz, 1992). Thus the credibility-validity of PR knowledge is measured according to whether actions that arise from it solve problems and increase participants' control over their own situation (Greenwood and Levin, 1998).

Feminist Action Research

> Participatory research taught me the necessity of being explicit about personal choices
> and values in the research process. Feminism taught me to recognize that the personal is
> political (Maguire, 1987, p.5).

Despite the ideals advanced by participatory researchers, gender and women's diversity were made invisible by early assumptions that women could be automatically included in terms such as "people," "community," or "the oppressed" (Hall, 1993). In traditional research as well as in participatory research, women have been largely excluded from producing dominant forms of knowledge. Maguire (1987) has pointed out the distinct silence around gender and women in PR discourse, calling it the "androcentric filter." Participatory research is built on a critique of positivism that often ignores and repeats many of the androcentric aspects of dominant social science research. Freire (1996) maintained that domination was the major theme of our epoch, but his conscientization tools ignored men's domination over women. Freire, like others "does not depart from taking androcentricity as the norm, and consequently, feminists need to do the work for women that he did for men" (Klein, 1983). Women's ways of seeing were not mentioned until 1981 and the general discourse of women has been excluded (Maguire, 1987). Without recognition of, and attention to, its male biases, participatory research cannot be truly emancipatory for all people (Hall, 1992).

Feminist researchers have attempted to address the androcentric biases inherent in traditional and participatory research, yet have not articulated distinct methods or methodologies. Within "feminisms"[26] there is no single or monolithic method, methodology, or theoretical base of feminist scholarship; in fact, there are competing theoretical foundations and varied methodologies (Maguire, 2001). As well feminists have not agreed upon one definition of research (Maguire, 1987). There has been resistance to a rigid, dogmatic "correct" feminist methodology because it may reinforce domination and limit knowledge. However, there is a great danger in "feminisms" becoming co-opted by mainline methods that reinforce unequal power relations unless we commit ourselves to a distinctive methodology (Cancian, 1992).

Some common features of feminist methodology include focusing on gender and inequality

and using qualitative methods to analyze women's experience. However, very few studies adopt the more radical methods of including an action component, using strong participatory methods that give participants substantial control over involvement in the study, and critiquing the power relations in academia (Cancian, 1992). Despite embracing a call for transformational structural and personal action (Mies, 1991; Maguire, 2001), feminists have not outlined a clear strategy for eliminating androcentricism from research, nor have they "given adequate attention to the envisioning of truly emancipatory knowledge-seeking" (Harding, 1986, p. 19). Feminist theories, epistemologies, and methodologies have inspired and grounded many action researchers' work (Maguire, 2001), yet there are only a handful of systematic attempts to link feminism and action research (Greenwood and Levin, 1998).

Aspects of participatory research and feminist research cohere ontologically and epistemologically as both seek to shift the centre from which knowledge is generated (Hall, 1981). As well, they share an avowed intent to work for social justice and democratization (Lather, 1991; Greenwood and Levin, 1998; Maguire, 2001). By combining feminist research's critique of androcentricism with participatory research's emphasis on participation and social change, feminist action research provides a powerful approach to knowledge creation for social and personal transformation (Maguire, 1987). Despite the fact that few participatory or feminist researchers use "feminist action research" nomenclature, FAR guided my research and underscored my research values and goals.

I define feminist action research as a conceptual and methodological framework that enables a critical understanding of women's multiple perspectives and works towards inclusion, participation, action, and social change while confronting the underlying assumptions the researcher brings into the research process. Feminist action researchers facilitate building knowledge to change the conditions of women's lives, both individually and collectively, while

reconstructing conceptions of power so that power can be used in a responsible manner (Ristock and Pennell, 1996). Feminist action research is a tool, not a panacea, that involves a particular way of looking at the world and thinking about research participants (Maguire, 1987). Since many poor women are excluded from social processes and their communities, open and flexible theory-building grounded in a body of empirical work ceaselessly confronted with, and respectful of, women's day to day experiences is needed (Lather, 1991).

<u>Praxis: Developing A Feminist Action Research Framework</u>

Participatory research and contemporary feminism share a number of major underlying features centering on the analysis of political economy and praxis (Maguire, 1993). The notion of praxis challenges the theory-practice relationship and raises problems associated with value-free science. The term "praxis" originates from the Greek word *prasso* meaning "doing" and "acting", in contrast with the theoretical designs of epistemology, *theoria* [27] (Audi, 1995). Lal (1996) refers to pedagogical praxis – the erasing of the boundaries between theory, methodology, and practice, and between field and home (Lal, 1996). Other researchers define praxis as a dialectical process of collective reflection and action (Kirby and McKenna, 1989; Israel et al., 1994); the joining of theory and action so that each is informed by and changes through its relation with the other (Ristock and Pennell, 1996); and the integration of knowing and doing (Kirby and McKenna, 1989).

For praxis to be possible, theory must not only illuminate the lived experience of social groups, it must also be illuminated by their struggles (Lather, 1991). Theory is thought of as experience-based (Park, 2001), and reflection itself is embedded in praxis, not separate from it. Action upon reality and analyses of that learning may change awareness of the nature of problems and the sources of oppression (Gaventa and Cornwall, 2001). Indeed the processes of uncovering marginalized knowledges, giving priority to these knowledges, and enabling the

collaborative development of action strategies are simultaneously theoretical and methodological. Woven within and between each of the following characteristics of a FAR framework is the notion of praxis – theory, methods, and practice in dynamic interplay.

A Feminist Action Research Framework

For the purposes of this dissertation I have developed a feminist action research framework based on the principles of inclusion, participation, action, social change, and researcher reflexivity. In this section I present these principles as ideals, and recognize that they do not always reflect the reality of engaging in FAR. In chapter 7 I examine the realities of these FAR ideals and the ways that they may be reframed to more realistically portray feminist action research.

Inclusion

The first principle of feminist action research is inclusion. To include is to cause to be a part of something, to consider with, or to put into a group (Morris, 1982). Feminist action researchers contend that no social practices or activities should be excluded as improper subjects for public discussion, expression, or collective choice; no one should be forced into privacy (Young, 1990). Gender and women's daily experiences are central in the construction of theoretical frameworks and feminist action research methods. Women's experiences are central in several ways – in understanding patriarchy as a system of domination and oppression, in identifying key issues and questions in all phases of the research process including action and evaluation, and in giving explicit attention to how women and men as groups benefit from the project.[28]

Feminist action researchers expose the inadequacy of androcentric research and its partial, inaccurate, and incomplete representation of human experience when women are muted (Maguire, 2001). By beginning with the experiences and research needs of women who have

44

traditionally been silenced, the process of knowledge production is transformed and the ideological power base is challenged (Kirby and McKenna, 1989). Feminist action researchers seek to connect the articulated, contextualized personal with the often hidden or invisible structural and social institutions that define and shape our lives. Feminist action researchers attempt to make possible the development of strategies and programs based on real life experience rather than theories or assumptions, providing an analysis of issues based on a description of how women actually experience those issues (Barnsley and Ellis, 1992). Drawing on WOAW as an example, diverse women on low income were included; fundamentally, their experiences, barriers, and needs were seen as central to WOAW's vision, mandate, and research processes.

Participation

Inclusion is a precursor to the second principle of feminist action research – participation. To participate is "to take part, join, or share with others" (Morris, 1982). Feminist action researchers are committed to making women's voices more audible and facilitating women's empowerment through "ordinary talk" (Maguire, 2001). Some researchers have attempted to outline different kinds and levels of participation. Herbert (1996) discussed levels of participation as the "seven Cs," ranging from collusion, co-opting, and coercion, convincing, coordination, and cooperation, to true collaboration. It is essential that researchers in partnership with communities be clear about the level of participation they are expecting and inviting (Herbert, 1996). It is also important to question *who* is participating, *why* they are participating, to what degree and in what phase of the project they are participating, and where the true power lies (Wallerstein, 1999).

Feminist action researchers contend that at all stages of research, full collaboration and participation should occur between the researched and the researcher and among the research

participants. Shared decision-making must be promoted. Collaboration is seen as central to building knowledge and co-creating meanings that will engage the researcher and the research participants in mutual dialogue (Van Den Bergh, 1995). Participation is a value that guides WOAW organizational processes, particularly sharing stories and experiences, hearing all voices, learning from one another, honouring different levels of involvement, and fostering different ways to be involved in meetings, activities, and research.

Individual and Collective Action

The third principle of feminist action research is individual and collective action. Action is defined as "the transmission of energy, force, or influence" (Morris, 1982, p.13). Action is a dynamic process (McWilliam, 1996); what action looks like is based on one's social, economic, and political situations; and action can occur on both individual and collective levels. People with problems figure out what to do by first finding out their causes and then acting on insight (Park, 2001). Through action we learn how the world works, what we can do, and who we are – we learn with mind and heart – and this is how we become aware and emancipated, or how we learn our powerlessness. Action is an integral part of reflective knowledge, and can be conceptualized as speaking, or attempting to speak, to validate oneself and one's experiences and understandings in and of the world (Gordon, 2001). Lorde (1984) advocates turning silence into language and action.

Action can produce changes in participants that go beyond intellectual understandings. Thus the processes of individual and collective action can encompass a wide range of endeavours – leaving the house, managing one's day-to-day life and health issues, attempts at negotiating the welfare and health care system, the development of an identification and shared fate with a group, the growth of a sense of self and collective efficacy, the belief that action is possible, and the capacity to develop individual and collective strategies for action (Israel et al., 1994). The

46

WOAW organization provides useful examples of individual and collective actions. Leaving the house, going for a walk, learning to manage depression, and joining a support group are examples of individual actions taken by WOAW women. Collective actions occur when groups of WOAW members, either formal or informal, initiate an activity, meeting, community involvement, or political activism for themselves, for other WOAW women, or for women in their communities.

Social Change

The purpose of feminist action research is to create new relationships, better laws and improved institutions (Reinharz, 1992). Social change can be envisioned as the outcome of deliberate individual and collective actions. Many feminists envision social change as moving towards "a society that would develop individuality but shift the balance from individual rights towards the rights of the majority and the collective, and that would validate the pursuit of the common good rather than individual self-interest" (Adamson, Briskin, and McPhail, 1988, p.101). Social change is the process of altering the initial situation of a group, organization, or community in the direction of a more liberated state (Greenwood and Levin, 1998). Maguire (2001) envisions social change as "the long haul struggle to create a world in which the full range of human characteristics, resources, experiences, and dreams are available to all our children" (p.66).

It is important to note that although most feminist action researchers avow social change as the ultimate goal of their research endeavours, it remains poorly understood and conceptualized. From the FAR literature it is difficult to know exactly what it looks like and what can count as social change. Not surprisingly, the ambiguity of social change also posed problems for the WOAW organization. The WOAW organization has a vision of social change that included all women in the community being empowered, respected, and treated with dignity. To be sure,

accomplishing WOAW's vision requires a number of individual and collective actions. Although social change is an implicit goal shared by most WOAW members, few of them articulated specific strategies to realize it. Consequently, in this dissertation's research questions and analysis social change is framed as "doing the work of social change" and "taking action towards social change."

Researcher Reflexivity

The final principle of feminist action research is researcher reflexivity. Feminist action researchers advocate high standards of reflexivity, openness, and transparency about the choices made throughout any empirical study (Kirby and McKenna, 1989; Hertz, 1996; Reay, 1996; Rose, 1997; Tom, 1997; Edwards and Ribbens, 1998; Coleman and Rippin, 2000). Reflexivity is the capacity to locate one's research activity in the same social world as the phenomena being studied and to explain the nature of research within the same framework as is used to theorize about the objects of study (Reason, 1994). Feminist action researchers need to openly and honestly recognize their "conceptual baggage" (Kirby and McKenna, 1989), and consider the implications of their power. Feminist action researchers are expected to be transparent and to appreciate methodological, epistemological, and political influences, contradictions, and complexities in all stages of research (Ristock and Pennell, 1996). In order to be cognizant of the class and power differences between myself and the research participants, in chapter 3 I describe my strategies for being deliberately reflexive.

The Marginalization and Co-optation of Feminist Action Research Ideals

Feminist action researchers are critical of traditional authoritarian approaches to knowledge generation that use only a tiny fraction of the knowledge generated to confront important problems (Greenwood and Levin, 1998). In most societies the gap between those who have power over the process of formally recognized knowledge generation and those who do not has

reached dimensions no less formidable than the gap in access to the means of physical production (Rahman and Fals-Borda, 1991).

Although feminist action researchers may use methods that intend to "give the research subjects more power," it is not clear that they have succeeded (Cancian, 1992, p.627). Academic feminists have tended to maintain control over research projects and knowledge creation as have conventional non-feminist researchers, rarely empowering the women they study (Maguire, 1987). By maintaining this control and distance, most feminist scholarship ends up furthering the gap between the researcher and the researched and benefiting the researcher more than those studied. This behaviour undercuts some of the goals set forth by feminist action researchers and reproduces aspects of traditional academic research. Although feminist action researchers demand that the researcher give up some of these controls and share them with others, this is still rare in academic feminist academic research. Feminist fieldworker-scholars have tended not to take up the call of more participatory research and have held on to the reins of research and writing (Wolf, 1996).

At times the esoteric language of much feminist scholarship keeps feminist action researchers from putting their research to use. Esotericism effectively keeps the knowledge constructed by feminist scholars out of the hands of feminist activists and practitioners. It can also keep feminists inside the academy from understanding one another (Martin, 1996). Research with a more participatory component, like feminist action research, challenges feminist scholars to practice what they believe and may preach – more egalitarian approaches to empowerment that are with, and not simply for, the researched population. While this is deeply connected to the structure of power and privilege in the academy, it nonetheless points to a highly problematic contradiction among feminist scholars (Wolf, 1996).

Such difficulties arise in part because there are different uses of knowledge in the academy

from those in community or workplace situations. Knowledge is a commodity by which academics do far more than exchange ideas – it is the very means of exchange for the academic political economy (Hall, 1992). Academics are under economic, job survival, or advancement pressures to produce in university-approved ways. The dominant methodology of an academic discipline usually supports the existing power structure of the discipline and its environment. Often, leaders in academia favour complex methods that outsiders cannot use or understand and devalue the knowledge of lower-status colleagues and the general public (Cancian, 1992). Public confidence in scholarly objectivity has consequently been eroded by growing awareness of the material interests and ideological prejudices that have a profound influence on the consciousness and practices of researchers and on the conclusions drawn from their work (Ristock and Pennell, 1996). Indeed some argue that "the word 'academic' is a synonym for irrelevant" (Alinksy, 1969, p.xi; cited in Nyden and Wiewel, 1992).

In many cases the academic reward system renders traditional discipline-bound research the main form of legitimate research in the eyes of university tenure and promotion committees (Nyden and Wiewel, 1992). People who challenge this methodology risk being marginalized, rejected, or otherwise punished (Cancian, 1992). These structural pressures impede academic engagement in participatory and feminist research processes (Hall, 1992). FAR discourse promotes shifting power or structural changes through the knowledge generated. Such radical methods directly challenge the system of inequality in academia and may draw opposition (Cancian, 1992).[29]

Currently few academic researchers use PR or FAR processes (Hall, 1992) since they are time-consuming and challenging to academia's status quo. Paradoxically, however, some disciplines, including (but not exclusively) health promotion, education, women's studies, and organizational studies, promote the feminist action research ideals of inclusion, participation,

action, and social change. In fact, in these fields the proliferation and popularization of participatory and feminist research have diluted the meanings of these terms - they have become open, multiple, contested, and contestable, and have adopted the appearance of slogans or mantras that are so charged with multiple meanings that they are now empty and almost meaningless (Poland, 1998). For example, the popularization of PR and FAR has caused many activists to worry legitimately about co-optation of their perspectives for the purposes of obscuring and blunting democratic initiatives (Greenwood and Levin, 1998). In many cases participation has been exclusively looked at as a way to improve the final product rather than as a tool for developing a process of social transformation. With new words, but old techniques, the separation between the subject and the object of research persists and the dominant features of such practices continue. FAR and PR, devised for liberation, are "converted into a new, and perhaps more efficient, tool for manipulation" (Vio Grossi, 1981, p.44). Such problems are related to idealized characterizations and promises of FAR and to vague definitions (Vio Grossi, 1981).

The challenges of FAR, as described by Vio Grossi (1981), propelled me to provide clear definitions of the FAR principles that guided this dissertation and to examine the lofty ideals and lived realities of engaging in FAR (chapter 7). As a graduate student researcher I had to consistently examine my own role in and expectations of the research process, and to clearly articulate what it means, both theoretically and methodologically, to participate in feminist action research.

In this chapter I argued that mainstream understandings of the gradient of health inadequately capture the complexity of poor women's experiences. Poor women, as the Other, are culturally, institutionally, and materially excluded from participating in society. They are stereotyped and invisible, and as a consequence forced to negotiate their socially derided

identities. In problematizing mainstream conceptual and methodological approaches in the health equity field, developing a theory of women's exclusion, and exploring the dominant discourses of poverty and health, I attempted to advance understandings of exclusion and poor women's health. Adopting a FAR framework can enable more complete understandings of the factors that perpetuate women's exclusion and poor health and the diverse and disparate ways that poor women negotiate their lives, while providing strategies for responding to social injustices through advocating collective action towards social change.

Notes

[1] **B.C. Benefits** includes social assistance, disability benefits, and seniors' pensions that are paid by the provincial government (British Columbia). "Employable" one-parent families with one child receive $845.58 per month on social assistance; one-parent families with two children receive $935.58. Single people on Disability Benefits I receive $802.92 per month; one-parent families with one child receive $896.58. Disability Benefits II recipients who are single adults receive $981.42, and recipients who are single parents with one child receive $1 050.08. For adults over the age of 65, a person living alone receives $786.42 per month; two adults living together over the age of 65 receive $1 329.06 per month (B.C. Ministry of Human Resources, 2002). Throughout this dissertation B.C. Benefits is also referred to as "assistance," "the system," and "welfare."

[2] Although the "health and income equity" field originated primarily in Europe, North American "socioeconomic status and health" researchers also study the relationship between health and poverty. The majority of researchers in this field are social epidemiologists.

[3] It should be noted that in Canada universal health care is increasingly contested as fiscally unrealistic and unsustainable.

[4] **Socioeconomic status** is "a composite measure that typically incorporates economic status, measure by income; social status, measured by education; and work status; measure by occupation" (Adler, Boyce, Chesney, Cohen, Folkman, Kahn, and Syme, 1994, p. 15). Socioeconomic status refers to the position in the social hierarchy that gives individuals relative power and recognition due to wealth and certain forms of income (Ballantyne, 1999).

[5] A series of studies in the United Kingdom document how those living on lower incomes are more likely to suffer and die from cardiovascular disease – and a number of other diseases – at every age. A recent study found significant differences in overall death rates between those in the lowest two income groups and those in the highest two income groups in England and Wales. Lower income women had a 55% greater chance of dying than those with higher incomes. In the United States, low-income Americans have a higher incidence of a range of illnesses including cardiovascular disease. In Canada, data on individuals' income and social status are not routinely collected at death, so national examination of the relationship between income and death from various diseases must use census tract of residence to estimate individuals' income. In both 1986 and 1996, those Canadians living within the poorest 20% of urban neighborhoods were much more likely to die from cardiovascular disease, cancer, diabetes, and respiratory diseases – among other diseases – than other Canadians (Raphael, 2001). Latest estimates are that 23% of premature years of life lost prior to age 75 in Canada can be attributed to income differences. That is, 23% of all of the premature years of life lost to Canadians is accounted for by the differences that exist among wealthy, middle-income, and low-income Canadians (Raphael, 2001). According to a Health Canada report, Canadians with the lowest income were five times more likely than those from the highest income groups to report their health as only fair or poor, two times more likely to have a long-term activity limitation, and only one-third as likely to have dental insurance (Health Canada, 1999).

[6] **Relative poverty,** or **relative deprivation,** is the degree of disadvantage, or, the proportion of the population who fall behind and the distance they fall behind. Relative poverty socially and materially excludes people from society and enforces a sense of being disadvantaged and stigmatized in relation to those better off (Wilkinson, 2000). Relative deprivation refers to the disadvantaged position of an individual, family, or group relative to the society to which they belong, and focuses on the condition of deprivation as well as the lack of resources (Shaw et al., 2000). People are relatively deprived if they cannot obtain the conditions of life – that is, the diets, amenities, standards, and services – that allow them to play the roles, participate in the relationships, and follow the customary behaviour which is expected of them by virtue of their membership in society (Raphael, 2001). **Absolute poverty,** or **absolute deprivation,** refers to living in material scarcity and not having the resources for living essentials such as food, shelter, and clothing. Absolute poverty is a lack of the means of providing material needs and comforts, deficiency in amount, insufficiency, paucity, and scantiness (Morris, 1982).

[7] While there have been fluctuations in the prevalence of low income and of average income over the last 15 years, the trends in income disparity have been more consistent. In Canada the incomes of the wealthiest 10% of families with children grew 14% from 1981 to 1996, while the incomes of the poorest 10% declined 5% during this period (Health Canada, 1999).

[8] Taken from Brunner, Eric and Michael Marmot. (2000). Social organization, stress, and health. *Social Determinants of Health.* Ed(s). M. Marmot and R. G. Wilkinson. Oxford, UK: Oxford University Press, pp. 17-43, by permission of Oxford University Press.

[9] **Stress,** a term widely used in the biological, physical, and social sciences, is a construct whose meaning in health research is defined in relationship to stressful events, responses, and individual appraisals of situations. Common to these definitions is an interest in the process in which environmental demands tax or exceed the adaptive capacity of an organism, resulting in psychological or biological changes that may place the person at risk for disease (Cohen, Kessler, and Underwood, 1995). Stress has been used not only to refer to extreme environmental or psychosocial conditions, but also as a substitute for what otherwise might have been called anxiety, conflict, emotional distress, ego-threat, frustration, threat to security, tension, and arousal (Mikhail, 1981). Although stress research has been focused primarily in psychology, the study of stress is truly interdisciplinary. An environmental stress perspective focuses on environmental demands, stressors, or events, while a biological stress perspective focuses on activation of the physiological systems that are particularly responsive to physical and psychological demands (Cohen et al., 1995). **Depression** is a disabling condition characterized by feelings of sadness, sometimes accompanied by a sense of irritability, helplessness, and hopelessness (Health Canada, 1999). From a clinical perspective, depression is the most common primary care psychiatric diagnosis, with a lifetime prevalence of major depression at about 5% for men and 10% for women (Nicoloff and Schwenk, 1995). Women are twice as likely as men to be depressed and the duration of their depression is likely to be longer (Ballantyne, 1999; Health Canada, 1999). Recent surveys report that 20% of Canadians feel depressed some of the time, that younger adults experience depression more often, and that people with higher levels of education and income report less depression (Canadian Fitness and Lifestyle Research Institute, 1998). About 9% of people in the lowest income group were depressed, compared with 3% of Canadians in the highest income group. In addition, sad people in the lower middle income group were by far the most likely (23%) to be blue for more than half the year, while sad people in the highest income group were the least likely (6%) to be blue for the same length of time (Health Canada, 1999).

[10] A recent study on the role that stress plays in disease identified the psychological and biological pathways through which exposure to adverse psychosocial circumstances – of which low income is one of the most potent – leads to the onset of cardiovascular disease. The social environment can create adverse conditions that produce the "fight or flight" reaction. This works through the sympathetic nervous system and the hypothalamic pituitary-adrenal axis to produce lipid abnormalities, high blood pressure, and clotting disturbances (Raphael, 2001).

[11] Women's paid work has been treated as an additional rather than a primary role: this reveals an unstated, stereotyped assumption of a traditional unpaid role for women as homemakers. Few studies have attempted to treat work and home conditions symmetrically, although those that do have found that work conditions may be equally or more important for women's health than for men's (Macintyre and Hunt, 1997). It is not only women's experiences that have been poorly represented in socioeconomic classifications. Non-White women and men have fallen into the catch-all category "ethnicity." The characteristics generalized from the word are unclear and subject to many interpretations. It makes little sense to categorize as "Asian" people with distinctive histories, geographic origins, and cultures including Cambodian, Chinese, Filipino, Japanese, Korean, Laotian, Thai and Indian

Canadians. As well, people who recognize multiple ancestries may not identify with a single culture or geography, and an individual's identity may shift in response to the way the question is asked or with the purpose of the survey (Jones, Snider, and Warren, 1996).

[12] The GNP is a misleading measure of wellbeing because it tells us little about the quality of our health and our lives. In Canada over the last 50 years the GNP has risen while many components of living capital (social cohesion, human health, environmental health) are worsening. Anielski (2001) proposed the Genuine Progress Indicators (GPI) to take a holistic, integrated, and living-capital-systems approach to measuring the conditions of our economic lives, social cohesion, human health, and environmental health. The GPI includes the full monetary cost benefit accounting of economic growth by considering the "value" of unpaid work (volunteerism, domestic work) and the costs of crime and environmental degradation (Anielski, 2001).

[13] **Low income** refers to the Low Income Cut-offs identified by Statistics Canada. These cut-offs define low income in relative terms, based on the percentage of income that individuals and families spend on the basic needs of food, clothing, and shelter in comparison with other Canadians. Families and unattached individuals with "low incomes" usually spend more than 54.7% of their income on food, shelter, and clothing (Health Canada, 1999). The category identifies those who are substantially worse off than the average Canadian and are living in dire circumstances (Raphael, 2001).

[14] According to Health Canada (1999), in Canada women aged 18 to 24 and aged 70 and older had the highest incidence of low income in 1990 and 1995. This report also found that overall men earned 62% more than women in 1995 ($31 117 versus $19 208). The largest wage disparity was found between men and women aged 55 to 64, where men earned almost double what their female cohorts did. In fact, men age 25 and older earned from 41% to 97% more than their female cohorts in 1995 (Health Canada, 1999).

[15] **Poverty** is a normative concept that can be defined – in both absolute and relative terms – in relation to "need," "standard of living," "limited resources," "lack of basic security," "lack of entitlement," "multiple deprivation," "exclusion," "inequality," "class," "dependency," and "unacceptable hardship" (Krieger, 2001).

[16] In a review paper on the research on health of low-income Canadian women, the following SES indicators were used: employment sector, social assistance recipient, income decile, family income, per capita income, perception of financial strain, education, life-circumstances index, low-income geographic area, subsidized housing, personal income, employment status, income quintile (geographic area), occupation, index of possessions, median income (geographic area) (McDonough and Walters, 2001).

[17] For example, concepts of individual control over existing life circumstances might be a higher order variable that can synthesize a number of factors. Individuals higher on the SES ladder may have more frequent or more significant opportunities to influence the events that affect their lives, compared with people at the lower levels. This sense of control could affect education, occupation, housing, nutrition, health behaviours, medical care, and other aspects of social class experience not previously discussed (Adler et al., 1994).

[18] **Mortality** (life expectancy) is the number of years one can expect to live. Infant mortality rates mean of 1000 infants born alive, how many die before living one year (Raphael, 2001). **Morbidity** rates measure incidence of disease.

[19] Currently there are no universal definitions of health. Perceptions vary across individuals and cultures depending on the meaning and importance people give to it. Reviewing the literature revealed three major themes regarding health – health as the absence of disease, a functional capacity, and a positive condition (Colantonio, 1988). Generally, conceptualizations of health range from narrow to broad – from the physical body to the ecosphere – and use terms such as biological, psychological, social, societal, environmental, cultural, economic, and political (Rootman and Raeburn, 1994). Jones and Meleis (1993) conceptualize health as empowerment. According to them **health** is a process of growth and becoming, of being whole and maximizing the development of one's potential. Health is being empowered to define, seek, and find conditions, resources, and processes to be an effective agent in meeting the significant needs perceived by individuals (Jones and Meleis, 1993). **Wellbeing** involves improved quality of life, efficient functioning, the capacity to perform at more productive and satisfying levels, and the opportunity to live out one's life span with vigor and stamina (McAuley and Rudolph, 1995). The "emerging consensus among researchers is that the term 'wellbeing' implies an emphasis on the individual's perception or sense of wholeness of self, groups, or community" (Schlicht, 1993). Health is an important component of wellbeing, but it is not the only component (Deaton, 2002).

[20] A prevailing ideology during the early years of the women's health movement was that health concerns were so fundamental to women that they cut across race and class lines. Health was seen as a powerful link that could serve to unite all women into a strong and unified social movement. As a result of the criticisms leveled against white, middle-class feminists for generalizing the needs of dominant groups of women to all women, race and class were identified as the second and third "axes" of domination. Extensive theorizations about the "additive," "multiplicative," or "interwoven" nature of the gender, race, and class triumvirate resulted. More recently, however, some feminist researchers argue that "any naming or categorizing tends to call attention to similarities and to neglect differences, and any human or social phenomena can be understood in countless different ways" (Martin, 1994, p.643). Although feminists affirm diversity, it remains difficult to be certain that it means race, gender, and class to all women. How do we know that diversity does not mean being fat, religious difference, involvement in an abusive relationship, disadvantage at the workplace, or decisions made by girls in high school that attract them to female-dominated, lower paying jobs? The very categories we have assumed a priori (race and class) to be definitive of our differences may in fact be less significant than some others (Martin, 1994). For my purposes, I am focusing on urban Canadian women living in poverty. In this dissertation I am unable to fully consider the various other ways that the women may understand and experience their diversity.

[21] I use the terms "unhealthy," "ill-health," and "the unhealthy" to represent the experiences of declining health, disability, and disease. Although I consciously use these terms as "catch-alls," in many cases the experiences of health, disability, and disease are distinctly different. It is beyond the realm of this dissertation to explore the particular ways that these experiences are different.

[22] **Stigmatization** captures what Swanson (2001) calls "poor-bashing." Poor-bashing occurs when people who are poor are humiliated, discriminated against, shunned, pitied, patronized, ignored, blamed, and falsely accused of being lazy, drunk, stupid uneducated, having large families, and not looking for work (Swanson, 2001, p. 2). To stigmatize is to characterize or brand as disgraceful or ignominious. A **stereotype** is a conventional, formulaic, usually oversimplified conception, opinion, or belief (Morris, 1982). It denotes something fixed or lacking in originality. In common usage stereotyping can be seen as an ideological discursive strategy which demarcates an us/them binarity which functions to reinforce the domiant discourse (Gamble, 1999). To be **invisible** means to not be easily noticed or detected; to be inconspicuous (Morris, 1982).

[23] **"Culture** is a matrix of beliefs, values, and norms that inform, give meaning to, and regulate experience" (Westkott, 1998, p.816). According to Young (1990), culture includes symbols, images, meanings, habitual comportments, stories, and so on through which people express their experience and communicate with others. The symbolic meanings that people attach to other kinds of people and to actions, gestures, or institutions can often significantly affect the social standing of persons and their opportunities (Young, 1990).

[24] It is important to note that not all authorities are paternalistic and discriminating. The majority of welfare and health care workers, whether or not they agree, are forced to comply with their insitutional policies. Some attempt to resist and to use covert practices in order to help the poor.

[25] For clarity and consistency I use the term participatory research (PR). **Participatory research** (PR) includes the sister trends of action research, participatory action research, and other schools of participative inquiry, including co-operative inquiry, participatory rural appraisal, and participatory evaluation (Greenwood and Levin, 1998; Maguire, 2001).

[26] **"Feminisms"** is a term used to convey the diversity within feminist theoretical and political views on understanding the oppression of women (Ristock and Pennell, 1996).

[27] Marx and neo-Marxists linked the concept of praxis with a production paradigm in the interests of historical explanation. In more recent times praxis has played a prominent role in the formation of the school of critical theory, in which praxis is seen to be more directly associated with discourse, communication, and social practices (Audi, 1995).

[28] **Integrative feminism**, which recognizes diversity, is central to theoretical discussions on FAR (Maguire, 2001). Multiple inequalities exist on the basis of race, class and other factors (Cancian, 1992). Feminists have clarified how the concept of 'women in general' falsely universalizes and privileges the perspective of middle-class, heterosexual white women and denies and devalues the experiences of other women (hooks, 1984). Gender and women's diversity should be central in emerging explanatory frameworks. Hearing and affirming a multiplicity of voices can

'bridge the gaps' between people from different social positions (Ristock and Pennell, 1996).

[29] On a personal note, at several academic conferences I have been warned that feminist action research is risky for graduate students, that I may encounter opposition in doing it, and that only tenured academics have the "liberty" or "freedom" to engage in such work.

Research Context and Methods

Everybody gets together and basically is given the opportunity or the chance to express their concerns or views.... Or problems, it could be personal or whatever. And suggestions and ways and means of problem solving. Like what you can do about it. Or where you can go to get help (Joanne's interview, June 9, 2000).

Over time social, political, cultural, and economic factors are solidified and reified into a series of structures that are taken as real, natural, and immutable (Guba and Lincoln, 1994). These factors are constructed with particular interests and goals in mind, and often they require critique and change. Both my ontological and epistemological understandings were linked to elements of critique and hope – my research framework centered on the experiences of a group of marginalized women, required dialogue between the researched and the researcher, and was action-oriented. Feminist action research (FAR) guided this dissertation because it fostered a critical understanding of women's multiple perspectives and promoted inclusion, participation, and collective action. Through being deliberately reflexive, as a feminist action researcher I attempted to remain as self-conscious and transparent as possible in the research process. While the ultimate goal is critiquing and demystifying power relationships and working towards social change, feminist action researchers do not try to produce universal or objective accounts; rather they believe that having partial and local knowledge that values women's experiences, autonomy, and diversity is still knowing (Tom, 1997; Richardson, 2000). Not only do feminist action researchers promote inclusion, participation, and action, but they emphasize researcher

reflexivity and transparency that can illuminate and possibly untangle qualitative research's current "crises of representation and legitimation" (Lincoln and Denzin, 2000). What follows is a description of this dissertation's context and methods and how, in it, my ideals for FAR were both upheld and forfeited. This chapter begins with an overview of the research context – the WOAW organization – and why, how, where, and with whom I carved out my dissertation project. I then explain the data gathering methods, including the Research Team meetings, one-on-one interviews, participant observations, and fieldnotes. A detailed description of the analysis methods and issues of representation, power, legitimation, and trustworthiness follows. Finally, I conclude with an exploration of qualitative writing as a method of inquiry (Richardson, 2000) and the promises of collaborative writing projects for producing truly authentic texts. In chapter 4 I provide a more detailed description of the research participants stories and experiences.

The Research Context: In Collaboration with WOAW

A Brief History of "Women Organizing Activities for Women" (WOAW)

I conducted my dissertation in a larger feminist action research project named "Women Organizing Activities for Women" (WOAW). In June 1999 representatives from community recreation, social services, community schools, a women's centre, and a researcher from UBC (Dr. Wendy Frisby) collaboratively organized a 6 hour workshop for women on low income. The goal of this workshop was to uncover barriers to poor women's involvement in community recreation. Over 85 women, including single mothers, middle-aged and older women, and recent immigrant women, attended. At the end of the workshop the attendees decided to continue meeting to discuss their barriers and possibilities for increased involvement in community recreation because they saw involvement as contributing to their health. They named the impromptu organization "Women Organizing Activities for Women" (WOAW). At that time

they divided into four WOAW subgroups, with the intention of meeting regularly as subgroups and planning activities and workshops for themselves and women in their immediate communities.[1] There were 10 different service providers[2] affiliated with WOAW, and each subgroup had at least one service provider affiliated with it who worked as a resource and support person.

The "WOAW Project Team" was a layer of the organization where all WOAW members – including subgroup members, service providers, and UBC researchers – met. The Project Team fostered communication and networking among the four subgroups and developed important resources and relationships with community organizations. Generally the subgroups met every two weeks while the Project Team met once a month. This formation of the Project Team and the subgroups remains, though one of the original subgroups of primarily immigrant women disbanded in November 1999, while a new group, CoPoMo WOAW[3], formed in the East Coqutilam/Port Moody area in April 2000.[4]

In September 1999 I became involved in WOAW when Wendy Frisby was completing a research proposal to the Social Sciences and Humanities Research Council (SSHRC). Though funding was not secured, Wendy was committed to supporting and researching WOAW, and with the remaining funds from a SSHRC seed grant[5], she hired me as the Project Manager. I began attending WOAW subgroup and Project Team meetings in order to observe decision-making processes and to write fieldnotes. I also volunteered to write a monthly newsletter that was distributed to all WOAW members to foster communication and collaboration. During the fall of 1999 I met individually with most of the community representatives and with some of the women on low income to answer their questions about the research grant, the possibilities for the funding, and other general inquiries. At that time my role was to maintain a UBC presence in WOAW while building trust and making research, the grant application process, and the role of

university-based researchers as transparent as possible.

In December 1999 Wendy received 3 years of funding from SSHRC to study WOAW.[6] The overall goal of the research proposal was to examine the health problems of physical inactivity, stress, and social isolation through a feminist action research process designed to increase the involvement of women on low income in community recreation. The specific research objectives of the project were: i) to examine the lay meanings that physical inactivity, stress, and social isolation have for this diverse group of women on low income; ii) to examine the models of feminist action research that emerge as the 4 groups develop action plans to address these self-determined health problems; and iii) to develop an initial framework that would inform the evaluation of community recreation interventions for women on low income. Refer to Appendix A for an overview of the 3 year SSHRC project.

The SSHRC research proposal referred to WOAW as a feminist action research project within a collective organization. Although some WOAW members had read the SSHRC research proposal and knew we identified our research as feminist action research, they rarely referred to FAR directly. As an organization WOAW had the primary goal of reaching women with financial, social, cultural, or physical barriers to participate in their communities. WOAW members, with the guidance of a two service providers, decided to organize as collaboratively and inclusively as possible. The WOAW members determined that in order to redress poor women's isolation and alienation from many community services, WOAW should function as a collective organization. According to the two service providers, collective organizations made decisions through consensus, had a flat organizational structure, and encouraged equal participation at all meetings. There were ongoing challenges, however, with group process at all levels of organizing, and many WOAW members were confused and frustrated by consensus decision-making and did not clearly understand the differences between a collective organization

and a more traditional hierarchical one. Most WOAW members had little or no experience

working in a collective and had never made decisions through consensus. Misunderstanding the

collective process was evident when Katharine, a woman on low income, showed me a diagram

that represented her understanding of WOAW. Beth, a UBC graduate student, wrote in her

fieldnotes that the diagram Katherine drew of WOAW for the newsletter "is hierarchical, with

Wendy at the top, followed by Colleen, the Project Team, and then the subgroups. Sydney [a

UBC graduate student] and I are at the bottom; she called us 'Wendy's secretaries'" (Beth's

fieldnotes May 15, 2000). Although this was not the only time that there were clear differences

between the ideals of WOAW and how some WOAW women understood and experienced it,

overall there was support for organizing as a collective and determining ways to facilitate

everyone's participation.

In the year 2000 the Project Team met several times to discuss WOAW's vision and values

and the challenges of organizing as a collective. These meetings fostered a commitment to

developing a greater understanding of collective organizing. As well, WOAW developed a vision

statement:

> Women Organizing Activities for Women (WOAW) is diverse women working together
> to enhance quality of life and create positive and sustainable change. Women are
> empowered, respected, and connected to their communities. All thoughts and feelings
> are valued and important, and women are treated with dignity (WOAW vision statement,
> written collectively on May 10, 2000).

Although WOAW members identified WOAW as a collective organization, at times

"community development" was also used to describe the work of WOAW. Several service

providers adopted community development discourses because it was consistent with their

organization's rhetoric for increasing capacity in the local communities. In fact, community

development was an espoused mandate for all of the service providers who worked in the local

parks and recreation departments. Community development can be understood as a process of

engaging individuals and organizations in collective action towards social change (Seebaran, 2000; cited in Millar, 2002)[7]; its ideals are consistent with both collective organizing and feminist action research. "Collective organization" and "community development" were used interchangeably by many of the WOAW members, and differentiating them was never raised as a need or concern. For the purposes of my dissertation I refer to WOAW as a collective organization.[8]

Important WOAW Phraseology

Since my dissertation occurred within WOAW it is important to delineate the people involved and the organizational terms that were used.

WOAW Members: The People Involved in WOAW

Women on low income: *WOAW women* refers to a diverse group of women in the Tri-City area who had limited incomes, were socially isolated, and encountered barriers in accessing community services. During the three year SSHRC research project there were between 40 and 80 women on low income involved with WOAW. Throughout this dissertation **research participant(s)** refers only to the WOAW women who were actively involved in the dissertation research project as part of WOAW. The research participants were Susan, Elizabeth, Kelly, Maey, Caroline, Helen, Wanda, Rene, Martha, Arlene, Cynthia, Teresa, Cassie, Willow, Katharine, Alexa, Joanne, Trina, Virginia Dawn, Gloria, Christine, and Julie. Most of the women chose to use pseudonyms; this is discussed later in this chapter.

Service Providers: refers to people who had paid employment in the Tri-City Area (Coquitlam, Port Coquitlam, Port Moody), were affiliated with WOAW, and through their paid employment supported WOAW's organizing. Between 10 and 14 recreation centre, women's centre, community school, and social service workers were service providers. I called them service providers since they brought resources and support from their workplaces to support

WOAW. The service providers were active to varying degrees – some attended all subgroup and Project Team meetings, some attended some of the meetings, and others acted primarily as liaisons for the subgroups, facilitating the organization of activities, childminding, room bookings, and general networking. The service providers were not research participants in this dissertation study and did not participate in the Research Team.

Researchers: *The UBC Working Group* includes Dr. Wendy Frisby, Pam Ponic, Sydney Millar, Jo-Ann Zyla, Beth Pinnington, and myself. Wendy was on faculty in the School of Human Kinetics at UBC and we were graduate students who worked with her. Periodically other research assistants were hired to do specific work tasks and attend Working Group Meetings. From September 1999 to April 2001 I was the Project Manager and attended most WOAW meetings, wrote fieldnotes, coordinated data collection and analysis, managed the research budget, and established organizational systems for the research study.[9] In May 2001 Pam Ponic became the Project Manager. The UBC Working Group met every 2 to 4 weeks at UBC to discuss WOAW, the SSHRC grant, and our roles as feminist action researchers. Most of us were involved in data collection for the SSHRC project, and Pam, Sydney, Beth, and I also gathered data for our own graduate work.[10] Beth, Pam, and Sydney wrote fieldnotes that contribute to the data set of this dissertation.

WOAW members refers to everyone involved in WOAW including the women on low income, the service providers, and the researchers. Although the above descriptors are useful for distinguishing the different group of people involved and their different reasons for involvement, in naming them it is possible to falsely categorize or falsely differentiate those involved. For instance, before their involvement in WOAW, two WOAW women were social workers, a researcher was previously a woman on low income, and one service provider had engaged in graduate work. These categories roughly describe WOAW members at the time of

their involvement in WOAW, and are not to be understood as fixed or static.

Layers of the WOAW Organization

WOAW (Women Organizing Activities for Women) refers to the collective organization that was initiated in June 1999 and includes both the organizing and the research components of WOAW.

SSHRC project refers to research project that was funded by SSHRC (Social Sciences and Humanities Council) to study the WOAW organization and women on low incomes' primary health concerns. The SSHRC research budget supported all research-related activities, some WOAW activities, and research honoraria.[11] In order to manage the SSHRC research budget, Wendy divided the three-year study into six phases with each phase six months in duration (i.e. Phase 1 – January to June 2000; Phase 2 – July to December 2000; and so on). She allotted money for each phase and asked that one Project Team meeting per phase be devoted to discussing the budget. Although the phase budgets and honoraria varied over the course of the SSHRC project, the collective principles for determining the budget remained consistent.

The WOAW Project Team met every 2-4 weeks; any person who was involved in WOAW was invited to attend the Project Team meetings. On several occasions, people who were interested in WOAW and in possibly starting a WOAW group in their local community attended Project Team meetings in order to learn more about WOAW. Typically there were between 15 and 25 people in attendance at the meetings. A variety of issues were discussed at these meetings, including subgroup activities and updates, upcoming events, resource sharing, relevant community issues, challenges and conflict with group process, and the SSHRC research project. At each meeting a facilitator and a minute-keeper volunteered; these positions rotated at most meetings.

The majority of the WOAW women and service providers were affiliated with a **WOAW**

subgroup. Some WOAW women were involved exclusively in their subgroup while rarely attending other levels of organizing in WOAW, while other WOAW women were more active in the Project Team and Research Team. Although membership and activities varied over the course of the SSHRC project, the subgroups were as follows:

Aged to Perfection (ATP) formed in June 1999, and 20 to 25 women and 1 service provider were active in this group. The majority of ATP members identified themselves as seniors, though the group did not impose strict age requirements. They worked primarily out of Dogwood Pavilion and Hoy Creek Housing Co-Operative in Coquitlam and organized activities such as belly dancing classes, tai chi, computer training, and "Safety Day".

CoPoMo WOAW formed in April 2000, 15 to 20 women, primarily middle-aged and recent immigrant women, and 4 service providers were involved. The meetings and activities occurred at three locations in Coquitlam – the Coquitlam Aquatic Centre, Pinetree Community Centre, and Hoy Creek Housing Co-Operative. They organized activities such as career planning, fitness training, and hosted a series of workshops including one on "Stress Management."

PoCo WOAW formed in June 1999 and 6 to 12 women and 2 service providers were affiliated with this group. Meetings and activities began in the Port Coquitlam Area Women's Centre Society, though they moved to Hyde Creek Recreation Centre in April 2000. The majority of PoCo WOAW women were young mothers with dependent children. This group organized activities such as qi gong, tai chi, yoga, mom and tots, weight training, aerobics, First Aid, and computer classes.

SWCo WOAW formed in June 1999 and 5 women and 3 service providers met regularly. They organized activities such as a walking group, health cooking classes, and an English discussion group, and held most of their activities and meetings in Mountainview Public School and Poirier Recreation Centre, Coquitlam. They were also active in their community, making

connections with groups such as a single mothers' support group and a multi-cultural society. This group was diverse – they were a variety of ages and some had young children, grown children, or no children.

Table 1 – The Women's Subgroup Affiliations

WOAW subgroup affiliation	Subgroup size	Names of research participants
Aged to Perfection	20 to 25	Rene, Wanda, Arlene, Joy, Trina
CoPoMo WOAW	15 to 20	Katharine, Alexa, Cassie, Teresa
PoCo WOAW	6 to 12	Kelly, Virginia Dawn, Julie, Joanne, Caroline, Cynthia
SWCo WOAW	5	Susan , Willow, Maey, Elizabeth, Gloria

Note: Although some women moved between subgroups, when I wrote my dissertation the 20 women involved as research participants belonged to these subgroups.

The Research Team first met in March 2000. I initiated the Research Team as a place for the WOAW women to discuss common issues and concerns, particularly those associated with their health and living in poverty. Throughout my dissertation I refer to the women who regularly attended the Research Team meetings as **Research Team members**.[12] I attended most of these meetings and often another researcher attended to record fieldnotes. Only once, when invited by the Research Team members, did a service provider attend. Between 1 and 17 women attended, with an average attendance of 11 women. Although these meetings were the primary data source for my dissertation (from March 2000 to June 2001) the meetings and my involvement in them continued and is ongoing today. My involvement is further explained later in this chapter.

Research Parties occurred every 6 months (corresponding to phases of the SSHRC project) and were organized for the UBC researchers to meet with the WOAW women to review research findings or to discuss ongoing issues in WOAW. At these 3 hour meetings the SSHRC grant provided a catered lunch and an honorarium for women in attendance. At the **Service Providers' Research Parties** the researchers met with the service providers and discussed issues and concerns that they were encountering. Most of these meetings had an open agenda and the service providers raised pertinent issues – for instance, at one meeting we discussed the

power issues and dynamics that were surfacing at different levels of WOAW. Consult figure 2

for a graphic representation of the WOAW organization and its members.

Figure 2 – The WOAW Organization

Women on low income in
the Tri-City area –
"WOAW Women"

WOAW
Subgroups

Research Team (and
Research Parties for
WOAW women)

WOAW
Project
Team

Service providers in the
Tri-City area -
"WOAW service
providers"

Research
Parties for
service
providers

Researchers –
"UBC Working
Group"
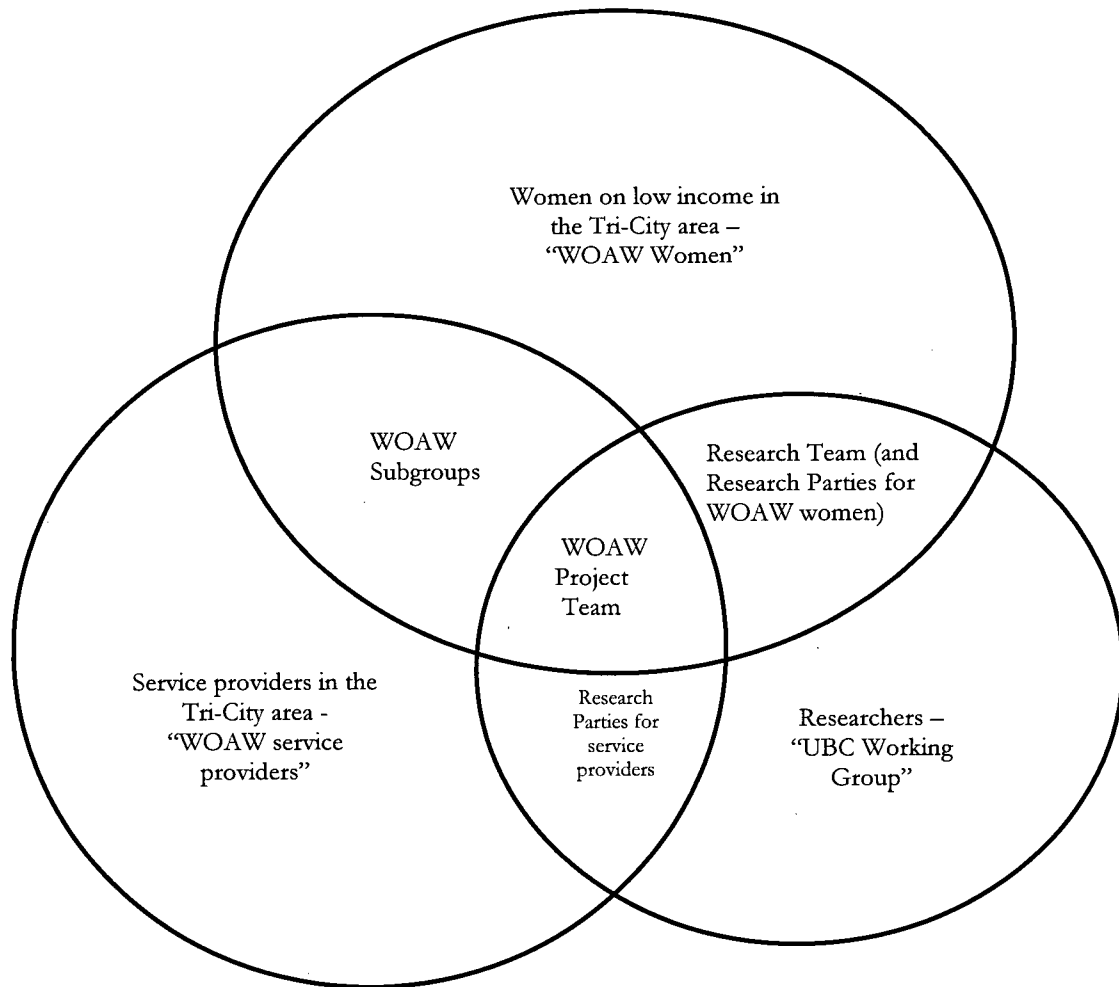
Conducting FAR Collaboratively

There was a seamless fit between WOAW as a new grassroots collective organization and my research interests. From the beginning of my involvement as the Project Manager, I intended to carve out my dissertation research from within the WOAW organization. In November 1999 I met with Louise, a WOAW service provider, who articulated a need for a "research perspective" in her subgroup because discussions of the "politics of poverty" had not yet occurred. At that time there was no place in WOAW for the women to discuss major life issues and constraints as the focus of Project Team meetings was on activity planning and resource sharing. According to her, through discussing the politics of poverty the women could share experiences, better understand their poverty and health, and possibly engage in collective action. Together we brainstormed and determined that the creation of a "Research Team" could fill this void and be an ideal site for collecting data for my dissertation project. The first Research Team meeting occurred in March 2000.

In Maguire's (1993) reflections on participatory action research, she states that "it may be easiest and most instructive to try becoming involved in an ongoing or established participatory research project in which you can contribute your work without having to mobilize the entire project from scratch" (Maguire, 1993, p.175). Collaborating with the SSHRC project and working as the Project Manager facilitated all phases of my dissertation project. The challenges of access, start-up, trust-building, resources, and support were better handled through the larger FAR project since there was a budget for research activities and a number of researchers, research participants, and service providers involved. Nevertheless, the number of researchers involved and the large SSHRC budget, collaboration and power dynamics were complex and multi-faceted. As both a Ph.D. candidate and the Project Manager I worked with Wendy Frisby as one of my research committee members and also as my "boss." My research advisor, Allison

Tom, was a collaborator on the SSHRC project and in the second year initiated her own research

project to study the challenges of feminist action research. Given that one of FAR's goals is to

work collaboratively, these power dynamics reflected the reality of conducting FAR and

provided insights into the challenges and potential contributions of working collaboratively as

feminist action researchers with community groups.

Despite these complex power relationships, conducting my research within the WOAW

organization and the SSHRC project had many benefits. The relationship between the Research

Team, WOAW, and the SSHRC research project enabled the Research Team meetings to evolve

as they did. From the beginning the Research Team explored personal and emotional issues that

had not been raised at other meetings within WOAW. Susan explained:

> My idea of the Research Team is very different than the other groups in the sense that it
> has its own agenda and to me it's been the fact that we're taking particular issues that are
> vitally important to the individual, as well as the groups, 'cause I noticed there's a lot
> more personal conversation going on here than in a lot of the other groups (Susan, RTM
> October 19, 2000).

At the Research Team meetings we focused on the women's more personal issues because the

subgroups and Project Team handled WOAW's "business", including membership, the research

budget, and organizing activities and workshops. As well, to some degree the structure of

WOAW allowed the women to choose how and where they wanted to be involved. Maey said

"And one group doesn't work out, just go 'ok, this isn't the group for me, I'm going to try the

other group and see how this group works for me cause every group is different'. Every group is

a lot different" (Maey, RTM October 19, 2000). The layers of the WOAW organization enabled

some flexibility and choice for the WOAW participants and possibly helped them to maintain

their energy and enthusiasm for the Research Team meetings.[13]

Not only did the WOAW organization provide different avenues for the women's

involvement, but, significantly, the SSHRC grant covered important costs that facilitated the

women's involvement in all aspects of WOAW, including the Research Team. As well, the SSHRC grant provided me with resources to facilitate my own research, such as covering my own travel expenses and paying for a researcher to record fieldnotes, transcribe interviews, and watch the women's young children during one-on-one interviews. As a doctoral candidate and neophyte feminist action researcher, I was in the enviable position of having the support of WOAW and the SSHRC grant to pursue my research interests.

Data Gathering

Given the methodological limitations and dearth of qualitative studies in the health equity field as described in chapter 2, qualitative methods were appropriate for this study. The use of qualitative methods locates the individual in the context of social structures and can broaden the range of debate. In the qualitative arena the individual is not only inserted into the study, the individual is the backbone of the study. The description of persons, places, and events has been the cornerstone of qualitative research (Janesick, 2000). "Qualitative research is conducted not to confirm or disconfirm earlier findings, but rather to contribute to a process of continuous revision and enrichment of understanding of the experience and form of action under study" (Elliott, Fischer & Rennie, 1994; cited Lincoln, 1995). Qualitative methods were chosen because of their potential to show how broader structures constrained and shaped poor women's lives, while enabling them to describe these influences. Poor women are often excluded from knowledge production processes and qualitative methods legitimize their experiences and let their voices be heard.

Research Questions

I posed questions in three areas:

- How did a group of women on low income understand and negotiate their experiences of poverty, exclusion, and health, both individually and collectively?

- From the perspectives of a group of women on low income, what was the connection between poverty and health? In what ways did they believe that the experiences of exclusion, stereotyping, and invisibility affected their health?

- How did a group of women on low income collaboratively identify, organize, and enact action towards social change to address their shared concerns?

The findings from these research questions are discussed in chapters 6, 5, and 7 respectively.

Only a fraction of the qualitative data that were gathered for the SSHRC project were used to examine my research questions.[14] These data are represented in Table 2.

Table 2 – Overview of SSHRC and Dissertation Data

	Subgroup meetings	Project Team meetings	Research Team meetings	Interviews WOAW women	Interviews Service providers	Working Group meetings	Research Parties
Phase 0 Sept-Dec 1999	Fieldnotes	Fieldnotes				Fieldnotes	
Phase 1 Jan-June 2000	Fieldnotes	Fieldnotes Transcripts	Fieldnotes Transcripts	Transcripts[a] - schedule 1 - schedule 2	Transcripts	Fieldnotes Transcripts	Fieldnotes Transcripts
Phase 2 July-Dec 2000	Fieldnotes	Fieldnotes Transcripts	Fieldnotes Transcripts			Fieldnotes Transcripts	Fieldnotes Transcripts
Phase 3 Jan-June 2001	Fieldnotes Transcripts	Fieldnotes Transcripts	Fieldnotes Transcripts	Transcripts	Transcripts	Fieldnotes	Fieldnotes Transcripts
Phase 4 July-Dec 2001	Fieldnotes	Fieldnotes Transcripts	Fieldnotes Transcripts				Fieldnotes Transcripts
Phase 5 Jan-June 2002		Fieldnotes Transcripts	Fieldnotes Transcripts				Fieldnotes Transcripts
Phase 6 July-Dec 2002		Fieldnotes Transcripts	Fieldnotes Transcripts				Fieldnotes Transcripts

Note: Data used for my dissertation
[a] There were two "rounds" of interviews in this phase of the SSHRC project. Refer to Appendices E and F for the interview schedules.

As can be seen in Table 2, the major data sources for my dissertation were transcripts from the Research Team meetings, the Research Parties, and two rounds of interviews, and fieldnotes. As I explain later in this chapter, I remained connected to the Research Team throughout the SSHRC project though I did not use all of its data for my dissertation. Throughout my dissertation the data are identified according to Table 3.

Table 3 – Key for Reading Quotations

Type of Data	Example
Interview data	Willow's interview, September 14, 2000
Research Team meeting (RTM) data	Willow, RTM June 29, 2000
Fieldnote data	Colleen's fieldnotes, October 19, 2000

The Women's Involvement as Research Participants

All of the women who participated as research participants in my dissertation were WOAW members. Involvement in my dissertation was entirely optional – some WOAW women were consistently involved throughout my project, some were involved in the beginning and ceased their involvement, others became increasingly involved towards the end, while other WOAW members were never involved. The majority of the data used throughout this dissertation are based on the 20 women who were initially involved in the Research Team and who participated in the first round of interviews. Over time, 5 of these women withdrew from the Research Team, while another 10 women became involved to varying degrees. Only one woman who was interviewed in the first round never attended a Research Team meeting (she was active in other aspects of WOAW). An overview of the women's involvement in my dissertation appears in Table 4.

The women who were involved in my dissertation were diverse in terms of their ages, educational backgrounds, and work experiences. They all identified themselves as "poor," and the majority of them received social assistance, disability benefits, or a seniors' pension. Two-thirds of the women were mothers and identified as single. In chapter 4 I provide detailed accounts of the women's backgrounds and experiences.

Table 4 – Overview: WOAW Women's Involvement in Dissertation

• Average number of women in attendance at the Research Team meetings	11
• Number of different women who attended the Research Team meetings - Number of women who attended 1-3 RTMs - Number of women who attended 4-6 RTMs - Number of women who attended > 7RTMs	30 13 4 13
• Number of different women who were interviewed - Number of women interviewed in 1st round - Number of women interviewed in 2nd round	20 20 12
• Number of women who were interviewed but never attended a Research Team meeting	1
• Number of women who were interviewed but who, as of December 2000, were no longer involved in WOAW or the Research Team	5
• Number of women who became involved in the Research Team after July 2000, were not interviewed for the purposes of this dissertation[15], but who signed consent forms and contributed to this dissertation's findings by participating in Research Team meetings	11

Chronology and Overview of Data Collection

This section provides a general overview and chronology of the data collection. A detailed description of the data collection activities, including the Research Team meetings, the one-on-one interviews, and the participant observations, follows this section, and in chapter 7, I analyze the Research Team as feminist action research. For more detailed information, consult Appendix A, "Overview of the SSHRC Project" and Appendix B, "Detailed Overview of Research Team Meetings."

Gaining Access and Building Trust: September 1999 to February 2000

From September 1999 to March 2001, I worked as the Project Manager, identified the Research Team as the primary site of my data collection, received committee approval for my "second stage" research proposal, received UBC ethical approval, and generated interest in the Research Team meetings. Maguire referred to this stage as "entering, experiencing, establishing relationships with actors" (Maguire, 1987, p.116). During this time I attended all WOAW meetings as a participant observer and recorded fieldnotes. I became acquainted with most of the WOAW women and service providers and learned about the Tri-City area.

<u>Intensive Data Collection: March 2000 to June 2001</u>

March and April 2000: Orientation to the Research Team

There were three Research Team meetings between March and April 2000. At these meetings we discussed the purpose of the Research Team, the role of research, general expectations and guidelines for meeting, and issues around informed consent, tape recording, anonymity, and confidentiality. The women were not concerned about tape recording the meetings and at times they reflected that tape recording was important because it facilitated the research.

During this time the Research Team resembled group interviews more than group meetings. I asked the women questions about their experiences living in poverty, their major health issues, and the relationship between poverty and health. I pursued these topics in a first round of one-on-one interviews that occurred in March and April 2000. The first three Research Team meetings were attended by a variety of different women; some of whom became regular attendees while others did not. In these early meetings I was uncertain whether the women would choose to continue to meet as the Research Team.

May and June 2000: Anticipation and Celebration

Energy and enthusiasm for the Research Team grew in the spring and summer of 2000. New members continued to join the Research Team while a core of Research Team members developed. By May 2000 the Research Team more closely resembled a meeting place with a core group of members than a group interview. The Research Team members seemed increasingly familiar and comfortable with the purpose and structure of the meetings, and began to ask their own questions. During this time the women shared a sense of celebration for what they had accomplished as the Research Team and the WOAW organization.

In June I conducted the second round of interviews with 12 women and asked them about

74

the Research Team. Katharine said:

> [The Research Team is] very big. A big aspect of WOAW. We don't want it to stop. I
> want it to grow. I want it to have more power. We need to come to a point where we can
> make recommendations or at least explain some facts. And then approach the
> community and say "look at things that are not done" (Katharine's interview, June 9,
> 2000).

Generally the women shared a sense of collective power and believed that the Research Team
played an important role in WOAW. Wanda commented "it's [the Research Team] the most
important thing. Without the Research Team I don't think the rest would gel together.... I don't
see WOAW itself as being held together without that Research Team" (Wanda's interview June
5, 2000). The women felt that the Research Team engaged in relevant discussions, and that the
actions they had identified were important to pursue.

August to December 2000: Work and Conflict

After the high energy of the spring and early summer of 2000, the Research Team members
chose to not meet in July and to reconvene in August. The meetings that followed were riddled
with conflict. There was little evidence of the connection and closeness that characterized the
previous stage of the Research Team. The members experienced an increasing need to do work
and to be productive, and a decreased value in exploring issues and sharing as a group.

In September 2000 the women identified that they wanted to work towards registering
WOAW as a non-profit society and coordinating a community forum to address their grievances
with the welfare system. With the Research Team's impetus for doing work, meetings were
lengthened to 3 hours with half of every meeting devoted to each action item. Once this
decision was made conflict arose. The Research Team members were increasingly frustrated and
at the November 2000 meeting only one woman attended. At this point I too was frustrated – I
felt that there was little energy for the Research Team and decided to not initiate another
meeting. During this time I recorded my emotions and reactions in my fieldnotes and journal.

The UBC Working Group organized the December 2000 Research Party in order to collect data on the women's experiences in the first year of the SSHRC project (2000). Although 12 women attended they were clustered into small groups around the table. There was antagonistic "side-talking" throughout the meeting and tension between the attendees.

January to June 2001: Renewal of the Research Team

In mid-January 2001 I received an email from Wanda inquiring about the Research Team and our next meeting. She asked to schedule a Research Team meeting and suggested that six women she had consulted would attend. I then organized a Research Team meeting for February 6, 2001, and 9 women attended. We discussed our previous disappointments and strategies for managing our shared frustrations with the Research Team meetings. The woman determined that the Research Team would meet once a month, for 2 hours, and would only focus on the welfare grievances workshop. We then had monthly meetings, had a WOAW service provider attend, and hosted a workshop with DERA (Downtown Eastside Residents' Association) to gather information on B.C. Benefits.

Continued Researcher Involvement and Commitment: July 2001 to the Present

Although I completed my data collection in June 2001, I remained committed to and involved in WOAW and the Research Team. I was no longer the Project Manager and therefore met with WOAW members less often. However, I continued to coordinate and attend Research Team meetings, attend UBC Working Group meetings and the occasional Project Team meeting. During this time I corresponded with some WOAW members in order to devise strategies for communicating the findings from my dissertation to the WOAW organization and the broader community.

Data Sources

The Research Team

The Research Team meetings' transcripts and fieldnotes were the largest data source for my dissertation. There were many benefits in establishing a group situation as my primary data collection method. According to Madriz (2000), groups are particularly suited for feminist research because they minimize the control of the researcher during the data gathering process by decreasing power over the research participants and limiting the control of the moderator, who has less power over a group than over a single individual. As well, groups emphasize the collective, rather than the individual, and can foster free expression of ideas while encouraging the members of the group to both recall experiences and to speak. Group meetings can allow moments of not having to talk, of being able to listen to others, thus enabling rethinking initial accounts that, upon reflection, may need amplification, qualification, amendment, or contradiction (Lofland and Lofland, 1984). Researchers working with groups can witness participants engaging in dialogue, sharing ideas, opinions, experiences, and even debating with each other. It is also possible to see the participants' own power relations and hierarchies (Madriz, 2000).

However, group meetings can be a challenge for the researcher. At times it may be difficult to keep one person from dominating the group, to encourage reluctant respondents to participate, or to obtain responses from the entire group to ensure the fullest coverage on the topic. As the researcher and facilitator of group meetings it is often difficult to know what to do. In group meetings the researcher must balance the directive, interviewer role with the role of the moderator, which calls for the management of the dynamics of the group. The researcher must simultaneously worry about the script of questions and be sensitive to the evolving patterns of group interaction (Fontana and Frey, 2000).

Despite its challenges, group meetings were the most suitable primary data collection method for this feminist action research project since we were exploring experiences of poverty and health and working collaboratively to uncover action strategies. According to Randall (1980), groups can provide ways for women to face social isolation and oppression. Shared testimonies, individual and collective, can become a vehicle for capturing the socioeconomic, political, and human challenges that women face (Randall, 1980; cited in Madriz, 2000). Groups are ideal for social researchers interested in building new paradigms of social research promoting social change (Madriz, 2000).

The Research Team meetings were two or three hours long, occurred in Port Coquitlam at Hyde Creek Recreation Centre, and all but two were tape recorded. I handled logistical issues such as booking the meeting room and the childminding, bringing snacks, and ensuring that all women who wanted to attend had transportation. I always picked up at least one woman for the meetings, and I often had a full car. These meetings, which occurred every three to five weeks, involved a considerable amount of my time. Every meeting required approximately fifteen hours of work, including meeting preparation and organization, transcribing the tapes of the meetings, writing fieldnotes, and travel. I characterized my roles on the Research Team as "researcher," "facilitator," and "Research Team member." These roles are examined in detail in chapter 7.

The general activities of the Research Team included the identification and description of key health needs, concerns, and experiences; the exploration of common and divergent issues with poverty and B.C. Benefits; the identification of action plans and strategies; and the "work" of action. The Research Team evolved through the typical developmental stages of group formation, identification, and action. However, these stages were not linear nor were they discrete. In fact, action strategies emerged from the beginning of the Research Team. Many of the women who were involved were interested in engaging in the research component by

questioning and analyzing their experiences, observing and critiquing group processes, and working towards social change. Initially the Research Team meetings were semi-structured; at the first four meetings the women relied on me to ask questions to initiate discussion. As the Research Team gelled as a group and identified actions, the meetings became increasingly unstructured, though this was not always seen positively. The perceived need for structure in the Research Team meetings is further explored in chapter 7. Consult Appendix B for an overview of all of the Research Team meetings in terms of dates, attendance, and discussion topics. An overview of the Research Team meetings is provided in tables 5 and 6.

Table 5 – Research Team Meetings (March 2000 – June 2001)

Research Team Meeting DATE	Data Collected	
	Transcripts	Fieldnotes
March 7, 2000	None - Consent forms signed [a]	Colleen, Beth
April 4, 2000	Primary transcript	Colleen
April 26, 2000	Primary transcript	Colleen, Beth
May 16, 2000	Primary transcript	Beth
June 7, 2000: *Research Party*	Primary transcript	Beth
June 29, 2000	Primary transcript	Colleen
August 17, 2000	Primary transcript	Colleen
September 6, 2000	Primary transcript	Colleen
September 27, 2000	Primary transcript	Colleen
October 19, 2000	Primary transcript	Colleen
November 9, 2000	Primary (interview) transcript	Colleen
December 12, 2000: *Research Party*	None - Tape recording blocked [b]	Beth, Sydney
February 6, 2001	Secondary transcript	Colleen, Pam
March 6, 2001	Secondary transcript	Colleen, Pam
April 3, 2001	Secondary transcript	Colleen, Pam
April 17, 2001	Secondary transcript	Colleen, Pam
May 29, 2001: *Data analysis potluck*	Secondary transcript	Colleen
June 19, 2001: *DERA Workshop*	Secondary transcript	Pam

Note: *Primary transcript* refers to tape recorded Research Team meetings that I transcribed and analyzed in my primary data set. *Secondary transcript* refers to Research Team meetings that were tape recorded and transcribed though the transcripts were not considered for my primary data set because of the volume of data already collected for my dissertation. By the end of the year 2000 I had a large data set, had reached saturation in addressing my research questions, and, with the encouragement of my research committee, decided to end the data collection for my dissertation. These secondary transcripts may be used at a later date by myself or the other research collaborators from the SSHRC project.
[a] This Research Team meeting was not tape recorded since at this meeting the women signed consent forms and were familiarized with the process of tape recording, transcribing, and analysis.
[b] Tape recording was blocked anonymously at this meeting.

Table 6 – Data from the Research Team Meetings

• Total number of Research Team meetings	18
• Number of primary RTM transcripts	10
• Number of secondary RTM transcripts (not analyzed for this dissertation)	6
• Number of RTM that were not tape recorded (primary RTMs)	2

One-On-One Interviews

Intensive interviews seek to discover the informant's experience of a particular topic or situation (Lofland and Lofland, 1984). One-on-one interviews are active interactions between two people leading to negotiated, contextually based results. Each interview context is one of interaction and relation; the result is as much a product of this social dynamic as it is a product of accurate accounts and replies. The nature of the social dynamic of the interview can shape the nature of the knowledge generated. Interview participants are "actively" constructing knowledge around questions and responses (Fontana and Frey, 2000).

I conducted 32 one-on-one, semi-structured interviews, and they ranged in length from 45 minutes to 2 hours. Twenty women were interviewed in the first round; in these interviews I asked the women about their experiences with WOAW, their major health concerns, and specifically about stress, depression, social isolation, and physical inactivity. These interviews were used for both the SSHRC project and my dissertation, and in general I used two-thirds of the data from them to address my research questions. Before each interview I explained the nature of the research, the differences between my research project and the larger SSHRC project, and issues around confidentiality and informed consent. Together we read through the consent form (see Appendix C) and I explained why the UBC Ethics Committee requires them to sign such a form. I also explained the entirely voluntary nature of both my project and the SSHRC project.

In the second round of interviews, 12 women identified as wanting to be interviewed; these

women had remained consistently involved in the Research Team meetings and WOAW. In this round of interviews I asked the women about their health, the relationship between health and living in poverty, the experience of being stereotyped and stigmatized, and their reflections on the Research Team. All of these topics had been discussed at the Research Team meetings; I used the interviews to uncover individual experiences that may not have emerged in the group setting of the Research Team meetings. In the second round of interviews the participants' comfort and understanding of the research project and the interviews as a form of data collection had grown. By this time they had a clear sense that there were two distinct projects occurring and that the transcripts from the Research Team meetings and interviews were to be used as "data." Consult Appendices D and E for the interview schedules.

I approached the interviews as an intensive guided conversation with the goal of eliciting rich, detailed, and personal reflections. Another goal of the interviews was to build rapport and reciprocity between myself and the women. I provided feedback to the women in a maximally reciprocal way, and did not presume neutrality. According to Oakley (1993), in feminist interviewing the interviewer refuses to stay detached and instead carries an obligation to reveal some of her own feelings in order to introduce greater reciprocity into the interaction. Women who lack opportunities to engage collaboratively with other women and women who are socially isolated may welcome the opportunity to talk to a sympathetic listener. But it is possible that the very effectiveness of these techniques leaves women open to exploitation through the research process (Finch, 1993). As much as possible I developed reciprocal relationships in terms of sharing my own experiences and personal information, though there were power and income differences between myself and the women I interviewed. I attempted to not minimize interviewer-interviewee differences and was honest and upfront about my interests in this research project and my personal background and differences.

Although the interviews provided an opportunity for the women to reflect individually on the discussions and group process of the Research Team, the research participants had different reactions to them. Oakely (1993) claims that the convention of the interviewer-interviewee hierarchy is a rationalization of inequality and that what is good for the interviewer is not necessarily good for the interviewee. Indeed, in some interviews I realized that interviewing is an academic exercise that may raise insecurities and discomfort in some participants. After one interview, I wrote:

> She [research participant] said that she was uncomfortable [in the interview] because she didn't feel like she was answering the questions correctly. She felt like she used to feel in school, when she was really worried about getting the right answers. She had purposely not asked me for the interview questions in advance because she wanted to practice answering questions without knowing what the questions would be. But she was nervous about the interview and struggled to find the "right" answers (Colleen's fieldnotes, June 2, 2000).

Another participant said she had difficulty articulating her thoughts in an interview. "I have all these thoughts going through [my head] and I can't get them all to form... it's half there... half floating" (Elizabeth's interview June 12, 2000). Additionally, there were many instances where the participants ended their remarks with "I don't know," "you know?" or "I'm not sure if I'm answering the question." I was concerned about the comfort of the research participants when they suggested that they felt awkward or uncertain through the interviews. Some participants thought that there were right and wrong answers. These experiences conformed with Oakley's critique of interviewing, and I questioned what some of the women had gained from being interviewed.

I had the opposite reaction from other research participants, however. At her first interview, Kelly greeted me at the door: "Colleen, I've been looking forward to this, I've got a lot of things I want to tell you" (Colleen's fieldnotes, March 14, 2000). She had made coffee and muffins and our interview was 2 hours long. Katharine began our interview with "So how does this work, do

I start or do you?" (Colleen's fieldnotes, March 14, 2000). She had made notes and had a list of things she wanted to raise with me.

Through the interviews I was able to check for individual experiences, assumptions, and reflections. Importantly, I was able to talk in-depth with those research participants who were typically more quiet and withdrawn in group settings. Alexa said "I'm not an outspoken person. I'm not willing to share, I don't feel comfortable enough because I'm not used to being in the group" (Alexa's interview, June 2, 2000). The women who appeared the most uncertain about the responses they gave in the interviews were also the women who had difficulties expressing themselves at the Research Team meetings. I cannot assess whether the discomfort they expressed stemmed from their involvement in the research alone or whether it is something they encountered in other contexts. Tables 7 and 8 provide an overview of the interview data.

Table 7 – One-on-one Interviews (March – September 2000)

Interviewee	Date(s)
Alexa	March 2, 2000; June 2, 2000
Arlene	April 4, 2000
Caroline	April 12, 2000
Cassie	April 18, 2000
Cynthia	April 12, 2000
Elizabeth	March 20, 2000; June 12, 2000
Gloria	March 24, 2000
Joanne	March 20, 2000; June 9, 2000
Julie	March 14, 2000
Katharine	March 14, 2000; June 9, 2000
Kelly	March 14, 2000; June 6, 2000
Maey	March 27, 2000; June 9, 2000
Martha	April 4, 2000
Rene	Match 15, 2000; June 9, 2000
Susan	March 24, 2000; June 2, 2000; November 9, 2000
Teresa	March 20, 2000
Trina	March 21, 2000; June 5, 2000
Virginia Dawn	March 14, 2000; June 6, 2000
Wanda	March 15, 2000; June 5, 2000
Willow	March 15, 2000; September 20, 2000

Table 8 – Data from the Interviews

• Number of women interviewed in March – April 2000		20
• Number of women interviewed in May – June 2000 [a]		12
• Total number of interviews conducted		32

[a] Note: The women who were involved in the second round of interviews were all interviewed in the first round in March 2000.

Participant Observation and Fieldnotes

Observation has been characterized as "the fundamental base of all research methods" in the social sciences (Adler and Adler, 1994, p.389) and as the "mainstay of the ethnographic enterprise" (Werner and Schoepfle, 1987, p. 257; cited in Angrosino and Mays de Perez, 2000). According to Adler and Adler (1994), observational research is a powerful source of validation. Observation rests on something researchers can find constant – their own direct knowledge and their own judgement. The keeping of careful and detailed fieldnotes over time is meant to serve as a protection against the inevitable loss of sharpness of perception as the researcher becomes a more central member of the community under study (Acker, 2000).

In my role as the Project Manager I was a participant observer at most WOAW meetings and recorded fieldnotes; I wrote fieldnotes for over 50 subgroup and Project Team meetings. My involvement as a participant observer in Phase 0 (September to December 1999) helped me hone my research questions, determine appropriate language, and gain an intuitive understanding of WOAW. I continued recording fieldnotes throughout my dissertation, during and after the Research Team meetings, the interviews, WOAW meetings (Project Team meetings, WOAW subgroup meetings), phone conversations, informal discussions, and email correspondences. I also kept a journal to document my personal reactions, assumptions, feelings, and insights. For many of the Research Team meetings there are two sets of fieldnotes since another member from the UBC Working Group attended. In table 9, a breakdown of the fieldnotes that were recorded is provided. The guidelines that were followed for the participant observations are in

Appendix G.

Table 9 – Data from the Fieldnotes

• RTM fieldnotes written by Colleen	18
• RTM fieldnotes written by other UBC researchers (Beth Pinnington, Pam Ponic, Sydney Millar)	11
• Ongoing reflective journal	ongoing
• Total number of sets of fieldnotes	29

Data Analysis: "Sense Making"

The Analysis Process

Denzin (1994) refers to the data analysis process as "sense making" – how the writer moves from data gathering to the actual writing process, making decisions about what will be written about, what will be included, how it will be represented, and so on (Denzin, 1994). I engaged in an analysis process similar to many qualitative researchers. I used Atlas.ti 4.1 to organize, sort, and code my data; the ways that my use of Atlas.ti enhanced the trustworthiness of the analysis are explained in the section "Legitimation and Trustworthiness." Coding is the heart and soul of whole-text analysis, and forces the researcher to make judgements about the meanings of blocks of text. The fundamental tasks of coding include sampling, identifying themes, building code-books, marking texts, constructing concepts, models, and theory, and testing these models against empirical data (Miles and Huberman, 1994; Ryan and Bernard, 2000).

My data set included 71 primary documents; refer to table 10 for an overview of my data set.[16]

Table 10 – Overview: Dissertation Data

• Number of interview transcripts	32
• Number of Research Team meeting transcripts	10
• Number of sets of fieldnotes	29
• Total number of primary documents for analysis	71

The analysis process I adopted is best described by Ryan and Bernard (2000). I used chunks of text as the unit of analysis, and they were assigned "codes" representing thematic units. I began my analysis with general codes that I derived from reading the literature and my work as the Project Manager. The coding was an iterative process; I went through the data several times, recalled codes, and reconfirmed my analysis. Through this process I revised and added codes and subcodes. I developed a "code book" to organize the list of codes; it appears in Appendix H.

The coding process involved marking quotations from the primary documents with code names. The marking of text enabled me to see which codes reoccurred, to determine the codes that required further examination and the codes that were too specific. I also used the Atlas.ti function "autocoding" to search all of the primary documents for key words such as "poverty," "disability," "health," and "stress," and to double-check the consistency and thoroughness of my coding. I did some counting with the coding and autocoding to assess the weight of the emerging themes. For instance, the code "poverty-barrier" had 120 quotations and required a more detailed analysis. I recoded the "poverty-barrier" code to more specifically capture the reason and nature of the barrier – was it a consequence of having little money, the treatment of welfare workers, or something else? Through this process I recorded code and theory memos and operational notes concerning emerging conceptual and theoretical understandings. Memoing is a principle technique for recording relationships among themes (Denzin, 1994). Finally, through Atlas.ti's "network" function I visually represented the relationships between concepts and analytic terms.

The Realities of Collaborative Data Collection and Analysis

Feminist action research is characterized by the negotiation of description and interpretation (Lather, 1991). The early and final stages of my dissertation were not fully collaborative. I

established my research questions prior to meeting the women in WOAW or the Research Team. I also wrote the interview questions and the questions I posed at the first three Research Team meetings. Before the formation of the Research Team in March 2000, my involvement with WOAW enabled me to confirm that my questions were relevant and important to the women. Yet I was in the position to determine how the Research Team and interview discussions transpired and I had some influence on the major issues that arose. Similarly, I also influenced who remained involved with the Research Team and who did not. The women who gravitated to my questions and felt that they were meaningful to them remained involved. Possibly, the women who did not stay involved with the Research Team felt less attached to or comfortable with the questions I asked.

The data analysis process for this dissertation was iterative, dynamic, and partially collaborative. At seven of the Research Team meetings (April 24, 2000, May 16, 2000, June 7, 2000, June 29, 2000, August 17, 2000, September 27, 2000, April 3, 2001, May 29, 2001) I either distributed summaries and themes from the previous meeting's discussion or wrote major discussion topics and outcomes on a flip chart. I was diligent about transcribing the meeting within a week so that I could extract the major discussion topics, decisions, outcomes, and themes, and present them at the following meeting. Early on I had determined that this was an ideal way to collaboratively analyze the data while furthering the conversation. After the third Research Team meeting I wrote:

> I then put up the flip chart with their descriptions of "the label of welfare" and said that this is what I learned from the last meeting. The women were really interested in this and a few asked if they could get copies. I said that at the next meeting we could go over what they had said, and what I had gleaned from the conversations, and add to or amend their comments. They were all very interested in this and I realized that this may be a great way of guiding the discussion (Colleen's fieldnotes April 26, 2000).

Freire referred to this process as "starting where the people are at" through finding the "generative themes." Generative themes are those issues that spark animated discussion among

people because they are "close to the heart" (Freire, 1996). As we collaboratively analyzed the data I probed and questioned the women with open questions and invited reflection. Susan said that she appreciated the opportunity to collaboratively analyze:

> I appreciate the fact that we're working together to see how we're working together as a group. 'Cause I've done research before where you're just "the person," and you never get the feedback. Actually, sometimes you don't even get the feedback! You just give your input and that's it. It's nice to know how we feel is really important, 'cause we're on the opposite end of the table (Susan, RTM April 4, 2000).

The most in-depth collaborative analysis occurred at the Data Analysis Potluck in May 2001.[17] At this meeting I went through my code-book. I framed the discussion as "things I had learned," and with each theme asked if I had "got it right and if anything was missing." There were a few additions and revisions to my findings, but the women said they were comfortable with my analysis.

Despite my attempts at collaborative data analysis, I cannot claim that the analysis was fully collaborative. Certainly I did "member checks" throughout the data collection, but after the Data Analysis Potluck I continued with the analysis through writing my dissertation and had little input from the women. The later stages of analysis and writing are the most difficult for collaboration, particularly for graduate students with timelines. In this regard, I feel that I did not meet the ideals of FAR.

Although feminist action researchers contend that it is possible and desirable to collaborate with research participants through all stages of the research process, a growing number of critics suggest that FAR is partisan, partial, incomplete, and inextricably bound to the contexts and rationales of the researcher and the positions she may knowingly or unknowingly represent (Regehr, 2000). The use of FAR strategies does not ensure that rapport and trust are built, or that research participants are fully comfortable with the researcher and with honestly portraying their lived realities. In feminist action researchers' determination to have women tell their stories,

at times we have forgotten that stories are told to particular audiences and that sometimes women do not want to tell their stories. Research participants may feel forced to reveal personal information, may tell us what they think we want to hear, or may fabricate stories. Indeed, research participants construct narratives for specific purposes and audiences (Poland, 1998), and honest and faithful accounts may be contradictory or inconsistent (Alvesson and Skoldberg, 2000). In conversation people are constantly positioning themselves, positioning others, or being positioned by others as powerful or weak, cautious or bold, virtuous or evil, and so on, drawing upon culturally shared notions of what it means to be these things (Tierney, 2000).

Importantly, no text is singularly created. It is not a matter of simply uncovering truths and untruths, but of exploring the role of the author in translating the text. For sure, the questions asked can frame how interviewees think about what to say (Tierney, 2000), and meanings are not unitary or fixed but multiple and shifting and depend on who is doing the interpreting and in which context they are used (Drew and Dobson, 1999). Despite FAR's inclusive and participatory ideals and my efforts to collaborate at most stages of the research process, it was impossible to escape my inextricable role as the feminist action researcher in a position of power and privilege to transform the women's words into this analysis.

Power and Representation: Attempts at Deliberate Reflexivity

With the postmodern age many qualitative researchers assert that we are in a crisis of representation. Lincoln and Denzin (2000) claim that this crisis speaks to the representation of the Other in our texts and the authority we claim for our texts. They ask: "Who is the Other?"; "Can we ever hope to speak authentically of the experience of the Other, or an Other?"; and "How do we create a social science that includes the Other?" (Lincoln and Denzin, 2000). No longer is the researcher an objective observer or data collector; rather, the researcher must be conscious of her location and subjectivity in the narratives constructed. What knowledge we are

able to observe and reveal is directly related to our vantage point, to where we stand in the world. Our interaction with the social world is affected by such variables as gender, race, class, income, sexual orientation, age, and physical ability. This does not mean that facts about the world do not exist, but that what we see and how we go about constructing meaning is a matter of interpretation (Kirby and McKenna, 1989).

Since I am a white, middle-class, educated woman who has never lived in poverty nor had children, it was particularly important for me, as a feminist action researcher, to reflexively consider the power differences between myself and my research participants. Researchers who adopt a reflexive stance do not see themselves as occupying a privileged position outside the world they study. The research they engage in is not a neutral procedure for discovering an "objective" external reality that exists independent of human perception and interpretation. The aspects of the environment that are noticed and singled out for inquiry, and the procedures which are used to describe and explain phenomena are ideological in the sense that they are socially constructed in a particular time and place (Poland, 1998). In fact, some researchers contend that the Other, who is presented in the text, is always a version of the researcher's self. Writers are positioned outside, yet alongside, those Others they write about, never making clear where they stand in these hyphenated relationships that connect the Other to them (Denzin, 1994; Fine, 1994).

At its core reflexivity is about reflecting on power – a researcher's power to perceive, interpret, and communicate about Others. In her discussion of developing authentic student-faculty relationships, Tom (1997) writes about being "deliberate." A "deliberate relationship" is one that is entered consciously and ethically. Often the reasons for wanting and entering a relationship are unclear and very different – "because I have initiated the relationship, they may not be as clear about what they want as I am about what I want" (p.4). As a feminist action

researcher I strove to be "deliberately reflexive," to take responsibility for thoughtful and reflective practice and to remain conscious of the inherent power dynamics in the research process. In one interview, when I asked Elizabeth about the benefits and challenges of partnering with researchers, she questioned whether researchers were able to understand and represent her reality.

Colleen: What are the advantages and challenges of partnering with researchers?

Elizabeth: Well, the challenges may be not knowing the area or what our obstacles are. Or maybe not being, I don't know.

Colleen: Not being...not being the same?

Elizabeth: Yeah, like, I don't know people's financial situations. It's like, how well do you really understand the low income thing and being in the same boat, you know, that aspect.

Colleen: So do you feel like in order to be able to represent what's going on, being on low income and being a single mother, that you have to be living on low income and be a single mother?

Elizabeth: Maybe not at present, but it certainly couldn't hurt to have had it at some point so you can understand where we're coming from.

Colleen: So how do you feel, let's say for the next set of interviews, there's me asking you about your experiences about being a single mother and living on low income. How does that make you... are you comfortable with that if you know that I'm not in the same situation as you?

Elizabeth: Well, oh yeah. That's ok. Just some people you've come across it's like "I'm better that you" and snooty. You know, you're very easy to get along with (Elizabeth's interview, March 20, 2000).

Elizabeth said that she was "ok" with me interviewing her, yet her comments highlight the need to be consistently and deliberately reflexive throughout the research process. Indeed, being deliberately reflexive does not resolve "power plays," but it can increase the complexity of the research process by employing an analytical approach that doubles back on itself (Ristock and Pennell, 1996).

As well, in my efforts to be deliberately reflexive I attempted to be as vulnerable as possible. As Richardson (2000) suggests, I worked to be self-aware and self-exposed and to hold myself accountable for the standards of knowing and writing about women I studied (Richardson, 2000). In my reflective fieldnotes, memos, and research journal I documented my assumptions,

my uses of power, and my reflections on the process of knowledge generation. My purpose in being deliberately reflexive was to improve the quality of my research and to stay accountable to the research participants through being as authentic, truthful, and vulnerable as possible. A text that displays honesty and authenticity "comes clean" about its own stance and about the position of the author (Lincoln, 1995, p.4). A reflexive researcher ask the reader to accept her text as authentic, that is, as a conscientious effort to be truthful about the making of the account (Gergen and Gergen, 2000). Through all stages of my research project, and particularly when considering my withdrawal from the field, honoraria payments, and anonymity and confidentiality, I strove to be deliberately reflexive.

Withdrawal From the Field

It was important for me to make deliberate choices about my behaviour and the long term goals for the relationship I developed with the research participants (Tom, 1997). As a feminist action researcher committed to being deliberately reflexive I decided to not withdraw from the field at the completion of my data collection. Withdrawal from the field in order to analyze and write is a typical phase in most research projects, particularly for graduate students who are confined by university timelines and limited resources. I initiated the Research Team and experienced its development into a meaningful place for the women to share experiences and explore ideas for action. I was committed to the FAR process and to my role on the Research Team, and withdrawing because I had completed my data collection felt artificial and unethical. Despite the differences between myself and the women on low income, I was not only a researcher, I was also a Research Team and WOAW member. Although members of my research committee encouraged me to withdraw completely, I remained involved but shifted the nature of my involvement. I continued to record fieldnotes and to tape record the meetings but did not transcribe or provide summaries of them.[18] Indeed being deliberately reflexive made me

question mainstream assumptions that it is possible and desirable to withdraw from the field when the data collection is completed.[19]

Honoraria Payments

Through the SSHRC research grant the women were paid for their involvement in the interviews, in the first 4 Research Team meetings, and in the Research Parties.[20] Given the monetary value of the research grant, I felt that the women should financially benefit from their participation – it would have seemed inherently inequitable if the women did not receive some compensation for their involvement. Both the researchers, through the SSHRC grant, and the service providers, through their employment salaries, were paid for their involvement in WOAW. Yet I was conflicted about paying the women. I was concerned that the honoraria would coerce some women into participating on the Research Team. I hoped that the Research Team members would participate because of their interest in the discussions and the potential for action, not because of an honorarium. I raised this concern at several Research Team meetings and the women acknowledged that some may be motivated to attend the Research Team meetings because of the honoraria. They also suggested that they appreciated and looked forward to receiving the honoraria payments.

The Working Group decided that from Phase 2 onwards the honoraria would be attached to research activities but not to the Research Team. Some women did not return to the meetings, though a significant core of women remained involved. By virtue of my job as Project Manager to manage the SSHRC research grant's budget I retained control and power over the women through being in the position to determine how, when, and for what they got paid. I was constantly conflicted about the honoraria and found no resolution. Even though honoraria payments are a difficult issue laced with power and ethical dilemmas, as a deliberately reflexive researcher I had to confront these challenges and make the best choices possible.

Anonymity and Confidentiality

Anonymity and confidentiality were discussed at the initial Research Team meetings and in the interviews. The women were aware of the openness of the Research Team and I reinforced the fact that it was a public forum – any WOAW woman could attend, at times some women invited friends, and the events and outcomes of meetings were not confidential. To avoid the circulation of raw data and to prevent the potentially harmful identification of the women I did not distribute Research Team meeting transcripts. When a participant wanted to review a transcript, we did so together and I retained the copy of the transcript.

On several occasions I asked the women about using pseudonyms, and each time they said they wanted to use their real name.[21] Yet throughout the research process I was concerned some women could be harmfully identified, particularly since several were critical of the welfare system and their workers. In May 2002 I mailed each woman all of her quotations that I used in my dissertation. In detail I outlined the possibility that they could be identified if they chose to use their real names, and that this could have negative repercussions for them. Consequently, in follow-up phone conversations, only 4 women wanted to use their real (first) names; all but 2 of the women who preferred a pseudonym chose their own. All of the researchers and the community service provider were comfortable with using both their first and last names, possibly because they were not the focus of this study. Regardless, the fact that most of the women on low income chose pseudonyms and that none of the researchers or community service providers did highlights the power differences between these groups of participants and how engaging in feminist action may carry different and possibly more severe risks for women on low income. This is further explored in chapter 7.

Legitimation and Trustworthiness

The objective truth about a society or a culture cannot be established (Angrosino and Mays

de Perez, 2000). In fact, "in the social sciences there is only interpretation. Nothing speaks for itself" (Denzin, 1994, p.500). Given that objectivity cannot be established and that there is only interpretation, qualitative researchers have long asked how a text legitimates itself, or makes claims for its own authority. Seidman (1991) proposes a local, personal, and political turn in the postmodern era. "Instead of appealing to absolutist justifications, instead of constructing theoretical logics... I propose that we be satisfied with local, pragmatic rationales for our conceptual approaches" (Seidman, 1991, p.136; cited in Denzin, 1994). The criteria for legitimating the trustworthiness of my data analysis were crystallization, credibility, and transferability. Atlas.ti, a qualitative data analysis software program, was a tool that facilitated a more legitimate analysis.

Crystallization

Crystallization recognizes the many facets of any given approach to the social world as a fact of life (Janesick, 2000). According to Richardson (1994), the crystal "combines symmetry and substance with an infinite variety of shapes, substances, transmutations, multidimensionalities, and angles of approach. Crystals grow, change, and alter, but are not amorphous.... Crystallization provides us with a deepened, complex, thoroughly partial, understanding of the topic. Paradoxically, we know more and doubt what we know" (Richardson, 1994, p.522). There were two ways that I addressed crystallization as a trustworthiness criteria. First, the different data sources – the Research Team meetings, one-on-one interviews, and fieldnotes from multiple authors – provided different perspectives, or angles of approach, to the research questions. Second, multiple lenses were used in the analysis and writing. As described in chapter 1, I approached chapters 4, 5, 6, and 7 with different voices, literatures, and analytic perspectives in an attempt to represent different facets of the data. Both strategies provided a more complete picture, meanwhile raising contradictions. Crystallization allowed me to weigh the evidence

because "slices of data" were drawn from different data sources, researchers, and analytic perspectives.

Credibility

Qualitative researchers do not claim that there is only one way of interpreting an event. The traditional assumption that the truth can be established through careful cross-checking of researchers' and insiders' reports is no longer universally granted. Contemporary social scientists are increasingly inclined to expect differences in testimony grounded in gender, class, ethnicity, and other factors (Angrosino and Mays de Perez, 2000). Indeed, there is no one "correct" interpretation (Janesick, 2000).

Validity in qualitative research has to do with the credibility of the description and explanation and whether or not the explanation fits the description. According to Greenwood and Levin (1998), credibility is "the arguments and the processes necessary for having someone trust the research results" (Greenwood and Levin, 1998, p.80). There are three types of credibility – internal, external, and catalytic. Internal credibility is the degree to which the research participants agree with the research findings. The process of collaborative data collection and analysis rendered this account internally credible since the research participants were involved in the construction of meaning. The process of sending quotations back to the research participants after the dissertation was written also contributed to the internal credibility of the analysis.[22]

I conducted "member checks" with the UBC Working Group and members of the WOAW organization. At various times different UBC Working Group members attended and recorded fieldnotes at Research Team meetings. At many Working Group meetings we discussed the Research Team and I was able to check my assumptions, experiences, and emerging analyses with them. As well, I co-wrote the Phase 1 and 2 WOAW Research Reports (Reid, Frisby,

Millar, and Pinnington, 2000; Reid, Frisby, Millar, Pinnington, and Ponic, 2001). These reports summarized the research activities and provided some initial research findings and reflections. In the Phase 1 Report I included a section on the women's health issues and the relationship between health and poverty, and in the Phase 2 Report an analysis of the Research Team meetings was provided. After the reports were distributed, the Working Group met with WOAW members to check the credibility of our analyses. We asked for additions, deletions, and topic suggestions for upcoming reports. Working with the UBC Working Group and co-writing and validating the Phase 1 and 2 Reports with all WOAW members contributed to the external credibility of my findings. The Working Group and the broader WOAW organization were not directly involved in my study though they were familiar with it and the women involved said that the findings were convincing and credible (Greenwood and Levin, 1998).

Catalytic validity represents the degree to which the research process reorients, focuses, and energizes participants toward knowing reality in order to transform it. Catalytic validity lies not only in recognizing the reality-altering impact of the research process, but also in the desire to consciously channel this impact so that respondents gain self-understanding and, ultimately, self-determination through research participation. Over the course of the Research Team meetings the women identified shared problems, barriers, and desired actions. Despite its challenges (addressed in chapter 7), working together towards social change increased the catalytic credibility, or "workability," of the actions, and enhanced the women's sense of control over their situations (Greenwood and Levin, 1998).

Transferability

FAR-developed knowledge can be valuable in contexts other than those where it is developed. Transferring knowledge from one context to another relies on understanding the contextual factors of the situation where the inquiry took place, judging the new context where

the knowledge is supposed to be applied, and making a critical assessment of whether the two contexts have sufficient processes in common to make it worthwhile to link them (Greenwood and Levin, 1998). In terms of this study, important considerations are the demographics of the research participants, the structure of WOAW and the Research Team, the purpose, configuration, and length of the SSHRC research project and my dissertation, and the varying involvements of the service providers and researchers. Other important considerations are the political, social, economic, and cultural environments in which this study occurred.

Atlas.ti 4.1: A Trustworthiness Tool

To manage the volume of data gathered and to ensure the comprehensiveness of my analysis I used the qualitative data analysis software program Atlas.ti 4.1. Software can help competent researchers do more rigorous, consistent, and thorough analyses than they otherwise might. It is not that the software itself makes it more rigorous, but that the researcher can use the software to do more rigorous work than she could do without it (Weitzman, 2000). According to Weitzman (2000), using Atlas.ti can increase the rigor of an analysis in four ways – through facilitating consistency, speed and efficiency, representation, and consolidation. Atlas.ti enabled me to search all the places a given key word, code, and combination of codes appeared. I was able to review all the data assigned to a particular code and check my initial interpretations. With Atlas.ti I searched and re-searched almost instantaneously to find data that applied to a particular question. I quickly resorted my database, redefined codes, and reassigned chunks of text. The speed and efficiency afforded by Atlas.ti encouraged me to check and revise my analysis whenever necessary. Additionally, Atlas.ti facilitated the dynamic representation of my thinking through identifying themes, building codebooks, marking texts, creating memos, and developing theoretical models (Ryan and Bernard, 2000; Weitzman, 2000). Finally, with Atlas.it I kept everything in one place. The consolidation of my data freed up large amounts of energy for me

to see and keep track of connections that might otherwise easily fall through the cracks (Weitzman, 2000).

Writing

Just as conducting interviews and recording fieldnotes are essential skills for the qualitative researcher, so is writing. All too often our writing suppresses individual voices and accepts the omniscient voice of science as if it were our own. Richardson (2000) contends that writing is a method of inquiry and should not be taken for granted – it is a way of knowing and a method of discovery and analysis. Writing is how we "word the world" into existence (Rose, 1992; cited in Richardson, 2000). Although this "worded world" never accurately, precisely, or completely captures the studied world, approaching writing as a method of inquiry honours and encourages our attempts and provides a research practice through which we can investigate how we construct the world, ourselves, and others (Richardson, 2000).

Qualitative writers can challenge the questionable meta-narratives of scientific objectivity and still have plenty to say through engaging our subjectivities in the knowing and telling about the world as we perceive it (Richardson, 2000). A postmodernist position does allow us to know "something" without claiming to know everything. Having a partial, local, historical knowledge is still knowing, and this perspective can free us from trying to write a single text in which we say everything at once to everyone (Richardson, 2000). As we write we make decisions about what will be written, and as one moves from a blank page to a written text, an emergent, reflexive interpretation of the subject matter is built (Denzin, 1994).

Two core principles of feminist action research are researcher reflexivity and collaboration through all stages of research. I attempted to be deliberately reflexive and transparent throughout the data collection, analysis, and writing, particularly in terms of my own assumptions, interactions, analyses, and relationships with the research participants. In a feminist

action research project all participants should have a role in negotiating the final meanings of the research (Lather, 1991) and in writing the report. There has been far less feminist attention paid to the processes of retaining the research participants' voices in the phases of data analysis and writing up (Edwards and Ribbens, 1998). I did a significant amount of analysis through the writing process, and while I did member checks with all WOAW members to check the credibility my analyses, this process was not fully collaborative. Although writing may be one of the most difficult aspects of a research project for collaboration, collaborative writing is a strategy for increasing the internal validity and authoritative claims of the text. In the future I hope to explore the potential for collaborative writing in producing authentic texts from the research participants' perspectives that would be consistent with a feminist action research framework.

While qualitative researchers are in a crisis of representation, legitimation, and writing (Lincoln and Denzin, 2000), the development of research methods consistent with a feminist action research framework can illuminate these crises and provide strategies for addressing them. In particular, FAR's principles of inclusion, participation, and researcher reflexivity are a starting point for increasing the transparency and credibility of our work. The FAR context and methods that were described in this chapter both upheld FAR's ideals and reflected more traditional qualitative approaches. Nevertheless, the continued development of FAR methods can advance understandings of the qualitative crises of representation, legitimation, and writing.

Notes

[1] At that time shared identity was the basis for two of the subgroups – Aged to Perfection (senior or older women) and Iranian Mutual Support Group (recent immigrant women from Iran). The other two subgroups were based on the women's geographic communities - PoCo WOAW (Port Coquitlam) and SWCo WOAW (South West Coquitlam). It so happened that the PoCo WOAW subgroup was primarily single mothers, while the SWCo WOAW subgroup had a more diverse group of women involved.

[2] The number of service providers involved with WOAW remains approximately the same, though some have discontinued their involvement and newer partners have more recently joined WOAW. The service providers

represent different organizations in the local communities, including community parks and recreation (6), a woman's centre (1), local social service agencies (2), and a community school (1).

[3] CoPoMo WOAW is short for the Coquitlam Port Moody WOAW subgroup.

[4] The reasons why the group of primarily immigrant women (Iranian) disbanded are complex and poorly understood. Possible reasons for the dissolution of this group are presented in chapter 4.

[5] Wendy secured a seed grant from SSHRC ($5000) in July 1999. The purpose of the SSHRC seed grant was to support the writing of the larger research proposal to the "Society, Culture, and Health of Canadians" SSHRC competition. I helped Wendy with formatting, revisions, the letters of support, and compiling the curriculum vitae of the supporting research collaborators.

[6] The name of the project on the application to SSHRC was "Addressing the Self-Determined Health Problems of Low-Income Women Through Participatory Community Interventions: Meanings, Process, and Evaluation Issues." The project was rarely referred to by this title, and was more commonly known as WOAW "Women Organizing Activities for Women."

[7] In her Master's thesis, Sydney Millar, one of the UBC Working Group members, examines the "community development" discourse that was used by three of the WOAW service providers. She also examines the context in which this discourse was used (community recreation, social services, advocacy organizations). For a more in-depth analysis of community development discourses consult Millar (2002).

[8] There are substantial literatures on both "collective organizing" and "community development." WOAW identified as a collective organization as a consequence of making decisions through consensus and promoting a flat (versus hierarchical) organizational structure. It is beyond the realm of this dissertation, however, to provide a more in-depth analysis of them.

[9] For the purposes of the research study I established a data management and analysis system (Atlas.ti 4.1), a budget management system (Excel 2000), a research bibliography (Endnote 4.0), a database to track project attendance and activities (Access 2000), and an office management system for tracking correspondences and events.

[10] A group of interdisciplinary research collaborators, who had expertise in different areas that related to the SSHRC grant, were distantly involved in the project. Aside from Dr. Allison Tom (UBC), the collaborators were not actively involved with WOAW. Allison Tom was also my research supervisor and had regular interactions with the UBC Working Group. The other collaborators, from UBC and from SFU, were Drs. Heather McKay, Susan Crawford, Bonnie Long, and Peter Crocker.

[11] The honoraria were problematic throughout the research project. The ethical dilemmas regarding the honoraria are explored later in this chapter.

[12] Note that not all Research Team members were research participants. See section "The Women's Involvement as Research Participants" for an explanation of their involvement in the dissertation.

[13] The structure of the WOAW organization and how I believe it facilitated the women's continued involvement in the Research Team is further explored in chapter 7.

[14] Although the Research Team was initiated for the purposes of my dissertation and was initially an unanticipated aspect of the SSHRC project, all data that were gathered by researchers working with the SSHRC project belong to it. However, in order for any other UBC Working Group member or research collaborator to use data from the Research Team meetings, agreement must be reached between myself and that person.

[15] These women were interviewed by Pam Ponic for the purposes of the larger SSHRC research project in June 2001 with Interview Schedule #1 (see Appendix E).

[16] The 71 primary documents totaled over 1600 pages of data.

[17] In April 2001 I asked the women if we could devote an entire Research Team meeting to collaboratively analyzing and reviewing the findings for my dissertation. They agreed that they did not want materials to read in advance but would prefer if I did a presentation (some joked that they expected power point slides with the presentation). They also suggested that the meeting be a potluck and extended to 3 hours. It then became known as the "Data Analysis Potluck."

[18] This refers to distinction I made previously between primary transcripts and secondary transcripts. The secondary transcripts (meetings from January 2001 onwards) were transcribed by a UBC Working Group member and have not been analyzed to date. At the very least these transcripts are a good record of the evolution of the Research Team, though in the future I plan to use the data from these meetings for analysis and writing.

[19] As discussed in the epilogue, my ongoing involvement with the Research Team (beyond the primary data collection phase) did not challenge this analysis, rather it deepened my understanding of the complexities of engaging in feminist action research and the difficulties faced by many women on low income to particpate in such endeavours.

[20] The women were paid $100 for being interviewed and participating in 2 Research Team meetings. They were paid an additional $100 for being interviewed a second time and participating in 2 more Research Team meetings. After Phase 1 of the SSHRC project, the honoraria was no longer based on attendance at Research Team meetings.

[21] The consent forms said that the women could choose to use their real names or a pseudonym. See Appendix C.

[22] Each participant received an outline of my dissertation with all of their quotations that I used. I called each participant and asked if they were comfortable with what they read. All of them reflected that my analysis was accurate and captured our Research Team and interview discussions, and only one woman asked that I clarify something in a footnote (in chapter 5).

4

The Women's Stories

Multiple small spheres of personal experience both echo and enable events shared more widely, expressions of moments in which we recognize that no microcosm is completely separate, no tide pool, no forest, no family, no nation. Indeed, the knowledge drawn from the life of some single organism or community or from the intimate experience of an individual may prove to be relevant to decisions that affect the health of a city and the peace of the world. *Mary Catherine Bateson*

In this chapter I attempt to provide a sense of the women's complex lives and experiences. I tell the stories of the 12 women who were twice interviewed and who were actively involved in WOAW and the Research Team in the year 2000. Since I did not embark on my dissertation with the intention of gathering life stories, the subsequent stories have gaps and omissions. Through the lens of my research questions, I formulated partial stories based on crude classifications. As well, the stories are not equal in length – half are long and detailed because of availability of data, while the others are significantly shorter. The stories are grouped according to the women's WOAW subgroup affiliation. After the women's stories I have drawn together emergent themes that relate to the research questions I posed in this dissertation.

Table 11 – Profile of Individual Research Participants (n=20)

Name	Age	Domestic Status	WOAW subgroup & status	Education	Race/ Ethnicity	Major health concerns	Financial support
Alexa	28	Single no children	CoPoMo - active	Grade 12	White	Arthritis, depression	Disability benefits I
Arlene	> 60	Single (separated) 2 adult children	Aged to Perfection - inactive	Grade 12	White	Fibromyalgia	Seniors pension
Caroline	36	Single (divorced) 3 children, aged 5, 8, and 11	PoCo - inactive	Don't know	White	Clinical depression	Social assistance
Cassie	40	Married 2 children, aged 1 and 3	CoPoMo - active	Bachelor of Human Kinetics	Chinese	Depression, back problems, stress	Working husband
Cynthia	Late 20s	Single (divorced) 2 children, aged 2 and 5	PoCo - inactive	Grade 12	White	Depression, stress	Social assistance
Elizabeth	32	Single (separated), 1 child, aged 4	SWCo - active	Grade 12	White	Hyperthyroidism, eating disorders, post-treatment breast cancer	Social assistance
Gloria	Late 40s	Single (divorced) 2 adult children	SWCo - inactive	Don't know	White	Depression	Ex-spousal support
Joanne	30	Single (widowed) 2 children, aged 2 and 5	PoCo - inactive	Grade 12	African American	Hyperthyroidism, migraines	Social assistance
Julie	28	Single (divorced) 2 children, aged 2 and 4	PoCo - active	Some high school	White	Learning disability	Social assistance
Katharine	50	Single (divorced) 2 adult children	CoPoMo - active	Grade 12, some university	White (French Canadian)	Multiple sclerosis, clinical depression	Disability benefits I
Kelly	34	Single (separated) 1 child, aged 3	PoCo - active	Grade 12	White	Endometriosis, osteoporosis	Social assistance
Maey	33	Single 1 child, aged 10	SWCo - active	Some elementary	White	Eating disorders, "elephantitis," scoliosis, learning disability (dyslexia)	Disability benefits II
Martha	>60	Single no children	Aged to Perfection - active	Don't know	White	Chronic fatigue syndrome, fibromyalgia	Disability benefits II
Rene	Late 50s	Single (divorced) 2 adult children	Aged to Perfection - active	College diploma, art school	White	Angina, diabetes, irritable bowel syndrome, high blood pressure, sleep apnea	Disability benefits II

104

Table 11 – Continued

Name	Age	Domestic Status	WOAW subgroup & status	Education	Race/ Ethnicity	Major health concerns	Financial support
Susan	44	Single (separated) no children	SWCo - active	College diploma	White	Fibromyalgia, diabetes, clinical depression, irritable bowel syndrome	Disability Benefits II
Teresa	mid -40s	Married 2 children, aged 11 and 14	CoPoMo - active	Don't know	Chinese	Diabetes, arthritis	On medical leave; has a working husband
Trina	56	Single (divorced) 3 adult children	Aged to Perfection - active	Some high school	White	Clinical depression, arthritis	Disability benefits II
Virginia Dawn	25	Single (divorced) 1 child aged 3	PoCo - active	Grade 12	White	Depression	Social assistance
Wanda	61	Married (twice widowed) 7 adult children	Aged to Perfection - active	Grade 12	White	Diabetes, sleep apnea, high blood pressure	Seniors pension
Willow	26	Single, 2 children, aged 1 and 4	SWCo - active	Some high school	White, First Nations children	Social anxiety disorder, depression, stress	Social assistance

Note: These data were compiled from the 20 women who were interviewed in the first round of interviews. They appear in alphabetical order by first name.

The Women's Lives and Experiences[1]

Aged to Perfection Subgroup

Rene

Rene, a single woman in her late 50s, had a diverse past. She had worked in bush camps, as a jade cutter, had gone to art school and computer school, been a Tupperware manager, and led a union in solidarity. When she was 16 she was made a ward of the Catholic Children's Aid after her father's suicide.

> I think a lot of my attitude and that comes from the fact that when I was sixteen my father killed himself. My mother was in hospital. And I was made a ward of the Catholic Children's Aid. I was on my own virtually. My sisters were married and had kids. And I was very independent, even before that because my mom was in hospital. And my dad and I were baching from the time I was thirteen. We were resourceful and independent right from the beginning. And I think a lot of the counseling in the Catholic Children's Aid gave me made me resourceful. I got a good worker, a really good worker at that time. So even then I knew how to ferret out what I wanted to know. And I was not a

passive person in any sense (Rene's interview, June 5, 2000).

In her 20s she became a jade cutter, and then moved into the "bush" with her husband.

> I worked at that [cutting jade] 'til I got married and went to the islands. Silly girl.... I was
> up the Alaska Highway. And I discovered that I was left alone in camp with my child.
> And it wasn't the four-legged animals I was afraid of. It was the ones that wandered in
> off the road. So I went and got a gun and learned how to use it.... We worked together in
> [bush] camps. He [husband] had one leg amputated. He wore an artificial limb. And I
> would work along side him rather than take the passive role. I would help with the
> carrying and so on and so forth. And put in the 18 hour days. And look after my kids. So
> that I think that has more to do with the health and the way I am today than anything
> else. And when I kicked him out I was looking working full time as a head cook (Rene's
> interview, June 5, 2000).

After leaving her husband, Rene had a series of jobs and at one point chaired her union.

> I used to be a very shy person and then I started selling Avon door to door. I did it
> purposely to make myself get out and meet people 'cause I didn't like doing it, and that
> was one step. And then I went to work at the hospital and they brought in a union and
> we kicked the union out and got another union. I didn't want a union, but that was the
> rules they gave us, so I joined the union and I got involved. 'Cause I wanted to learn.
> And I ended up chairing the union, but they gave me a lot of education in public
> speaking and solving problems. So I've had a lot of opportunities other women may not
> have had. And a chance to use it. And then Tupperware, you get a lot of sales training
> and what not and you know, just how to co-operate in work and that sort of stuff. So,
> I've been very fortunate (Rene's interview, March 15, 2000).

Rene felt that the work she had done and her experiences with her husband contributed to

her failing health.

> And then him [husband] screwing around and bringing home some nasty diseases and
> me having to go on all these great antibiotics which was not good for the bowel. When I
> got rid of him I got rid of the big problem (Rene's interview, June 5, 2000).

When I asked her about her health, she explained "I'm as healthy as can be under the

circumstances.... I have IBS [irritable bowel syndrome]" (Rene's interview, March 15, 2000).

Later at a Research Team meeting, Rene explained her vision of good health.

> For me, it would be being able to eat when I go out without worrying that's it a
> minefield, because I'll have the runs or be sick for days afterwards, and to be able to walk
> up and down the stairs without pain. And to get around, and not to have to sleep with a
> machine, because all these things limit my ability to travel, and to do things that I want to
> do, and it is hard. If I go somewhere I take food with me (Rene, RTM April 26, 2000).

Rene was politically active through her involvement with WOAW. She initiated a bus riders' union, went to meetings at city hall, joined protests, and wrote letters to her local MLAs. She chaired the board of her housing co-operative and ensured that people on low income were able to move in. Her days were filled; she was active in her community and worked with many WOAW women, teaching English, quilting, and cooking, and providing support. She was an avid quilter, and quilted through every WOAW meeting I attended. I saw Rene as resourceful, sharp, and tough, with rich and diverse experiences.

Trina

Trina was a 56 year old single woman with three grown children. She grew up in Vancouver with an abusive mother who moved constantly – in one school semester Trina went to five different schools. At 16 she left school and was forced to marry a friend of her mother's. She explained what happened when her oldest son was 4 months old.

> I didn't raise my first son, [he's] 37. My mom and my ex-husband kidnapped him when he was 4 months old. I had already left [my husband], but my mom and my husband came and kidnapped him. So I didn't see him for ten years. So I didn't bond with him at all. So when I had my daughter, I ran, so my mother couldn't find me (Trina's interview, March 21, 2000).

With her daughter and youngest son, she moved to a housing co-operative in East Vancouver.

> I lived in a co-op at 36th and Main and my daughter was five when we moved in there and she was 13 when we moved out.... my children go to school with all these kids. And there's nothing but drugs and alcohol and abuse and everything in those little communities. And it was the biggest mistakes, living in that community. But I didn't know that at the time. Because my kids had everything. We had a nice home, we had three meals on the table and everything else. But our neighbours and everybody else didn't. Prescription drugs, alcohol, drugs of any kind. If I could have lived anywhere else on the money I was making we would have (Trina's interview, March 21, 2000).

As a low-income single parent raising two children, she worked as a waitress "I was working at Denny's. Raising two kids by myself" (Trina's interview, June 5, 2000). She explained:

> But being a single parent was my problem financially. I never got any assistance and I didn't stay at one job long enough to get into a pension or anything like that, so you're

just left with [being paid] by the hour and then, at 56, with nothing (Trina's interview, March 21, 2000).

She spoke of the toll her work had taken on her body.

> I've always been tiny. I've been a waitress so it's all physical. I haven't had any serious accidents. It's just heavy lifting, you know those great big tubs of dishes and serving. I can't even carry two dishes anymore. I love hobbies; I can hardly even crochet. I just can't hold it [crochet needle] 'cause of my shoulders.... And from my hips to my shoulders I am just so sore all the time. It's arthritis and tendonitis (Trina's interview, March 21, 2000).

Since being diagnosed with arthritis, Trina had been on disability II. She had limited contact with her children – she never sees her oldest son and she sees her daughter and youngest son occasionally.

> My daughter just had her daughter, 8 weeks old just about. But even before she had her child she never gave me the time at all. She worked nights and I worked days and I'm a morning person; she's a night person. So if I didn't go see her, I didn't see her. The younger generation doesn't like the older one (Trina's interview, March 21, 2000).

Trina said that until her mother died 4 years ago, she would not go through Port Moody for fear of seeing her and would only go shopping at night. For five years she had been involved in therapy and support groups to come to terms with her abusive past and her clinical depression. She was isolated and felt invisible.

> I don't know if you noticed, but I have three TVs. My isolation is, this is it. But it doesn't matter where I go in my tiny apartment, I can see something. I can see the TV, I can hear the voices. Even out on the patio (Trina's interview, March 21, 2000).

Trina said that one of the WOAW service providers had called her every week for four months about WOAW meetings. In February 2000 Trina summoned the courage and attended an ATP subgroup meeting. Despite bouts of depression, isolation, and her initial tentativeness, Trina became increasingly involved in WOAW over the three years. She established friendships with the Aged to Perfection members and spoke up at meetings. On several occasions I heard her support WOAW's consensus decision-making process and say that she had a voice. She was critical of women who she felt did not support collective organizing, and once asked me

"where's her sisterhood?" Despite her troubled past and fragility, she developed a sense of women's strength and seemed stronger over the course of being involved with WOAW.

> I think women are very powerful and once we put our minds to anything, we can do it. And I think we can, I really think we can reach around the world. We really can.... We keep the family together.... we're the glue (Trina's interview, March 21, 2000).

Wanda

Wanda was a 61 year old married woman who was twice widowed and had seven children and 14 grandchildren. She grew up in Rexdale, Ontario, and spoke of raising her three younger brothers.

> I was living at home, raising three brothers. I got up in the morning and did bottles and diapers and put them on the line. And came home at noon and took them off the line and went back after supper and fed them and cleaned them. I told you my mother did nothing.... And my husband, he was the oldest of five. And so was I, the oldest of five. And he had a business. His father was the town drunk. So it was Jack's responsibility even if he wasn't working the shift to go back at night, close up, take the money home to his mother's place. And then open up again in the morning. Then we decided we were both tied down, why not getting married? We always figured that by the time we were 35 and 40 our kids would be grown and we could have our life then. But then husband died at 32. Yes, how great plans go astray (Wanda's interview, June 5, 2000).

Wanda got married to her first husband just before her 17th birthday.

> I was married at seventeen.... I got married on the 7th of December. And my birthday's the 29th. And I turned seventeen on the 29th.... I'd been dating my husband since I was eleven. And I was engaged for a year before I got married (Wanda's interview, June 5, 2000).

Wanda and her first husband had five children and lived on a farm in Ontario. Although they did not have much money, she felt that her family ate well.

> My kids ate a bit better because we lived on a farm for the first ten years I guess of Bruce's life. I had a big vegetable garden. And we ate a lot of vegetables. Meat was expensive, vegetables were cheap (Wanda's interview, June 5, 2000).

When her husband committed suicide at 32, she was left as a single mother and moved to British Columbia to be closer to her sister.

> After my first husband died I brought five kids and came out here [British Columbia]....

109

In '68. Somewhere around there. My husband died at 32. And I immediately reverted to being a child as far as my parents and his parents were concerned. And I thought I can't handle this. I've been on my own too long. So I packed the kids up. My sister was out here at the time. And I came out here with her. And then about two, three years later she went back. And I stayed (Wanda's interview, June 5, 2000).

Within two years of living in British Columbia Wanda remarried and had twin daughters.

I had 7 [children], first 5 were all 15 months apart. And then I had a pair of twins, and I'd have twins any day, because they keep each other amused, they're going through the same stages at the same time (Wanda, RTM June 29, 2000).

Wanda raised her seven children, had four foster children, and also had a career with Tupperware. She rarely spoke of being "poor" – rather, she suggested that she raised her children with limited finances. "I raised 7 children and I never had money, my husband worked, sure, but he was handicapped so we just didn't have it" (Wanda, RTM April 4, 2000). In her second interview she said: "They [children] learned what a second-hand store was. But I don't think that hurts anybody" (Wanda's interview, June 5, 2000). Wanda suggested that she needed to work to support her family, but that because she had a career her husband had learned to be a father.

I worked for myself for 20 years, part of the reason I worked was to be away from the kids. I was raising 7 of them and I had 4 fosters at one time in the house as well. And it still worked. But the other thing, that's the only time my husband became a father. If I had stayed home all the time, he never would have. He was quite happy not being a father (Wanda, RTM April 26, 2000).

Through her career with Tupperware she had also made friends who supported her when her second husband died 10 years ago.

The best thing that ever happened to both of us was when we became Tupperware ladies. As silly as that sounds.... When my husband died, those girls [from Tupperware] were through my door, and that was the only thing that kept me sane. They brought meals, they cleaned house, they looked after whatever needed to be looked after, and they were there to talk to me (Wanda, RTM April 4, 2000).

When I met Wanda she lived in New Westminster with her third husband. They were both pensioners; on several occasions Wanda said that she lived on $730 a month. She was active in

the local Shriners' Lodge, seniors' housing projects, and with her grandchildren. "I'm the recorder at the shrine.... That's the secretary-treasurer's job. And I do have time for my grandkids because I make time" (Wanda's interview, June 5, 2000).

Wanda spoke of her health as being the "mirror image" of her mother's. Most often, she referred to diabetes as her biggest health problem.

> My health very is almost like a mirror image of my mothers. All my mother's problems I have. My sister doesn't. Which is fortunate for her but we've discussed this. I have the legs and the feet like my grandmother. And my mother had. I have the high blood pressure. The diabetes. The whole nine yards. And my sister's almost as healthy as a horse. She's way overweight, but she's healthy (Wanda's interview, June 5, 2000).

She also spoke of women's roles and emotional health.

> I think your whole health is tied up with your emotional health and if it's not right, nothing is going to go right. And particularly with women they fall in to this category very easy: "I don't feel well today, I think I have a headache." You know if they could get through the door and go do something their headache would be gone, but they have no place to go and nothing to do. So they stay home with their headache. We have some women who shop till they drop; that's never been my thing. They seem to get pleasure out of that. But if you haven't any money you can't even do that. So we end up at our age, and I'm really focused on my age right now because it seems to me that a lot of women are still the caregivers. They're still making the meals, they're still cleaning the house. A husband retires, but a woman never does. So all of a sudden she's sitting in the evening and what will she do? She'll watch the boob tube because she's too tired to go anywhere. Women get tired very easy. What used to take me an hour to do takes me sometimes all morning and sometimes longer (Wanda's interview, March 15, 2000).

Wanda was an energetic and consistent WOAW member and often provided interesting insights into women's roles and responsibilities. In one case she said "The world's run by men, what can you say. We haven't changed that yet" (Wanda, RTM June 7, 2000). She adopted problem-solving roles for several WOAW women and was active in most meetings and activities. She believed in women's strength and capacity, and told me that she was increasingly interested in older women since she felt they had a lot to offer.

> By the time they reach 50 they've been a caregiver all their life. They've either had their children or they're parents, and now all of a sudden there's nobody. The husband's left with a bimbo or he's died. Which was my case. And now what do you do with your life? Nobody wants to hire you at that age, even though I think that's the biggest fallacy

around. There are lots of people between the age of 50 and 65 that have got more to give than what they realize. There's a lot of hidden talent out there (Wanda's interview, March 15, 2000).

CoPoMo Subgroup

<u>Alexa</u>

Alexa was a 28 year old single woman on disability benefits. She lived with her parents and brother; her father was disabled and her mother worked for minimum wage. She spoke of how difficult it was for her parents to accept help.

> My parents don't have the money, we've had to move around a lot and rent and maybe rely on people more than my parents would like to. Or go to agencies, they find that really hard. Even though there's resources to use... they're too embarrassed to go to them (Alexa's interview, March 20, 2000).

At various times she also spoke of taking on her parents' worries. She worried because her parents relied on Alexa's contributions to the rent (through her disability I benefits). Eventually, she hoped to live on her own and be more independent.

> Even though I don't have kids, I have to take on my parents' worries, because my dad's on disability, my mom makes minimum wage babysitting, and they have a lot of money problems, they owe lots to income tax, they owe lots of bills, and I take on their stuff, plus my own. And, I want to get living out on my own, but I need them because I just don't have the rent right now to live on my own. I take on theirs [stress], plus I have mine, and then I want to get better, improve my future too. So I'm also worried about them (Alexa, RTM April 26, 2000).

> Alexa had debilitating arthritis – she had difficulty walking and used a cane. Her arthritis was both hereditary and a consequence of a manual job.

> Part of it's [arthritis] hereditary and a past job I did I had to be on my feet all the time and I guess I didn't know how much it was going to impact my health 'cause it sort of happened soon after (Alexa's interview, March 20, 2000).

She spoke often of wanting to find work "my main goal is to eventually get work." She was ambivalent about the "benefits" of being on disability, though she did not like being labeled "disabled" and was concerned that it may prevent her from being hired.

112

I've been out trying to look for work for the last few years, you're labeled under disabled because of all the things, like you can…anytime you go through them you have to…like it gives you benefits being labeled that but I don't like to label myself like…. I feel for the most part that my arthritis, it limits me. But it doesn't limit me enough that I feel that I need a label that they give me (Alexa's interview, March 20, 2000).

Alexa had not worked for four years and expressed concern about being unemployed for a long period of time. At one meeting in May 2002, she became emotional when speaking about her desire for work but being unable to find a job. Although Alexa could not participate in many WOAW activities because of her arthritis, she attended most WOAW meetings. Often she quietly took notes and spoke only when addressed. She suggested that her involvement in WOAW provided important skills that she hoped were transferable to a work environment.

Katharine

Katharine was a 50 year old single woman with two grown children. She grew up in Montreal but had lived most of her adult life in Calgary and Vancouver. As a single parent she had struggled to provide for her children, and now that they were independent (and living in Calgary and Montreal), she felt that she had the time and space to focus on herself.

I've been single now since '78, 22 years. I've been divorced and never remarried, so I raised my kids myself so I was single, but I was not single. When you have two kids everything goes to them. All the food in the fridge goes to them; all the money goes to them. So when that's finally over you can breathe. It's a big stage in life. And some women find, well, I'm nobody anymore. I did not have that problem. Because now I take my life back (Katharine's interview, March 14, 2000).

Katharine had worked as a secretary, a realtor, and had owned her own pottery business. "I've been a realtor; I've had my pottery business. And when I was a realtor I did a lot of business…. I am resourceful and artistic but it's sometimes hard to have the guts to do it" (Katharine's interview, March 14, 2000). Katharine had also worked as a translator "I've translated legal and very deep engineering and instruction, computer, oil, heavy industrial and everything" (Katharine's interview, June 9, 2000) and as a researcher for a pharmaceutical

company:

> I've worked in a hospital for a year and a half. I worked in pharmacology at Hoffman la Roch.... And I've done a lot of research because I'm able to research and that's why Hoffman la Roch hired me. And I'm bilingual. And I love research. I did a lot of research on specific medications (Katharine's interview, June 9, 2000).

After over 25 years of work, seven years ago Katharine lost her management job as a consequence of downsizing. At that time she was 43 years old. She then spent two years looking for work.

> I used to fax a hundred resumes a week, and get nothing back.... I've looked for work in anything, everything that's office work. From management to just straight typing. Not even secretary or clerk or whatever. And nobody wanted to hire me. I was too old for them, older than the managers and bosses, but I was only 43 (Katharine's interview, June 9, 2000).

After not finding work, Katharine felt that she had been rejected because she was an older woman.

> You're looked down, there's no room for failure on this planet. When I was a business woman I was in real estate, I was making $90 000 a year. I had guys who wanted to go out and things, and I didn't want any of them, didn't have time for boyfriends. But then you're a magnet; people come to you. Why? 'Cause you're successful. But once you start going down, they disappear.... in this world people are too judgmental. They typecast people right away, like a fat woman, a slim woman, but men don't have those judgments. It's always women. And women are the first victims of bank system or credit card system or anything that is money. When I went through my divorce with my lawyer, my lawyer agreed that that women are the first victim of everything (Katharine's interview, March 14, 2000).

Katharine said that being rejected affected her health, and that after two years of not finding work, she fell into a deep depression.

> It does affect your health. Because you're starting to question yourself. It takes quite a while to realize why they truly are rejecting you. You almost have to be a shrink yourself. And that was humiliating. That was your life. And then all a sudden, nobody wants you anymore.... when I was in real estate, I had a lot of guys ask me out. God I've been proposed seven times.... Some people say excluded, kicked out or whatever.... I felt totally rejected by a lot of people. Totally rejected. When I left real estate and I went back to the office work in Calgary, again I was totally rejected from whole bunch of money-orientated people (Katharine's interview, June 9, 2000).

It was only two years ago, however, that Katharine was diagnosed with clinical depression. She

said "Well a year and half of the depression. And about a year before that I started really going down financially. Before that I was okay. But I couldn't get a job. I couldn't get anything" (Katharine's interview, June 9, 2000). Katharine experienced her depression as fear, confusion, and social isolation. She explained:

> Fear is the biggest enemy. It's like a person in front of you. It's like an intelligent being in front of you tricking you. It's really it's like it's got it's consciousness. And it's toying with you. It's very fascinating. If you start having fears… agoraphobia… isolation, and confusion (Katharine's interview, June 9, 2000).

It seemed that Katharine's unsuccessful attempts at finding work had a significant effect on her. At a Research Team meeting she suggested that "nobody wanted" older, single, and poor women.

> The status of women, I've been divorced 22 years, I raised my children on my own, and a woman alone is the most challenged of all the people, compared to couples, compared to women alone with money, I'm saying financially challenged as we are, we are at the bottom. We are at the bottom, and nobody wants us. A lot of couples have friends, as soon as you are separated, you are divorced or alone, they don't want to see you anymore. The status of women who are financially challenged, and are alone, no husband around, no Mrs. George Smith, or whatever, there's no male name there, we are at the bottom. To get credit, to get a credit card, to bank, to get anything, we're nothing. They want right away for somebody to co-sign this, co-sign to buy a car, everything (Katharine, RTM April 4, 2000).

After suffering from debilitating depression for a few years, Katharine determined that she needed to be "inspired" and involved in her community.

> I need to be inspired and that I'm reading constantly, I have books outside my bedroom. They're even on the floor because I just have a little bedroom to live in. To inspire me, to give me good reading and the same time good ideas in that from one line in a book, I can go and say that is a bloody good idea. So you get ideas from everywhere, watching a movie you can get ideas, too. But, this is what I need…. depression is that you don't believe in yourself, you don't believe in life anymore. I need to believe in life again. My strong belief in WOAW is power to make a difference in women's lives (Katharine's interview, March 14, 2000).

Katharine saw herself applying the skills she had gained from her previous work to her work with WOAW. She said "I come from the corporate world, working with presidents and vice-presidents and chairmen of the board, and now I work with community" (Katharine's interview,

March 14, 2000). She felt that she had a role to play in reaching women in her community.

> Women are totally invisible by nature, we don't have a stick shift between our legs. So, we're invisible... if a woman is depressed or poor she doesn't reach out, she doesn't speak up. So we can't find her. The way to find her is through advertising. Constant advertising. And it's free, so we have to establish that. Silence and invisibility is the curse of the woman (Katharine's interview, March 14, 2000).

At times she worked over 30 hours a week on WOAW-related tasks "The newsletter and preparing for the meetings. And following up. And calling people. A lot of hours.... some weeks I easily put in thirty hours" (Katharine's interview, June 9, 2000). In one interview she was critical of other WOAW members who she perceived as not taking the work of WOAW seriously enough.

> But I've organized many activities and many groups and I've been a manager of a big department before, so I know.... And having been in big management talking millions of dollars you know it's always serious. It's always serious. Everything you type is serious, every meeting I attended and I took the minutes, it was a very serious matter, so I tend to take things maybe too seriously, but I think this should be taken more seriously than it has been taken.... What I find with WOAW, women are not taking it seriously. If you want to be, if we women want to be considered seriously, we have to take ourselves seriously. And we have to take WOAW seriously. Many don't realize how lucky they are to have money from the grant, education, and social activities. This is the first step of self-empowerment (Katharine's interview, March 14, 2000).

In 2001 Katharine was diagnosed with multiple sclerosis, and over that year and 2002, I saw her health steadily decline. After the government cuts in 2002, she told me that she could not afford the necessary medications for her MS. Despite her poor health and doctor's recommendations to slow down, she remained heavily involved in WOAW. She initiated the formation of the CoPoMo WOAW group, and organized several major activities, including the "community women's studies course" that was held at Douglas College in 2001 and 2002.[2]

PoCo WOAW Subgroup

<u>Joanne</u>

Joanne was a 30 year old single mother with 2 children. When she was in her mid-20s she

116

moved to Montreal. From that time, she had lived in poverty with her drug-addicted husband.

> We were practically living in poverty before because he [ex-husband] was a drug addict. And he wasn't around or whatever. So it [poverty] started back then too. Because even though he was working I never had money to do nothing (Joanne's interview, June 9, 2000).

After her marriage she and her husband moved to British Columbia.

> My ex., he was from Montreal. And when we got married we moved over here to B.C. And it was hard because I'd never been away from my mom, lived with my mom for 24 years, then came up here and he was a total jerk. He passed away.... He treated me like a servant, I would cook, clean, do laundry (Joanne's interview, March 20, 2000).

Joanne stayed home raising their son and daughter. She had worked as a babysitter and in childcare, and hoped to return to that kind of work.

> All I ever did was work with kids. I left school at 16 and I worked at preschools and daycare and I did private babysitting at home and that's where I got my money 'cause it paid. People who came to my home, I got the same clients from my daycare. If they had to go out at night and they brought their kids home, so it was people who knew me and I knew. That was kind of cool, I loved working with kids (Joanne's interview, March 20, 2000).

In 2000 Joanne returned to school to take university psychology courses. She spoke frequently of her boyfriend "[I've been dating my boyfriend for] almost a year. And he's really great with the kids. That's really good" (Joanne's interview, June 9, 2000). Joanne withdrew from WOAW in the fall of 2000; I contacted her on several occasions and she explained that she wanted to focus on her university courses and finding a job. When I spoke to her in May 2002 she told me that she was engaged, eight months pregnant, and had completed her courses. Joanne was not comfortable with having detailed personal information written and asked that I keep her story brief.

Kelly

Kelly was a 34 year old single mother with a 3 year old daughter. She said that she had difficult relationships with her three siblings, her mother and step-father had been abusive, and

her father had recently committed suicide.

> I'm the baby of the family, there's four of us. I'm 34, then it's 37, then it's 39 and 40. I've got two sisters and a brother... my dad committed suicide 4 years ago, that was pretty bad. Blew off the top of his head. I cleaned up and stuff. I was the only one out of the 4 kids that could do it. I wasn't that close to my Dad, he left when I was about 5 (Kelly's interview, March 14, 2000).

Kelly grew up in East Vancouver and then moved to Hundred Mile House in northern British Columbia with her abusive husband. She said that the welfare system had put her life in danger when she tried to get welfare in order to leave him. Despite her husband's history of abuse, Kelly was told to live with him and rely on him financially.

> My husband had been charged with assault, he had several things in his background, and they [welfare] actually put my life in danger... they said that they weren't giving me my cheque, I almost fainted, I was pregnant (Kelly, RTM April 4, 2000).

Eventually, Kelly was given social assistance and had been on welfare ever since. "[I've lived in poverty] since I left my husband, so for the last two and half years" (Kelly's interview, June 6, 2000). She explained the choices she had made.

> I knew that it [leaving husband and going on welfare] was going to be really hard. And I think that's why a lot of women stay in abusive relationships because they know it's going to be really hard. They know they're going to be on welfare or they know they're going to get a lower paying job. But I know I'm smart. I know I got a good head on my shoulders. And I know I could become anything that I want to become. And it's just a matter of time.... It's just putting in the time that's really hard.... Because you got the weight of the world on you, like most of my friends, the dad's on the scene. And they get their breaks every weekend, or every second weekend. Or they get support money.... Like I got nobody I can phone up and say she [daughter] needs a new pair of shoes.... But then you flip the other side – I always like to flip the coin – I don't have to share her with anyone. I don't have to worry that I'm sending her off to an abusive father. So many women they have to share their kid with someone that's emotionally unsound right? So I'm lucky in a lot of ways too. It's my way or the highway (Kelly's interview, June 6, 2000).

Once she left her husband Kelly moved to Port Coquitlam with her nine month old daughter and was socially isolated.

> I was isolated, I was on the other side of Port Coquitlam and I had just moved down here. I grew up down in East Vancouver and then I moved away for nine years, up to Hundred Mile, got married, got abused, finally left the relationship. Nine years later I

118

came back down. I don't know Port Coquitlam at all. I was totally isolated. I'm a single mother. I do have people that I know in Vancouver. I knew nobody out here (Kelly's interview, March 14, 2000).

She said that her family, who lived in Port Coquitlam but with whom she had limited contact, had been unhelpful and judgmental. When her sister-in-law said to her "you've made your own bed, now lie in it," Kelly responded:

> I said "I can't help that I picked a cocaine addict for a father for Taylor," but I said "I'm not going to tell you I made a mistake." Look what I got out of the deal. Sure it's a tough road. "Well you made your own bed." And I said "you shouldn't be such a snotty little bitch because you never know what life's going to dish for you." I know if there was an earthquake tomorrow I'd be helping people, and I can survive without food or water for a while. But I know other people, they wouldn't. They'd be devastated. I have unbelievable strength. I get a little sick of it sometimes 'cause I think, how much do I have to endure? I do see a light at the end of the tunnel, but it's so far away. And, that's the thing that's frustrating, is the stereotyping, too. The thing is I am very intelligent, and I could be a doctor or a lawyer or a paramedic, or whatever I choose to be. I have the brains to do it. It's just right now, I can't. My hands are tied. I have my daughter. That's the most important. And, you can go back to school when you're 50, if you like to be a nurse. You can go back to school whenever (Kelly's interview, March 14, 2000).

On numerous occasions Kelly said that being a good parent was her top priority. She suggested that she chose to stay home with her daughter and that staying home and relying on social assistance was only temporary.

> I'm one of the most balanced people you'll ever meet. I'm very intelligent yet I'm just putting in time right now. I'm raising my daughter. It just really bugs me because I am smart. And I do have a career goal and I will achieve it. And it just but really bugs me because they make it like you're a dummy. And you're not a good parent.... they don't even know what they're talking about. That you don't know how to budget your money.... you need to know how to budget money when you're on welfare. Because you have so little to work with that you have you're very good at it like we could probably teach courses on it.... that's the thing is just a lot of people think you're a loser. You should be working. It's like excuse me like I am working. I have a full time job and I don't get holiday pay and I don't get breaks. It's 24-7. And the thing that really bugs me is it's the most important job to raise a child. It's the most important job you'll have. And you get the least recognition for it. And it's the most this is our next generation coming up. This is our next scientists, presidents, everything. We're raising these people... I just don't understand it (Kelly's interview, June 6, 2000).

Kelly said that one of the advantages of staying at home with her daughter was that she could control who had contact with her daughter.

I'm very nervous. 'Cause it's usually kids getting molested by people they know. Correct? I think it's 80% or something, it's pretty high. And I don't want my daughter diddled. That's another reason I'm a full-time stay at home mom. 'Cause once it's done it's done. I can't change it. And then, not that you're screwed up forever if that happens to you, but you're going to have some problems.... That's probably why I stay single as a woman, too, and don't really have men around my daughter is 'cause I'm afraid that they're pedophiles (Kelly's interview, March 14, 2000).

At times Kelly suggested that she had low self-esteem and had struggled with depression, but

that she had learned to "pump" herself up and look at the positive "flip side."

I've never really had too much of a struggle with it [depression] because I mentally pump myself up. I have these things that I say to myself, like it's not going to last forever. It's only temporary. You know you're smart. I got a lot going for me.... I try to find something positive in a negative situation. And it's really helped. But I have had my moments where I get depressed for sure (Kelly's interview, June 6, 2000).

At one point Kelly's doctor had suggested that she needed Prozac for her depression. She

insisted that she was depressed because it was a "hard life."

I've actually had doctors say to me, "maybe you need some Prozac." And I said "Prozac is for people who have chemical imbalances in their brain. I don't have a chemical imbalance, I have a hard road to travel." I don't need that crap. Don't be pushing that stuff on me because I'm far from having a chemical imbalance. I'm depressed because it's a hard life. I don't have the money to put my daughter in swimming lessons or tap dance. I don't have the cash to do that (Kelly's interview, March 14, 2000).

Although Kelly had endometriosis and osteoporosis and struggled with tiredness and pain, she

said that stress was a big concern for her.

I have my endometriosis, which has always been an ongoing problem for me since I was 20 and I'm 34 now, so it's been 14 years of problems. I seem to be fairly stable with that now 'cause I'm on the depo-provera, but I know stress is a killer. Like, I worry sickly. For example, we get paid next week on the 22nd, I'm all worried, am I going to get my cheque ok? There's no reason that I shouldn't, but I just moved, and I'm all worried. I've got a new landlord and I'm just all worried. Stress is a big one for most of us. Just having to deal with the welfare makes you really stressed out. And, being tired. That's my biggest problem with being a single mother is never having enough sleep. I'm always tired. Even if I go to bed early with Taylor it's not enough, I'm three years behind.... When Taylor naps, I go down for a nap. I am exhausted. It's been three years of doing it on my own. I'm tired, man, and I'm not afraid to tell people that.... I also have developed osteoporosis from treatment for the endometriosis.... I find my legs and my arms hurt.... I'm only 34 years old. I don't feel my bones should hurt. And they do. I'm tired and I'm sore (Kelly's interview, March 14, 2000).

In 2002 Kelly was told that she should no longer take medication for her endometriosis because her osteoporosis had advanced significantly. Kelly's doctor said that she needed a hysterectomy, and although she wanted to have the operation, she did not know how she would manage with her young daughter, insufficient homecare services, and no social support.

At times Kelly was critical of the government and how she had been treated as a welfare recipient. She also felt, however, that she had to take her own initiative to change her life. "My biggest thing is you got to help yourself. If I just sat here and felt sorry for myself nothing's ever going to happen for me. But if I get out there and I apply myself, something will happen for me" (Kelly's interview, June 6, 2000). At a Research Team meeting later that year Kelly said:

> I'm a total entrepreneur, right? I'd totally go that way with whatever I wanted to do, right? But I would like to work with the elderly. My mom was a nurse, and she worked with the elderly (Kelly, RTM June 29, 2000).

In 2001 Kelly returned to school to become a nurse. Although she had completed her grade 12, she had to upgrade and take science and math courses to be admitted to university. She could only take one course per term because Taylor was still in pre-school, though she planned to return to school full-time once Taylor was in grade one. Kelly was seen by most WOAW members as the leader of the PoCo WOAW group. I saw her as smart, determined, and driven, and felt confident that she would eventually reach her goals.

Virginia Dawn[3]

For the last three years, Virginia Dawn, a 25 year old single mother, has lived on social assistance. She spoke of her upbringing:

> I came from a toxic home environment and was repeatedly sexually exploited and abused. I left home at 18 to escape my negative home environment and to avoid having to move from Vancouver to a small isolated town. As a consequence of my upbringing I had a poor sense of self worth and a longing for unconditional love. I feel that this longing caused me to start a family too young and too soon which limited me from attaining my potential to be well-educated (Virginia Dawn, phone conversation, July 22, 2002).

When her marriage ended, she lost her security and plans for the future and became dependent

on the government.

> I would say that it's because I didn't get enough of an education when I chose to have a child. We had purchased a condo and I figured that I was pretty set and I was going to run a small family daycare out of home. So I wasn't really worried about my future. And then the change came of our relationship. And I chose to leave. So basically my choice to leave put me in poverty. I knew that before I entered it (Virginia Dawn's interview, June 6, 2000).

Virginia Dawn's first years on social assistance were difficult. She told me that she felt "ripped

off," not only because of her "poor choices and failed marriage" but also because, when she was

22, her mother revealed that her childhood abuser was not her biological father. She said:

> I realized that I had been betrayed far more than I knew when I was growing up. My own mother sold me out and only owned up to her own deception once I disowned my father. My family on both sides had lied to me about who I was and it deeply damaged my sense of belonging (Virginia Dawn, phone conversation, July 22, 2002).

For several years Virginia Dawn felt that everyone was "out to get her." She spoke of her anger.

> I used to be a very, very angry person.... I'm finding it's not so bad any more. I know enough people now that I can just pick up the phone and vent. And then it's gone. I used to really internalize it. And I'm sure that contributed a lot to my depression (Virginia Dawn's interview, June 5, 2000).

In the first Research Team meeting, when I asked the women about their biggest health

concern, Virginia Dawn immediately said "depression." In our conversation she spoke about

how stereotyping had affected her. She said:

> Certainly many single mothers receiving income assistance can relate to the negative feeling of being stereotyped. This feeling was compounded for me as I struggled with feelings of sexuality. I felt quite alienated among my peers when I came out as a lesbian, along with the welfare mom stereotype I fought to retain a decent image as a parent because of my sexuality. I have been discriminated upon by landlords because of it but ultimately it's hard to prove (Virginia Dawn, phone conversation, July 22, 2002).

Virginia Dawn said that her involvement with WOAW had helped her manage her anger and

feel less affected by the stereotype of the welfare mother. "I mean you get hit with it

[stereotyping] now and then but it doesn't bother me as much any more because I'm connected

with the WOAW group" (Virginia Dawn's interview, June 5, 2000).

Virginia Dawn was sporadically involved with WOAW over the three years. When she was most heavily involved, she was the treasurer for the PoCo WOAW group and attended most meetings and activities. At times, however, she became frustrated with the SSHRC funding stipulations and attempted to find other means of accessible recreation.[4] She maintained that recreation was her first priority, for both herself and her 3 year old daughter. "My top priority's basically having accessible recreation" (Virginia Dawn's interview, June 5, 2000). Virginia Dawn saw recreation in this way:

> Having accessible recreation has been crucial for fitting in to society and just feeling worthy and valid because it's a part of a framework that everyone should be able to fit into. Being able to obtain recreation for myself and my daughter assures us that we do belong and that it's not just there for those with money. For me it's about being a decent parent and providing a solid framework (socially and recreationally) that was so lacking when I was young (Virginia Dawn, phone conversation, July 22, 2002).

In our last year of WOAW Virginia Dawn was actively involved and organized several fundraisers. She also became involved in the UBC Humanities 101 course – a course offered to people on low income to learn the humanities in a university-style classroom in Vancouver's downtown east side. She hoped to go back to school and to gain enough education to escape living in poverty.

SWCo Subgroup

Elizabeth

Elizabeth, a 34 year old single mother, grew up in Port Coquitlam and characterized her family as middle-class. She had two sisters who lived at home with her parents.

> I got two younger sisters at home.... One's in high school. One starts her second year university this September. She was lucky because she got lots of scholarships. She wants to be a dentist (Elizabeth's interview, June 12, 2000).

On several occasions Elizabeth said that she never liked or "was good at" school. She said that

she had lived in poverty for over five years, and that it had started when she was with her husband.

> It [poverty] started when we were together because he's [ex-husband] always just used to just have minimum paying jobs. I don't think people ever realize how expensive it is to have a child. And of course you're going to put all their needs first. So the other bills can go aside. Definitely started like that, not that I ever regret having Alexander but if I could have changed things, I definitely would have waited (Elizabeth's interview, June 12, 2000).

Elizabeth had significant health problems. In 2000 she had a fourth thyroid surgery, and previous to that had undergone a double mastectomy.

> I've always been prone to growing lumps and bumps, that was the diagnosis with many doctors. First time I had the [thyroid] surgery, they were supposed to have taken out half of it. Second time they were supposed to have taken out the other half. Ok, so now you have no thyroid, so the third time it comes up it's kind of what's up? You guys said it was gone. And apparently it's impossible to get out every little sliver, so something grew on that lump. And the last one was kind of scary 'cause they said they were getting close to my voice box, so there was no guarantees that I wouldn't come out without my voice damaged. Now I'm just freaking and thinking "well what's it going to be like the fourth time?" Since I had the third one, I had both my breasts removed when my son was six months old, and that was because they found cancer in one of them and growing lumps and bumps. They said if I didn't do it I would have full-blown breast cancer within five years for sure. So, I said, seeing as my cells know how to make cancer, what's stopping this from being cancer, so I'm rather stressed out right now (Elizabeth's interview, March 20, 2000).

Shortly after her double mastectomy, "my ex told me that the biggest two mistakes of his life, the first one was marrying me and the second one was having our son" (Elizabeth's interview, March 20, 2000). After he moved out she did not receive child support "they're [welfare office] supposed to be enforcing it with my ex and they're not" (Elizabeth's interview, June 12, 2000). She was told by her welfare worker that it was her responsibility to secure support payments from her ex-husband. After the break-up of her marriage Elizabeth had a second bout of anorexia nervosa.

> I've twice gone anorexic.... I'm not the best of eaters. And I've really tried not to pass my bad habits onto him. But I think some of it might be slipping on to him (Elizabeth's interview, June 12, 2000).

On several occasions Elizabeth spoke of being frustrated with the welfare system for not providing her with more training opportunities.

> Everybody wants the twelve dollar an hour jobs. But you have to start at the bottom. And then it's just a vicious little circle. And then welfare won't help you get any further with your education. Because I've asked about it. And they say you don't need to worry. Your son's not seven yet. But I don't want to wait 'til he's seven. I want to do something now. Because anything I might have will be stale by the time he's seven (Elizabeth's interview, June 12, 2000).

Elizabeth was also concerned about her son being stereotyped as a "welfare kid." "A really big hang up for me is him going to school. I'll sooner wear rags, but he's not going to go to school looking like a welfare kid" (Elizabeth's interview, March 20, 2000).

In July 2000 Elizabeth had her fourth thyroid surgery. After a long recovery she returned to WOAW meetings and activities in October 2000. Since that time, she has worked part-time in a cafeteria, filed for divorce, and fortunately had no subsequent thyroid or cancer scares. She has been active with the SWCo WOAW subgroup, and although she frequently suggested that she had low self-esteem and difficulty speaking in groups, she made important contributions to both WOAW's organizing and my research project.

Maey

Maey, a 34 year old single mother, grew up in several foster homes. She explained her experiences with school and her welfare workers:

> I'm illiterate, and when I say that I can't read, they [welfare workers] say, "what do you mean you can't read, how old are you?" They just don't understand that I was labeled as retarded when I was younger, right? So they don't understand that I didn't get the opportunity the same as you guys did, when I was 19 they found out I just have dyslexia really bad (Maey, RTM April 4, 2000).

Because she was labeled "retarded," Maey never completed primary school. Although her opportunities had been limited as a result, in our second interview she said that God had chosen her to live in poverty.

Colleen:	How long would you say you've lived in poverty for?
Maey:	Off and on all my life.
Colleen:	All your life? Do you have a sense for what causes you to live in poverty?
Maey:	Education. And (pause) maybe it's chosen.
Colleen:	Do you think it's chosen?
Maey:	Maybe. Maybe. Yah.
Colleen:	Why do you say that?
Maey:	I don't know. I guess my opinion is God never gives anybody anything unless they can handle it. Or there's a reason he wants you to go through it (Maey's interview, June 9, 2000).

Maey spoke of not wanting to put the "burden" of poverty on her 11 year old son. "I hate saying [to son] I can't afford it. Because that's telling him we can't afford things…and I don't want to put that burden on him" (Maey's interview, June 9, 2000). She had significant health problems – she had "elephantitis," struggled with anorexia and bulimia, was deaf in one ear, and had scoliosis (and a rod in her back). When I asked her whether she was healthy, she said that she was. "I have been healthy since I quit smoking. I go swimming quite a bit now and that's really good exercise" (Maey's interview, March 27, 2000).

Maey was involved in WOAW in 2000 and 2001. Initially she was shy, yet she became more outspoken and outgoing as she made friends in WOAW. She was open about her illiteracy, we often read WOAW and research materials together, and in 2000 she teamed up with a woman in the ATP subgroup to learn to read. In 2002 she moved to Pitt Meadows and found it more difficult to attend WOAW meetings and activities. When I spoke with her in May 2002 she said that she was active with the PoCo Women's Centre and other community activities in Pitt Meadows.

Susan

Susan was a single woman in her early 40s who had lived most of her life in the Tri-City area. Because she had gone to college, separated from her husband, and never had children, she felt that she did not fit the mold of her family.

126

I didn't fit the mold in my family unit. My brothers just can't deal with the type of person that I am. There's nothing negative, it's just there's nothing in common. My family, too, I'm the only one who went to college.... So it's just like I'm different. I'm not married with kids, I didn't do the norm (Susan's interview, March 24, 2000).

Health figured prominently in many discussions with Susan; she had diabetes, fibromyalgia, clinical depression, and irritable bowel syndrome. At one point she explained that she had never had good health.

> I've never had good health.... There hasn't been a time when there hasn't been something going with me.... I mean pain is ill health to me. So my idea of what would be good health for myself is very different than it used to be. Now I accept the fact that there's going to be pain (Susan's interview, June 2, 2000).

Susan married in her early 20s, and from that time onwards, she had relationship, health, and money problems.

> I lived in on a very low income in my early marriage. I stopped work and couldn't find work. And my health wasn't very good. And we lived just on my husband's wages which were very low. And we had a lot of trouble then (Susan's interview, June 2, 2000).

Although she did not provide specific details, Susan suggested that trust was a big issue for her and that for several years she was involved in co-dependency programs.

> I've gone through depression over the years, and one of the biggest things I had to work with, mostly when I got ill, I actually had to face, was the self-esteem level. That's where the trust came in, I either over-trusted people or I didn't trust people at all. For women it's really hard also because my best girlfriend had an affair with my husband, so that kind of did the girl thing (laughter), so we had to kind of work on that too. You know, support groups, and counseling, support groups did it the best for me, and I think it helped me, but even in support groups there's not always safe people. So I had to learn who would be safe and who wouldn't. But I had to start building my own self-esteem up or it didn't work. I had to trust, I didn't trust me, I didn't trust anybody, even when my illness came, I was hiding it for years before I let anybody know how ill I was. And then once I started sharing those little things, but I tried it, I did test people, I tested people with things, then I started realizing I was picking, really, really, the wrong people to be with, so I had to change me, it wasn't really the people around me (Susan, RTM April 4, 2000).

In the interviews and Research Team meetings, Susan made frequent reference to her past career as a businesswoman owning a daycare. She had a staff and worked with many low-income families. As Susan's home life deteriorated, she immersed herself in her work.

127

I pushed myself too much. I was a workaholic and I was in a very bad relationship with an alcoholic. Home life was really bad. I lived at my work.... I couldn't cope anymore. I couldn't think (Susan's interview, March 24, 2000).

In her mid-30s Susan's health began to decline. She was diagnosed with diabetes, and her health continued to deteriorate to the point where she could no longer work to sustain her business.

I knew it was the diabetes, there was no question. I'd been warned about it already. I then went for tests, in one week I shut everything down, finished my relationship, sold my house, everything.... There just was nothing left to do anymore, and the clinical depression came in at that point, too (Susan's interview, March 24, 2000).

She struggled with diabetes and clinical depression and attempted to get help from her local welfare office.

Before I got disability I was on medical assistance.... And before that I had time off 'cause I had my business and then I shut it down, and of course I don't get UI because I'm self-employed. And so I sold my house and all my other things and lived on those earnings for a period of time, and then I had to go. And I didn't get better. But we never thought it was as bad as it was (Susan's interview, March 24, 2000).

When Susan first attempted to get help from the welfare office, she encountered a social worker who typecast her and accused her of not wanting to work.

I was just a woman who had lost everything. And obviously was too lazy to go out and work. Overweight. That was the other big mark against me right there.... And she [social worker] took something that was low anyway and just stomped on it.... I dug a hole and stayed there 'cause she [social worker] told me I couldn't get any help at all. And then working with another worker who opened doors for me that was unbelievable. So there's a lot of anger there for me. This woman I want to report in the end. I'm just not quite sure how to do it. Apparently I wasn't the only one (Susan's interview, March 24, 2000).

The experience of being mistreated by her social worker had a profound influence on Susan's self-esteem. She told me that after meetings with her worker she would go to bed and take days to recover. Although it took some time, she finally managed to get help from the office when her new social worker learned that Susan had serious health problems.

She [social worker] was absolutely shocked and started talking differently when she realized that I had been a career woman all of my life, and without my health, that was the only reason I was in there. So [she realized] I wasn't uneducated, I wasn't anything (Susan, RTM April 4, 2000).

128

Susan found the experience of losing her health and relying on social services shaming. "At first it was really embarrassing. I didn't want anyone to know. Because I'd always been a businesswoman. I used to just say to people I'm on medical assistance. So they didn't take it as social services" (Susan's interview, June 2, 2000). She suggested that it had been difficult for her to come to terms with her "diminished" life, and was, at times, unable to keep up financially and physically with her friends.

> Most of my friends are career-oriented people, women. They're out there, they have the money, they have finances. I don't fit that mold, so I couldn't do a lot of the things that they did because of financial reasons. I couldn't physically handle it. So, my friends also had to change their life to be in my life (Susan's interview, March 24, 2000).

Even though Susan was on disability II, she could not afford the medications she needed to manage her diabetes, fibromyalgia, and depression.

> For fibromyalgia, supplements and eating is the best form of getting well. And yet they [government] won't help me. But I can get any prescription medication I want free. But they don't help me. They just keep me addicted to the painkillers rather than being able to take supplements which would not be addictive (Susan's interview, March 24, 2000).

Despite these challenges and her major life changes, Susan looked upon her life and poor health positively and felt that she had grown as a person. She told me that she had learned to trust people and had gained self-esteem.

> That has been the advantage of the illness is that I've learned a lot about myself and I've learned to take care of myself at home. And I really like myself. I don't think I really liked myself that much (Susan's interview, March 24, 2000).

In WOAW's first year Susan said "I'm here 'cause I think this will lead to a job" (Susan's interview, March 24, 2000). She suggested that she wanted to "work with people. Particularly children and families, preferably on low income…. I've always had a goal… to own a ranch or something like that where kids and families can retreat" (Susan's interview, March 24, 2000). In 2000 I drove Susan to most of the Research Team meetings, and during our drives we discussed, among other things, my research project. She had many important insights and reflected on my

role with the Research Team.[5] In mid- and late-2000 Susan coordinated the WOAW newsletter, and in 2001 she and several women from the Aged to Perfection group attended an anti-poverty conference. She said that she wanted to be an advocate for other women on low income, and had on several occasions gone for support with Willow to the welfare office.

Willow

Willow, a 26 year old single mother with a 2 year old son and a 5 year old daughter, was one of the youngest WOAW members. She grew up moving homes and schools every year, and explained the difficulties she had encountered as a teenager at high school.

> Unfortunately I fall in a whole other stereotypical category [of welfare recipients] because I did not finish high school. And there's reasons for that too. And it always sounds like she's got an excuse for everything. "She's got an answer for everything as to why it's not her fault." So of course I carry that. I was one of those kids that got bullied in high school. And got beat [by kids at school] severely every day for four years. And there was nothing; there were no programs in place. There was nothing the school could do. I got thrown out of four high schools because they would not address the problem.... They expelled me from four different high schools. I had high marks, only the marks started to go down when I was running away. They gave me two classes a day instead of four. So they could avoid the problem. I could sneak in, sneak out and they didn't have to address it. By the time it got so bad that I couldn't even sneak in to those two classes, I was just running. And then they would have to throw me out for bad attendance (laughing). But I still was intelligent enough, I was still passing courses even though I had more absences than presences. I feel like I've slipped through the system somehow (Willow's interview, September 20, 2000).

After dropping out of school at 14, Willow had a series of low-paying jobs. Encountering abuse at one job forced her to quit and to subsequently rely on social assistance.

> I was working at a position where I was being abused as an employee. I wasn't given overtime hours. I wasn't given breaks. I was told to work at festivals and not paid for it. My final straw was I was being electrocuted by the food machines. It would zap me and I had to use this machine all day long. So after the first hour that morning I'd had enough. And I quit. So because I had quit my job, I couldn't go on assistance. And she [employer] kept my final cheque. So I couldn't go out and look for work. I applied for a student loan and found out that even if I were to go to school full time, work part time, the amount the student loan would be was not enough for me to survive on. So I went back to social services who then made me go through an appeal which was eight weeks. Eight weeks of appeal with no money for food, no money for looking for work. No money for rent.... And about a year later I was told no, you have to send this [student

loan] back. And I was starving. And I had nowhere to live. And I had no money to look for work. I had no other choice but to send back the student loan and go on welfare (Willow's interview, September 20, 2000).

Willow explained that she and her parents had negative experiences with social services, and that when she was living on the street her first worker was abusive and dispassionate.

My father was disabled, so he was applying [to social services] as well. And my mother worked. So they made them legally separate, told me I could not live there because it was my family and I didn't have to pay my family rent. And they had to legally separate because she couldn't afford to finance herself, her husband and me. So to get the assistance that we needed they split up my family.... When you go and have the lady [social worker] say snide remarks, like "how's your dog today?" Because I couldn't feed her. I'm out on the street with my dog. It was just awful. She was terribly abusive.... And of course I would break down and say "this is terrible. This is so terrible." And they [social services] said "are you sure there's not something else wrong with you? Do you need to see mental health?" Because I was crying (Willow's interview, September 20, 2000).

Since these first experiences with her welfare worker five years ago, Willow had been reliant on the system and, at times, had suffered such severe material scarcity that she had gone hungry.

There have been occasions where I have not had enough money to eat myself so that my children could. I've had medical situations that I couldn't get help with and I have to pay these things. So therefore I starve (Willow's interview, September 20, 2000).

Willow often spoke of the shame of being on welfare "it's very shaming [being on welfare].... I try not to talk about it" (Willow's interview, September 20, 2000). She was critical of the welfare system that could not provide support for recipients who wanted training and work.

What bothers me is that in our country, in our society, why is there no way that we can differentiate between those who don't want to do anything for themselves and those who do? And I know for a fact though that there are things available. Where do I get that information? How do I have access to it? I feel pretty beaten down (Willow's interview, September 20, 2000).

Although Willow was at times critical of the welfare system that imposed barriers and "obfuscated" information, she also felt responsible and blamed herself for her situation.

For the most part I feel responsible for it all. And whether I should or shouldn't that's kind of the way I was raised. You know it's that everything is your fault somehow. You get out of life what you give to life (Willow's interview, March 15, 2000).

Willow suggested that since she was 12 her life had been an ongoing struggle. She felt hopeless, helpless, and stressed.

> It's very stressful. And then you get that feeling of you know helpless, hopeless. And you have nobody you know no help. Because you're this little person (Willow's interview, September 20, 2000).

In fact, Willow said that her biggest health concern was stress. She explained the different "sides" of stress:

> [Main health concern is] stress on both sides. The stress of my position, my financial position. The stress of feeling like there's no way to enable myself to get out of that position. And the physical stress that comes with living everyday with two children in poverty with no vehicle.... I don't have friends, so therefore I don't have anyone who can baby-sit for me. So therefore, I don't get to go out. I don't have money for recreation, so I don't get to go out. And you become...the social isolation comes from the financial situation and the stress that goes along with that. So I said, everything with me always comes back to the stress (Willow's interview, March 15, 2000).

In the year 2000 Willow was diagnosed with social anxiety disorder that she felt was a consequence of her poverty – "I'm seeking medical help for anxiety and depression" (Willow's interview, September 20, 2000). Despite having social anxiety disorder, in our first interview Willow answered that she was healthy because she only smoked lightly.

> I'm pretty physically fit. I smoke but very lightly. One, two, maybe three cigarettes a day. I'm active. I'm 5'4, 125 lbs. So, I'm pretty healthy. I'm able to physically handle my two children and run around with them and play with them, and make sure their physical needs are met (Willow's interview, March 15, 2000).

Willow spoke consistently of wanting a career, and not knowing how to gain the experience or training she needed. She was often frustrated with the barriers she encountered and felt constrained as a consequence of living in poverty.

> There's so many things that I don't understand and just don't make sense to me. When I am intelligent enough to pass any course that I had the opportunity to take and could get out there and make a fine living. And a you know do something for society.... What I would give to have the troubles of a normal person who's working and struggling. And everything else just so I could feel like I am part of the community (Willow's interview, September 20, 2000).

After our second interview Willow shared with me a book of poetry she had written. I saw

132

Willow as an insightful, analytical, and articulate women with a deep understanding of the politics of poverty. In 2001 Willow worked part-time in a cafeteria, and then in 2002 she worked three hours a week at a recording studio. She remained involved in WOAW throughout the three years and at times took a leadership role in organizing events and speaking on behalf of WOAW. Despite the 2002 government cuts that reduced her monthly income by almost $100, she remained hopeful of somehow finding an opportunity for education or training that would lead to a career.

Common and Divergent Themes

In the above stories I attempted to provide a picture of the 12 women who were actively involved in my dissertation. There were 18 other women who were involved, to varying degrees, in my dissertation project. Of these 18 women, eight were interviewed in the first round and attended some Research Team meetings. Ten others were not interviewed for my dissertation but attended at least one Research Team meeting. The following discussion of common and divergent themes is based on the 20 women who were interviewed in the first round and for whom I have demographic information (consult Interview Face Sheet, Appendix F).

Age

The women were diverse in terms of their age – they ranged from 25 to 65 years of age. Many of the women suggested that this diversity was a strength of WOAW and a source of learning.

Table 12– The Women's Ages

Age	Number of women (n=20)	Names of women
20-30	6	Alexa, Willow, Joanne, Cynthia, Julie, Virginia Dawn
31-40	5	Kelly, Maey, Caroline, Elizabeth, Cassie
41-50	4	Susan, Katharine, Teresa, Gloria
51-60	2	Rene, Trina
>60	3	Wanda, Martha, Arlene

Living in Poverty

All of the women involved in my research identified themselves as being poor. The language they used to describe their poverty ranged between living on "limited incomes," "low income," having "limited resources," to being "poor." Virginia Dawn suggested that poverty was the main reason for most of the women's involvement in WOAW "that's why we've joined [WOAW], 'cause we're in a similar boat, it's a big boat, but we're in a similar boat" (Virginia Dawn, RTM April 4, 2000). Although all of the women lived on low income, their sources of financial support, length of time in poverty, and reasons for living in poverty varied.

The majority of the women clearly stated why they believed they lived in poverty. Their reasons included separating from a partner, being a single mother, not being able to find work, disability and ill-health, and being born into poverty. Generally, the younger women with young children cited a conscious decision they had made to leave their abusive partners or husbands, and that their decision subsequently forced them to live on the welfare system in poverty. None of the younger single mothers received child support from the fathers of their children. For some women there was a risk in attempting to receive support payments, often because of abusive ex-partners and possible threats to themselves and their children.

For six women, becoming disabled or chronically ill was their reason for being on disability benefits and living in poverty. These women ranged in age, and four of them said that their previous work, because it was repetitively physical, had compromised their health and rendered them disabled. The women spoke about not wanting to be on welfare, but said that it was the best or only option for them at that current time in their life. While the middle-aged and older women on disability thought they would be reliant on the system long-term, all of the younger women suggested that their reliance was temporary – something they needed in order to get the training, skills, or support in order to work outside of their homes.

Table 13 – The Women's Poverty Profile

Financial support	Number of women (n=20)	Name(s) of women
Social assistance	8	Caroline, Cynthia, Elizabeth, Joanne, Julie, Kelly, Virginia Dawn, Willow
Disability benefits I	2	Alexa, Katharine
Disability benefits II	5	Maey, Martha, Rene, Susan, Trina
Seniors pension	2	Wanda, Arlene
Working and supporting husband	2	Cassie, Teresa
Ex-spousal support	1	Gloria
Length of time living in poverty	**Number of women (n=20)**	**Name(s) of women**
1-3 years	4	Virginia Dawn, Kelly, Joanne, Julie
4-6 years	7	Susan, Elizabeth, Katharine, Alexa, Caroline, Willow, Teresa
7-10 years	6	Rene, Martha, Arlene, Cassie, Gloria, Wanda
Lifetime	3	Cynthia, Maey, Trina
Cited reasons for living in poverty	**Number of women (n=20)**	**Name(s) of women**
Left abusive partner	2	Kelly, Caroline
Left drug-addicted partner	1	Joanne
Left or was left by husband	4	Elizabeth, Virginia Dawn, Julie, Gloria
Disability or ill-health	6	Susan, Rene, Wanda, Martha, Arlene, Trina
Cannot find a well-enough paying job	5	Willow, Alexa, Katharine, Cassie, Teresa
Have always been poor	2	Cynthia, Maey

Note: Refer to the notes from chapter 2 for the income assistance rates in British Columbia. In 2000, on average, the women in this study lived on approximately $899.78 per month, or $10 797.39 per year. In 1995, the average annual income of Coquitlam households (in the Tri-City area) was $57 209. In that same year, the regional average income was $54 055 (Statistics Canada, 1996). The women therefore lived in a relatively middle to upper income community.

Past and Future Employment

There were many references to previous, current, or future work. The women's explanations for not having paid employment included disability, chronic illness, parenting responsibilities, little social support, limited education and work experience, and difficulties finding work. Although few of the younger women had previously had a career, they actively considered their employment options and discussed them openly in the meetings and interviews. Generally, the women emphasized their need and desire to have paid work and the benefits connected with it, including financial independence and a wider circle of adult acquaintances. The women

discussed work in two different ways – as being unable to work and therefore reliant on government assistance, or as wanting work in order to escape poverty and adequately provide for their family. Only occasionally did the women recognize the unpaid work they did as mothers as legitimate work.

Education

Generally, the younger women suggested that their low levels of education were related to living in poverty. Some felt that if they had more education they could find a well-paying job and not be on government assistance. Others actively pursued educational opportunities – two Research Team members returned to school in 2001.

Table 14 – The Women's Education

Education level	Number of women	Name(s) of women
Some elementary	1	Maey
Some high school	3	Willow, Trina, Julie
Grade 12 or GED equivalent	8	Virginia Dawn, Kelly, Cynthia, Elizabeth, Joanne, Alexa, Arlene, Wanda
College diploma	2	Susan, Rene
Some university	1	Katharine
University degree	1	Cassie
Don't know	4	Caroline, Gloria, Teresa, Martha

Note: 80% of the women involved in this study had at least completed high school, compared to the provincial average of 42% (Statistics Canada, 1996).

Domestic and Parenting Status

Seventeen of the women identified as single; 13 were separated or divorced and 4 had never been married. Three other women were married. Of the 17 women who were mothers, eleven had dependent young or teenage children and 6 had grown children. Aside from stories of abuse and explanations for living in poverty, relationships with adult partners were rarely discussed in the interviews or the Research Team meetings. However, mothering responsibilities weighed heavily on most of women. They recognized the challenges of raising children in poverty and how it was a constant source of worry. The young mothers struggled to provide their children

with a "normal" upbringing, one that they typically described in middle-class terms, so that their children would not be stigmatized as poor. The younger mothers spoke of worrying incessantly about their ability to provide for their children. The middle-aged and older mothers reflected more analytically on women's role as mother and primary caregiver, and in some cases critiqued women's traditional and devalued position in society.

Abuse was an issue for several women. Six women disclosed experiences of violence though I suspected that more had encountered it in their childhood or in their relationships. As well, several women had first-hand encounters with others' suicide or attempted suicide.

Table 15 – The Women's Domestic and Parenting Statuses

Domestic status	Number of women	Name(s) of women
Married	3	Cassie, Teresa, Wanda
Single, separated, or divorced	17	Willow, Kelly, Elizabeth, Joanne, Virginia Dawn, Maey, Cynthia, Caroline, Julie, Alexa, Susan, Trina, Rene, Martha, Arlene, Katharine, Gloria
Parenting		
Mothers with dependent children	11	Joanne, Elizabeth, Kelly, Maey, Cynthia, Caroline, Julie, Willow, Virginia Dawn, Cassie, Teresa
Mothers with grown children	6	Katharine, Rene, Wanda, Arlene, Trina, Gloria
Women with no children	3	Alexa, Susan, Martha

Note: Just over 5% of the total population of British Colombia receives income assistance. Of the entire income assistance caseload, 33.6% are single parent families, 88.5% of which are led by females (Friends of Women and Children in B.C., 2002).

Race, Ethnicity, and Sexual Orientation

Seventeen of the 20 women involved in my dissertation identified themselves as white. The three women of colour were less actively involved in the Research Team – two of them only attended one meeting. It is possible that race and ethnicity were reasons for these women's level of involvement. Since race and ethnicity were rarely raised as discussion topics these women may not have felt that they or their needs were heard. Importantly, their presence at the Research Team meetings, and in particular Joanne who was an active attendee at the first 8 meetings, did not ensure that the full range of their needs and interests was addressed, and, without follow-up interviews, it was difficult to know why they were no longer involved.

Outwardly, the women were also homogenous regarding sexual orientation; only two women identified as lesbian. It can not be assumed, however, that all of the other women were heterosexual. Race, ethnicity, and sexual orientation were rarely raised by the women, and references to either were gleaned primarily from the interview data and from informal conversations. One possible reason for this homogeneity was that WOAW came about as a call to women on low income who wanted increased access to community recreation. From this initial call for participants, the WOAW organization, the SSHRC project, and my dissertation project resulted. Therefore, the women who participated in my study were not a random representation of women in the community – they were particularly attracted to the notion of increased involvement in physical activity and recreation. It is likely that a group of women who were attracted to and comfortable with recreation, for cultural and social reasons, became involved in WOAW. Participation in community recreation – both as a means of improving health and increasing social networks – remains a culturally-bound activity.

At the first workshop in June 1999 there were over 40 Iranian women in attendance, though as mentioned in chapter 3, this group disbanded 5 months later. The WOAW service provider who worked with the Iranian women was unable to stay involved for work and personal reasons. She was the only Farsi speaking community service provider, and the women in her group strongly identified with her. Possibly, the combination of the foreignness of community recreation and WOAW's collective organizing, and the loss of their Farsi-speaking community service provider contributed to the dissolution of this group. Once the Iranian Mutual Support Group disbanded, what remained was an almost exclusively white group of women. The degree to which WOAW then became known, visually or otherwise, as a group for primarily white women is difficult to assess.

Two research participants disclosed that they were lesbians and stated that they did not

expect WOAW to address sexual orientation. In her interview one participant said "for one I'm a lesbian and I don't see too much lesbian community out here in the Tri-City. I know that if I needed to feel a sense of community I could go into Vancouver and find it" (Virginia Dawn's interview, June 5, 2000). Aside from informal conversations, in my involvement with WOAW sexual orientation was never discussed; through omission there largely remained a heterosexual assumption within WOAW and the Research Team. Though addressing the homogeneity of my research participants in terms of race/ethnicity and sexual orientation was beyond the realm of this dissertation, in 2001 the WOAW members recognized the exclusion of women of colour and embarked on a recruitment process.[6] Sexual orientation remained to be raised as a consideration in WOAW's organizing.

Table 16 – The Women's Race and Ethnicity

Race and Ethnicity	Number of women (n=20)	Names of women
White	15	Virginia Dawn, Elizabeth, Kelly, Caroline, Cynthia, Alexa, Julie, Maey, Susan, Trina, Wanda, Rene, Arlene, Martha, Gloria
White – French Canadian	1	Katharine
White – First Nations (children)	1	Willow
Asian	2	Cassie, Teresa
African American	1	Joanne

Note: According to the 1996 census data, 18% of the population of British Columbia are "visible minorities" (Statistics Canada, 1996). 15% of the women involved in my research study can be classified as visible minorities.

Health

In each interview I asked the women if they considered themselves to be healthy. Eight women answered "yes" and 12 answered "no."

Table 17 – The Women's Health: "Do you consider yourself to be healthy?"

Question: "Do you consider yourself to be healthy?"	Number of women (n=20)	Names of women
YES	8	Elizabeth, Virginia Dawn, Joanne, Willow, Maey, Cynthia, Julie, Alexa
NO	12	Susan, Katharine, Rene, Wanda, Arlene, Martha, Trina, Gloria, Cassie, Teresa, Caroline, Kelly

Half of the women referred to health behaviours, particularly over- or under-eating, smoking, and exercise, in response to this question. Six women suggested that their health was related to their body weight, and that they would be healthier if they lost weight. Three of the younger women said that they were healthy because they were not disabled and did not contend with major biomedical health conditions, while four of the older women said they were not healthy because they had to work around their health problems most of the time. All of the women suggested that health had physical and mental dimensions and that their mental health influenced their physical health and vice versa.

Table 18 – Self-Reported Health Problems

Health Problem	Number of women (n=20)[a]	Names of women
Angina	1	Rene
Arthritis	3	Alexa, Trina, Teresa
Breast cancer (post)	1	Elizabeth
Chronic back problems	1	Cassie
Chronic fatigue syndrome	1	Martha
Clinical depression	4	Susan, Trina, Katharine, Caroline
Depression	8	Willow, Kelly, Virginia Dawn, Alexa, Cynthia, Gloria, Rene, Teresa
Diabetes	4	Susan, Wanda, Rene, Teresa
Eating disorders	2	Elizabeth, Maey
"Elephantitis"	1	Maey
Endometriosis	1	Kelly
Fibromyalgia	3	Susan, Arlene, Martha
High blood pressure	2	Rene, Wanda
Hyperthyroidism	2	Joanne, Elizabeth
Irritable bowel syndrome	2	Susan, Rene
Learning disability	2	Julie, Maey
Migraines	3	Joanne, Cassie, Teresa
Multiple sclerosis	1	Katharine
Osteoporosis	1	Kelly
Scoliosis	1	Maey
Sleep apnea	2	Rene, Wanda
Social anxiety disorder	1	Willow
Stress	3	Cynthia, Willow, Cassie

[a] Note: All of the women reported at least 1 of the above health problems. Eighteen women reported 2 or more health problems.

Through providing their stories and drawing together common and divergent themes, in this chapter I attempted to provide an overview of the women who were involved in this

dissertation. Given the complexity of the women's lives, it was difficult to adequately and equitably portray their experiences. However, since the following chapters have layered analyses, these stories were important for grounding understandings of who participated in this research study.

Notes

[1] In the process of checking the quotations with the women, Maey and Joanne asked to keep their stories brief because they did not want too much personal information revealed about them. The other 10 women asked to clarify some of their quotations, and three of them asked to include more personal information.

[2] This course was initiated after the primay data collection for this dissertation. It is briefly described in the epilogue.

[3] When I first wrote Virginia Dawn's story, it was short and had little detail. After reviewing it, Virginia Dawn asked to include more specific details. For that reason, some of her quotations are from a phone conversation we had on July 22, 2002, and are connoted "Virginia Dawn, phone conversation, July 22, 2002."

[4] It is important to note that the SSHRC research grant was not intended to subsidize admission to recreation programs.

[5] This is discussed in detail in the section "Mutual Learning" in Chapter 7.

[6] To date WOAW remains a primarily White women's organization. Despite Project Team meeting conversations around including women of colour, WOAW has not actively diversified its members. As well, it should be acknowledged that all of the researchers and all but one of the WOAW service providers were White.

5

Poor Women's Exclusion and Health

You get a very bleak feeling. It's like a feeling that you're trapped in a position that you can't get out of. And every experience that you have in the system tends to hammer that home. No, you are not to do this. No, you're not capable of this because this isn't available to you. There is nothing for you. Just be happy where you are. Why should I be forced to remain in poverty? And that's part of what makes me feel ill, what makes me feel unhealthy (Willow's interview, March 15, 2000).

In this chapter I begin with an analysis of the women's experiences of cultural, institutional, and material exclusion. The women felt stigmatized, surveyed, and punished in their day-to-day lives. The control wielded by the major institutions in the women's lives – the welfare, health care, and community recreation systems – perpetuated their stigmatization and excluded them; they encountered inadequate services and material deprivation. They experienced exclusionary institutions that prevented them from accessing the full range of health-promoting services and entitlements, both within the health care system and beyond. Being stereotyped was shaming and had a profound influence on their psychosocial health. Meanwhile, exclusionary practices enforced the women's material deprivation and influenced their ability to access health-promoting resources. Finally, living in poverty was stressful and depressing, particularly for the younger women who struggled to provide for themselves and their children.

Experiences Living In Poverty: Cultural, Institutional, and Material Exclusion

I conceptualized the women's experiences of living in poverty as a "trickle-down" of cultural, institutional, and material exclusion. Willow explained it this way: "it all drains into the

whole pool of being in poverty. And that's where all the tributaries run" (Willow's interview, March 2000). In this section the women's experiences of exclusion are explored. Although they are described as distinct experiences, cultural, institutional, and material exclusion support and perpetuate each other.

Cultural Exclusion: "They label you, they typecast you" [1]

The women spoke passionately about being stereotyped: "You're poor or you're a welfare case. You hear those things coming from people's mouths. I guess on buses and in the malls. You hear people talking" (Virginia Dawn's interview, June 6, 2000), and suggested that the stereotype was rooted in the misperception that welfare recipients choose to be on welfare. "It's the biggest stereotype in the world is to be a single mother on welfare.... So I'm a welfare bum who could get out if she wanted to. But she chooses to be there" (Willow's interview, September 20, 2000). Maey spoke of the stereotype in these terms: "that they're [the stereotype of welfare recipients] lazy. They want everything just handed to them. They don't have to work. And you know live off the system" (Maey's interview, June 9, 2000). The stereotype of the welfare recipient is predicated upon the notion that recipients do not have a valid reason for being on social assistance, and that they choose to rely on the government for their financial support though they could easily find work and be financially self-reliant. "Like you're just laying back and enjoying a free ride" (Elizabeth's interview, March 20, 2000).

The women felt that they were treated with distrust as liars and criminals "even if you are honest it makes you feel that you're not" (Rene, RTM May 16, 2000). Perceiving welfare recipients as liars and thieves rationalized institutional surveillance and monitoring. Katharine relayed her experience of being stereotyped and treated as a criminal: "It's totally misunderstood, they think you're there because you want to be there, and you're killing inside. You're just as bad as a crook" (Katharine, RTM May 16, 2000). The women acknowledged that they were

143

stereotyped as choosing to live on welfare, stealing from society, abusing tax-payers' money, and illegitimately disabled or sick.

Stereotyping: Welfare Single Mothers

The younger women suggested that they were stereotyped as "welfare single mothers." Inherent in the stereotype of the welfare single mother was the judgment that they were bad mothers and did not know or care to do what was right for their children. Virginia Dawn commented that because of her young appearance she felt she had been stereotyped as a bad mother:

> You could just feel it, they [people on the bus] would be groaning because they'd hear her crying. They thought I was a bad mother. They thought I was just this young stupid teenager. I wasn't even a teenager when I had her. But because I look younger they did stereotype me that way (Virginia Dawn's interview, June 6, 2000).

In Canada, 15% of all families are lone-parent, and more that five-sixths of them are headed by women (Health Canada, 1999). Although increasingly fewer families conform to the pattern of a husband as the head of the household and an at-home wife who cares for the children, this standard continues to be held as the norm, and families headed by women are viewed as "failed families" and the women as "bad mothers" (Schroeder and Ward, 1998). According to Lynn and Todoroff (1988), attitudes towards mothers on assistance are one of hatred and are propagated by those who know little about it.

Not only do many single mothers bear the stigma of "bad mother," but single motherhood is also held responsible for the persistence of social problems from one generation to the next. Lone-mother families are demonized in government rhetoric, policies and popular media, leading to a moral panic over lone motherhood with lone mothers portrayed as a "social threat" or "social problem" (Standing, 1998). Some of the research participants remarked that the same stereotype was not cast on single fathers "I'm sure there are some single fathers out there, but

it's always just the single mothers that I think are stereotyped and more judged" (Elizabeth's interview, June 12, 2000). Mothers have been singled out while the role of fathers and of wider social conditions are ignored, thus leading to a highly distorted view of social problems and punitive institutional practices and policies (Abramovitz, 1995).

Consequently, single mothers' lives are under constant supervision from school, health, welfare, and benefit agencies (Standing, 1998). The lives of women on government assistance are scrutinized on a daily basis by social service workers and agencies. A woman can have as many as four social workers in her life at one time, each of them mandated by the social service system to monitor a specific aspect of her life, including parenting, housekeeping skills, and how she uses her leisure time (Wall, 1993). The young mothers reported that they were surveyed and threatened with the apprehension of their children. They acknowledged that raising a child in material scarcity with little emotional and financial support was difficult, but they did not risk telling their social workers for fear of being penalized with the apprehension of their children.

> She reached out for help, she was just going bonkers with her kid, she wasn't taking care of herself, she was getting worse and worse and worse, she went to social services, and the first thing they said "well, if you can't take care of your children we'll put them in foster care." And that's the threat that is constantly handed out to single parent families on social assistance (Susan, RTM April 26, 2000).

Willow suggested that social and financial aid workers investigated bad mothering when recipients struggled on their meager budgets. "She threatened me because I applied for the crisis grant, 'we're going to have to look into your childrearing capabilities if you can't manage your money properly'" (Willow, RTM May 16, 2000). As a consequence of being stereotyped, threatened, and surveyed, the women learned to never divulge their personal struggles and attempted to conceal their impoverished subsistence.

Invisibility: Women as the "Unseen Poor"

According to Young (1990), poor women are culturally excluded when dominant groups fail

145

to recognize the perspective embodied in their cultural expressions (Young, 1990). Many of the women spoke of being the "unseen poor" because they were women, middle-aged, single, and poor. Trina spoke of herself as "unseen," raising children in poverty, and not having the resources or support from the community or the government.

> My generation is kind of lost.... We worked, us single mothers have worked really hard with very little help from the government or our husbands or ex-husbands and we survived. We didn't have the good things for the kids. You know, we had the community centers and cubs and scouts, but we didn't have anything extra for the children. And they're losing, plus we've lost because we didn't get the education, we don't have the pensions, we don't have a house and we don't have the cars. We're just surviving (Trina's interview, March 21, 2000).

Rene explained that women, as the unseen poor, were socialized to be silent and to adopt roles unquestioningly. "Women are the unseen poor. We're taught to hide it instead of standing up and saying [slammed fist on table]" (Rene, Beth's fieldnotes, RTM March 7, 2000). In her second interview Rene suggested that women are shamed into concealing their impoverished situations and are thus invisible.

> That people are ashamed to say they're on welfare. Or to ask for help. Or to say, you know, what can I do, where can I go? This isolates them a big deal. And they talk about women between 45 and is it 60 or 65, as being the unseen poor. Because they will keep up appearances because we've been taught to. But they may go without food or whatever you know to keep those appearances up (Rene's interview, June 5, 2000).

Some women, particularly those middle-aged and older, articulated women's oppression in society. In her first interview Katharine emphatically recounted:

> [We are] looked down, discriminated, many times I feel that poor women once they've past the age of having kids, they're just the rots of society. They're the sewers of society because many men don't see us anymore; they don't want to see you (Katharine's interview, March 14, 2000).

As a singe middle-aged woman Katharine felt that she had become invisible. Later in her interview Katharine spoke of poor women "they're silent, they're invisible" (Katharine's interview, March 14, 2000). Wanda said that the stereotyping and mistreatment of welfare workers forced some women to isolate themselves and be invisible. "I've seen Rene go through

146

some dandies [with welfare]. And somebody less strong just wouldn't have managed. They would have gone home and shut the door. And I'm sure that's what happens to a lot of people" (Wanda's interview, June 5, 2000).

The women's isolation and sense of being invisible also arose from living in a "couples' society." Wanda said "this world seems to be dominated by couples, when you become a widow you learn that real quick" (Wanda, RTM April 4, 2000). Christine commented "a woman is not a real woman unless she has a man" (Christine, WOAW retreat, October 20, 2001). Susan went further in explaining her isolation in relation to her domestic status "you're more important as a couple, because you have a man in your life… you isolate into the male" (Susan, RTM April 4, 2000). Susan, a single woman with no children, stated that for her isolation occurred because she did not have children to introduce her to social circles: "I not only find it a couples society, I don't have children. So, it's hard for me to find somebody that is single, and doesn't have kids, to talk to. So, there's another isolation" (Susan, RTM April 4, 2000). The women's domestic status and poverty excluded them from society. As poor single women reliant on government assistance they did not conform to dominant social expectations. Many felt that they were the "unseen poor" and were generally unwanted in society. As a consequence they were excluded and felt invisible.

Simultaneous Stereotyping and Invisibility

As WOAW became a recognized organization in the Tri-City community, it gained the attention of some local newspapers. Two women who acted as WOAW representatives to the local media were culturally excluded – they were simultaneously stereotyped and rendered invisible. In one instance, Elizabeth felt pressured to answer leading questions in a way that would increase the newsworthiness of the story about WOAW while perpetuating the stereotype of a poor single mother. When being asked by a reporter about the lack of funding for a

community kitchens project, she commented "I was supposed to look into the bowls longingly as if I was wishing they were full" (Elizabeth, RTM May 15, 2000). Later she reflected on her experience:

> [Louise] said I did a really good job of not answering what I didn't want to answer, and in turn, he just made assumptions… but excuse me buddy, I didn't tell you that for one reason, I didn't want the world to know I'm a poor struggling single mother, you don't need to flaunt it to the world (Elizabeth, RTM June 29, 2000).

Katharine felt that she had been betrayed by her involvement with the local media, and as a result did not trust reporters.

> That journalist guy, he ticked me off. I told him not to use "poor," and many things that I said, I gave him a sheet, the night before, I typed a whole page [on WOAW]…. So I'm going to write a letter to that paper. Because he really tricked me, he said the article was going to be about WOAW, and yet it's all about me, and it's all wrong. This guy doesn't listen at all. He's just a male chauvinist pig (Katharine, RTM June 29, 2000).

Elizabeth and Katharine shared their negative experiences with the local media and warned other women about falling prey to the media's stereotyping of poor women. From these experiences there was an ongoing wariness and skepticism towards the media.

One can be excluded from social production through not being able to be an active contributor to society because of being labelled as undesirable, unacceptable, or in need of control (White, 1998). Through their interactions with the media and the convolution of their stories into existing stereotypes, Elizabeth and Katharine were openly stigmatized in a public forum. Their real challenges and realities were obscured from the news story, while the stereotype was portrayed and enforced. In this process they were culturally excluded and their realities remained invisible. Poor women's invisibility can be seen as an attempt to control, punish, and alienate. Their experiences and interpretation of social life find little expression that touches the dominant culture, while that same culture imposes on the oppressed group its experience and interpretation of social life (Young, 1990).

The stereotype of "welfare bum" and "welfare mother" stigmatized the women as cheaters,

liars, thieves, irresponsible, lazy, and "riding the system." The stereotype bred antagonistic public judgments that deeply affected the women's day-to-day lives. They had a heightened awareness of their low status in society and felt stigmatized and labelled as poor in many (or in some cases all) public arenas. Meanwhile, all of the women felt invisible – stereotypes obscured their real needs and experiences, and they did not fit the social fabric because of their domestic statuses and their poverty.

Experiences of Institutional Exclusion: Victimizing Policies and Practices

The following analysis examines how the practices and policies of the welfare, the health care, and community recreation systems institutionally excluded the women through viewing them as dependent, discriminating against them, and limiting their access to resources.

The Welfare System

All of the women spoke emphatically about how they were treated by their social and financial aid workers and the welfare system. Rene suggested that "one of the most discriminating places is welfare itself" (Rene, RTM April 4, 2000). In the interviews and the Research Team meetings, the women spoke at length about their encounters with the welfare office, social workers, and financial aid workers. The women said they were belittled, abused, and treated as files, numbers, and "non-persons." "The one worker I had she belittled me from the minute I went in because I was a middle-aged woman who was trying to get welfare" (Susan, RTM April 4, 2000). The women described their workers as snarky, rude, high and mighty, snooty, discriminating, and low-level threatening.

> I know they have humungous case loads. But any time you leave a message you always have to include your S.I.N. number and your phone number... it just makes me feel like you're just a statistic. Can't you relate to me without having the nine digit number? (Elizabeth's interview, June 12, 2000).

As well, the women believed that their workers and welfare offices changed frequently and that

"good" workers did not last long in a stressful system riddled with huge case-loads, bureaucracy, and repeated paper-work.[2]

Cynthia:	That needs to change, big time, but I know that there are workers that are really helpful.
Rene:	But they're the ones that burn out and leave...
Kelly:	That's probably why workers change so often, because they get a few good ones in there and then change it around, they're too helpful (RTM April 4, 2000).

They also reported that some workers were young and inexperienced, and as a result could not or did not relate to their struggles. "These welfare workers, they're just these young pups right out of school, and you can tell they're reading right out of the text book, they don't know a thing about real life" (Elizabeth, RTM April 26, 2000). Struggles with the welfare system were raised in every Research Team meeting and interview that was conducted for my dissertation. During the Data Analysis Potluck in May 2001, when we began to discuss "systemic injustices," the women joked that we would not get beyond this topic because it was so pervasive.

The workers' mistreatment was a consequence of the negative stereotypes of poor women that have become firmly embedded in the current social dogma and that fuel support for increasingly punitive social policies for poor women (Abramovitz, 1995). Stereotypes about inappropriate coping strategies and irresponsible decision-making are reflected in paternalistic policies and programs that strive to change poor women's deviant behaviour. Thus a moral reasoning justification rationalizes the government and various institutions to control policy and programs because poor women are considered incapable of looking after themselves or their children. Indeed, stereotypical notions of welfare recipients breed institutional surveillance and control. The welfare workers threatened and wielded power over the women. Susan explained:

> It's low-level threatening is what it is. And if you go into any of the offices it tells you how you're supposed to be treated and how you're supposed to treat the person... lack of integrity comes into it for a lot of the workers (Susan, RTM April 4, 2000).

All of the women spoke vehemently of the threatening, surveillance, and fear they experienced

when they interacted with the welfare system.

> I hate having them [welfare workers] go up my ass with a microscope. That's kind of a rude way to put it, but that's how I feel. I feel like I'm under a microscope all the time (Kelly's interview, March 2000).

They were surveyed by their workers and by the system, and felt that if they did not conform to it in ways expected of them they would not receive their welfare payment "they scare you. They say you won't get your cheque" (Kelly, RTM September 27, 2000).

Not only did the women feel mistreated and in some cases abused by their workers, but they encountered systemic barriers to getting help. Workers did not return their phone calls, welfare offices lined up recipients outside for public display, and the women were rarely afforded privacy in their meetings at welfare offices. Katharine said:

> They [social workers] never say, "how would it be to be in her shoes, how would it be to be in her pain, in her depression?" They never do that. They never return phone calls, it's not possible to make appointments (Katharine, RTM April 26, 2000).

As Katharine said, not only did the women have difficulty reaching their workers on the phone, but it was also difficult for them to make appointments to see their workers. At some offices, the only way to get help was to line up outside.

> You have to stand out there and line up, there's no such thing as an appointment, so it doesn't matter what the weather is, what your health is, you stand in that line and they only take the first so many and the rest come back tomorrow (Wanda, RTM April 4, 2000).

Elizabeth made the connection between the practice of lining up welfare recipients outside welfare offices and generating negative public sentiments towards welfare recipients: "they start lining up there about six thirty in the morning on welfare day and the people walking by you – you can just see their faces. They're like 'look at all those bums'" (Elizabeth's interview, March 20, 2000). The women felt that they were rarely afforded privacy or confidentiality in their exchanges with their welfare workers and suggested that workers felt they did not deserve privacy since they were "on the system." Elizabeth remarked:

If you go in and ask if you can get a food voucher, "well why didn't you judge your money better?" And they give you such an attitude. And it's just so hard. And there's no privacy in that place at all. You and everyone in the world can hear you. But you know all that plays on you. I get this big knot in my stomach (Elizabeth's interview, June 12, 2000).

Some felt that welfare recipients were not given privacy since they were supported by public money and had not earned the same respect and consideration as someone who was financially independent. Being "dependent" is used as a warrant to suspend one's basic rights to privacy and respect (Young, 1990).

Another barrier encountered by the women was a lack of information. The women believed that knowledge was important to making a change in their lives and improving their current situations - "knowledge is power" (Rene, RTM June 7, 2000). They consistently encountered barriers to finding information despite the fact that important information regarding entitlements, training, and education existed. Willow said that "information is a barrier, just information in general on training projects, just information gathering" (Willow, RTM May 16, 2000). Katharine commented:

They don't tell you benefits, they don't tell you how it works, they don't tell you about your healthcare… they don't offer information, you have to extract it from them like, it's like doing a root canal or something. They don't explain all of it, they don't tell you your rights (Katharine, RTM April 4, 2000).

Some of the women felt that their workers were trained to withhold information, both to prevent welfare recipients from accessing all possible resources, and to maintain their power and control over recipients.

Kelly: Like it seems like when you do start asking all they do is get snotty with you and you get the run around and all you're trying to do is better yourself. You want to go back to school or you want to find out what's available to you to better yourself. And it's just crazy.

Maey: They want you to get off welfare, but once you do get ahead, they penalize you (RTM October 19, 2000).

The women felt that they were constantly "punished and penalized" for relying on welfare

(Elizabeth, RTM May 16, 2000). In one meeting when we were reviewing data Wanda explained "the one thing I think that's missing there, under 'experiences of welfare' is the fact that you're treated as a liar when you walk through the door" (Wanda, RTM May 16, 2000). Katharine said that welfare recipients were hated. As we reviewed data at one meeting, she commented "under welfare, the word 'hate' is not there…when I deal with welfare, I deal with other people knowing I'm on welfare, automatically there's a hate…those people hate you" (Katharine, RTM May 16, 2000).

Overwhelmingly, the women characterized their experiences with the welfare system as antagonistic and exclusionary. They reported a variety of injustices of the welfare system, including the mistreatment by welfare workers, workers' large case loads, unresponsiveness, and under-training, and dehumanizing practices and policies. These institutional injustices excluded the women from participation in daily life through subjecting them to discriminatory practices and policies.

The Health Care System

Although government rhetoric denies that Canadian health care is two-tiered, the women reported significant barriers to accessing the health care system. They suggested that the system was "two-tiered" in three ways – access to and affordability of health-promoting resources, access to health care services, and discriminatory treatment by health care professionals. All of the women said that they could not afford health-promoting resources or health care "extras," including various therapies (physiotherapy, massage therapy), vitamins and supplements, eye glasses, and non-generic medications. Alexa, a young woman with debilitating arthritis, said:

> I don't have the income so I can't take part in physiotherapy and do the exercises. Because I don't have the money I can't do all the things I would need to get myself in that healthy state of mind and everything… I feel I'm limited to the resources I can get to because of money (Alexa's interview, June 2, 2000).

153

Willow stated that she had not been able "to take care of medical needs, basic medical needs, necessities" (Willow, RTM May 16, 2000). Seven women spoke of sacrificing essentials, such as food and paying their bills, to cover the cost of medications or therapies. Other women made the opposite choice and sacrificed their medications or therapies to buy food or pay essential bills. Susan explained her situation:

> This month I had to go off my supplements because I had to pay for other things. So I'm feeling it... the supplements are very expensive. They're good quality and they're what I need. But it was a choice this month to not feel very good (Susan's interview, June 2, 2000).

According to the Statistical Report on the Health of Canadians (1999), "the level of income adequacy has some effect on the likelihood of having unmet health care needs. People in the lowest income level had a 9% chance of having unmet needs, compared with 5% of people in the highest income level. The lowest income group also had the greatest likelihood of unmet needs of an emotional nature" (Health Canada, 1999).

The cost of health care "extras" was not the only form of exclusion within the health care system. The women reported that the health care system was two-tiered, was more difficult to access for people on low income, and as a consequence excluded poor people. When I asked the women about the notion of universal health care, the following exchange occurred:

Colleen: I keep hearing that health care is equal to all whether you are rich or poor (vocal disagreement)

Susan: I'm yelling at them, well that's fine if you're rich, you can stay in the hospital for how many days, getting all the care that you need, because you don't need to leave because of financial reasons. If you're not well, you need to go home to your kids because you can only get a sitter for awhile, so your health care is not there, you have to leave that hospital earlier, you really can't do it. So I mean, what a farce. We all supposedly get it, and I don't put down the hospital staff, it's just we have to get out of there because, we have to take care of things.

Rene: And if your condition requires a private room you don't necessarily get it... it's a $100 and something a day now.

Elizabeth: When I had my big surgery [double mastectomy], I was only hospitalized for a week and then they shipped me home... .That's what it all comes down to.

Rene: And with homecare being what it is you're not getting that, the support when

Elizabeth:	you get home.... Yep, at that time he [son] was only 6 months old.
Rene:	Yeah, that's a lot, you have surgery, you are lifting that 6 month old child, it is not good.
Wanda:	And the load of stress you must have been under must have been unbelievable (RTM April 26, 2000).

Over half of the women felt that they had been treated inequitably by the health care system, specifically regarding length of stay in hospitals, consideration and respect from health care professionals, dental care, and homecare support after surgeries and during major illnesses. The women felt that their stays in hospitals were shorter than people who had more money. Katharine explained: "because we have no money, they don't keep us long. They are like, 'next'.... But if you're rich you have a private room then you can stay longer, the nurses treat you better, everybody treats you better" (Katharine, RTM April 26, 2000).[3]

The women also suggested that the health care system was two-tiered by virtue of how they were treated by health care professionals. Discrimination by health care professionals was raised as a major barrier to achieving good health or managing ill-health and disability. "I went to Pearl Vision, and I said that I was on low-income disability, and what was the price range for my glasses, and he just pointed his finger over, and said 'the welfare glasses are over there'" (Trina, RTM May 16, 2000). Indeed, some health care professionals had stereotypical understandings of welfare recipients and acted as gatekeepers who effectively excluded the women from equitably accessing the health care system. "It's like the foot specialist I went to who told me that if I lost weight and got off welfare I'd be ok. Now what that had to do with the shin splints or the pain I was having I don't know" (Rene, RTM April 26, 2000). The health care system's discrimination of poor women systemically excluded them by preventing them from accessing and maintaining health and managing disability and illness.

Despite the rhetoric of the Canadian universal health care system, the women's experiences were a revealing commentary on the system and how they experienced two-tier service delivery.

The poor women, who received the "second-tier" of health care services, were unable to access the full range of options to address their health. Health promotion discourse supports the notion that individuals must do all they can to support and enhance their health, while infusing the notion that all people are equally able to pursue their health and that education is the key to promoting good health. In a recent article in the Globe and Mail, the title headline in the feature section on women's health was "Lack of Awareness Is Biggest Threat" (The Globe and Mail, 2001). However, the women's experiences within the system excluded them from accessing what most consider to be the basic elements of the health care system. Their lives were not bound by a "lack of awareness"; rather, minimal resources confined them and discriminatory practices prevented them from fully participating in the complete range of services that fall under the rubric of the "health care system."

Community Recreation Departments

The hope of gaining access to community recreation motivated many women to become involved with WOAW and my dissertation project; for varying reasons recreation and physical activity were important to many of the research participants. Yet the women reported that they faced considerable barriers to accessing market-driven forms of community recreation. These barriers included material deprivation (affordability of programs, equipment, and dress), programs and services that failed to consider transportation and childcare needs and expenses, stigmatizing policies and practices that marked the women as "poor," and the discrimination and stereotyping of community recreation workers. Virginia Dawn explained how the cost of programs was a barrier to her involvement.

> Not being able to have access to recreational activities is also a barrier too, because you don't have the money to go.... And, therefore you don't get out and you don't meet anyone else. Recreation is tied in with your social life, and if you can't afford recreation, you can't afford to be social (Virginia Dawn's interview, March 14, 2000).

Similar to the women's experiences with the health care system, community recreation departments' two-tiered service delivery enforced the women's exclusion – making it uncomfortable for them to access programs because of being stereotyped and discriminated against, and making it more difficult or impossible to access services because of the cost. For those who are not a part of the consumer class in society, systemic barriers to community recreation services are prevalent, especially in local government departments operating from the new public management ideology where revenue generation and efficiency take priority (Thibault, Frisby, and Kikulis, 1999).

The majority of the community partners who were involved in WOAW worked in the local community recreation systems. Though the majority of the WOAW-affiliated recreation staff members and their recreation departments were important resources for WOAW members, one particular recreation department posed consistent barriers to the women's full participation. At one point two women expressed their frustrations with their community recreation department and a particular staff member who systematically imposed barriers to programs, childcare, and room bookings.

Kelly: We feel like we don't get any respect here. It's quite a political thing here, you know?

Maey: [We should move out of the recreation facility] so she can't humiliate us, like treat us like dirt, low-class citizens. We're not, we're just as important as anyone else, right?

Kelly: Let's have her step in our shoes for a day, see how hard it is (RTM June 29, 2000).

At times the women discussed strategies for managing the mistreatment they encountered within the community recreation departments, though they struggled with the possibility of alienating themselves from important community resources. After the meeting where the above exchange occurred, Katharine said "they're trying to get us out" (Colleen's fieldnotes, June 29, 2000). She felt that the recreation centre did not want to be involved with poor women.

157

The community recreation departments in the women's communities offered subsidies for some recreation programs. "Leisure access" policies were designed to increase access to community recreation for impoverished populations and provided at most a 50% reduction in program registrations.[4] However, the requirements for accessing subsidies were humiliating and dehumanizing.

> But what's discomforting to people is that a person at Parks and Leisure will take your taxes and photocopy them and keep them in their records, so you are bringing in your tax forms and having some untrained person who has nothing to do with you seeing your taxes, not only seeing them, but having a copy of them in their files for anyone to look at (Willow's interview, March 15, 2000).

Not only was the system for accessing a subsidy a barrier to many of the women, but the treatment they received when attempting to gain access to community recreation was a major deterrent. Several women spoke of getting the "run-around" and wondering why a subsidy was offered if it was so difficult to obtain. Virginia Dawn explained:

> I was trying to get some kind of swimming entry for myself and my daughter and I felt it [stereotype of welfare mother] there when I tried to get financial assistance. They were really putting me through the wringer and giving me the run-around for everything. And I felt like they had a personal vendetta against me because they were making it so hard for me to get what I needed. I didn't understand why they were even offering this if they weren't going to help. In some ways I felt stereotyped there, like I was begging basically for assistance when I heard that it was offered by them (Virginia Dawn's interview, June 5, 2000).

The treatment the women encountered when attempting to access a subsidy proved to be as big a deterrent as the cost of the program or service. There is the widespread notion that recreation is a "fringe" benefit only to be enjoyed by those who have the disposable income and time to participate. With community recreation service provision deemed a fringe service in mainstream political and social agendas, community recreation becomes the commercial sector's responsibility and is increasingly offered on a fee-for-service basis making it inaccessible to low-income populations (Frisby, Crawford, and Dorer, 1997). Policy makers, eager to ensure the economic viability of their initiatives, have essentially ignored or overlooked the issues and

concerns of women on low income (Anderson and Jack, 1991). Furthermore, the dominant middle class ideology espousing self-responsibility for one's health through the pursuit of an active lifestyle pervades most recreational initiatives (White et al., 1995). Those unable to achieve and maintain good health through recreation are considered individually responsible, thus obscuring social and material factors that mitigate against such involvements.

While leisure access policies did not come close to addressing the real costs and barriers to accessing community recreation, the discriminatory and dehumanizing practices furthered the exclusion of women on low income. Given the health benefits of physical activity for girls and women (Reid and Dyck, 2000), the women's exclusion from community recreation put them at a disadvantage in addressing their health and becoming socially engaged in meaningful and health-promoting physical activities (Reid, Frisby, and Ponic, 2002).

Poor women on government assistance depend on bureaucratic institutions for support and services. Being a dependent in our society implies being legitimately subjected to the often arbitrary and invasive authority of social service providers and other public and private administrators. Institutions enforce rules to which "dependents" must comply, and restrict people's material lives including the resources they have access to and the opportunities they have or do not have to develop and exercise their capacities (Young, 1990). Not only are the rights and entitlements of the poor limited and viewed with suspicion, but they are also controlled and defined from the outside – by authorities who, by virtue of their independence, claim to know what is best for them. Women on welfare are therefore institutionally excluded in two ways – in terms of the treatment they encounter when attempting to access services and entitlements, and in terms of being materially deprived "legitimately" because of their dependency.

Material Exclusion

All of the women spoke at length about their material deprivation and the challenges of budgeting and paying for food, housing, clothing, and transportation. After Elizabeth paid her rent, "I get $359 and that's to cover everything. I get child welfare and that brings it up $200" (Elizabeth, RTM May 15, 2000). Wanda, who was on a seniors' pension, "went to the welfare office because I lived on $730 [a month], I had no medical, no dental, none of the extras that you don't think of as extras but they are when you don't have them" (Wanda, RTM April 4, 2000). The women's material deprivation was so severe that they were never able to pay all of their bills "and it never stops, you're always thinking of how can I do this, how can I do that? Who can I not pay this month, who do I have to pay?" (Kelly, RTM April 26, 2000).

<u>Housing</u>

Safe and affordable housing was a concern for all of the women.[5] Housing was a challenge for two reasons – there were few affordable places to live, and many landlords were unwilling to rent to people on income assistance. "I had one lady, she was just downright rude on the phone. 'Well if you're anyone from assistance I don't want you. And I won't rent to you'" (Elizabeth's interview, June 12, 2000). For some women housing co-operatives were an alternative to high rental rates, but often there was up to a three year waiting-list to enter a co-operative. Rene spoke about her co-operative and how it made her limited income more manageable: "I've got the accommodation that's realistic to what I'm making. I only pay $300 a month here. Whereas I would be paying $500 or $600 elsewhere. And when you take that out of $789 that I get that's a big chunk" (Rene's interview, June 5, 2000). Trina, who was also in a co-operative, spoke of being relieved in having her housing arranged and affordable "at least I can live here. I can afford the rent. I can afford the hydro, I can afford the cable and the telephone. I'm sitting real pretty…. I can breathe. I can breathe" (Trina's interview, June 5, 2000). Many other women,

however, did not have secure or affordable housing and were constantly worried about having a safe and dependable place to live. Several mentioned that they did not want to live in a government housing project because of the dangerous environment (drug dealing and violence) it presented to them and their children. During the 18 months of my research study over half of the women moved at least one time. Towards the end of my study, several women had become involved in various community initiatives to generate more affordable housing to seniors and other families on limited incomes.

Parenting Costs

Since the women had limited support structures and very little money, most did not have access to childcare. The women with children under 5 years old rarely had respite from their mothering – "I raise my daughter 24-7, without holiday pay, without any time off" (Kelly, RTM June 29, 2000). Their day-to-day existence was a constant struggle of providing and caring for their children. Willow explained how getting out of her house with her two small children was a challenge: "I have two little children, no car. How do you carry anything when you have a stroller and another child and a baby and a baby bag?" (Willow's interview, September 20, 2000). School fees and childcare were expenses encountered by the mothers. Although the education system was publicly funded and theoretically accessible to all, school expenses marked their children as poor. Rene suggested that the school and welfare systems should work together to ensure that essential costs were covered for all students:

> Then give them the $50 towards clothes and stuff like that. I'm not talking want, I'm talking need…. The schools should be able to print out what is needed for lab fees, locks, class pictures, and all this sort of stuff, and that should be given to the welfare office and they just write a cheque (Rene, RTM September 6, 2000).

Transportation

All of the women struggled with affordable and accessible transportation. Two women had

bus passes paid for by the welfare system, four women had cars, and the remaining women did not have ready access to transportation.[6] Transportation arose as a barrier to accessing health care, attending WOAW meetings and activities, and generally being involved in community life. The cost and accessibility of public transportation was cited as a major cause of isolation.[7] Elizabeth said: "transportation… that's a big isolation thing. Because with these bus fare increases who can afford to go anywhere?" (Elizabeth's interview, June 12, 2000). The women who owned cars often car-pooled to WOAW meetings and activities. However, all of the car-owners expressed concern over the cost of running a car and the reality that they could not afford to replace their current car once it no longer functioned. Despite car-pooling and efforts by the service providers and researchers to accommodate all WOAW women, transportation remained an ongoing barrier to the women's participation in WOAW. At various times different women said they were unable to participate in activities or attend meetings because of transportation. Julie recounted that she had not been involved in WOAW for the first 6 months because of transportation: "why I didn't stay involved at the very beginning was transportation" (Julie's interview, March 14, 2000). Transportation constraints not only influenced the women's ability to participate in WOAW; such constraints also restricted their access to other community services and activities and forced many women to live in isolation.

The institutions that wielded control over the women's lives were organized to prevent welfare fraud and to ensure that no recipient lived "in the lap of luxury" (Elizabeth's interview, March 14, 2000).[8] Yet forcing women to live in scarcity perpetuated scarcity, inhibited good health, and reinforced the juxtaposition of those dependent on the government and the morally righteous self-reliant.

> How much money is the woman on welfare raising kids living on? Less than half the poverty level. Her welfare money is divided into two parts – shelter and support. If she's not lucky enough to live in public housing or a co-op, the rest of the rent has to come from the support portion, which is for food, clothing, transport, recreation, Hydro,

telephone, and so on (O'Connell, 1988, p.78).

By virtue of their dependence on the welfare system, poor women are stereotyped as cheaters, lazy, and choosing to not work. These negative stereotypes, so often publicly voiced, have permeated the institutions that control women's fates (Kelly, 1996). The welfare, health care, and community recreation systems enforced and perpetuated stereotypical notions of welfare recipients as intentionally abusing the system, being undeserving, and needing surveillance. These institutions excluded the women from fully participating in and accessing their services. They provided minimal or deficient services and programs, had discriminatory practices and policies, and forced many women to live in severe material scarcity. The women's exclusion enforced the stigma of welfare, removed rights and entitlements, perpetuated material deprivation, and made them feel invisible.

Exclusion and Poor Women's Health

Discriminatory policies and practices, enforced material deprivation, and the obfuscation of information excluded the women from participating in the very institutions that were meant to help them. Both the health care and the community recreation systems were "two-tiered" and provided a better range and higher quality of services to those who could pay while discriminating against and excluding the poor from the full range of options to address their health. Not only did their exclusion from these institutions prevent them from accessing important health promoting resources, but their exclusion influenced their health through being shamed and humiliated, living in material deprivation and not affording health essentials, feeling stressed and depressed as a consequence of material scarcity, and at times coping through engaging in unhealthy behaviours. In this section I describe the various ways that exclusion had an impact on the women's health.

163

Psychosocial Health Problems as "Shame Markers"

Health is powerfully affected by social position and by the scale of social and economic differences among the population (Wilkinson, 1992, 1996, 2000; Raphael, 2001). Social position has its effect on health through psychosocial pathways and psychosocial conditions such as stress, depression, low self-esteem, and anger influence health and wellbeing (Wilkinson, 1996; Brunner and Marmot, 2000; Wilkinson, 2000; Raphael, 2001). Shame, inferiority, subordination, and people being put down and not respected are extremely important, yet largely unrecognized, sources of recurrent stress and anxiety that result from inequality and hierarchy (Wilkinson, 1992, 1996, 2000). In this section I argue that being stigmatized and stereotyped deeply affected the women's health.

The research participants discussed at length their psychosocial health concerns, particularly stress, depression, low self-esteem, and anger.[9] Yet, often these terms were used interchangeably, "Depression and stress. How is that? I thought depression was stress" (Trina's interview, March 21, 2000) to describe their shame, humiliation, and loss of pride.[10] The literature suggests that shame is the primary social emotion generated by the virtually constant monitoring of the self in relation to others (Scheff et al., 1989). Shame involves painful feelings that are not always identified as shame by the person experiencing them. Rather they are labelled with a wide variety of terms that serve to disguise the experience of shame – being stressed and depressed, having low self-esteem, feeling foolish, stupid, ridiculous, inadequate, defective, incompetent, awkward, exposed, vulnerable, insecure, and helpless. Lewis (1971) classified all of these terms as "shame markers" because they occurred in a context that involved a perception of self as negatively evaluated by either oneself or someone else (cited in Scheff et al., 1989). What is at stake is the sense of pride and need for self-confirmation on the one hand, and shame, humiliation, and rejection on the other. It is the unacknowledged or repressed nature of shame that "explains

how shame might be ubiquitous, yet usually escape notice" (Scheff et al., 1989, p.184).

Authorities who controlled the women's lives cast them as reprehensible through various exclusion processes. Significantly, these exclusion processes led the women to evaluate themselves and each other negatively – they were shameful and dependent clients of public charity. For instance, Elizabeth felt that she was "less of a person" (Elizabeth's interview, March 20, 2000), and Willow said that "when someone has power over you, it can feel like they have a personal vendetta" (Willow, Beth's fieldnotes, March 7, 2000). Susan felt that humiliating treatment was purposeful "[a welfare worker] worked on a shame factor. You know, shame to be on social services" (Susan's interview, March 24, 2000). Not only were the women's interactions with authorities shaming, but the very nature of the services that were meant to help them was humiliating. Community recreation's "leisure access" cards, food banks, and other community services that labelled people as "poor" embarrassed many of the women. Elizabeth said:

> From October to January I had to swallow a lot of pride. I had to go to the food bank and I registered us at Christmas for a hamper. It was a really humiliating experience... and everyone was like 'oh you've got to think of your son first.' Well that's what I did. Of course I hid the sack from him, he doesn't need to know that (Elizabeth's interview, March 20, 2000).

All of the women spoke of their shame, loss of dignity, and humiliation, and at times "marked" their shame with terms such as stress, depression, self-esteem, and anger. Kelly said:

> I'm just very low on the totem pole... there's that stereotyping again. Like you're just a single, welfare mother... if you don't feel like you belong and you don't feel like you're valued it's definitely going to impact you. For sure. If you feel like all your neighbours think you're a loser welfare bum it's going to impact you. I think the biggest for me with being on welfare is self-esteem. And a lot of people is the self-esteem. Like it's hard on you, right. It's really hard on you (Kelly's interview, June 6, 2000).

And Willow commented on feeling shame and depression when she left her house:

> I feel shame. I feel a lot of shame and humility and that's where depression and anxiety [come from]. I feel like everybody's looking at you everywhere you go. So I've actually been diagnosed with social anxiety disorder because I turn red all the time and I can't

speak to people. Always looking down (Willow's interview, September 20, 2000).

Alexa felt that her poor self-worth was a consequence of being judged for being on welfare "I have low self worth because I always feel like I'm being judged because I'm on welfare. I just don't feel very good about myself" (Alexa's interview, June 2, 2000). Katharine referred to being "rejected" and how her health was implicated:

> It [being rejected] does affect your health. Because you're starting to question yourself. It takes quite a while to realize why they truly are rejecting you... and that was humiliating. That was your life, and then all of a sudden, nobody wants you anymore (Katharine's interview, June 9, 2000).

In the same interview Katharine explained how struggling with depression, which was a consequence of her exclusion, doubled-back on itself and contributed to the stigma of welfare.

> You're there because you want it. You want to stay to home. You don't want to work. You're lazy. You're not depressed. And you're not sick.... There's always people around who don't believe in depression. It's ignorant people. But yet the stigma is so common it's so big that they say "oh well it must be nice to stay home" (Katharine's interview, June 9, 2000).

> For at least 6 women, anger was a response to their shame and humiliation. Virginia Dawn said:

> At the time it used to really upset me when I was feeling it more. And you know doing that, having that happen, you just you go inward. And you have a lot of anger. I used to be a very, very angry person (Virginia Dawn's interview, June 6, 2000).

Susan described her anger towards the dehumanizing lack of privacy at the welfare office: "I was angry. Why should this man who I don't know know my personal life? I wouldn't ask you, you know" (Susan's interview, June 2, 2000). The women who reported struggling with anger felt that it was a consequence of institutional and cultural exclusion and, for some, previous experiences of abuse. Scheff et al. (1989) contend that as humiliation increases, rage and hostility increase proportionally to defend against loss of self-esteem. Hostility and anger can be viewed as an attempt to ward off feelings of humiliation and shame, and a lack of power to defend against insults (Scheff et al., 1989). As the women said, the shaming and victimizing of the

166

welfare system fueled their anger. It is possible that their anger preserved their albeit diminished sense of esteem, power, and self-worth.

While some women's shame was expressed through their anger, others felt powerless and hopeless. Consistently encountering barriers, being stereotyped, and feeling invisible made some women feel helpless in changing their situations "If someone is not willing to address it, how do you stop feeling helpless about it?" (Willow, WOAW retreat, October 20, 2001). Many of the women explained that they currently or had previously felt hopeless and powerless "once you get so low you can't see beyond. You just you can't. I don't even know what I want to be when I grow up... because there is no tomorrow" (Trina's interview, June 5, 2000). The women's hopelessness often prevented them from seeking the help they needed. Alexa explained how shame was a barrier to getting help "even though there's resources to use, they don't see how it's going to help them, it's just they're too embarrassed to go to them" (Alexa's interview, March 20, 2000). Willow said that she had been turned down so often, and had so rarely received help, that she felt isolated, hopeless, and alone. "What do you do? And how do you feel not so alone? How do you feel like you can continue after all these agencies and all the steps that you've been told to take are turning you down?"(Willow, RTM September 27, 2000).

Information was obfuscated by welfare workers and welfare recipient entitlements were withheld or concealed to varying degrees. Information gathering then became a difficult and shrouded process for all of the women, some of whom feared negative repercussions for challenging their workers or demanding more public resources. However, welfare recipient entitlements were available on the internet and could be accessed through a personal or public computer. Being constantly shamed and denied information and entitlements undermined the women's sense that information was readily available. Possibly, through the barrage of mistreatments they assumed they had no entitlements. Some women knew friends who had been

167

denied certain benefits and therefore they did not request information from their own workers.

Some women felt invisible because of their hopelessness and powerlessness. Elizabeth spoke how being stereotyped bred contempt and exclusion.

> Just feeling like you get more isolated and feeling alone. You almost feel like you're getting dumped on because no one wants to be involved with you. Because you're low income a lot of people think you must be a cheap, a liar, a thief. So they don't want to get involved with helping you out (Elizabeth's interview, June 12, 2000).

Susan explained that because she was poor she was not important and was consequently invisible.

> We're not part of society. We're not part of the running of the community. We shouldn't have a say... because we're not putting anything into the community. That's the stigma.... If you're on welfare you don't count. I don't mean that in a negative way, you're just not there (Susan's interview, June 2, 2000).

Another way that shame and "shame markers" affected the women's health was through health-related behaviours. According to Wilkinson (1996), to some degree eating comfort foods and staying at home and not exercising are attempts to satisfy what may be partly social needs. The social gradient in some behavioural risk factors may be more important for what it tells us about people's morale, stress, and the extent to which they feel in control of their lives than for its direct impact on health (Wilkinson, 1996). Maey described how the shame of poverty so significantly lowered her self-esteem that she no longer cared about herself and in turn adopted stereotyped and unhealthy behaviours.

> It'll [the stereotype of the welfare recipient] make you feel like scum. You feel rotten and then your self-esteem will go. And then when your self-esteem goes your health will go with it.... Because you're not going to give a care about yourself. They think I'm scum so I might as well be scum. Act like scum. Dress like scum... if you treated a dog bad that dog is going to eventually turn on you and start peeing in the house and everything, right? Destroying stuff. It's just like if you put a person down constantly, humiliating them, their self esteem's going to be so low, they're going to start acting out (Maey's interview, June 9, 2000).

As Maey explained, defiant behaviour was a means of asserting herself in the face of shame. The above quotation underscores the complex relationship between health behaviours and

psychosocial health and illustrates the ineffectiveness of health promotion campaigns that focus entirely on health behaviours without considering a person's social and economic context. In contrast to Maey's experience of low self-esteem and unhealthy behaviours, Abood and Conway (1992) contend that high self-esteem might increase the general tendency for a person to engage in a wide variety of health-enhancing behaviours. Additionally, engaging in a wide variety of health behaviours may enhance one's perceptions of self-worth (Abood and Conway, 1992). There is also some evidence to suggest that self-esteem and a sense of control may make it easier to keep to resolutions about giving up smoking or adopting other health-promoting behaviours. This might explain why behavioural risk factors such as body mass index, smoking, and sedentarism appear to be related to the extent of inequality (Wilkinson, 2000).

Health behaviours and physical appearance enforced the stereotype of the welfare recipient and negative public judgments, and marked the women as shamed and deviant. The women felt that their clothes, body weight, and health behaviours (smoking, physical inactivity, food shopping) were outward markers of the stereotype of the welfare recipient. Young (1990) claims that stereotypes function by confining people to a nature which is often attached in some way to their bodies, and which cannot be easily denied (Young, 1990). Thus the women's stigmatization was branded on their physical selves. Most of the women suggested that how they dressed stereotyped them. They acknowledged that they did not have the resources to dress well, and believed that people could "tell" that they were on welfare. For some this judgement of their physical appearance affected their self-esteem.

> It does play on your self-esteem, too, right. Because like you can't afford to buy nice clothes. Or you know like I wear rags because she [daughter] needs clothes. Then people judge you by the way you dress. And it's like who cares how I dress? Isn't it who I am? If I won the lottery tomorrow you'd like me (Kelly's interview, June 6, 2000).

Susan explained that there was a societal expectation for people on income assistance to appear a certain way and to exhibit certain behaviours:

> People on assistance are not supposed to look good. They're supposed to be overweight because they don't do anything. So all they do is stay at home and eat... or they're skinny, gangly young girls who don't dress nicely. And look slobbish (Susan's interview, November 9, 2000).

She also suggested that the women's body weight fueled stereotyping and furthered their stigmatization:

> You know, "look how fat she is." And now I'm beginning to realize that you eat such poor food, you don't have a choice. You can't afford the food that makes you healthy and thin. And you can't get the activity, the women can't get the activity because they've got the kids all the time. So most of us are overweight (Susan's interview, June 2, 2000).

Elizabeth felt that she was stereotyped when she went food shopping "They just judge you. You know 'look at all the junk she's buying.' They judge you all the time" (Elizabeth's interview, June 12, 2000). Cynthia suggested that widespread notions about "wasting" money on cigarettes stereotyped poor people. Smoking fueled negative public sentiments towards people on assistance, while little was known about the difficulties of quitting. "You're burning money away, and when you have no money, and you're in such a space, it's so hard to quit, it's expensive too, expensive to quit" (Cynthia, RTM April 4, 2000).

Through outward markers of the stereotype, the women were culturally excluded and shamed. They were seen as reprehensible, further stigmatized, and "justifiably" subjected to punitive treatment. According to Young (1990), our society enacts the oppression of cultural imperialism to a large degree through feelings and reactions. Such reactions of aversion deeply structure the oppression of all culturally imperialized groups. When the dominant culture defines some groups as different, as the Other, the members of those groups are imprisoned in their bodies. Dominant discourse defines them in terms of bodily characteristics, and constructs those bodies as ugly, dirty, defiled, impure, contaminated, and sick. Those who experience such an "epidermalizing" of their world discover their status by means of the embodied behaviour of others: in their gestures, a certain nervousness that they exhibit, their avoidance of eye contact,

and the distance they keep (Young, 1990, p. 123).[11]

According to Frank and Mustard (1994), an individual's sense of achievement, self-esteem, and control over her life appear to affect health and wellbeing. In the Whitehall civil service study (Marmot, Shipley, and Rose, 1984; Marmot, 1991),[12] a high proportion of people in the lower tiers of the civil service felt they had less control of their work than did individuals in the top tiers of the civil service. When the health of individuals was measured against their position in a well-defined job hierarchy there was a clear social gradient of health. People's position in the hierarchy of society, the degree of control they enjoyed, and their diets appeared to be important factors in determining vulnerability to a wide range of diseases (Frank and Mustard, 1994). The social hierarchy presents itself as if it were a hierarchy of human adequacy, from the most superior, successful, and capable, at the top, to the most incapable at the bottom. The possible centrality of shame and inferiority is important because, according to health equity researchers, a central part of the research task is to identify the most potent sources of recurrent anxiety related to low social status (Wilkinson, 2000).

The Cost of Good Health

Being materially deprived severely influenced the women's access to health essentials such as food, clothing, transportation, and child rearing expenses. For instance, the women shared stories of sacrificing their own food so that their children could eat. At one Research Team meeting Willow appeared gaunt and thin: "there have been occasions where I have not had enough money to eat myself so that my children could... last month I lost almost fifteen pounds" (Willow's interview, September 20, 2000). At times the women could not afford enough food, and at others they could only afford less-nutritious and more filling food options for themselves and their families. Kelly spoke of juggling her expenses and having to decide between eating and her phone:

Or you don't get to eat. It's just that bad. It's like do I eat this week or do I pay my phone bill? It is health related for sure. For sure. For sure it is…. because you're on such a low income you can't eat properly (Kelly's interview, June 6, 2000).

Almost all of the women had at one time frequented a foodbank, though for various reasons none of them attended regularly. Some said that the food was poor quality and often stale, and for others the foodbanks were inaccessible and either a very long walk or bus ride away (which they could not afford). Maey said that the location of the closest food bank was inconvenient: "I think there should be one [food bank] closer by. But of course there's not enough facilities for that" (Maey's interview, June 9, 2000). As well as affecting aspects of their lives – where they live, how they eat, and where the children go to school – living on a low income makes it difficult to exercise control over family health, and as a result the health needs of parents, particularly women, are often compromised for those of children (Shaw et al., 2000).

For financial reasons the women reported that they were unable to access services or resources that could improve or manage their health – some, including food, health promoting resources, and community recreation, were too costly, while other services or resources were inaccessible due to transportation constraints. All aspects of material deprivation profoundly influenced the women's ability to connect with individuals or groups in their communities. Being isolated for financial reasons contributed to the women's exclusion: "We're excluded, because we're the poor ones. We can't afford to pay for anything. If there's a fee or whatever, forget it" (Katharine's interview, June 9, 2000). Many of the women remarked that leaving the house cost money, which they could not afford. Isolation for financial reasons not only prevented the women from accessing community services, but it also hampered their ability to meet friends and other people in their communities. Indeed, material deprivation creates differences in individuals' exposures to the beneficial aspects of the physical world.

Material deprivation is the phenomenon by which those with lower incomes have less access

to health enhancing resources and greater exposure to negative influences upon health than the income group above them and experience disease in corresponding degrees (Raphael, 2001). Some research suggests that material conditions are the underlying root of ill health, including health-related behaviours. Poverty imposes constraints on the material conditions of everyday life – by limiting access to the fundamental building blocks of health such as adequate housing, good nutrition, and opportunities to participate in society.

The Stress and Depression of Material Scarcity

Poor women experience more frequent, threatening, and uncontrollable life events than do members of the general population. For example, inadequate housing, dangerous neighborhoods, burdensome responsibilities, and financial uncertainties, are common-place; all of them are potent stressors (Belle, 1990). The women's lives were unpredictable and stressful because of their material deprivation. Elizabeth commented: "I know life has to have its ups and downs. But not continually having to worry 'is my hydro going to get cut off, or my cable, or my phone?' Having no food, that's a killer" (Elizabeth's interview, June 12, 2000). Budgeting was a major source of stress - learning to juggle expenses, choosing which bills to pay and which to defer to the following month, and determining the exact amount of money to survive on each month. Kelly, who was "one cheque away from being homeless" (Kelly, RTM April 26, 2000), said that she was stressed and depressed as a result. For most of the women stress was ubiquitous and omnipresent "when I get stressed out, you tighten your muscles up, and you're constantly in a state of anxiety. It doesn't seem to ever leave me" (Martha's interview, April 2000).

The mothers discussed the physical stress and tiredness of parenting, the worry of adequately providing for their children, having little support and security, and the uncompromising government stipulations to find work when their youngest child turned 7 years old.[13] The single

mothers acknowledged that being solely responsible for their children, exhaustion, and wanting better for their children were major sources of stress.

> It's [stress] very huge. Also just being a single parent is very stressful. Knowing that you're the sole person that's responsible for your child, and then having the weight also of being on welfare and knowing that you're not going to stay there forever, which is something that you wouldn't want anyway because it's so hard to live on. But knowing that you have to get off eventually, and not having any skills to do that.... It's like having the weight of the world on your shoulders (Virginia Dawn's interview, March 2000).

Although the women discussed depression as a consequence of stress, anger, or social isolation, in all cases they reported that it was aggravated by the stress of living in material scarcity. Belle (1982) reported that the social and economic trends that are forcing many women and children into poverty have tremendous significance for the mental health of women. Women who live in financially strained circumstances and who have responsibility for young children are more likely than other women to become depressed (Belle, 1982).

All of the women reported that their unrelenting financial worries caused them stress and depression. Repetti and Wood (1997) cite that people living in poverty are likely to be exposed to multiple, persistent, uncontrollable demands and to live in environments characterized by "chronic burden." The experience of living on low income creates uncertainty, insecurity, and feelings of lack of control over one's life (Raphael, 2001). Families facing chronic poverty must react immediately and regularly to constant demands, and, for this reason, their coping may be at times less planned (Repetti and Wood, 1997). Chronic economic strain may "grind away and deplete emotional reserves" (McLoyd & Wilson, 1991; cited in Repetti and Wood, 1997), possibly resulting in a diminished ability to reflect upon and develop a problem-focused plan of action. Poverty is among the chronic stressors that may require constant coping in the short term – coping that is likely to be unintentional and less action-oriented. Living in poverty does not allow time for recuperation (Repetti and Wood, 1997).

174

Unhealthy Behaviours

The women's health behaviours were a consequence of their living situations, coping strategies, and choices within a range of options severely confined by material deprivation. The social conditions under which health-damaging choices occur reflect efforts at stress management, a desire to conform to peer group norms, or a minimal expression of power in the context of lives characterized by isolation, alienation, or excessive strain (Ruzek and Hill, 1986). Several research studies have found that, contrary to popular belief, women possess adequate knowledge, skills, and motivation to engage in health-enhancing behaviours, but that their unhealthy behaviours result from struggles to meet conflicting health priorities in the face of decreased resources (Anderson, Blue, Holbrook, and Ng, 1996). The health behaviours that are subsequently discussed include smoking and other addictions, eating, and physical activity.

Smoking and Other Addictions

Four women on the Research Team were regular smokers. Trina explained that the only indulgence she enjoyed was cigarettes.

> The only thing I do is smoke cigarettes. I don't drink. I don't do drugs. I only smoke cigarettes. And I live in a co-op here. And there's nothing extra. Paid my taxes for my cigarettes that's for sure (Trina's interview, June 5, 2000).[14]

Trina suggested that smoking was comforting and a small luxury. For some women, cigarettes represent one of the few purchases directed solely toward their own pleasure and one of the few luxuries in their lives (Greaves, 1996). People facing difficulties often engage in behaviours that are short-term stress reducers but that entail risks to health (Health Canada, 1997). Smoking is a way of coping or maintaining "equilibrium" (Calnan and Williams, 1991); some women smoke instead of expressing their anxiety and frustration with limited resources and decreased personal control (McDonough and Walters, 2001). The factors that predict smoking include material circumstances, cultural deprivation, and indicators of stressful life events including marital,

personal, and household circumstances (Jarvis and Wardle, 1999). Indeed, smokers are drawn disproportionately from those who are disadvantaged within their gender and class groups, and are concentrated among those who are most disadvantaged.[15]

Although addictions were rarely raised in the Research Team meetings or interviews, in passing conversations I ascertained that at least three women had previously struggled with an alcohol addiction. Several women had been raised in homes with addicted parents and siblings, and three of the women's ex-partners had been drug- or alcohol-addicted. Although smoking and other addictions were a reality for many of the women, the women rarely spoke about them as a health concern or something to address with WOAW or the Research Team. Possibly, drug and alcohol addictions were not raised because the women felt they were too private or shameful.

Unhealthy and Disordered Eating

Food and eating were raised as major concerns by all of the women. The women's material deprivation and their psychosocial health influenced how they ate. As previously mentioned, most had experienced having insufficient money to buy food for themselves and their children, and as a result had been undernourished and gone hungry. Katharine explained:

> Food is a big concern. Because I don't eat, don't eat well....because of poverty you don't eat as well.... Nothing that you do is normal anymore. Even eating. You eat terribly. You don't have your vitamins (Katharine's interview, June 9, 2000).

Others spoke of not being able to afford nutritious foods and sacrificing healthy options for cheaper options that would last longer and provide for more meals. Trina spoke about the illusion of choice regarding healthy foods:

> You watch on the news how wonderful it is that you should be eating all these fruits and vegetables and it shows a handful of grapes and strawberries and stuff like that. You can't go out and buy that when you're on assistance. Or even disability you can't go out and buy that. I've lost my car, lost my job, lost my health (Trina's interview, March 21, 2000).

Trina felt that her eating behaviour was a direct result of living in poverty – she managed with the few resources she had and as a consequence had "lost her health." Most people, irrespective of social position, consider food and diet a key element in the maintenance of health (Calnan and Williams, 1991). Yet good nutrition is more than an issue of knowledge of the healthiest foods; to a large degree eating behaviours are determined by the cost of food. Lower income women shop more often because they are less likely to have the money for a single large outlay and are less likely to be able to store large quantities of food. They are also more likely to shop locally[16] instead of travelling to larger discount stores since they cannot afford bus transportation in addition to the cost of their groceries. Material deprivation also forces many women to go without food in order to feed their children or partners (Walters et al., 1995).

Susan suggested that many women on low income had disordered eating – either they under-ate or they over-ate – and that many used food for comfort and to manage chronic psychosocial health problems.

> [Poor women] have eating disorders.... Either they don't eat or they're bulimic, [or they] eat for comfort. And we do admit it. You know so it's interesting how food does play a big aspect on our emotional [health]. There's another one [research project] for you (Susan, RTM November 9, 2000).

Julie affirmed that stress caused people to under-eat or over-eat: "if you get totally stressed out, then you don't eat, or you eat too much... it can go either way" (Julie's interview, March 14, 2000). According to Walters et al. (1995), using food for comfort is an embedded social behaviour. From our earliest experiences, we learn that food is a source of comfort and it is used by women as a way of coping with their lack of control over their lives, particularly if they are at home with young children (Walters et al., 1995). Bloch (1987) found that a group of poor women who were socially isolated were overwhelmed by an urge to overeat. These episodes were followed by an effort to control their socially visible body by dieting (Bloch, 1987).

Three women reported that they consistently under-ate because of the stress of living in poverty. Caroline explained "a lot of it is 'cause I'm not eating properly, not like I should. Very seldom do I eat. I eat once a day, once every couple of days. I get so much on my mind, it just turns me right off of food" (Caroline's interview, April 12, 2000). As well, two women reported that they struggled with anorexia and bulimia nervosa. Both suggested that low self-esteem was the primary reason for their disordered eating.

> I've never really felt that good about myself. So when my ex told me that the biggest two mistakes of his life - the first one was marrying me and the second one was having our son. So, you were like 'What's wrong with me? There must be something wrong with me.' And I think that was what started all my eating-type things (Elizabeth's interview, March 20, 2000).

Poor women's eating behaviour is not determined by a lack of knowledge; the women in this study were familiar with the basics of good nutrition and healthy foods. Yet contrary to common perceptions their eating behaviour was influenced by both material deprivation and their psychosocial health.

Physical Inactivity

All of the women became involved in WOAW as an initial means to gain better access to community recreation; only one woman had been regularly active in community recreation prior to her involvement in WOAW. The women saw recreation as a means to improve their health, manage chronic pain, reduce stress, decrease social isolation, meet other women in the local communities, set a positive example for their children, and involve their children in physical activities. All of the women cited the cost of community recreation, the transportation required to get to a community centre, the lack of available childcare, and discriminatory practices and policies as barriers to becoming involved. Willow explained the barriers she faced in trying to access community recreation:

> It just became impossible to do any programs that other people have access to who are

in a middle income setting. It would be so easy for somebody to pick up in their car, go down with their kids, drop them off at day program and leave again. For me it's get on the bus with two children, a bag and a stroller, and you're scraping up that bit of money that you have so you can't pay for a full length swimming program, and I can't stand through a situation where I have another little child who's hanging off me and screaming and be an instructor to her, or be a watcher to her. So, it's, just everything becomes so difficult, that access to leisure (Willow's interview, March 15, 2000).

The women said that their material deprivation contributed to their low participation levels.

Trina said: "If you don't have any money, you can't get there and you can't do anything if you don't have any money. You have to have money. You need money to buy tickets. You need money to have proper apparel" (Trina's interview, March 21, 2000). Other women saw exercise as a coping strategy for managing their psychosocial health problems. Cynthia spoke of physical activity in the following way:

Anybody who isn't active can easily become depressed or stressed or whatever and anybody who's depressed can tell you you don't need to take medicine, you need to start some kind of exercise program. Because when your body's active it stimulates your mind or whatever. I don't know how it works, all I know is it does work. Exercise is huge for keeping your mind going (Cynthia's interview, April 12, 2000).

Additionally, community recreation was seen as a way of becoming socially integrated, thus helping to deal with psychosocial health problems such as stress and depression.

It's like a cycle. If you're physically inactive, obviously you're not going to go out for a walk. And if you're not going for a walk, you're not meeting anybody out there. But, I walk lots and I don't meet anyone when I'm on my walks. I think if you're socially isolated that can lead in to depression and possibly physical inactivity if you don't know anyone. I think they're all interrelated, stress is in there, too because you'd be stressed out if you were lonely and you don't know anyone. They all affect each other (Virginia Dawn's interview, March 14, 2000).

There is considerable evidence for the relationship between physical activity and health (Reid and Dyck, 2000). The women considered regular physical activity as a means to address some major health problems such as heart disease and diabetes, as a strategy for managing chronic health conditions such as fibromyalgia and back problems, and as a way of meeting other women in the community and to socially integrate in a meaningful way. Yet all of the women

faced barriers to being regularly physically active – including the costs of program registrations, transportation, childcare, and discrimination.

"Choice" is always shaped by the options that exist within one's specific life circumstances, and women's choices are often more rhetorical than real (Ruzek et al., 1997). People do not have equal choices about how they live their lives or the health behaviours available to them. Several researchers have suggested that the link between social structures and patterns or styles of life can be explained by different groups having differential access to a range of resources in the management of their everyday lives (Calnan and Williams, 1991). As well, material restrictions operate through a number of processes, and "unhealthy" behaviours need to be understood in the context of the constraints on everyday life which accompany them (Shaw et al., 2000). Smoking, drinking, poor nutrition, and physical inactivity are socially patterned and represent structural challenges that women face (Walters et al., 1995). Behaviour is related to the social context in which people live and is difficult to change in isolation. Indeed, if behaviour was not partly determined by the social environment, there would presumably not be a social class gradient in smoking, in dietary composition, or in the amount of leisure-time exercise which people take. In other words, to change behaviour it is necessary to change more than behaviour (Wilkinson, 1996).

Exclusion, Inequality, and Women's Health

While there is substantial evidence for the "gradient of health," few researchers have employed qualitative methods to examine the ways that the experience of living in poverty influences women's health. Exclusion emerged from the data as the most significant experience of poverty – the stereotyping and invisibility of cultural exclusion, the discriminatory practices and policies of institutional exclusion, and the limited subsidies and scarcity of material deprivation. The women were stigmatized when they interacted with the welfare, health care,

and community recreation systems. The stigma of poverty shamed and humiliated the women, and as a consequence some women struggled with anger, others felt increasingly hopeless, powerless, and invisible, and still others adopted unhealthy behaviours as a way to cope. Meanwhile widespread stereotypes justified the women's material scarcity, thus denying them access to important health-promoting resources, programs, and services. In these multi-faceted and interconnected ways, exclusion had a deep and serious impact on poor women's health.

Health equity researchers argue that the quality of social relations is a prime determinant of human welfare and the quality of life. As well as more egalitarian societies having a smaller burden of relative deprivation pressing down on health standards, they also seem to be more socially cohesive (Wilkinson, 1996). Yet in many societies people are systematically excluded from resources and opportunities (Raphael, 2001b). Exclusionary institutional practices and policies preserve relative and absolute disparities between the rich and the poor. They also confine people's material lives including the resources they have access to and the opportunities they have or do not have to develop and exercise their capacities. Unquestioned norms and stereotypes mark poor women as deviant and reprehensible. Poor women live with shame and humiliation and are controlled by exclusionary institutions that reflect "the same patterns of control and power that are often characteristic of relationships between men and women, between parents and children" (Wall, 1993, p.285) . According to Wilkinson (1996),

> To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debts or job and housing insecurity; to feel devalued, useless, helpless, uncared for, hopeless, isolated, anxious and a failure; these feelings can dominate people's whole experience of life.... The material environment is merely the indelible mark and constant reminder of the oppressive fact of one's failure, of the atrophy of any sense of having a place in the community, and of one's social exclusion and devaluation as a human being (Wilkinson, 1996, p.215).

While low-income people, particularly women, are cut off from the ongoing economic growth enjoyed by most Canadians, "most governments are not yet prepared to address these problems

seriously, nor are they prepared to ensure a reasonable level of support for low-income people either inside or outside of the paid labour force" (National Council of Welfare, 2000, p.145). Furthermore, attempts to recognize and do something about the association between exclusion and health is threatening to the status quo. Doing something about exclusion, discrimination, and inequitable access to resources involves planned social and economic change (Becker, 1986). Addressing these larger issues turns the concept of health into a battleground over rights and resources (Rootman and Raeburn, 1994). While theory and research evidence support the link between exclusion and ill health, the extent to which any new program actually succeeds in empowering a community and the ultimate impact this has on its collective health remains to be demonstrated (Shiell and Hawe, 1996). Ultimately the decision all of us have to make is between valuing human development and all its potentials, including good health and the avoidance of illness, or living within a society that excludes the poor and furthers inequities (Raphael, 2001b).

Notes

[1] Katharine, Research Team Meeting, April 26, 2000

[2] This was the women's experience of B.C. Benefits. I cannot confirm that "good" workers did not last long and were pushed out of the welfare system.

[3] Although the women believed that their stays in hospitals were shorter than the stays of people who had more money, it is difficult to say whether this was in fact the case. Current public discourse contends that all people have shorter stays in hospitals due to reduced government spending on the health care system.

[4] It should be noted that leisure access policies only cover a fraction of the cost of the program itself and do not cover childcare, transportation, or other expenses (clothing, equipment) associated with participating.

[5] Five of the women lived in housing co-operatives, eleven women lived alone in apartments (some with their children), one woman lived with her parents, and three women lived with their partners in apartments or houses.

[6] The welfare cuts announced in British Columbia on January 17, 2002 affected thousands of seniors on low income who were no longer to be entitled to bus-fare subsidies, something "that was necessary because such subsidies are not available elsewhere in Canada" (Lunman, 2002, p. A4).

[7] Transportation was a barrier for several reasons. Welfare recipients in British Columbia do not receive subsidies for transportation, therefore the cost of taking the bus comes from recipients' monthly cheques. This cost was prohibitive for many women: "Everything costs money, even the bus. There was one activity last year that I wanted to do.... I had to take the bus three times a week to go, I couldn't afford the bus three times a week" (Katharine, RTM April 4, 2000). The women also suggested that the transit system did not accommodate them in terms of schedules and routes: "Trying to get anywhere on transit, especially in this area, you have to leave sometimes two hours before you want to get somewhere" (Elizabeth's interview, March 20, 2000). The older women suggested that transportation was a barrier in a couple of ways. The 'handi-dart' service for people on disability had restricted

hours and limited service areas, and needed to be booked three days in advance. "You can't go out after a certain hour at night. I just see it as not being a very independent way for a senior to live" (Wanda's interview, June 5, 2000). Some of the older women were concerned about taking the regular bus because of their health, difficulties climbing the bus stairs, the distance to and from the bus stops, the waiting that was required, and the possibility of not being able to sit on the bus.

[8] The women said that their limited incomes forced them to become good budgeters, which often conflicts with the common stereotype of the welfare recipient as being careless with her money. According to Susan, "if anybody can stick on a budget it's someone on assistance, because you have to feed the kids, you have to eat, and you may not have enough, but you take care of that budget as good as you can" (Susan, RTM April 4, 2000).

[9] All of the women said that stress was a health concern, ten women reported depression, and four of the women who had depression said that they were clinically depressed.

[10] The four women who had clinical depression were notable exceptions. At times they spoke of the relationship between stress and depression, while at other times they cited their depression as a biological problem rather than a consequence of societal factors. The women's psychosocial health discourses, specifically their uses of the terms "stress" and "depression," would be a fruitful avenue for future study but is beyond the scope of this dissertation.

[11] According to Poland (1998), attempts to define smoking or obesity as socially unacceptable represent something more than a health promotion intervention aimed at increasing exercise or smoking cessation for the public good. In framing smoking or obesity as "base" and "vulgar", the middle and upper classes remodel their own rejection of smoking or their embracing of fitness as worthy of emulation. However, there is a certain irony in the historical reversal of earlier attempts by the dominant classes to claim smoking or rich foods as distinctive and elite, not to mention the more recent popularity of the cigar as a status symbol. Health promotion interventions reproduce and accentuate class divisions by casting what is desirable in the image of the health professional, who by virtue of her class position is already vested with considerable symbolic, cultural, and social capital (Poland, 1998).

[12] The Whitehall civil service studies in Great Britain were ground-breaking research studies that aimed to determine the relationship between social status and health. These studies have been widely referenced and have provided a foundation for debates in the health equity field (Marmot et al., 1984; Marmot, 1991).

[13] Under the provincial Liberal government elected in May 2001, single mothers are now expected to return to work when their youngest child turns 3 years old. According to the provincial human resources minister Murray Coell, he aims to "break the cycle of welfare dependency in B.C." and the best social safety net "is a job.... Welfare in Canada has been an attitude of entitlement" (Lunman, 2002).

[14] When Trina and I reviewed her quotations, she asked that I footnote that she rolled her own cigarettes in order to save money.

[15] In a study conducted by Walters et al. (1995) with a group of women on low income, 71.7% of women who were lone parents were smokers (Walters et al., 1995). For a thorough analysis of the context of women's smoking, consult Greaves (1996).

[16] There is some evidence to support the idea that smaller grocery stores in low-income neighborhoods in Vancouver B.C. have on average higher prices than larger grocery stores in middle-class suburbs (Baxter, 1988).

6

Negotiating The "Other" Identity:
Legitimacy, Power, and Discourses of Poverty and Health

Once you tell somebody you're on welfare they look down on you. They think you're not
as good a person because you can't make it your own. And support yourself. And for
years I would go out of my way not to let people know.... when I first got on welfare it
made me feel really horrible that you have to take a hand out. But you need money to
live on. I just find a lot of people they stereotype you as soon as they know you're on
welfare (Alexa's interview, June 2, 2000).

Experience affects consciousness, including how and what people know, yet similar

experiences do not necessarily produce similar points of view (Wendell, 1996). Previously I

defended the use of the terms "poor women" and "women on low income" to describe the

research participants. Through examining the women's identities as reflected in their discourses,

in this chapter I shift the analysis to the multiple and at times contradictory ways that this group

of women labelled as "low income" made sense of their health and their lives in poverty. The

women's discourses revealed their dynamic and fluid identities that were shaped through

repudiating, resisting, and accommodating the dominant discourses of poverty and health.

The discourses in this chapter were contradictory, provisional, and co-created. An example

from the data illustrates this point. In Joanne's first interview she commented "At the beginning

I thought it was a racial issue, I never thought it was because you're on welfare, I just thought

they treated me differently" (Joanne's interview, March 20, 2000). In her second interview,

however, Joanne suggested that she was not mistreated: "sometimes I would hear in the group

meetings people say when they go places they're treated differently. To be quite honest I never really got that.... I'm lucky because I've never had that problem" (Joanne's interview, June 9, 2000). The disjuncture between Joanne's comments highlights how the manner in which the question was asked and her consciousness in the moment of being asked influenced her responses.

The analysis of the women's identity is divided into four major discourses: the "powerless victim" discourse, the "legitimacy and entitlement" discourse, the "individual work ethic" discourse, and the "critical and collectivist" discourse. Within each discourse the women attempted to find legitimacy and power in a society that systematically de-legitimized and disempowered them and marked them as Other. When the women identified the most closely as the Other they felt powerless, and as they distanced themselves from the Other they gained a sense of power. The following discourses capture only partial moments of the women's identities; they are not meant to be seen as static or fixed representations. Despite these variable and contradictory discourses, individual and collective empowerment were possible given the ways that the women subverted the dominant discourses, uncovered a "legitimate" identity within their experiences of poverty and ill-health, and advocated for the work of action towards social change.

The Powerless Victim Discourse

At times the women adopted a "powerless victim" discourse. In this discourse the women felt they had no free will – their fates were controlled by "bad apples," welfare workers, or ubiquitous and inevitable health problems. Within this discourse the women felt unjustly shamed, othered, and disempowered. Although they strove to articulate their individual legitimacy, their victimization and powerlessness prevented them from being seen outwardly as legitimate.

185

"Bad Apples" Are Disempowering

In this aspect of the "powerless victim" discourse the women suggested that "bad apples" made it impossible for welfare recipients to be seen as legitimate. Through referring to mothers, sons, brothers, father-in-laws, and friends the women suggested that some people – "bad apples" – actually fit the stereotype of the welfare recipient and were lazy, unmotivated, and chose to live off the system. Joanne said:

> They spend their days smoking and drinking... they can try and get back to school. Ask for help. Or get a part time job. But they choose to stay in the system because it's an okay way. Once they've got a kid under seven then they don't need to go out to work and they can get paid for not working... it's like that small percentage [of people on welfare] and it gives a lot of people a stereotype.... It only takes one. Like they say one bad apple to spoil the bunch.... Like sometimes women just wanted to have babies just to keep them on welfare. I've known lots of women like that (Joanne's interview, June 9, 2000).

Maey referred to the existence of the welfare stereotype in this way: "There are a lot of people out there that do take advantage of the system. Like poor me. Poor me. I can't do this. I can't do that. So gimme gimme gimme gimme" (Maey's interview, June 9, 2000). The women suggested that "bad apples" took advantage of the system, chose to be on welfare, drank and smoked, and enjoyed a "free ride," and that their behaviour and attitudes had a negative impact on all women on welfare.

While the women actively negated their personal conformity to the stereotype of the welfare recipient, through this discourse they stereotyped others. Foucault's (1997a) notion of the panopticon illustrates how at times people who are stereotyped can themselves perpetuate the stereotype. Metaphorically, the panopticon is an architectural apparatus that induces a state of conscious and permanent visibility and that assures the automatic functioning of power. Those surveyed are then caught in a power situation in which they are themselves the bearers of power (Foucault, 1977a; cited in McHoul and Grace, 1993). Disciplinary power functions by relying on surveillance and the internal training it produces to incite states of docility; the subject of

186

surveillance disciplines herself and others (McHoul and Grace, 1993). Rene suggested that she "tried harder" and worked at distancing herself from the stereotype. "I think I try harder [because of the stereotype].... I don't want to be in that group. Or have to say that I am that" (Rene's interview, June 5, 2000). Katharine explained how she negotiated her stereotyped and shamed identity: "So to work at saying 'I'm not guilty. I did not want to be in that boat. I did not want to be depressed. I didn't want to be sick. And I'm having a good life. I'm a good soul. I'm a good woman'" (Katharine's interview, June 9, 2000). Katharine was deeply affected by the stereotype and did not want to think of herself, or for others to think of her, as a "bad apple."

Within this discourse the women suggested that to some degree the stereotype was inescapable and that regardless of how they negotiated it, they were unjustly affected by it. Through affirming the stereotype while rejecting its relevance or applicability to them personally, the women stereotyped others. Within this discourse the women did not explore "reasons" for living in poverty. They projected themselves as not choosing poverty, being unjustly branded as a consequence of others' actions or inactions, and having no control over being stereotyped. Additionally, this discourse portrayed the individual as the solution to the problem "they can try and get back to school. Ask for help. Or get a part time job" (Joanne's interview, June 9, 2000). Within this discourse the women did not extend their analysis to how stereotypes function in society, the processes underpinning public perceptions of poor women as deviant, and whose interests are served through their perpetuation (Vertinsky, Batth, and Naidu, 1996). The emphasis was placed on the "bad apple" to change her behaviour so that the stereotype could be dispelled.

Welfare Workers and the Industry of Poverty Are Disempowering

In this aspect of the "powerless victim" discourse the women suggested that dependency on the government was not chosen but that due to unfortunate experiences (abusive relationships,

family history, bad luck, declining health, disability) some people were forced to rely on the system. In this case the women did not choose their dependency – it was something that initially happened to them and was now forced upon them by irrational policies and practices and uncompromising welfare workers. In this discourse the women suggested that once someone became dependent on the government, it was nearly impossible to be independent. Elizabeth spoke about not wanting to be on welfare but encountering barriers to getting help.

> Most people don't realize nobody wants to be in this position. But don't have much of a choice. It's all just a catch-22 all the way along. You want education but you got to get daycare. Well to get a good daycare you got to do this, that and the other. And then because there are so many people in this position, there's huge wait lists (Elizabeth's interview, June 12, 2000).

Many women spoke of wanting and trying to get help but facing barriers from within the system. Several suggested that they did not fit program criteria for getting help. They were not the right age "If you're 18 to 25 they got that youth program, great, you're in. Well, I'm not 18 to 25. There's a lot of discrimination" (Kelly, RTM September 27, 2000), or they did not have a drug or alcohol problem "Somebody's who's a drug addict or an alcoholic receives more benefits. And I don't understand that…. I still I can't fathom why all these barriers are placed there" (Willow's interview, September 20, 2000).

In this discourse the women were powerless to change their situations because of the welfare system. Willow distanced herself from the stereotype by suggesting that she was not a stereotypical welfare recipient because she wanted to work but that the system prevented her from realizing her dreams.

> I have the same dreams, the same hopes that other people have. So, because I've had a rough spot in poverty, should I be forced to stay there the rest of my life? Should my children be forced into that for the rest of their lives? I don't think so…. Not all taxpayer money is going to feed people who don't want to care for themselves (Willow's interview, March 15, 2000).

For some women, their stigmatization rendered them powerless – despite being "no

different" from others who had more money, they had no control over their personal situations and could not exercise the full and desired range of choices in changing their impoverished situations. Since the welfare office exerted so much control in their lives, the women were forced to comply in order to receive their welfare payments. "You don't want to rock the boat. And you don't want to fight the system or fight society. Because you're afraid of the consequences... the powers that be are a very big threat" (Elizabeth's interview, June 12, 2000). The women asserted that they wanted to change their situations, they were dissatisfied with living in poverty, but that the stereotype, their welfare workers, and systemic barriers inhibited their full range of choices.

In some conversations the women suggested that their welfare worker was the biggest barrier to getting off the system.

> The workers aren't there to solve problems unfortunately. They just aren't. They're there to save the government a dollar. Instead of helping people up, they're giving them a hand out. And that's the mistake. Instead of trying to make their life better in some way helping them to function at the best level they can. It's not about that. It's about "I'll frustrate you until you stop bothering me" (Rene's interview, June 5, 2000).

The women portrayed welfare workers as systematically preventing the women from getting help, not only to save the government money, but to preserve their own jobs. Workers would not help the women because to help recipients was not in their best interests.

> A lot of the times I get the impression that they [welfare workers] think they're taking the money out of their own pockets, and I've even said to them, "if I wasn't on the system, you wouldn't have a job"; that's true, isn't it? And they're, "off the record? Yeah, it's true." I said "so you want to keep me on the system, you don't really want me to get a job, because if everyone suddenly went off the system you wouldn't have a job" (Kelly, RTM April 4, 2000).

This discourse located welfare workers within the "industry of poverty" that relied on the perpetual dependency of welfare recipients. Independence was presented as the women's desired yet unattainable goal. They resisted the dominant stereotype of "welfare recipient" through portraying themselves as wanting to change their situations through participating in government

189

programs or going back to school, but encountering barriers in attempting to change their situations. Within this discourse the women had little free will, choice, or control – their dependency was forced upon them through limiting their options to improve their situations – and they were powerless vis-à-vis government policies, practices, and personnel that functioned to preserve its own interests.

Stress and Ill-Health Happen

In some instances the women spoke of health "happening" to them. In thinking that health "happened" and with little suggestion for why it happened or how to manage it, the women portrayed themselves as "powerless victims." Some women discussed their psychosocial health, particularly stress, as ubiquitous and inevitable. Teresa reflected on stress and depression's infusion in society and in her life:

> Stress, depression, those kinds of things were big words to me.... We were just living day to day [in Edmonton], I mean, just an ordinary day to day living. Nothing big, the exciting thing was just camping up in Banff, going to Calgary was a big trip, that sort of thing. And then you come here [Coquitlam] and going to Mission is sort of like, got to worry about it. So it's sort of then the word stress came in the picture. What is that...? Stress, yeah, you kind of get stressed out thinking, you know you're not used to, a person is not used to that kind of living, like thinking, how are we going to do this, how are we going to do that? Then the word stress comes in to the picture, whether we like it or not it's just there all of a sudden (Teresa's interview, March 2000).

Teresa portrayed stress as an inescapable part of urban modern-day living "then the word stress comes into the picture, whether we like it or not it's just there all of a sudden." This discourse naturalized stress by locating it in nature rather than social relationships or society (Crawford, 1977). According to Pollock (1988), the stress discourse has important ideological consequences by providing epistemological grounds for conventional beliefs about society that serve to legitimize existing social arrangements (Pollock, 1988). With the steady increase in the use of the term stress, some women suggested that stress was inevitable, happened to them, and that they had little control over it.

Conversely, other women suggested that although they knew why they were unhealthy they were powerless to do anything about it. In this aspect of the "powerless victim" discourse the women suggested that their choices were constrained by their incomes, their occupations, and other features of their lives. Such constraints shaped their control over their life chances, the quality of their housing, and the occupational hazards to which they were exposed. In one instance three women discussed how the physical toil of living in poverty was a health risk.

Willow: And the physical effort it takes, in general, if you have a disability, you don't have a vehicle, you have small children, you don't have a vehicle, how do you do that? It's hard, it's very hard... the simplest things for people are physically taxing on us.

Rene: If you're not feeling well it's like climbing a mountain.

Willow: Everyday is like that, going out and doing your things, everything's physically difficult.

Katharine: And you start asking why, then you get depressed.

Willow: Because you feel that there's no way to get out of it.

Katharine: There's no hope, there's no hope in hell (RTM May 16, 2000).

Other women felt that their declining health was a direct consequence of living in poverty. Willow made the association between her social status, living in poverty, and being unhealthy. "My doctor himself said 'you're not suffering from anything that's physical, it's your social status'" (Willow's interview, September, 20, 2000). Willow supported her discourse with the diagnosis of a medical expert who confirmed that her social status was the cause of her poor health.

Most women said that their experiences living in poverty influenced their psychological health and in turn their overall health. Implicitly they related declining mental health with declining overall health. Whether the cause of ill-health was stress, the physical demands of living in poverty, their social status, or systemic barriers, the above examples of the "powerless victim" discourse illustrated how the women understood their health in relation to their living conditions but felt powerless to address them. Regardless of the etiology of ill-health and disability, within this discourse the women saw themselves as pawns of an unjust society.

191

Through the "powerless victim" discourse the women felt shamed, victimized, and illegitimate. They suggested that they had little power to challenge the injustices they experienced since they were othered, and had little or no control over their lives and health. Indeed in many cases this was in fact the case – they were stereotyped, had little power within the welfare system, and had no control over some health issues. When the women adopted this discourse, they felt that they had little or no free will – they were at the mercy of other people, distant social factors, or abstracted conditions that affected their health.

The Legitimacy and Entitlement Discourse

The women's "legitimacy and entitlement" discourse surfaced when discussing both poverty and health. In various ways the women used the dominant discourses of poverty and health to legitimize their dependency while delegitimizing others' dependency. Since this discourse was rooted in self-identifying as legitimate and entitled, there was little discussion of the shame associated with being dependent. There were two aspects of this discourse – references to biomedical health conditions as legitimate and the notion that a biomedically recognized disability sanctioned "good" dependency. Paradoxically, within this discourse only by othering did the women feel included and powerful.

Biomedical Health Problems Are Legitimate

In many discussions, the women referred to their health in biomedical terms. In these cases the notion of "good health" related directly to the absence of disease, illness, or disability. Katharine spoke of good health as not having certain health conditions or diseases.

> Fibromyalgia, diabetes, arthritis, that are chronic, and therefore for good, and they come and go, come and go, come and go. So, good health would be not having those things, but also that the stress itself, does not give you conditions like bulimia or stress-related headaches (Katharine, RTM April 26, 2000).

As well, a biomedical discourse surfaced in discussions of stress. Arlene suggested that stress had

biological implications.

> I think stress is a terrible, terrible thing to your body. And people react, your body's going to react to stress differently than mine. You might develop heart problems, or ulcers or whatever.... Like I believe definitely in the fight or flight syndrome. You know, how do you feel? You know what happens to you how do you feel? And that's adrenaline and a bi-product of that is cortisol and cortisol is damaging to your body (Arlene's interview, April 2000).

Arlene had strong beliefs about stress' biological impact on her body. According to her stress was bad for health because it affected hormone levels. Her explanation of stress resided within the dominant and traditional biomedical discourse.

Discursive practices reproduce institutions and the employment of a discourse is often a practice that reproduces the material basis for the institution (Parker, 1992). A biomedical discourse exists in many texts and has given rise to the dominance and proliferation of medical institutions and authority. Within this aspect of the legitimacy and entitlement discourse, references to health conditions in biomedical terms, and the validation of ill-health and disability by medical experts, fostered a sense of legitimacy. The biomedical discourse frames health, illness, and disability on the basis of biological and physiological pathways and relinquishes individual control and autonomy to the authority of medical "experts." Health conditions, illnesses, or disabilities that can be seen and measured and are proven or validated by biomedical experts are thus knowable and legitimate. Consequently, "invisible" or difficult to diagnose disabilities such as chronic fatigue syndrome, endometriosis, depression, and fibromyalgia are less legitimate.

The perceived illegitimacy of some diseases, because they were not visible by medical experts, made some women feel increasingly stigmatized. Martha explained her experience living with chronic fatigue syndrome and fibromyalgia. "There is always that stigma attached to chronic fatigue and fibromyalgia, that it is all in your head, and I always scream at them" (Martha's interview, April 11, 2000). In these cases the women looked to the biomedical health

193

discourse to validate their disabilities. Some women had more difficulty proving their disability, being taken seriously, and receiving their benefits and entitlements. Kelly explained: "I heard that about my endometriosis too. Oh you're fine, you look good, it took them [doctors] 7 years to diagnose it. I don't care what I look like, I hurt, man" (Kelly, RTM April 26, 2000).

According to Foucault (1994), "the knowledge of diseases is the doctor's compass; the success of the cure depends on an exact knowledge of the disease" (Foucault, 1994, p.8). The biomedical health discourse has been criticized as male-biased in the choice and the definition of the problems to be studied, the methods employed to carry out the research, and the interpretation and application of the results (Doyal, 1995). Traditionally the biomedical discourse understood women as a special case, a deviation from the male norm (Cohen, 1998), and defined women in reference to the physiology and pathology of their reproductive systems. Within the biomedical health discourse and the "doctor's compass," depression, chronic fatigue syndrome, endometriosis, and fibromyalgia are often stigmatized as unknowable and invisible "women's diseases." Since medical authorities within this discourse find it difficult to understand these "women's diseases," their very existence is questioned, and women who suffer from them are stigmatized as illegitimately sick.

The biomedical discourse worked simultaneously to legitimize and de-legitimize the women's experiences of illness, disease, and disability. When the women's health conditions fell within the gaze of biomedical discourse, experts, and institutions they were affirmed and legitimate; when they went beyond the gaze, they and their health conditions were stigmatized and invisible, and they became the Other. Being stigmatized because of the nature or visibility of their disability othered some women. In turn, Others were rendered powerless in facing welfare or medical authorities who could not see or understand their ill-health and who controlled their health diagnoses and accessibility to disability benefits. However, at other times the women adopted a

194

biomedical discourse to validate their health experiences and disability, while simultaneously othering those who did not fit mainstream understandings and diagnoses.

Indeed, the legitimacy of the biomedical health discourse is pervasive, particularly since public and government rhetoric supports Canada's "universal health care system" that is collectively responsible for biomedical health problems. Within the "universal" health care system all Canadians, regardless of their ability to pay, are entitled to equal access. Yet the biomedical health discourse and the health care system ignore the social patterning of disease, focus only on biological factors (Krieger and Fee, 1994), and represent the "prerequisites" for health in gender-neutral language. The system fails to consider how access is shaped by gender as well as many other social and cultural factors (Ruzek et al., 1997). Viewing health from a strictly biomedical perspective risks leaving unchallenged the social forces that continue to create vast inequalities in health (Krieger and Fee, 1994). Paradoxically, the women's use of a biomedical discourse both legitimized some health concerns and de-legitimized others. Meanwhile the adoption of a biomedical discourse maintained the power and authority wielded by medical institutions and authorities while discrediting some health problems that did not fit within its ideology.

Disability Is Legitimate Dependency

Within this aspect of the "legitimacy and entitlement" discourse references to previous work and disability justified the women's dependency on B.C. Benefits. Some women stated that they were disabled and unable to work. Being disabled meant that dependency was not a choice and that the women had no control over their health and their subsequent reliance on government funding. Susan spoke of "being handed" her disability and how her consequent poverty was out of her control and not her choice. "Being handed this [diabetes and fibromyalgia] and that was it. It's just my health dropped and then my life dropped" (Susan's interview, June 2, 2000).

Not only did the status of disability legitimize some women's dependency on the government, but it gave them more benefits and better treatment. The women classified as disabled were distanced from the stereotype of the welfare recipient and were the "highest status" of all recipients. Susan explained that people on disability benefits were surveyed less and had more rights. "We're not screened as much. You get a lot more rights being on disability than you do on the regular [welfare] system" (Susan's interview, November 9, 2000). B.C. Benefits ranked recipients' deservedness from social assistance, disability I, to disability II.[1] Social assistance recipients were seen as being the least "deserving," and therefore received the fewest entitlements and benefits and were regularly threatened and surveyed. Disability I recipients were considered "short-term" disabled, were forced to continually complete paper work and rationalize their disability, and despite their disability were pressured to return to or find work. Conversely, disability II recipients were disabled for the long-term, and, among other things, received monthly bus passes.[2] Not surprisingly, reaching the disability II status was seen as a desirable yet difficult thing to do. Often, the women on disability distinguished themselves from those receiving social assistance. Trina mirrored B.C. Benefits hierarchical rationale and explained that her inability to work differentiated her (on disability II) from social assistance.

> I'm classified as disabled. I'm not welfare. Same office. I'm disabled.... I'm not well enough to go to work. Welfare people are well enough to go to work.... Like this is my opinion when someone talks to me about disabilities. Either they're ill. Or they worked hard and they've ruined their body compared to being on welfare. My son calls welfare Wednesday payday. And he's 26 years old. And he's a bum (Trina's interview, June 5, 2000).

Trina suggested that welfare recipients chose not to work while people on disability benefits did not have such a choice. Susan explained that although her worker pressured her to work, her doctor had legitimized her dependency and that it was not her choice. "I said well I don't know what else is wrong, but I can't work. My doctor's advised me not to. You know this isn't a choice" (Susan's interview, June 2, 2000). In order to be classified as disabled by the welfare

office one had to receive an "expert" recommendation from a doctor. Medical professionals acted as gatekeepers to the women's disability status, and once they received it, the women's dependency was sanctioned and more legitimate.

This discourse suggested that women who had previously worked and were on disability benefits were entitled to receive benefits while those who had not worked were not entitled to government support.

> I've paid my taxes in this country for however many years I have up to 61. I've paid my unemployment. I've paid all these things. I've never claimed on them. I figure I have a right, yes. But my god at 24 you don't have any rights. You've done nothing for this country yet. So yes do say thank you. I mean nobody expects you to get on your knees. But thanks is nice (Wanda's interview, June 5, 2000).

According to Wanda, those on disability who had previously worked "earned" the benefits they received, while those who had not worked or were not labelled disabled were not entitled to social assistance. In contrast, when one receives social assistance one must express gratitude for the charity of others. Wanda defended and felt entitled to her dependency because she had paid her taxes and unemployment insurance. Wanda and other older women suggested that it was morally wrong to benefit from social services without contributing to its maintenance. Indeed, those who did not contribute through paying taxes, or those who had not earned their rights and dependency, were "free riders." A free rider is person who benefits from a social arrangement without bearing an appropriate share of the burdens of maintaining that arrangement (Audi, 1995). Freire (1996) explained:

> For them [the oppressors] having more is an inalienable right, a right they acquired through their own "effort".... If others do not have more, it is because they are incompetent and lazy, and worst of all is their unjustifiable ingratitude towards the "generous gestures" of the dominant class. Precisely because they are "ungrateful" and "envious," the oppressed are regarded as potential enemies who must be watched (Freire, 1996, p.41).

The women's use of this discourse marginalized welfare recipients on social assistance who were portrayed as having no rights, illegitimate, and unworthy of B.C. Benefits. The moral

197

boundaries of "deservedness" reflects how at times researchers, policy makers, and the public believe that it is possible to distinguish and serve those who are "deserving" and neglect those who are "undeserving." Indeed, the discourse of deserving constructs Others, banishes them to the margins of the culture, represents them as unworthy, immoral, and damaged (Fine, 1994). The women's juxtaposition of "good" and "bad" dependency mirrored the dominant discourse of dependency that neglected the full context of many women's lives. Within this discourse, barriers to help, experiences with abuse, parenting responsibilities, social isolation, and other daily challenges were not raised as legitimate reasons for being dependent and receiving welfare.

Through the "legitimacy and entitlement" discourse some women reified the dominant discourses of biomedical health and poverty. Since some women felt legitimate within this discourse they did not see themselves as othered, their identity was not tarnished or compromised, and they were not shamed. Although the women could be seen as having no free will over their poverty and ill-health, their accommodation of the dominant discourses that legitimated their poverty and ill-health effectively empowered them while disempowering others. Yet, when the women had invisible disabilities that did not fall within the dominant discourse they felt othered and excluded. Through stigmatizing "bad" dependency, non-workers, and invisible or non-biomedical health conditions, poor and unhealthy women who could not or did not adhere to the dominant expectations were de-legitimized.

The Individual Work Ethic Discourse

When the women adopted the "individual work ethic" discourse they portrayed themselves as having free will in managing their poverty and ill-health. All three aspects of this discourse – "good mothers," "individual responsibility," and "strength and resilience" – portrayed the women as having a full range of choices and control. Through portraying themselves as actively working at managing their poverty and health, the women both aligned themselves with the

middle-class ideology of self-discipline and work and distanced themselves from the stereotype of the welfare recipient as passively not working and accepting the charity of others. Within this discourse the cause of poverty and ill-health was infrequently discussed; rather, despite the cause the women suggested that their poverty and ill-health were manageable because they chose to be good mothers, individually responsible, resourceful, and resilient.

Good Mothers Choose Dependency

Within the "individual work ethic" discourse some of the young mothers portrayed themselves as "good mothers" choosing to stay at home with their children. Through this discourse the mothers negotiated their reliance on the government and suggested that they had chosen welfare dependency in order to be good mothers. Social assistance was chosen as a way to leave an abusive or drug-addicted partner, in order to no longer "live a lie" as a lesbian in a heterosexual relationship, and to have more disposable income than would be possible working long hours for minimum wage and paying for daycare. The mothers distanced themselves from the stereotype of "bad mother" because they had consciously chosen to stay at home and to work as mothers. Cynthia said that the stereotype no longer bothered her because she was raising her young children with government support.

> I have two small children under the age of 7, and so, I don't care, I feel that the government has provided me with income so that I may stay home with my children, I think that's right, it doesn't bother me. But, a lot of people it really bothers them (Cynthia, RTM April 4, 2000).

Kelly suggested that because she had made the choice to stay at home with her daughter she was "a wonderful mother."

> Being on welfare and being a single mom, the label really bothered me. But I see what I've done. And I see the work that I do. I have so many people compliment me and respect me, it's really helped me. But if you don't hear it from people I could see how people would really feel bad about themselves. But I'm lucky because I have a lot of people that tell me on a regular basis what a wonderful mother I am and what a good job I'm doing (Kelly's interview, June 6, 2000).

199

The acknowledgments that Kelly was doing a "good job" legitimized her choice to stay at home and validated her dependency on B.C. Benefits. In both quotations Cynthia and Kelly suggested that the label of "welfare mom" no longer bothered them because of their choice to work as mothers. Although their discourses were couched in having made a "choice," some women recognized that their choices were limited and that welfare was the best alternative in a host of undesirable options. Certainly the women's choices did not reflect the range of choices that many middle- or upper-class people enjoy. However, in suggesting that they had "chosen" welfare, the women exerted some control over potentially difficult and painful situations where many may not see a choice at all. Indeed, framing their situation as "choice" gave them a sense of power in having a decision to make. While "choice" and "no choice" can be seen as a simultaneous reality, affirming a "choice" may have been a way of structuring their lived experiences (Duneier, 1999). They legitimated their choice to stay home and be supported by welfare through portraying themselves as active decision-makers while refuting dominant notions of welfare recipients' passivity and powerlessness.

Poverty and Health Are Individual Responsibilities

A predominant aspect of the "individual work ethic" discourse was the women's assertions that through personal resolve and effort they could manage their material deprivation and their health. Within this discourse the notion of individual free will was strongest – despite their poverty and ill-health, the women had full control, could act proactively, and were thus empowered. The women suggested that with their motivation, self-discipline, determination, and will power they could manage their poverty and health.

When the women spoke of taking individual responsibility for their poverty it was in terms of managing their day-to-day lives in material scarcity. Consequently the women discussed

making the most of their situations and learning to cope with poverty despite its challenges. Wanda reinforced the dominant ideology of poverty through suggesting that poor people could learn to shop better, garden, and cook.

> Sometimes I wonder how much education would help poverty. I don't mean formal book education, I mean learning to put a little garden in the back yard. And how to look after your vegetables. Or how to shop correctly.... You don't eat any better than you do in this [Rene's] house. And Rene does not have a lot of money. It's called learning how to do it correctly (Wanda's interview, June 5, 2000).

Wanda's comments suggested that people would be able to cope with living in poverty if they were sufficiently educated in how to manage. Despite discussing systemic barriers and stereotyping at the Research Team meetings, at times some women reflected philosophically on poverty and affirmed an acceptance of their impoverished situations. Rene supported Wanda's comments and suggested that through learning to adapt she minimized her deprivation.

> There's a saying happiness is not having what you want, but wanting what you have. And I think we learn to live that way... for me it's been a matter of adapting. And luckily throughout my life I've had to adapt. So I've learned how. And I really don't feel that deprived personally (Rene's interview, June 5, 2000).

A younger woman concurred and suggested that she had taken an initiative to change her position.

> I mean, if you want a job, do you really think someone's gonna just come to your door and say "I want to hire you?" You know, it's not going to happen. If you want a better life for yourself you have to commit to change. You have to take it an initiative. You gotta do it, right? (Kelly, RTM April 26, 2000).

The above quotations suggest that the women were individually responsible for managing their situations and that they are accountable if they did not manage well.

The women's self-responsibility for health discourse mirrored their self-interpretations as being resourceful, taking initiative, and coping despite their material scarcity. Within this aspect of the discourse the women suggested that determination, self-discipline, and motivation were necessary in achieving and maintaining good health, and that their health could be managed and

controlled. In her second interview Joanne explained:

> So good health is... being in control, being in control of your body whether it's physically or mentally. And if there's stress, trying to eliminate that stress by one form or the other whether it's going out and doing something in a group or by yourself. Or physically exercising which is working for me and is helping a lot (Joanne's interview, June 9, 2000).

According to Wendell (1996), the essence of the myth of control is the belief that it is possible, by means of human action, to have the bodies we want and to prevent illness, disability, and death. It is a myth because people continue to cling to it despite overwhelming evidence against it. This has the ugly implication that if you are ill or disabled, you must have failed to take care of yourself. Another is that people "make themselves" ill or disabled by mismanaging their lives, their psyches, or their spirits in some way (Wendell, 1996, p.103). Indeed "healthy behaviour has become a moral duty and illness an individual moral failing" (Crawford, 1984, p.70).

Consequently the women bore personal responsibility for addressing their health. Many strategies were shared to "work at" their health including engaging in physical activity, organizing stress management workshops, and pursuing counseling or group therapy. Katharine affirmed the notion that a stress management workshop was the best strategy for dealing with stress. "A process of understanding and from this formulating direct action, suggestions. Like I said... we are organizing a workshop on stress management, everybody's stressed out" (Katharine's interview June 9, 2000). Elizabeth spoke of attending a workshop to improve her self-esteem. "I saw in the paper they were offering workshops at the women's center like the learning to love yourself type-thing. Maybe we could do something like that" (Elizabeth's interview, March 20, 2000).

The women shared many individual strategies for managing their poverty and health throughout our Research Team discussions. Joanne stated that she had the resolve and skills to manage in poverty and to cope with stress: "Personally, I don't let finances stress me out. I don't

have stresses over that because I have learned to budget really well" (Joanne's interview, March 14, 2000). Sharing coping strategies confirmed the notion that the women needed to and were capable of "taking responsibility." Alexa spoke about the work she had to do to get involved in her community:

> For years I've been wanting to get involved. And I knew I had to do something soon or I was never going to change the person I want to become I guess.... I think it was just before I didn't get involved at all even though I wanted to. I didn't put the effort to get involved. And now I'm just putting more effort to get involved. And to take part and do things (Alexa's interview, June 2, 2000).

The discourse of "individual responsibility" espoused a concept of wise living with the individual essentially independent of her surroundings and unconstrained by social events and processes. Within this discourse the women did not question social relations or systemic factors that contributed to their poverty or ill-health. In the discourse of individual responsibility the source and the treatment of poverty and health shifts to the individual, effectively closing other levels of intervention (Zola, 1972) and absolving the state and society of moral responsibility (Pollock, 1988). When social and environmental pressures are recognized, it is still the individual who is called upon to resist them (Crawford, 1977). When poverty and health are reduced to a set of values and behaviours, dependency and ill-health become a consequence of not having those particular values and behaviours, essentially being deficient. The fear of dependency, both explicit and implicit, posits an ideal, independent personality in contrast to which those considered dependent are deviant (Fraser and Gordon, 1997).

By framing any crisis or problem in individual rather than systemic terms, "the system is protected from itself" (Abramovitz, 1995, p.222). Kelly supported the notion of taking responsibility to work at feeling better about herself so that society and the health care system could be spared:

> In the long run it's good, if people feel better about themselves, their self-esteem and that, you learn valuable skills in the group also, but if you feel better about yourself, then

203

in the future you could be off the system. It would be better for everybody, for healthcare (Kelly, RTM June 7, 2000).

The effect of the ideology of individual responsibility reorders expectations, justifying a retreat from the language of rights and the policies of entitlements (White et al., 1995). From this perspective arises an emphasis on the need to reduce the expectations and utilization of ineffective and costly medical services, thus shifting the focus to the necessity for individual responsibility and the requirement for either education or economic sanctions to enlighten and reinforce one's sense of responsibility (Crawford, 1977).

Within the women's discourses of individual responsibility, they negotiated meanings and experiences particularly in relation to being stigmatized and the Other. With poverty and ill-health stigmatized, the work of self-improvement, so characteristic of the middle class, became important for the women to distance themselves from the stereotype. Through gaining this distance, the women also gained legitimacy and a sense of power, while poor and unhealthy women, or women who were not sufficiently working at managing their poverty and health, were othered and seen as contemptible and morally lax for being dependent and costing the welfare and health care systems money. Individual behaviour, targeted by society's gaze, came under the women's gaze as they surveyed themselves, monitored others, marked out deviant behaviours, stigmatized non-conformists, and legitimized themselves. By virtue of their work and consequent "independence" and health the women imposed their gaze on those who remained "dependent" and unhealthy. Thus the stereotype was preserved.

Strong Individuals Can Survive Poverty

Another aspect of the "individual work ethic" discourse was the women's suggestions that they were strong and resolved in surviving poverty. Kelly said "Poverty people are survivors man. Like it's amazing how you get through it. You always get through" (Kelly's interview, June

6, 2000). Maey felt that she struggled in poverty because she could handle it, and that in some way it was her destiny. "My opinion is God never gives anybody anything unless they can handle it. Or there's a reason he wants you to go through it... or maybe because I can handle it and there's a lesson for it" (Maey's interview, June 9, 2000). As well, within this aspect of the discourse some women portrayed themselves as the ones "chosen" for doing work in the community for those less fortunate. Katharine said:

> The rich don't need me. They're happy businessmen or businesswomen. They don't need me, I cannot affect them. I look more at the people who need something. This is how I look at it.... And it's my duty.... Because otherwise the whole community suffers (Katharine's interview June 9, 2000).

Katharine felt that "it's my duty" to help those worse off than her. Although poverty and welfare were not chosen, she had the strength and desire to help others less fortunate.

Through the discourse of strength and resilience the women resisted the imputation of "welfare recipient" through affirming, at times fatalistically, their ability to manage in material scarcity while a weaker person would be unable to survive. Through this discourse the women felt powerful and legitimate despite their adversity. There was little acknowledgement of the larger systemic, social, or material constraints that impinged on their daily lives. Focusing on their inner strength was possibly a strategy for coming to terms with difficult life circumstances. However, in claiming that they were the ones "chosen" to bear the burden of poverty, they effectively absolved society and the welfare system from addressing its injustices.

Within the "individual work ethic" discourse the women suggested that they had free will – they were in control and could choose – in terms of their mothering, managing their poverty and ill-health, and recognizing their inner strength and resilience. Through exercising their free will and choosing to "work" some women distanced themselves from the stereotype of the welfare recipient and consequently identified as legitimate and powerful. Meanwhile, through advocating their individual motivation, resourcefulness, and resiliency they defined structural impediments

205

as personal troubles and moralized personal choices, imposed difficult changes on the individual, and suggested that others were lax and accountable for not managing their poverty and ill-health.

The Critical and Collectivist Discourse

Through the "critical and collectivist" discourse the women spoke of being othered while understanding the social and economic factors that contributed to their marginalization. Within this discourse the individual women felt little free will as a consequence of powerful external forces, yet they suggested that their knowledge and ability to learn and think critically could facilitate individual and social change. The women also suggested that they were not entirely responsible for their health, rather the community and society were accountable for the health of individuals.

In one aspect of this discourse the women reflected on mainstream assumptions and questioned the notion of "good health." Specifically, two women suggested that the notion of "good health" was fabricated. Maey said:

> I don't know if there's such thing as good health.... I don't think so. I think everybody has some kind of a health problem no matter how healthy they are. And how well they eat. Or how busy they are in the community or outgoing. There's some kind of health problem in everybody (Maey's interview, June 9, 2000).

Not only was "good health" a fabrication, but it was one that was fed to the public by the media.

> The media telling you what you should be and what you should look like. And the expectations that go with it.... It tells you you should look a certain way. You should feel a certain way. And if not, here, take this or do that. Because this is the way you should be feeling. I don't think I really have a real idea of what good health is. Because I've never really met anyone who is in really good health. I think sometimes it's exaggerated. I mean, is there such a thing as somebody having completely good health? (Susan's interview, June 2, 2000).

In this discourse the women were critical of the dominant health discourses and the notion that the medical system or the individual were capable of choosing, controlling, or achieving good health. Through this discourse, the women rejected more individualistic discourses for

demoralizing and disempowering individuals, and for setting impossible standards.

In discussions of experiences of poverty, some women were critical of systemic and social arrangements and how such arrangements disempowered marginalized individuals. Helen provided an analysis of society while portraying an empowered individual as she described her vision of the relationship between individuals and the economy.

> And it's so empowering to know that the economy is stacked this way and the social situation is stacked this way and that the problems you're having are certainly not of your own making. And when you understand what's working against you out there, you feel much stronger to face up to it. And never mind if it's politically correct or whatever, you know. You're a human being and you deserve dignity and you should have some rights, that when you're not fully aware of what the society has, oh god it's our food, it's our politics, it's our institutions. And I'm just wondering if there could be some kind of education in that because it's so empowering when you realize "hey, it's not me" (Helen, RTM June 7, 2000).

Although society is "stacked in a way and that the problems you're having are certainly not of your own making," in this discourse individuals were not responsible for addressing or changing their poverty or ill-health, rather they were responsible for learning about the complex social forces that can disempower some people. Implicit in this discourse was a resistance to the stereotype of the welfare recipient and the notion that education is empowering.

The "critical and collectivist" discourse arose sporadically and can be seen as most closely aligned with the social determinants of health perspective. Through this discourse the women identified as being critical of the dominant discourses and as needing to educate themselves about the root causes of poverty and ill-health. Despite recognizing the significant social, political, and economic factors that were "stacked" against them, the women suggested that their learning could enable them to critique the stereotype of the welfare recipient. Some women suggested that this process was empowering and an important step in initiating individual and collective action.

Negotiating the "Other" Identity: From Individuality to Empowerment?

The dominant discourses of poverty and health "other" poor and unhealthy women who are unable to be independent and healthy. Examining the women's four discourses revealed complexes of meanings and networks of interpretation that subverted, accommodated, and reinterpreted the dominant discourses. In fact, the women's provisional and contradictory discourses reflected attempts at countering "ideological constructions" (Naples, 1996) as Other. As the use of dominant discourses of poverty and health attributes disparaging qualities to the Other, in various ways the women constructed their discourses to distance themselves from that social identity. While the intent of dominant discourses may be to produce regularity through stereotyping, the effect can be quite the opposite – a multiplicity of disparate identities (McHoul and Grace, 1993). In some instances the women's discourses accommodated the dominant discourses in order to find legitimacy, while in other cases they resisted and repudiated the messages inherent in the hegemonic discourses. In all cases stereotypes repeatedly got in the way of their full participation in social life (Wendell, 1996).

According to Foucault (1980a), people simultaneously undergo and exercise power – "not only do individuals circulate between [power's] threads; they are always in the position of simultaneously undergoing and exercising this power... individuals are the vehicles of power, not its points of application" (Foucault, 1980a, p.98; cited in McHoul and Grace, 1993). Through the women's interpretations and manipulations of the notion of free will they were involved in subtle yet ongoing exercises of power. Their sense of free will, choice, and control moved between being empowered and disempowered by their own actions, by particular individuals, by the authority of professional "experts," and by abstracted external factors.

In some instances the women's empowerment functioned to preserve peculiarities and deviance within a system concerned with seeking them out. Three of the discourses –

"powerless victim," "legitimacy and entitlement," and "individual work ethic" – highlighted differences and individuality. In the "powerless victim" discourse the women were victimized, isolated, and powerless because of injustices perpetrated by someone or something else – "bad apples," the welfare system, or health problems that "happened" to them. The women did not see themselves as vehicles of power, instead they were "its points of application." When the women identified as victims – as the Other – they felt incapable of directing their own lives and remained divided as a consequence of their powerlessness.

Within the "legitimacy and entitlement" discourse the women gained power through accommodating the dominant discourse, fitting the criteria for "legitimacy," while maintaining the distinctions between the "legitimate" and the "illegitimate." Through the "individual work ethic" discourse the women enforced their individuality as workers – working to cope in material scarcity, to address their health problems, and to be disciplined, motivated, and self-controlled. By virtue of their "work" the women felt legitimate and powerful, while positioning "non-workers" as illegitimate and justifiably disempowered. The women, as "vehicles of power," further stereotyped and stigmatized others. According to Wilkinson (2000), people subordinated by their social or institutional superiors and threatened with humiliation attempt to regain their sense of control and restore their self-esteem by asserting authority and control over those below them (Wilkinson, 2000). In both the "legitimacy and entitlement" and the "individual work ethic" discourses the women surveyed the poor and unhealthy and played an indispensable role in maintaining middle-class privilege and dominance. Much like the metaphor of the "panopticon" their discourses served as disciplinary power. When the women disassociated from the social identity of Other they felt more legitimate and powerful; however, as a consequence those who did not adhere to the hegemonic criteria for gaining legitimacy were de-legitimated and disempowered. Exercising power can be seen as a refusal of dominant meanings, discourses

that challenge power are often themselves oppressive (Parker, 1992).

In the "powerless victim," "legitimacy and entitlement," and "individual work ethic" discourses the women's identity mirrored the dominant middle-class discourses because they rarely considered social or systemic relations. The women did not extend their analyses of poverty and health to the economy stacked against them, high unemployment rates, policies that supported low minimum wages, or governments that cut social programs while providing tax cuts and business incentives. Through accommodating the dominant notions of dependency, choice, and control, the women's discourses subverted efforts to draw attention to the systemic, social, and material conditions that structured their lives (Croghan and Miell, 1998).

While adopting an identity is useful and meaningful in both political organizing and personal lives because it can make sense at that particular moment, identities are not fixed or everlasting (Spivak, 1990). Despite the individualism that surfaced in three of the women's discourses, their discourses were not perpetually divisive. Within all of the women's discourses places of resistance and collective empowerment surfaced. When the women adopted aspects of the dominant discourse and articulated a desire for collective empowerment and change, they suggested the possibility of an "alliance" of poor women. Ristock and Pennell (1996) wrote of the concept of an "alliance" that can foster empowered action among diverse groups of women while enabling individuals to express difference. Within an alliance, the provisionality of identity is accepted as well as women's solidity in the relations of power (Spivak, 1990).

Empowerment refers to the ability of people to gain understanding and control over personal, social, economic, and political forces in order to take action to improve their situations (Israel et al., 1994). "The heart of the idea of empowerment involves people coming into a sense of their own power, a new relationship with their own contexts" (Fox, 1988, p.2; cited in Lather, 1991). Empowerment can occur on both individual and collective or community levels. In the

"legitimacy and entitlement," "individual work ethic," and "critical and collectivist" discourses the women gained a sense of individual empowerment through accommodating dominant discourses, affirming their choices and work, critiquing the system, and educating themselves. Individual empowerment is an individual's ability to make decisions and have control over her personal life (Israel et al., 1994). As the women negotiated their identities and carved out sites of understanding and individual resistance, they fostered a sense of empowerment at being able to survive and in some cases thrive in spite of systemic oppression.

Instances of individual empowerment often translated into sharing strategies for surviving the system and actions they could each take to endure their day-to-day lives to foster a sense of health, belonging, and dignity. Yet some theorists argue that individual empowerment also incorporates the establishment of a critical understanding of the social and political context and the cultivation of both individual and collective resources and skills for social action (Young, 1990; Israel et al., 1994; Freire, 1996). Only in the "critical and collectivist" discourse did the women speak of collective empowerment and the possibility of initiating collective action. As is further discussed in chapter 7, this discourse emerged increasingly over time and became an impetus for both individual and collective actions. Yet within and across the women's discourses of poverty and health were examples of individual empowerment, empowered action, and analyses that resisted the common imputation of "welfare recipient." In this chapter I unraveled the labels "poor" and "unhealthy" in an attempt to show the diversity and provisionality of these identities. The following chapter examines how the women's identities interacted in attempts to do the work of social change in the context of a feminist action research project.

Notes

[1] Note that welfare recipients receive "social *assistance*," while people classified as disabled receive "disability *benefits*."

[2] More specifically, in addition to subsidies for housing, disability I recipients received $282.92 monthly and had an income exemption of $100, both of which were reviewable every 6 months. In contrast, disability II recipients received $461.42, had an income exemption of $200, and received a bus pass, none of which were reviewable (DERA Advocacy Service, 2001).

7

Lofty Ideals and Lived Experiences:
The Research Team as Feminist Action Research

> We're numbers. We're here to change things. I really feel we're here to change things. The norm, the way the government is run is not working for women and families in need. So we need to rock some boats, ask some questions (Susan, RTM October 19, 2000).

The rhetoric of feminist action research (FAR) presents the notions of inclusion, participation, action, and social change in relatively uncritical and idealistic terms. In response to feminist action research's idealism and calls for feminist methods that truly work with rather than for women, in this chapter I explore the experiences of working together as the Research Team.[1] I also examine the ways that the Research Team as feminist action research addressed, corrected, and reproduced oppressive relations and increased understandings of the role of research and the researcher in social justice agendas.

Throughout this chapter I theorize and challenge the ideals of feminist action research. Through reflexively portraying the FAR principles of inclusion, participation, action, and social change I question the role of feminist action research in truly achieving its emancipatory ideals. I also reflect on my fieldwork experiences and how anger, power, control, and conflict surfaced. I consciously chose to foreground the women's experiences with the Research Team and to leave my personal reflections to the latter part of this chapter. While my own reflections are woven intermittently throughout the analysis, for representational purposes, as described in chapters 1 and 3, I incorporated the majority of them in a separate section entitled "Reflections from the

Field."

The Challenges of Inclusion: Voice, Learning, and Emotions

Feminist action researchers aim to open horizons of discussion, to create spaces for collective reflection, and to develop new descriptions and analyses of important situations (Greenwood and Levin, 1998). Popular knowledge plays a central role in generating new knowledge that better represents the experiences of marginalized populations and motivates a community for political action (Comstock and Fox, 1993). This section examines the ways that the Research Team attempted to value women's knowledges through fostering an inclusive group process that in many ways resembled feminist consciousness raising groups. Finding and hearing "voice," sharing the same problems, reflecting on emotional experiences, and learning, problem-solving, and networking were important processes that promoted inclusion, honoured the women's knowledges, but also perpetuated some women's exclusion. The analysis addresses several questions that have, to date, been inadequately theorized in the FAR literature. They include: what does it take to feel heard?; what are the benefits and risks of sharing the same problems?; and, how does working together as a group both foster inclusion and perpetuate exclusion?

"Voice" and Sharing the Same Problems

The consciousness raising groups and public speak outs of the 1960s, 1970s, and 1980s were an essential component of the feminist movement and a necessary part of feminist action. These groups, that focused on fostering inclusion through women's shared problems and voice, provided a means to transform experience through reflection on aspects of women's lives previously considered politically unimportant or unspeakable (Maguire, 2001).[2] Bringing people together around shared concerns and problems permits people to achieve mutual understanding

214

and consensus about what to do (Kemmis, 2001). The telling, listening, affirming, reflecting, and analysis of personal stories and experiences "from the ground up," similar to the practices of feminist consciousness raising groups (Maguire, 2001), are important FAR strategies. Indeed, FAR is fundamentally about the right to speak and argues for the articulation of points of view by the subordinated (Hall, 1993; Regehr, 2000). FAR creates spaces for women's diverse voices and personal experiences (Acker et al., 1991).

As discussed in chapter 5, exclusion was a significant aspect of the women's experiences of poverty. The women felt that reducing social isolation and providing a sense of inclusion and belonging was one of the benefits of the Research Team. According to Susan, "I really feel part of something. It's been a very, very long time since I felt that way" (Susan's interview, June 2, 2000). The sense of inclusion that the Research Team fostered was a consequence of sharing the same problems and a collectivist group process that worked towards hearing all voices. For some women it was the first time, or the first time in a long time, that they felt included instead of suffering alone in poverty. At one meeting three women discussed the value of sharing the same problems.

Kelly:	Knowing you're not alone, you know, having a whole group of people that have been treated the same way. I like that. Knowing that we're all...
Maey:	In the same shoes.
Kelly:	Yeah, knowing we're all in the same boat.
Susan:	In particular, we haven't all been singled out. I know I've been through that. I went through the "why me?" stage. And now, so it's not just me, ok.
Kelly:	It doesn't discriminate does it? (RTM June 7, 2000).

Some women suggested the Research Team played an important role in the WOAW organization because previously there had been no place for them to share their experiences of poverty, exclusion, and health. At times the Research Team was referred to as the "gel" or "root" of WOAW. Katharine said:

Thank god we have the Research Team. WOAW wouldn't be WOAW without it. It is part of the infrastructure of WOAW And it is the part that if you look at it from the

215

middle it will root, it will root itself. And it helps WOAW to root itself. And it will grow, just like a tree (Katharine's interview June 9, 2000).

As the women shared their problems and realized that they, as a group of poor women on welfare, were oppressed by institutions, organizations, and individuals, they increasingly critiqued these injustices and realized that they were not to blame for living in poverty. The "politics of poverty" became a recurring theme at Research Team meetings. It is likely that some women came to identify the Research Team with such issues and politics. These discussions promoted feelings of togetherness and collective empowerment to initiate change. Susan suggested that sharing the same problems was a catalyst for action.

> We complain but nobody allows it to go into a "poor me" scenario. We're allowed that for a moment or so. And then it's okay well we don't like that and it's happened to all of us. We can't sit here anymore. We've got to move on. I think the Research Team has given us hope (Susan's interview June 2, 2000).

Since the women shared many of the same problems most of them recognized that every voice should be heard: "everybody's thoughts and words are just as important as the next person in the room" (Maey's interview June 9, 2000). Kelly recounted how she was overwhelmed by voicing her opinion. "Throughout WOAW you always get to voice your opinion. I'm still overwhelmed after a year that someone actually wants to hear what I have to say" (Kelly's interview, June 6, 2000). However, despite the Research Team members' recognition that they shared the same problems and that all voices should be heard, they struggled with speaking one at a time, giving air-time to quieter women, and truly listening. This may have been partly because of the emotional quality of the discussions and the women's belief that their voices would be heard at the Research Team meetings (Colleen's fieldnotes, June 29, 2000). Some women spoke about their shyness, their low self-esteem, their fear of speaking in public, and their discomfort with group environments. Elizabeth explained:

> I have a hard time speaking in front of others, I'm always worried about saying stupid things, I don't have the confidence that a lot of the girls do.... I think that shyness is a

216

lot about self-esteem… and even when I'm busting at the seams to try to say something
I can't (Elizabeth, RTM April 4, 2000).

Alexa expressed her concerns around voicing her own issues and how she feared being seen as

selfish.

> I guess fear of, I don't know, fear of them taking it too personally, I guess. Like, I don't
> know, maybe I don't, if I stood up and said something I'd fear they'd take it the wrong
> way and they'd think I was, it was sort of a selfish motive instead of something thinking
> for the whole group (Alexa's interview, March 20, 2000).

Discussions around group process did not translate into a mindfulness around speaking one at a

time, allowing others time to speak, and hearing differences of opinion.[3] Although some women

recognized their tendency to dominate, the practice of honouring voice remained problematic:

> Sometimes we're very strong in what we think. And how we would deal with it. And I
> would not want to see that sort of bully some quiet little thing that maybe had a different
> opinion but doesn't know how to say it (Wanda's interview, June 5, 2000).

Some of the women's strong opinions and rich life experiences did effectively silence others.

Women remarked in their interviews that they had been silenced by the group and that their

needs were not valued.

> I don't feel that if I said, you know I really want to do this, can we set that up, if nobody
> else wants to do it, I may as well not have said anything. Do you know what I mean?
> (Cynthia's interview, April 12, 2000).

Although the Research Team strove to foster inclusion through valuing shared problems and

voice – much like feminist consciousness raising groups – issues of inclusion required constant

attention. The ongoing dilemmas around voice demonstrated how groups function and how

they may not be the best environment for all. Oftentimes, problematic issues were not raised by

the quieter or even the more talkative members. To some degree the interviews enabled the

women to speak more openly about their personal experiences, yet I never assumed that I was

cognizant of all the dimensions of the women's struggles and challenges with their involvement

on the Research Team (Colleen's fieldnotes, September 6, 2000).

The ideal of "finding," "gaining," or "giving" voice requires further exploration. What does it really look like to "find" one's voice? According to Lather (1991), we must ask who it is that we select to "give voice," how that voice is selectively revealed, and given shape in our research, and the social and political consequences of "giving voice" in particular ways at particular times and to particular audiences (Lather, 1991). As well, voice is not only found, it must also be heard. Difficulties arose in many of the Research Team meetings around hearing the multitude and diversity of voices. The Research Team meetings were often a barrage of personal stories and advice-giving. Some women's voices effectively silenced others', while several women told the same stories repeatedly. In silencing others and in repeating stories the women were attempting to be heard. In groups whose members have been systemically silenced and not heard in most other environments, truly honoring many diverse voices is difficult. The feminist literature pays scant attention to whether disempowered women are capable of hearing others' voices. Indeed, many of the women had such strong needs to have their own voices heard that they dominated conversations, denied the needs of shyer or less confident women, and repeated stories of their own oppression.

The process of promoting inclusion through valuing voice and sharing the same problems effectively excluded some women. Many of the Research Team discussions revolved around the challenges of living in poverty. At various times some women suggested that they did not fit the "criteria" for being involved with the Research Team since they were not on social services. Cassie said "I don't know if I would qualify for the group anymore because most of them I'm thinking are on social services, and I'm not and that's another difference" (Cassie's interview, March 18, 2000). As the Research Team discussed common barriers and identified possibilities for collective action, some women were excluded from involvement because they did not, or perceived that they did not, share the same problems. It is also possible that the unspoken and

emergent "criteria" for meeting with the Research Team – struggling in poverty and desiring social change – culturally or socially excluded women in the broader community. As discussed in chapter 4, the Research Team was primarily a White women's group, and did not attract or foster the participation of women of colour and recent immigrant women.

Consequently, some WOAW women who felt excluded from the Research Team, by virtue of their exclusion, were less aware of the Research Team members' shared issues. In at least one instance a Research Team member felt judged by another WOAW woman for living on welfare.

> She said that to me "are you on welfare, why don't you work?" Just straight out. And I said "not that it's any of your business, but yeah I am on welfare and I'm not proud of it, and I'm a full time Mom." I said "you have your husband to support you, I'm married to welfare" (Kelly's interview, March 14, 2000).

There were benefits and risks in developing a sense of inclusion through voice and sharing the same problems. The women who were consistent Research Team members valued and promoted hearing all voices and the sharing of common experiences, much like feminists have in the past advocated the role of consciousness raising groups. Yet as the Research Team evolved and identified with a particular set of shared values and actions around the politics of poverty, some women were silenced and excluded.

Learning, Problem-Solving, and Networking

Feminist consciousness raising groups strive to foster learning, problem-solving, and networking among women. Similarly, the women on the Research Team felt that meeting as a group and sharing the same problems helped them to learn and solve their own or each others' problems. Alexa commented "I've found that I've learned a lot, people with similar experiences, and it's been useful" (Alexa's interview June 2, 2000). Virginia Dawn suggested that she came to the Research Team to help solve her own problems:

> There may be other people who have figured ways around it or people who know what to do about it. And then that gives you a map that you can follow. And different people

have had different experiences or even the same experiences and different results. So it's good to share that. Then maybe you won't have to have so much heartache (Virginia Dawn's interview June 6, 2000).

The women's learning was enriched by their diverse ages. Kelly, a younger woman, commented "there's so much knowledge there, with age comes knowledge. And like they're just so smart you could ask them anything and they'd know" (Kelly's interview June 6, 2000), while Rene, an older woman, said:

> I find those meetings [Research Team] really interesting because of the interaction between the different age groups. It's really nice to interact with the other ones.... I learn things when I go to those meetings (Rene's interview June 5, 2000).

Wanda suggested that women must start networking to develop the strength and power as the "old boys" have. "I think that it's really nice to see women networking, the old boys' network has been going on for years, and we need a women's network" (Wanda, RTM April 4, 2000). Feminist consciousness raising groups arose in opposition to men's skewed interpretation of and exclusion of women and their varied experiences (Maguire, 2001). As the women identified with each other and as the Research Team, they developed their capacity to network with each other.

In the early stages of the Research Team, the women spoke cogently of the value of networking and learning from others. At times, however, some women's ready problem-solving was poorly received. By the August 2000 meeting conflict arose when Wanda gave Kelly advice.

Wanda: But I also think that if you're not healthy Kelly, if you're not healthy here (points to head), it doesn't matter what your child has, it really doesn't.
Kelly: But I am healthy there so... where's that, what do you mean?
Wanda: How do you know? (laughs)
Kelly: Because I know. I'm healthy enough to know (RTM August 17, 2000).

By this point there had been many suggestions from the older women to the younger ones around parenting and increased resourcefulness. Kelly appeared frustrated with being told how to do things better and was impatient with the advice. As well, this incident raised questions about whether Kelly felt that Wanda had truly heard her problem and whether she felt that they

shared the same problems given their age difference. Despite some conflict over advice giving, several women felt that through learning and networking they developed confidence and self-esteem. "Just having more confidence in myself. I'm just doing fine for me. I'm coming out of a shell" (Trina's interview, June 5, 2000).

The Emotionality of The Research Team

The feminist consciousness raising group literature suggests that engaging in such processes can be emotional for participants. The women involved with the Research Team recognized that the issues they wanted to discuss, particularly around poverty, were inevitably emotional. Susan spoke about sharing emotions at Research Team meetings.

> I think it's [the Research Team] an integral part. I think it's really what WOAW is about. I honestly think it's the basis. And some of the other [meetings] are almost like a business meeting. The Research Team you allow a lot of feelings and emotions to come through which is one of the things that many of us have been fearful to do. The young moms speaking up about having their children taken away. That wouldn't come up in a Project Team meeting (Susan's interview June 2, 2000).

Yet for some WOAW members the emotionality of the Research Team meetings excluded them. In the check-in of the third meeting, Gloria said:

> I'm going to be perfectly honest. I find it gets me deep, and it hits me hard at times, I guess because I'm a sensitive emotional person, and I realize everybody's got problems.... I just find that it hits a note in me, and it makes me sad. I guess I feel it for everybody else too. I go back to things in my life, just talking about sadness, depression, unhappiness, I want to move forward, and so far, touch wood, thank god, I am (Gloria, RTM April 26, 2000).

From the beginning this was a concern of mine.[4] I never made the assumption that meeting to discuss health and poverty would be an easy or positive experience, and did not expect the Research Team to appeal to every woman in WOAW. Three women, who at one time attended a Research Team meeting, did not return because they felt the meetings were too emotional. Involvement in a consciousness raising type of group requires a willingness to reflect on personal and possibly painful experiences. Katharine spoke of the difficulties of working as the

Research Team "that part is very overwhelming for us and we need all the help we can get, man. Because it's totally abstract for us. It's scary" (Katharine, RTM September 27, 2000). Women have different needs and ways of managing their situations. For some discussing and reflecting on the intricacies of their oppression was too difficult and painful (Colleen's fieldnotes, September 27 2000).

The Research Team: Fostering Inclusion and Exclusion

A social group is defined not by a set of shared attributes but by a sense of identity (Young, 1990). The Research Team as a social group identified with hearing women's voices, sharing the same problems, learning from one another, and collectively and critically examining the politics of poverty. Most of the women on the Research Team said that they enjoyed and benefited from being research participants in a research project. Alexa spoke of valuing her learning from participating on the Research Team: "I think it's [the Research Team] really important. Maybe it's just me because I'm really interested. I like to learn things and I've never really been researched upon" (Alexa's interview June 2, 2000). Trina commented "I just know there's a future [for the Research Team]. And I'm glad I'm in the research. Yah I really am.... I don't know how you got me but I'm glad you got me" (Trina's interview June 5, 2000). In the interviews I asked the women to describe the Research Team. Willow said:

> We're researching people's situations. Researching the health aspect of it. The emotional aspect of it. And yes you're definitely delving into places that have not been uncovered before, whether it be for shame or, you know. People don't normally talk about these things. They keep it to themselves because they're feeling so bad about it (Willow's interview September 20, 2000).

And Susan commented:

> The safety of the Research Team has been really, really high. I can see that in other people as well as myself. I know myself anger has come out there for me. Not at the Research Team but for us to get any assistance or any help anywhere else we have to continually show people our receipts that show people exactly how much we earned.... I think the Research Team has brought it down to what our basic problem is. And one of

222

the biggest problems is the attitude [of] the government to low income people. Is the biggest one. The way we're treated (Susan's interview, June 2, 2000).

Other women commented that their involvement with the Research Team and WOAW "took the stigma out of poverty." The women discovered they were not alone, learned from each other, and at times felt powerful to change their situations.

However, mutual identification as an implicit group ideal can reproduce a homogeneity that may conflict with the organization's stated commitment to diversity (Young, 1990). The process of fostering inclusion through voice, sharing the same problems, and learning and networking was not a panacea for the daily struggles of the women on low income. Paradoxically some women were excluded through the very processes that included others, and aspects of the research process itself may have excluded some women from full participation. For instance, after a meeting one woman "approached me and said she said that she couldn't read the consent form. I said that we would go through it together after the meeting. I felt that I had created a barrier to her involvement and hoped that this hadn't intimidated her" (Colleen's fieldnotes April 4, 2000). Fortunately this particular woman identified herself as illiterate and asked for help; other women may have been less likely to do so. As a researcher striving to foster an inclusive environment, I should have anticipated the possibility of illiteracy and not forced this woman to identify herself by taking more time in the meeting to read the consent forms aloud.

It is likely that some women felt included at other levels of involvement in WOAW – the Project Team meetings, their subgroups, the research interviews – or through other community involvements. As a group with identified values and goals, the Research Team catered to a specific group of women and met their particular needs. Groups develop their identity around the individuals who participate, and have adherents who benefit through their involvement and women who feel little affiliation or belonging.

Participation: Work and Conflict

There were two aspects of the Research Team – the "research" component and the "work of action towards social change" component. Drawing back to Herbert's (1996) seven C's, rather than being fully collaborative, the women *cooperated* with the research component of the Research Team. I wrote the research and interview questions, conducted the data collection and the majority of the analysis, and wrote the dissertation; in that vein the women were not "co-researchers" who participated equally. However, as participants on the Research Team, the women *collaborated* with working towards social change. Together we identified the work to be done and strategies for doing the work. Despite the women's collaboration they struggled with different levels of participation, attendance issues, and conflict over getting work done. The following analysis is based on the women's attempts at working collaboratively on the Research Team.

Workers and Non-Workers

At the fifth Research Team meeting (June 29, 2000) the women determined that they should start working collaboratively to pursue desired social changes. This decision arose from lengthy discussions around shared barriers and constraints they encountered as poor women. Through discussing their common problems the women decided that as the Research Team they were in a position to collectively challenge the system and improve their lives. They identified two major "actions": registering WOAW as a not-for-profit society and organizing a welfare grievances workshop. (These actions are further discussed in the next section; in this section I examine issues around group process and conflict). At this time there was a striking shift from sharing, problem-solving, and networking to discussions of work. The women no longer considered their ideas and brainstorming to be enough; the Research Team had transformed into a place of work "we can effectuate the work better being in the Research Team than if we were in another

[WOAW] group" (Katharine, RTM October 19, 2000).

As the Research Team evolved into a place of work, issues around workers and non-workers arose. In Hall's (1981) reflections on participatory research, he suggested that a key methodological issue remains with the problem of how "collective" a PR process may be, given internal power relations within communities and workplace groups and the degree of new learning that individuals within a group must engage in (Hall, 1981). At the Research Team, the questions "what is our work?", "how to get work done?", "who should do what work?", and "who benefits from the work that we do?" were discussed at length. Generally the women were divided in addressing these questions. Some women felt that the work of the Research Team was for both themselves and women in the community, while others felt that only the women who did the work should benefit from it. The regular Research Team attendees spoke of themselves as workers and leaders and being committed and dedicated to the goals of the Research Team. They suggested that women who were not attending and not working lacked commitment and dedication. On the other hand, other women felt that different levels of participation and work were inevitable: "the labour and the work falls on very few shoulders. And we agreed it's unavoidable. I think that we are here, we are ready to give our time to learn" (Katharine, RTM October 19, 2000). Susan suggested that the unequal levels of participation and work reflected the different barriers that the WOAW members and women in the community encountered:

> We're all here for different reasons. Some of us are here to be totally involved. And others aren't. They're here just to be out of the house, just to be here. Some of them don't make it from the major groups even to the Project Team meeting (Susan, RTM October 19, 2000).

Despite the above comments there was limited tolerance for different levels of participation and attendance. With inconsistent participation and variable attendance some women felt that their work was not progressing as it should. Often, poor attendance was a reason for not doing certain tasks or for deferring decisions to the next Research Team. "See it's hard with half the

group missing. How do you make these decisions with half the group missing? How do you do it?" (Kelly, RTM September 27, 2000). At other times, women who had taken on a job from the previous meeting and who were subsequently absent prevented the group from doing the work at hand because the information they had agreed to gather was missing. Deferring or not doing work added to some women's feeling that little was accomplished at the Research Team meetings:

> I walk away from these meetings and we never really got a lot accomplished. We just do a lot of talking and eat a lot of muffins and grape juice and it seems like not a lot gets accomplished, you know. It's frustrating. We should nail some things down (Kelly, RTM October 19, 2000).

In contrast to the earlier Research Team meetings where the women shared stories, problem-solved and networked, in the fall of 2000 the women felt they had work to do and were frustrated with their slow progress towards reaching their collective goals. Yet the Research Team held unrealistic expectations of itself. Most of the women faced significant barriers to consistently meet and do work. Many of the older women had health problems that inhibited their involvement "my health is not very good, some days and I can't do things" (Lesley, RTM September 27, 2000). The younger women had children, little family or social support, and typically had unpredictable lives including sick children, transportation or childcare constraints, fear of having their children apprehended, and government pressure to find paid employment. Willow commented "I'm having a hard time getting out with two little ones who are running around, running around, running around. And I can't sit in a library; I can't go" (Willow, RTM September 27, 2000). All of the women lived on limited incomes, and most faced the relentless scrutiny of the B.C. Benefits authorities who surveyed their lives. Given the women's unrelenting daily realities at times I was amazed that they harnessed the energy to meet as a group (Colleen's fieldnotes, August 17, 2000).

There is significant PR and FAR literature on issues of participation between the researcher

and the researched. Regehr (2000) explained how differing views regarding the level of participation expected can result in feelings of resentment towards researchers and backlash from groups that they intended to assist (Regehr, 2000). Yet very little is written in the FAR literature about issues of participation that may arise between the researched. The women struggled with different levels of participation among members of the Research Team. Although many of them had at one time been socially isolated and excluded, some women did not value different levels of participation and felt that all Research Team members should participate equally despite their day-to-day constraints.[5]

Structuring Work

The need for structure, deadlines, organization, and rules emerged as the women strove to do the work of the Research Team. The group felt that their lack of structure prevented them from accomplishing things at the Research Team meetings. "I think that structure would be good. 'Cause I think that sometimes when we don't have structure, nothing happens. I think structure is a plus" (Katharine, RTM September 27, 2000). I pressed the group to explain what they meant by "structure." They responded "a system," "rules," "deadlines," "consequences for not doing one's work," "a format," "taking minutes," and "having jobs, lists, and handouts." As the women became increasingly frustrated with the slow progress of the Research Team's work, they identified structure as something they could control. At one point Alexa became visibly upset with the Research Team's lack of structure.

> I see that we need structure. We need rules. We need people who when they say something, they do it because [otherwise] nothing is going to get done. I've seen groups that we've joined that "oh, I'll do that" and two months later we haven't done anything because that person hasn't done the work. They went back on their word. There's no deadline. If there is no deadline, things are not going to get done. And that's important. I'm a person; I need rules; I need structure. It's the only way I work and I just get so mad at people who don't see it that way. We're just not getting anywhere and it makes me angry (Alexa, RTM October 19, 2000).

The women felt that if they did not do the work they had set out to do and force work to get done by imposing deadlines, their time at the Research Team was wasted. "You need deadlines. That's not to say we don't have deadlines, but nothing gets done. And, you know, it feels like a waste of time if we don't do what we say we're going to do" (Alexa, RTM October 19, 2000). As Kelly reviewed a handout I had distributed the previous meeting on organizing a workshop, she said:

> See this is what I mean by structure. You have a list here that tells you. This is what you need to do in order to have a successful workshop. This is exactly what I mean by structure (Kelly, RTM October 19, 2000).

At various times I attempted to provide some structure for the group by distributing handouts, suggesting agenda items, and summarizing the main discussion topics and "action items" at the beginning of each meeting. I realized, however, that what the women referred to as "structure" was a sense of their group togetherness, making collective decisions, and people doing what they said they would do. "Structure" needed to be determined and adhered to by the group. My attempts at providing external structure had not translated into the women's sense of structure at the Research Team meetings. At times the women blamed their lack of structure for the slow pace of their work rather than acknowledging the more significant barriers many of them faced (Colleen's fieldnotes, September 27, 2000).

Symbols of Work

The women's need for structure reflected traditional approaches to organizing and doing work. They conceptualized their work within a capitalist system in terms of time frames, notions of productivity, and work styles. There were also outward symbols of work. Many of the women had acquired daytimers and business cards, and at several WOAW meetings they requested old filing cabinets, folders, and binders. Over the course of the SSHRC research project 4 women procured computers through friends or family, and as I managed the budget for the SSHRC

project I often reimbursed the women for office supplies. As well, some women kept notes of the meetings; possibly, keeping notes provided a sense of "doing work" at the meeting and feeling productive. As the women felt that they had the work of the Research Team to do, they increasingly acquired things to symbolize their work.

Eroding Group Process and Conflict

With the impetus for doing work and the consequent frustrations at the unequal levels of participation, lack of structure, and slow pace of work, the Research Team's group process dissolved. The women no longer felt that they were working together as a group and conflict arose at several of the meetings in the fall of 2000. Some women felt "let down" by other members of the group.

> Colleen: Do you feel that there is a commitment from the group?
> Katharine: I feel sometimes that the commitment is psst, out the window.
> Alexa: Yeah, I'm getting to the point where I'm getting so frustrated with people who say they're going to do things and it doesn't get done. Especially when I put in my hours.... I'm frustrated with my group. It's not just the newsletter, it's everything. I just hate when people say they're going to do something and they don't do it (RTM September 27, 2000).

The women suggested that they had not been working together and that this prevented them from achieving their goals as the Research Team. When the women spoke of their work, there was a sense of urgency and defeat. "If we want to be a non-profit group we are going to have to learn to work together. If we can't do little things, how are we going to learn to do big things?" (Alexa, RTM September 27, 2000).

The women had different reactions to the Research Team's conflict. Some recognized that it was an inevitable outcome of working in a group and did not appear to dwell on it. After an emotional disagreement, two women said:

> Willow: Is everyone ok? (laughs)
> Katharine: Are we surviving here or what? Life is a bunch of frustrations (RTM August 17, 2000).

Others' reaction to conflict was to temporarily retreat from all levels of WOAW including the Research Team or to threaten to quit WOAW.[6] Conflict was not embraced by all of the women – at one point a woman commented on the phone to me that "I don't need to deal with the stress [of the conflict], I have enough other things to deal with" (Colleen's fieldnotes September 20, 2000). Just as the women responded differently to conflict, they also had varying influences upon the group's energy. In the fall of 2000 two Research Team members who had adopted major problem-solving and networking roles were absent for many of the meetings for health reasons. Possibly, their absence may have affected the Research Team's dynamics.

When the Research Team was riddled with conflict, I received many phone calls from the women about the nature and extent of the conflict. Although there were only three instances in the Research Team meetings that I identified as conflict, the phone conversations alerted me to many more conflicts that existed between the women "there are always undercurrents, things I don't catch, that are happening. Often there are different antagonisms between the women at the meetings" (Colleen's fieldnotes September 29, 2000). In fact, I heard about nine different conflicts between August and October 2000 from phone calls, and am certain that some were undisclosed. In many cases, blame and distrust for not doing the work of the subgroups, the Project Team, or the Research Team was the source of conflict.

Participation, Work, and Feminist Action Research

In the beginning the women valued the sharing, learning, and networking of the Research Team. Though many of the women faced extreme barriers, once the Research Team embarked on their work there was little validation for these barriers. What began to dominate the meetings was the pressing need to *have* work and to *do* work. Structure, working together, and having the necessary work items were then seen as important for progressing with the work of the Research

Team (Colleen's fieldnotes August 17, 2000).

The increasing need to have and do work can be considered in several ways. The women's participation on the Research Team was indeed "work." As Katharine said "the Research Team gives us power, and it's our work" (Katharine, RTM August 17, 2000). Work is defined as "a purposive activity directed toward meeting physical and social needs satisfying to those who either produce or consume goods and services" (Nash, 1981, p.3; cited in Tom, 1993). Meeting regularly, taking notes, networking, and organizing a community workshop are all work activities. Yet despite the women's work, in mainstream society they remained undervalued non-workers because their work was not recognized in the formal economy.

In Western capitalism, particular forms of work and independence are legitimized while other forms of work and dependence are de-legitimized. As explored in the previous chapter, the women, by virtue of their inability to do paid work and their consequent dependency, had been systematically de-legitimized. The Research Team as "work" validated them because they *had* and *did* work. Yet, although they were systematically invalidated by the mainstream system of work, the women's conceptualization and approach to work reflected that very system. They attempted to impose a system, a structure, and deadlines, while the demands of their daily lives conflicted with their ability to conform to the very structure, system, and deadlines they desired and self-imposed. The women found meaning in the Research Team's work but had difficulties finding an approach to their work that considered their personal barriers.

Not only did the women identify with the work of the Research Team, but the notion of "work" is central within FAR as both something to get done and a moral-evaluative term. On one level collective actions and social change are the desired outcomes of FAR and inherently require the work of those involved. Feminist action researchers judge the success of FAR by whether work is generated. Yet on another level, feminist action researchers presume that the

disenfranchised, who are usually the participants in FAR projects, will *want* to do work *because* they have no legitimacy. On both levels I subscribed to the need and desire for work – both as something that would mark the success of my dissertation, and my assumption that the women would want to engage in collective action. I strove to provide structure and work tasks for the Research Team and shared their need to have and do work. Since it was difficult for some women to attend the meetings, we collectively believed that we should be productive and not waste our time. At the same time I was interested in how the experience of being excluded and de-legitimized affected women's health. I was critical of the social structures that perpetuated such de-legitimation, while expecting that my participants would want to change their lives to become more legitimate. I assumed that living in poverty was bad and that they would want to work towards a better life.

In spite of these difficulties, engaging in the work of feminist action research can be meaningful and important for isolated and poor women. The challenge remains for feminist action researchers to check the assumptions they bring to their research, and for groups to work in a way that values different levels of participation and truly respects poor women's day-to-day barriers.

Individual and Collective Actions Towards Social Change

Calls for action and change are familiar to feminist action researchers. From the beginning of my involvement with the Research Team, however, I questioned FAR notions of action and social change. Action was an integral part of every Research Team meeting because it was a part of each woman's day-to-day survival. The women's lives were all about action – action to negotiate the welfare system, to break cycles of social isolation, to fight depression, to provide for their children. By being engaged in managing and negotiating their worlds, the women were active; action did not start with the beginning of this FAR project. Feminist action researchers

232

falsely presume that action begins once women meet and share their experiences. "PR provides a means for people to regain their ability to think for themselves and to innovate, as well as to remember their history and to revive their culture for the re-creation of the authentic life" (Park, 1993, p.17). I felt that it was important to acknowledge and value the women's individual actions both prior to, during, and after our FAR project, and to recognize that the work of the Research Team members, regardless of the outcome, was action.

On the other hand, as raised in chapter 2, the notion of social change remains ambiguous. While individual and collective actions could be seen and to some degree measured, social change was elusive and remained only an implicit Research Team ideal. In this section I discuss individual and collective actions and the ways that the actions taken by the Research Team members could lead to social change.

The Women: Individual Actions

The women were not passive and inactive before their involvement with WOAW or the Research Team. Reinharz (1983) wrote about women's assertiveness and the ubiquity of women's activism. She challenged the stereotype of female passivity in an effort to counter-balance the research focus on women's oppression (Reinharz, 1983). However much they may be victimized by the social construction of their reality, people nonetheless exist as thinking, feeling, social agents, capable of resistance and innovations (Weedon, 1987). Prior to their involvement with WOAW or the Research Team the women engaged in action that can be characterized as individual strategies to enhance the quality of their day-to-day lives. For instance, the women shared strategies for negotiating the welfare system. Susan explained what she had learned to do:

> The front person is usually the right person to talk to, that's the one who gets you all the information. She knows everything, I've got more done by dealing with the person just there, sitting at the desk (Susan, RTM August 18, 2000).

The women also spoke of using the library for information and going to the law courts and phoning their MPs (members of parliament) for information about welfare. As well, much of what the women said about their health in terms of stress, depression, and low self-esteem was couched in what they attempted to do about it. Many of the women consistently worked at managing their health problems. Katharine said

> I've done everything, good and bad. I've been depressed and just like I can't take a day even if it's sunny and beautiful, I just don't bloody care today and I go to bed and sleep the whole day. And another day I went and spent a little money on ice cream or whatever I needed. Another day I went and walk and walk and walked so far that I was exhausted to come back. And another day I had to call a friend and joke and laugh. You do it all. It just depends on the degree of your depression, the degree of need (Katharine's interview, March 14, 2000).

The women also shared individual actions for combating social isolation including finding female friends or a "buddy" for company or to help with childminding, developing a "family," using the phone to connect with others, and forcing oneself to leave the house. At a Research Team meeting two women exchanged ideas:

> Katharine: Do something or go somewhere.
> Gloria: Yeah, you have to do something, you can't just sit at home and woe is me, and wallow.
> Katharine: It's the strength to go out though. It's the strength to stop the isolation.
> Gloria: But sometimes you just have to, you just have to give yourself enough strength to get dressed, get out of that bed, get off the couch, and go out, and walk around the block (RTM April 26, 2000).

From the beginning the women shared, networked, and problem-solved for one another. There were few conversations that passed without suggestions for handling an issue or barrier. Much of the problem-solving and networking was based on experiences of individual actions and suggestions for what had and had not worked for them personally. While it is difficult to adequately capture the full range and extent of the women's individual actions, I attempted to track them in the first 4 months of the Research Team meetings; they appear in Table 19.

Table 19 – Examples of Individual Actions and Problem-Solving

Problem	Suggested Actions or Recommendations
Access to childcare	• Find a buddy and watch children for each other • Pair-up with a Aged to Perfection member who does not have grandchildren • Get a doctor's note asking for respite
Discrimination from the welfare office	• Phone your MP and report the problem • Write a letter (keep a copy) to your welfare office • Ask for policies in writing • Find out your rights • Invite welfare advocate and manager from Social Services for a panel with the Research Team • Get information at law courts
Lack of information on welfare rights	• Get information from the library and the law courts
Wanting a better life	• Commit to change • Take an initiative • Form a book club to learn about options and ideas
Wanting to find work	• Build and connect with people, networking, making jobs • Finding a way to take care of your own needs and working as well • Being self-employed • Have a plan of action; have a passion for what you're doing; • Finding information from Van City re. helping women set up a home business
Few activities for children	• Triple A • YMCA camps • Brownies, Guides, Scouts • Call local sports organizations; tell them you need financial help • Outdoor symphony by donation
Needing help with income taxes	• Two women offered to help others to complete their income tax forms.

Note: These data represent individual actions I witnessed and heard articulated by Research Team members between March and June, 2000.

The Research Team: Collective Actions

The Research Team did indeed begin the cycle of collective action. FAR can be viewed as a political resource to be used as ammunition in challenging and pressuring various institutions including governments, businesses, universities, and community organizations to support changes that will benefit a broader segment of the community (Nyden and Wiewel, 1992). FAR is oriented towards improving unsatisfactory situations and is meant to overcome the passiveness of the research process by turning research itself into a transformative activity.

The women identified collective actions over the course of the Research Team meetings. At one meeting (June 7, 2000) the women divided into four groups and collectively wrote their

vision of the Research Team.

> Group 1 – To grow and come together with other women, to empower each other, active health for everyone, that we have something to look forward to with the activities that each of the groups are doing. And to feel better about ourselves and that we're getting out in the community.

> Group 2 - To continue brainstorming, and doing political wrangling to solve the problems. Learn how to proceed and learn how to flex our muscles to do it in a way that works.

> Group 3 - That we'll spread, that we'll help change attitudes, to continue to grow and keep doing activities, letting the world know that just because we're on fixed incomes, we're members of the community. Taking our rights back from the government and gaining knowledge of how the system works.

> Group 4 - To make a difference to better direct the community services for all women so we can help the community services work better for us and our children. We'd like to register as a non-profit organization and then take on women's issues in the tri-city and beyond.

At this time the women also listed their "desired actions" for the Research Team. They included: organizing a welfare grievances workshop; registering WOAW as a non-profit society; forming a transit committee to deal with transit problems; determining strategies for handling and paying for childminding; exploring possibilities for having a welfare advocate in their community; increasing WOAW's visibility in the community; writing a resource book for women on low income; and getting information about starting a home business. As previously mentioned, at the following meeting (June 29, 2000) the women agreed to focus on registering WOAW as a non-profit society and organizing a welfare grievances workshop as the two major "actions" of the Research Team.

Individual and collective actions were raised at all levels of WOAW, in fact, action was discussed in every meeting. It was therefore important to portray the nature and extent of the actions I witnessed in the first year of the Research Team. The women were not passive receptacles of expert advice and action, they themselves were actors at all levels of WOAW. The collective actions I witnessed through the lens of my involvement with the Research Team

appear in Table 20.

Table 20 – Examples of WOAW and Research Team Collective Actions

Type of Action	Description and Examples	Representative Quotes
Organizing subgroup activities and workshops Discussed at the Research Team; discussed and enacted by the subgroups and Project Team.	All subgroups organized regular activities and workshops for WOAW members and occasionally for women in the local communities, for example stress management, home business, self-esteem, and safety workshops; yoga; tai chi; belly dancing; qi gong; self-defense; weight training; aerobics; swimming; and "Cook to win" classes.	I'm making Hyde Creek [recreation centre] my baby. So, I'm doing that work there (Kelly's interview, March 14, 2000). My top priority is having accessible recreation. I'm getting that right now through WOAW for the most part. I'm pretty busy now. My days are filled up by my regular life and then in the evenings there's a lot of WOAW activities during the week. And that's nice to have. I'm not just sitting at home all the time (Virginia Dawn's interview, June 6, 2000).
Advertising for WOAW Discussed at the Research Team; discussed and enacted by the subgroups.	Two groups regularly submitted free advertisements for their WOAW subgroup to increase the number of participants and to raise WOAW's profile through articles in the local papers.	Wednesdays and Saturdays is the paper, and every time we should have WOAW activity... I'd like to see an article in this local paper. And I'd like somebody to write and do that. It would come maybe every second month cause it takes time to get the ladies to write (Katharine's interview March 14, 2000).
Fundraising for WOAW Discussed at the Research Team; discussed and enacted by the subgroups.	Three of the groups engaged in fundraising to cover expenses that were not covered by the SSHRC research grant. One subgroup opened a bank account to manage money raised through fundraising.	We've been pretty busy 'cause our fundraiser is coming up on Saturday. Everyone come to Save on Foods for a hot dog on Saturday. We're doing a fundraiser. We're scared. We're really hoping it works (Kelly, RTM October 19, 2000).
Writing a resource book for women on low income Discussed and enacted by the Research Team and the subgroups.	An UBC student was hired by the ATP subgroup to compile a Resource Book with all community services in the Tri-City Area for WOAW members.	One of the things I'm going to get Amanda to do is pick your brain. I want her to make a pamphlet. She phoned me and she's thinking that she needs to do something to get started. And she wants to put together a booklet of some kind with all the resources that are available (Wanda's interview, June 5, 2000).
Forming a transit committee Discussed by the Research Team.	A small group of women from the Research Team formed the Transit committee and had a meeting with the local transit company. The committee met only once.	They brought someone in [from transit] to talk, but they've done nothing. Like we've got to go after it because that's what's affecting our lives most. You can't get from point A to point B. And we've had one incident when a baby was crying and the mother was kicked off the bus (Rene, RTM June 7, 2000).

237

Table 20 – Continued

Type of Action	Description and Examples	Representative Quotes
Involvement with other community groups or individuals Discussed and enacted by all levels of WOAW	Some Research Team members networked with other groups in the community to learn and make connections. Examples included: • Liaising with Cabbie school for single mothers; • Forming an English speaking group for recent immigrant women; • Forming a quilting group for women on low income; • Working with Cottonwood community development project; • Working with seniors' housing project; • Advocating for WOAW in different communities, including Burnaby, Surrey, and North Vancouver.	I'm on the committee, and I tried to go about the community to set that up myself, and then seeing if there's any interest in the community to attend (Cynthia's interview, April 12, 2000). 'Cause if we get WOAW in the parade... We could have a banner or something, saying "We're here." That will help. 'Cause other companies will see and stuff... I'm hopeful (Julie's interview, March 14, 2000).
Involvement in community politics as a WOAW member. Discussed and enacted by all levels of WOAW	Different Research Team and WOAW members were involved in lobbying local politicians at community forums, marches, demonstrations, and community meetings.	The people from Leisure were at the table and they were listening very carefully to what I had to say about how the single moms need a break and they have to have something in order to charge their batteries and know that their kids are safe during that time. And so, there's an ear there. And I've got the names down if you want them. Maybe we can invite them here (Rene, RTM June 7, 2000).
Registering WOAW as a non-profit society Discussed primarily at the Research Team, raised at the Project Team.	Registering as a non-profit society was one of the two goals of the Research Team in the fall 2000. It was discussed at several meetings and information was brought to the group to review.	I have been calling everywhere and will be getting what I promised I would. It's just the time... getting copies of by-laws and constitutions and stuff like that. What I can do hopefully is get a few for the next meeting, and find out if somebody wants to come here (Katharine, RTM October 19, 2000).
Organizing a Welfare grievances Workshop Discussed and enacted by the Research Team.	Organizing a welfare grievances workshop was the second major goal of the Research Team in 2000. It became the groups' primary goal in 2001, and contacts were made with other poverty activist groups including End Legislated Poverty (ELP) and Downtown Eastside Residents' Association (DERA).	I think we have to sit down and write down what our concerns, gear down to exactly the questions we want answers (Susan, RTM August 17, 2000). I am curious about the first point, working on welfare grievances and solutions, and we would like to have somebody come in and talk, maybe a district supervisor (Willow, RTM August 17, 2000).

Note: These data represent collective actions I witnessed in WOAW and the Research Team between March and December, 2000. Some actions that occurred may not be represented in this table.

Powerfulness and Powerlessness in the Work of Collective Action

As the work of collective action emerged as a central task of the Research Team, emotions and energy fluctuated and feelings of both powerfulness and powerlessness emerged. At times the women suggested that as a group they had the power to intimidate, challenge the system, and make changes for themselves and for other women in poverty. At other times, and particularly when we were struggling with work and conflict in the fall of 2000, some women expressed their own frustration and powerlessness.

At various times the women spoke of their interest in collective action towards social change. Over time the women recognized their own knowledge and realized that they could help one another. "Networking is one of the biggest things I've seen. And it's interesting because we don't have the community partners there... they couldn't help us with a lot of problems that we have" (Susan's interview, June 2, 2000). Susan suggested that alone the women would help each other and did not need the help of "expert" others. Others felt that they or other women were strong and leaders, and that if given the opportunity women could be important agents of change. "If they would take some woman from the poverty level, one that's had a little bit of smarts and I don't even mean education, and put her in the prime minister's chair, she'd probably run the country a whole lot better" (Wanda's interview, June 5, 2000). Talk of being powerful and instigating change generated high energy and enthusiasm at the Research Team meetings. At one meeting Katharine said "we have the power to make waves," and Rene added "or lightning" (Beth's fieldnotes, June 7, 2000).

Despite comments about challenging the system and women's strength and leadership, at other times some women suggested that they were powerless individually and needed others' help. At one meeting, two frustrated women felt that they needed "expert" help.

Kelly: We're getting paper-logged. Like I have...

Susan:	That's what I'm saying.
Kelly:	We really need someone to come in and talk to us about all this.
Susan:	Oh absolutely.
Kelly:	"Let me hold your hand and guide you right to the end" (RTM October 19, 2000).

As previously discussed the women were active in their day-to-day lives and shared their knowledge and problem-solved for each other in all of the Research Team meetings. Yet the broader goals of collective action towards social change, as espoused by many feminist action researchers, were more elusive. According to hooks (1984)

> Feminism in the United States has never emerged from the women who are most victimized by sexist oppression; women who are daily beaten down, mentally, physically, and spiritually – women who are powerless to change their condition in life. They are the silent majority. A mark of their victimization is that they accept their lot in life without visible question, without organized protest, without collective anger or rage (hooks, 1984, p.1).

At times the women on the Research Team felt powerless and victimized. Yet the "mark" of their victimization was not a total acceptance of it as hooks (1984) states above, but an ambivalence and passivity in enacting the Research Team's collective actions. Some women were tentative in engaging in collective actions. The Research Team identified collective actions yet had difficulty completing the work. Unequal levels of participation, uncommitted and undedicated members, a lack of structure, and inconsistent attendance were cited as reasons for the slow work pace. However, the women were reticent about the work; they deferred to their subgroups or to experts outside of the Research Team and felt that they could not do the work alone. Despite their frustrations over the Research Team's work and their sense of powerlessness, they did not retreat from the meetings but continued to schedule and attend them.

When the women were stalled by the challenges of their work, often one would suggest having someone come to the Research Team to provide information, a workshop, or guidance. Alone they felt unable to do the work they wanted to accomplish. "To have people who are

knowledgeable and can help us 'cause we can make recommendations but they are just like air" (Katharine, RTM June 7, 2000). The women's hesitancy in doing the work of collective action reflected their feelings of lack of control and powerlessness. For a group of stigmatized women to engage in collective action and to feel empowered to challenge the system contradicts the messages they have systematically received as welfare recipients – that welfare recipients are unmotivated, reprehensible, and contemptible. Kelly confirmed the need to have outside help "I'd like to have Louise there, right? Because we don't have that power without Louise, or Colleen, or Wendy with us. We're just welfare bums" (Kelly, RTM June 29, 2000).

Not only is it difficult and at times unlikely for disenfranchised populations to feel powerful about acting collectively, but participation in any action research endeavour may also carry risks for participants. Many feminist action researchers assume a co-operative context where all members have sufficient security to act publicly (Regehr, 2000). However, Razavi explains possible risks in engaging in collective action:

> In these circumstances it is not just difficult, but also dangerous, for individual women, isolated within their families, often cut off from the communities in which they grew up, to challenge the social norms that define them as lesser beings. Collective action in the public arena makes the project of social transformation an act of solidarity rather than individual self interest and is therefore likely to be effective in the long run – but the interlinkages between collective action and transformations at the individual level are complex, diffuse, and unpredictable (Razavi, 1998, p.15).

At several Research Team discussions women raised concerns about organizing a welfare grievances workshop and the risk of their welfare worker finding out about their involvement or, worse, attending the workshop. The institution that controlled the women's lives, the welfare system, does not support collective action. In fact, this system relies on the inactivity and passivity of welfare recipients. The women could be further stigmatized or penalized because they challenged the system and could be seen as wanting more or dissatisfied with the "charity" they were receiving as recipients. Feminist action researchers underestimate research

participants' feelings of powerlessness in the work of acting collectively towards social change. The Research Team members thrived in the early stages of brainstorming, discussing common barriers and concerns, and networking. Though the women articulated their desire for collective action, they did not smoothly transition into it. In fact, as soon as collective action was the focus of the work, conflict arose.

Some feminist action researchers portray the transition from consciousness raising to action as smooth and linear. Shiell and Hawe (1996) neatly describe "outcome measures" from action-oriented research. Projects that have an action component generally have as their intermediate outcome measures changes in structures, policies, decision-making processes, organizational processes and inter-relationships, and changes in the community environment. Evaluations paint a portrait of a community better able to deal with common issues with the procurement of more external resources, the creation of an improved physical environment, an improvement in community cohesion, and the sense that the community is a better place to live in (Shiell and Hawe, 1996). Given the ideals portrayed by Shiell and Hawe (1996), Maguire (1987) writes that

> The temptation is to dismiss or underestimate our efforts because they do not appear long term, transformational, radical, or important enough. The challenge is to celebrate our collective accomplishments, however small, and nurture ourselves as we move, however slowly and imperceptibly, in the direction of change for social justice (Maguire, 1987, p.199).

Yet it is not only about resisting the temptation to dismiss our FAR efforts, but also about realistically portraying the messiness, uncertainty, and riskiness of the work of collective action. Collective action is not an inevitable outcome nor is it necessarily a benefit for all involved. Summoning a sense of powerfulness despite constant messages to the contrary and instigating collective action was a messy process riddled with conflict that did not flow easily from the initial sharing and togetherness of the Research Team. Though collective action was desired by all of the women, some engaged in it while others were reticent, tentative, and uncertain about

the challenges and repercussions of their participation. Nonetheless the women were actors in their day-to-day lives and in their efforts to "work" as the Research Team— finding childcare for their children, sharing strategies for managing depression, attending Research Team meetings, deferring to the authority of others, or initiating the work of collective action.

The Onus for Action

The full range of "acting" – turning silence into language (Lorde, 1984) or organizing a welfare grievances workshop – can be an intimidating process for many people. The FAR rhetoric that places the onus for initiating change on marginalized populations requires revisiting. In this case a group of poor women on welfare was expected to identify and enact collective actions. It is dangerous and wrong, however, to view women on low income as being the sole actors and having the answers to the embedded problems of poverty and health. Sites of individual action can remain "so fundamentally isolated, so severed from social movements and a broader critique, so safe and disciplined (Foucault, 1985) as to secure, that is to reinforce, the very systems of oppression which have organized the work, streets, schools, and homes of these women" (Fine and Weis, 1998, p.254-5). Relying on the most marginalized to do the work of social justice can serve to further stigmatize and isolate them, and without material resources action and social change are unreachable.

As the feminist action researcher I too was responsible for identifying and working towards individual and collective actions. I organized room bookings, childminding, and transportation, drove some women to meetings, facilitated meetings, provided resources to inform the Research Team's work, and called women between meetings after conflict had arisen. I was constantly uncertain about my involvement and reflected on it in my fieldnotes. I had to learn to exercise my power legitimately in the service of what the Research Team members wanted to accomplish while respecting their need and desire to be actors themselves. I also recognized the importance

243

of questioning who held power (Wallerstein, 1999), and remembering that participation without the redistribution of power is an empty and frustrating process for the powerless (Whitemore and Kerans, 1988).

Through my involvement with the Research Team, I recognized that the rhetoric of feminist action research presumes that women on low income will personally and collectively transform themselves and society. Ironically, there are few expectations on middle- or upper-income populations to become individually or collectively transformed (Colleen's fieldnotes, September 6, 2000). I often experienced this disparity as I drove home from Research Team meetings, contemplated the challenges many of the women faced in doing the work of collective action, and realized how my privilege enabled me to easily do my work with the Research Team. Through witnessing the fundamental inequities between myself and the women, I came to terms with different kinds of action based on one's social, economic, and political position. Although I was accountable to the women for taking part in the Research Team's collective actions, I also felt responsible for taking individual actions that were consistent with the social changes identified by the Research Team. For instance, I saw the implications of my day-to-day actions and connected my privilege with the inequities the women experienced. How I shopped, where I lived, and who I spent time with were directly related to and perpetuated by my privilege. In a sense, I was privileged *because* the women were not. Through my personal realizations I learned that research concerned with social change should focus just as much on the rich and powerful as those on the margins (Regehr, 2000). As Williamson said, emancipatory social research calls for empowering approaches where both researcher and researched become the changer and the changed (Cris Williamson, cited in Lather, 1991).

"The value is being together but the goal is to change the world" [7]**: Did Social Change Happen?**

The Research Team became a site for the work of collective action because it provided a sense of sharing and support among a group of socially isolated and poor women. Many women spoke of being isolated, lonely, and having little support: "I feel isolated and lonely" (Caroline's interview, April 12, 2000); they felt excluded as a consequence of living in poverty and suggested that it was important to feel included in a social group like WOAW or the Research Team.

> That's what I was going to say, it's to become a part of the community, that's something that we have had no part, if you're on welfare, you feel like you're not important, so that's very important, to feel like you're a part of something (Cynthia, RTM April 4, 2000).

The Research Team became a social group, much like feminist consciousness raising groups, that supported and fostered a common identity around sharing experiences of living in poverty. Despite the challenges of working together as the Research Team, most of the women felt positive about meeting, exploring their shared problems, and working collectively towards taking action. Kelly commented:

> I feel good about myself... since I've been involved with the WOAW group, I know my self-esteem has gone up. I feel pretty important in the group. I feel like I'm an asset to the group (Kelly's interview, March 14, 2000).

According to Reinharz (1983), consciousness raising group discussions can enhance personal clarification and the willingness to take risks, and groups that focus around particular issues or life changes enable women to convert their previously perceived problems into a new avenue of competence (Reinharz, 1983).

The women's efforts at finding a sense of legitimacy and power through negotiating their identities, as explored in chapter 6, were important in the work of collective action. Moments of contested stigmas and rebuked dominant discourses provided the women with a sense of possibility for working in a group and engaging in collective action. What remains uncertain,

however, is whether the Research Team achieved social change. Despite the implicit assumption of all Research Team members (including myself) that we worked towards social change, it is important to examine the ways that the Research Team fell short of such a lofty goal. In this regard, Nancy Fraser's (1997) notion of a "subaltern counterpublic" is useful for theorizing the challenges and possibilities of enacting social change among a group of marginalized women.

According to Fraser (1997), members of subordinated groups, many of whom are socially isolated and excluded, have no arenas for deliberating among themselves about their needs, objectives, and strategies. They are less likely than others to "find the right voice or words to express their thoughts," and more likely than otherwise to "keep their wants inchoate" (p.81). Fraser argues that it is possible for members of subordinated groups to create subaltern counterpublics in order to form discursive arenas where they can invent and circulate counter-discourses. The development of counter-discourses permits marginalized groups to formulate oppositional interpretations of their identities, interests, and needs. Subaltern counterpublics have a dual character – they function as spaces of withdrawal and regroupment and they also function as bases and training grounds for agitational activities, such as social activism directed toward wider publics. The theory of counterpublics enables us to look at the empowering dimensions of discursive struggles and to counter the disabling assumption that women are just passive victims of male dominance, while helping us understand how even excluded women can participate in the making of a culture (Fraser, 1997). Rene's comments illustrate how she identified as having the power to not be "intimidated" and to "ask questions" while suggesting importance of social groups, like WOAW, in working towards social change.

> I'm not the type of person that's going to sit here and be intimidated. I'll ask questions. Because I learned long ago the only stupid question was the one that wasn't asked. And if you want to make a life you've got to get out there and ask the question. Welfare's not going to tell you anything about what's available for you. I've not found them helpful at all... and we really have a lack of information and getting it to the people that need it. The ones with money, they get out there and they join all this. They go on these trips

and tours and that. There's no way I can. And a lot of people don't realize there are avenues available to them like WOAW where you can do things without costing a lot of money. And that's why I think it's an idea whose time has come. Because there's a lot of people that are sitting in rooms by themselves (Rene's interview, June 5, 2000).

The dialectical nature of subaltern counterpublics has emancipatory potential through providing both spaces of withdrawal and spaces for collective action. Implicit within this is that spaces of collective action can lead to important forms of social change that are emancipatory for marginalized groups. Elizabeth's comments about the power and energy of the Research Team illustrate how supporting each other, sharing the same problems, and uncovering the "politics of poverty" can generate enthusiasm for the possibility of social change.

> In the discussion you could hear people getting pumped. And energy and the like 'yah!' Like you all get together and different things seem to be brought up and approached. And dealt with. You know you feel stronger.... And it's such a good feeling to know that you're not alone. It's happening to other people too. (pause). Powerful. Powerful comes to mind. Very powerful meetings (Elizabeth's interview June 12, 2000).

Despite extensive literature on "empowered communities" where individuals and organizations apply their skills and resources in collective efforts to meet their respective needs (Israel et al., 1994), the notion of a subaltern counterpublic better captures the dialectical process between negotiated identities and collective action, and provides a useful frame for thinking about the complexities of social groups engaged in the work of social change. Over time I saw the Research Team become a subaltern counterpublic where the women found legitimacy, recognized the systemic factors that contributed to their own poverty and health, initiated individual actions, and developed strategies for working collectively towards shared goal of social change. The women articulated a desire for social change, particularly in terms of sustaining WOAW through forming a non-profit society and redressing their discriminatory treatment within the welfare system. However, since they continued to struggle with acting collectively and neither collective action was realized, it remains difficult to know whether social change was in fact achieved. Indeed, questions remain – do individual actions and working collectively towards

social change count as social change?

Reflections From the Field

Through this chapter and chapter 3 I made references to my involvement in the Research Team as the feminist action researcher. This section, however, focuses exclusively on my role as the researcher and the emotional reactions I encountered during the research process. In this section I analyze the multifaceted roles I adopted and my struggles with working reflexively and honouring myself and my emotions throughout the research.

My Role as the Feminist Action Researcher

There is significant literature on the role of the feminist action researcher. Acker (2000) explains Banks' (1998) typology of four possible locations for the researcher. They include the "external outsider" (researcher does not belong to or join the field under study); the "external insider" (researcher leaves original field and joins or affiliates with the field under study); the "indigenous insider" (researcher belongs to the field under study and shares mainstream perspectives); and the "indigenous outsider" (researcher belongs to the field under study but is marginalized and/or takes a critical view). Acker (2000) suggests that these locations are not fixed, rather they are fluid, simultaneous, and allow researchers to shift back and forth with some degree of agency (Acker, 2000). For most of my involvement I was an "external outsider" particularly in my role as "researcher" and "facilitator." At times I moved more closely to that of "external insider" when I was a perceived as a "Research Team member" and mutually learned from the women. Despite the range of my roles, I considered myself a "friendly outsider" – one who did not share the same background as the research participants but who worked conscientiously with them, reflecting back to them in a way that was supportive rather than domineering while making evident the tacit knowledge that guided local conduct (Greenwood

and Levin, 1998).

<u>The Researcher as a "Researcher"</u>

As the researcher I initiated the Research Team in order to engage in FAR and was committed to being as honest and transparent as possible. I asked questions and initiated discussions, raised major themes from previous meetings, engaged the group in collaborative analysis, wrote fieldnotes, and transcribed the meeting tapes. I also tracked meeting attendance and major occurrences and decisions as a way of researching the group process of the Research Team. Finally, my role as the researcher involved conducting two rounds of interviews with the Research Team participants.

At the first Research Team meeting, my research role reflected that of a more traditional qualitative researcher. The women relied on me to ask questions and keep the discussion going. Afterwards Willow reflected:

> I was saying to Susan, poor Colleen had to do all the talking because nobody else knew what to say. In the explaining of what everybody, or what you wanted from us, then everybody just sort of looked to you to keep talking (Willow's interview, March 15, 2000).

After the first meeting, I still had particular questions to pose to the group but the conversation flowed easily and some questions generated over 45 minutes of discussion. Several women commented on the role of my questions in triggering "explosions." Rene commented "I believe things evolve. I think you've started something, like I said it's an explosion. And it's going to happen. It'll change as it's needed to. Because it has to. It has a life of its own now" (Rene's interview June 5, 2000). Susan said:

> I don't really remember you leading us into that conversation [about poverty and health]. You did ask certain questions and then it sort of exploded. And I knew that was a very strong interest of yours. You actually brought up several different little things, in looking in different directions. I mean that's when the emotions just flew (Susan's interview, June 2, 2000).

The above comments suggested that the questions that I asked the group about poverty and health resonated with them and initiated relevant, important, and emotional discussions. Greenwood and Levin (1998) write that the action researcher systematically discovers the unexpected and counterintuitive explanations often hidden from view by assumptions and other elements in cultural training and social systems (Greenwood and Levin, 1998). The women suggested that initiating the Research Team and asking questions about poverty and health pushed them to consider things in alternative ways, thus triggering "explosions." Throughout the Research Team meetings I reflected back to the women things I heard and asked for verification and confirmation. By setting the local situation in the context of these broader comparisons, it was possible that I assisted the women in learning more about their situation and options for the future (Greenwood and Levin, 1998).

The Researcher as a "Facilitator"

Throughout my involvement in the Research Team a major role I adopted was that of "facilitator." This role derived from my instigation of the Research Team, and from the beginning the women looked to me to facilitate the meetings. It was not always clear how my role as the "researcher" was separate or different from my role as "facilitator." Indeed, at times I facilitated the research process. Although I was consistently interested in the Research Team from a research perspective, my role as the researcher asking the women questions decreased over time while my role as the facilitator remained more constant.

I was conflicted about my role as the facilitator. In many ways it was inevitable because I instigated the Research Team. I was also aware that the women did not feel comfortable facilitating.

Colleen: Anyone want to facilitate? (silence) No one likes facilitating.
Kelly: It's probably 'cause we're not really sure how we would do it
(RTM September 27, 2000).

Many of the women did not feel that they had the necessary skills for facilitating. Though they took notes and some of them engaged with the group as a facilitator would, they did not want to openly adopt that role.[8] Yet the FAR literature suggests the increased participation of the group participants and the loosening of the role of the researcher/facilitator as a criteria of success. I was concerned with creating a reliance and felt that the Research Team meetings were an ideal place for the women to learn how to facilitate and to increase their confidence in group process.

It is possible that my outsiderness made the women to look to me to facilitate. Some women perceived that I was able to facilitate since the discussions were not emotional or personal for me. Susan commented on my role:

> Whether you just help coordinate it [Research Team] to a point and we just carry on. You're helping us get to the basic problem. And you're helping facilitate something that we needed somebody from the outside which we've never been comfortable with to facilitate. Because you're not getting anything out of it. And we're not taking anything from you. I think it's come down to we don't want to fight. We just want to know why. And the 'how comes?' (Susan's interview, June 2, 2000).

Susan's suggestion that they "took nothing" from me can be considered in a couple of ways. Despite the fact that I was working towards my Ph.D. dissertation through my involvement with the Research Team, the women considered what we gained from the Research Team to be different possibly because I was not low income and did not have the same needs as the women. As well, Susan's sense that I "got nothing" from the Research Team suggests that she and possibly others considered my involvement as purely altruistic.

Tom and Herbert (2001) write that we need to attend to the responsibility we take on when we engage in research relationships where people talk with us about experiences that hold personal pain and shame. They assert that it is our responsibility as researchers to remain open to different levels of participation to create projects and meaningful co-participation in the joint exercise of understanding and changing social inequality (Tom and Herbert, 2001). Although I

was open to different levels of participation among the women, I had predetermined notions of how my role would change over time. Instead of remaining flexible and open, I had determined that after 4 or 5 meetings we should begin sharing the facilitating role. Yet after unsuccessful attempts at co-facilitating, Tom and Herbert's (2001) call for different levels of participation resonated with me. For example, after witnessing the chaos in one woman's life, I wondered if the women's participation entailed simply getting to the meeting. "I picked her up this morning and saw the chaos of her life; I felt exhausted witnessing twenty minutes of her life. Then I drop her off and realize that's her reality" (Colleen's fieldnotes September 27, 2000). It was my responsibility to be flexible and to honour different levels of participation because of my privilege, my relative ease at attending and engaging in meetings, and my eventual earning of a Ph.D. through my involvement with the Research Team.

I struggled with my facilitation role throughout 2000, though I now realize that it was important for me to remain conflicted. The FAR literature demands that as researchers we remain concerned and uncertain about our roles and that we do not rest in unquestioning comfort. Habituating a conflicted space forced my humility and raised important questions about my role as the researcher. Possibly, my uncertainties enabled me to experience some of the discomfort that is typical in many of the women's lives.

The Researcher as a "Research Team Member"

Over time the women considered me as a member of the Research Team. This does not suggest that the differences between myself and the women diminished or were less frequently acknowledged. Yet we became more familiar with one another and at times transcended the "researcher – researched" relationship. During a check-in at one meeting, "when it came to my turn the women joked that I was a part of every subgroup, that I was their 'honorary member'" (Colleen's fieldnotes, May 15, 2000).

Since I drove women to and from the Research Team meetings and saw them at Project Team meetings, we often discussed personal things such as who they were dating, issues with their children or their families, thoughts on returning to school or employment. At times they asked me questions and I openly shared with them. In these moments when we were not reduced to a role or a label our relationships felt authentic and rewarding. At several interviews I stayed for drinks, snacks, or lunch. At times I was also invited to social gatherings within and outside of WOAW.

My wedding in July 2000 was an opportunity for us to celebrate together outside of the demands or expectations of the Research Team or WOAW. The Aged to Perfection subgroup hosted a surprise wedding shower for me and each woman made a wedding gift. As well, two of the other subgroups gave me wedding gifts. During this time I felt that I had become a group member alongside my other roles as researcher and facilitator; my involvement with the women was not bound by Research Team or WOAW meetings.

Mutual Learning

Just as the Research Team members reported a major benefit of their involvement as learning, I characterized my involvement as a time of tremendous learning. The researcher, along with the community, learns and develops through the educative process (Hall, 1981). A part of my learning entailed understanding what was involved in really hearing what the women had to say (Colleen's fieldnotes, April 26, 2000). For instance, though it was initially frustrating, I learned that some women's repetition of their stories of oppression expressed their need to be fully heard. Instead of suggesting that we had already heard the story, I learned to provide the space for women to fully share their stories. Through enabling the women to fully share their stories and asking the group for feedback or comments, over time the women felt heard. By early 2001, fewer stories were repeated.

I learned to not only better hear the women and to better understand their needs regarding the Research Team, but I also learned from the women's life experiences and wisdom. On several occasions, women reflected back to me how I engaged in the group and the ways that, in times of conflict, I did not stand my ground. In one instance, a group of women was angry about the restrictions of the SSHRC grant and complained about its inability to cover some expenses. Although I knew that it was beyond the parameters of the grant to cover this particular expense, I told the group that "I would see what I could do." I wrote about my learning from Susan in this way:

> Susan told me that I said "well, I'll see what I do." She said that I should have said "there's nothing I can do." Twice now, Susan has pointed out things that I have said that have been too accommodating or too apologetic, and it's interesting because it's helping me to learn how to be in the group, she illustrates times when I am putting myself in a position to be taken advantage of (Colleen's fieldnotes Aug. 17, 2000).

"Dialogue cannot exist without humility.... How can I dialogue if I am afraid of being displaced, the mere possibility causing me torment and weakness?" (Freire, 1996, p.71). I learned over the course of my involvement with WOAW, both in terms of what my role should be and the realities of the women's lives. My learning from the women helped me to find greater comfort with my role on the Research Team. I appreciated the women's feedback and valued and respected what I learned from them.

Confronting Reflexivity, Power, and Emotions

> I was seduced by the promise of these lofty ideals – collaboration, social change, emancipation from poverty and powerlessness. But what is really being asked of the researcher, the researched, and the research process? And when such massive expectations are unmet, who's held to blame? (Colleen's journal, October 1998).

Feminist action research opens the conditions for knowledge creation to scrutiny, attempts to unsettle and equalize power relations between researchers and participants, wrestles with dilemmas of representation and interpretation, and experiments with polyvocal research

accounts (Maguire, 2001). Through questioning our power and positions in the research process, feminist action researchers are placed at the edges between public knowledge and private lived experiences. This "liminal" position not only applies to the research process and product but also concerns me personally in my own lived experiences. As researchers we embody and directly experience the dilemma of seeking knowledge and understanding on these edges (Edwards and Ribbens, 1998). Fine (1994) refers to the liminal position as the "hyphen." When we opt to engage in social struggles with those who have been exploited and subjugated we work the hyphen, revealing more about ourselves, and far more about the structures of othering. By working the hyphen, researchers probe how we are in relation with the contexts we study and with our informants, understanding that we are all multiple in those relations (Fine, 1994).

Working the hyphen demands heightened awareness and reflexivity on the part of the feminist action researcher. Just as we research others we must research and question ourselves and understand our relative power and privilege in all stages of the research process (Reid, 2000). Consciously working reflexively avoids producing more alienated knowledge that leaves no trace of the conditions of its production or the social conditions from which it arose (Maguire, 2001). Through working reflexively feminist action researchers critically analyze their own power and attempt to use it responsibly to bring both material and discursive perspectives to questions of power (Ristock and Pennell, 1996). Yet recognizing the complexity of power and the multitude of ways that it can be expressed is an ongoing challenge for feminist action researchers.

Feminist calls for greater reflexivity and awareness of the power and control of the researcher have truly transformed research relationships and have spurred important advances such as FAR. Yet the process of working reflexively can be debilitating for the feminist action researcher. As with all research projects, within this project power inequities remained. As I reflected on them and felt unable to rectify them, I became increasingly apologetic. Although my

humbling uncertainty was important for my growth and learning as a researcher, I risked becoming perpetually apologetic for my role in the project. Indeed feminist advances that recognize women's diversity are essential, though what has resulted for some white middle-class feminists is an ongoing regret for their relative privilege.

With my heightened awareness of my own privilege and power I struggled to maintain my boundaries, meanwhile feeling that my own emotions and needs within the research process were illegitimate. I agonized over the Research Team conflicts though theoretically I knew that conflict was an inevitable part of any group process. Often I was selfishly consoled by the conflicts that had arisen in the subgroups and the Project Team; knowing that conflict had arisen at all levels of WOAW confirmed that it was a part of a collective group process and was not my fault. Yet with the conflict I lost my sense of compassion and humility and was easily frustrated with the women on the Research Team. I became angry with them for not staying on topic or not doing "their work." Although I was cognizant of their barriers and had read extensively on group process, I struggled with my reactions and often vented in my fieldnotes. In one instance I wrote:

> Over the course of the meeting I was frustrated by the ways the women did not stay on track with the conversation. When we were talking about welfare grievances they were everywhere. I know that this is a big topic for them, but I was trying to figure out what they wanted to do about it (Colleen's fieldnotes September 6, 2000).

I believe that I had lost my humility and compassion because I had stopped valuing being together and only measured the success of the Research Team through our work and the collective actions we accomplished. I then felt disappointed with the women as though they were letting me down. Again I wrote in my fieldnotes:

> Here I am, I'm committed. I'm doing all this work. I want all these things for them and they don't want this for themselves and they're not trying as hard as I am. Or they're not investing as much of themselves in the situation. Or they're not...that's really how I was thinking. Then I was thinking that maybe it is normal that I want this more than they do. Maybe they don't really want to change their lives, or it's too hard or too scary (Colleen's

fieldnotes October 19, 2000).

Although feminist calls for increased reflexivity are widespread, they did not help me to better understand my own emergent emotions. I did not anticipate losing my compassion or humility. I remained conflicted with my anger; as a feminist action researcher I was not entitled to feel in the research process, I was there to facilitate and reflect. My emotions and the ways I thought about the women unnerved me – in honestly portraying what I felt and my perceptions of the women I did not want to perpetuate the very structures and stereotypes that I aimed to challenge. As feminist action researchers it is our role to translate between the private world of women and the public world of academia, politics, and policy, though "the dilemma remains of how we do this without reinforcing the stereotypes and cultural constructions we are challenging" (Standing, 1998). Although calls for increased reflexivity have elevated the feminist collective consciousness towards new understandings of power and representation, currently there are few feminist researchers who risk acknowledging or revealing unflattering thoughts or emotions about themselves or their participants.

In allowing myself to explore my feelings I believe that, in the long run, I deepened my analysis. While developing self reflexivity should enable us to look more closely at our own practice in terms of how we contribute to dominance in spite of our liberatory intentions (Lather, 1991), the current feminist practice of denying our own emotions while claiming to work reflexively boosts our control and power in the research process. We claim to "work the hyphen" yet we resist realistically portraying our own emotions when they do not conform to the ideals of academic feminist research. As the feminist action researcher I maintained control of the research agenda and held the real power in taking the women's private words into the public world of academia. I also held the power to withhold my own experiences and emotions. According to Standing (1998), it is the ways that we represent and interpret women's voices that

reinforce hierarchies of knowledge and power. But it is also the ways that we represent ourselves as feminist action researchers. We cannot dismiss our own emotions and reactions to the research process all the while revealing significantly personal aspects of our research participants' lives. As feminist action researchers it is important to confront such feelings and to not become powerless or deceptive in their midst. Confronting and exploring such emotions, without becoming self-indulgent, may be a significant, yet often overlooked, step towards bridging relationships with our research participants, challenging unequal power relations, and engaging in truly collaborative research.

While openly acknowledging our emotions can deepen the analysis and openness to power issues in the research process, as long as feminist researchers maintain their power and control, the research ends up benefiting the scholar more than those studied, and furthers the gap between the researcher and the researched. This undercuts some of the goals of feminist research and reproduces aspects of traditional academic research (Reid, 2000). As Lal (1996) asserts, "feminism is an encounter that unfortunately was, and sadly continues to be, primarily defined through academic debates and theories" (Lal, 1996, p.191). If, as feminist researchers, we truly strive to break the academic monopoly over knowledge production processes, we must question our "chosen silences" as control mechanisms (Chataway, 1997). Paradoxically, efforts at working reflexively may in fact perpetuate silences and thwart feminist efforts at the authentic representation of both ourselves and our research participants. If we remain apologetic for who we are and resist claiming our emotions, we effectively silence ourselves and place all of the burden for self-disclosure on our research participants. As well, unless we honestly portray who we are and how we feel, we risk perpetuating unrealistic portrayals of FAR and fallaciously lead feminist researchers to feel illegitimate – remaining cyclically apologetic and denying their emotions while perpetuating the illusion that "good" feminist action researchers remain

compassionate and humble throughout the research process.

Feminist action researchers are in a position to develop truly reflexive texts that leave both the author and the reader vulnerable. This is not a position of weakness, but one from which to attempt change (Tierney, 2000). Martin's (1994) vision for feminist research advances our collective goals while enabling a truly open and reflexive environment where, as researchers committed to the ideals of FAR, we can begin to confront and address our power and control in the research process.

> My vision is of a collective enterprise of a research community governed by an open welcoming spirit, one that is inclusionary on the methodological level as on the personal. It is of people who hold high standards of themselves and others but do not demand perfection (Martin, 1994, p.654).

The Research Team as Feminist Action Research

This chapter began with a call for more realistic portrayals of feminist action research and for a detailed analysis of what it really means to conduct FAR. Examining the Research Team as feminist action research provided insight into the realities of inclusion, voice, participation, action, social change, and the role of the researcher. Yet an important question remains. Do feminist action research projects result in empowerment or meaningful political change? Or perhaps, as Wolf (1996) asks, the more appropriate question is whether these projects have brought us farther along than other methods?

FAR imposes a heavy agenda on both researcher and participants; often the implementation and realization of feminist action research can be exceedingly tedious, time-consuming and complicated for everyone involved (Maguire, 1987; Reid, 1997). Defining relevant community issues, coordinating a suitable research design, and mobilizing a community group towards a research process and an ultimate goal are difficult realities faced by the researcher and the researched. A FAR process may be additionally limited by the resources, energy, and other

elements of the situation in which it is taking place (Greenwood and Levin, 1998). Indeed FAR is demanding and difficult for both the researcher and the research participants.

Research logistics and organization are not the only challenges faced by the researcher and the participants. Power dynamics surfaced in all interactions and through all phases of the research. These dynamics were subversive and complex. They conflicted with the research ideals of inclusion, participation, and researcher reflexivity. As well, given the complexities of redistributing power, the FAR goals of transformative individual and social change seem like a long-haul, collective struggle (Maguire, 1993). Feminist action researchers must remain cautious about the promises of social change, define the limitations of their projects, and better understand how a number of individual and collective actions can contribute to social change. While it is important to remain reflexive, honest, and realistic about the possibilities of feminist action research, it has indeed brought us farther along than other methods.

Notes

[1] For the purposes of this chapter, the unit of analysis is the Research Team (meetings, interviews, and fieldnotes) in the year 2000. It is important to acknowledge, however, that feminist action research was the framework for the three-year SSHRC study and that different "slices" of data from the larger SSHRC data set may be used to analyze the ideals and realities of feminist action research.

[2] Recently feminist researchers have problematized the concept of consciousness raising. According to Wolf (1996), the question of consciousness raising becomes politicized when it is First World white feminist researchers attempting to raise the consciousness of Third World women research subjects. What is implied is that the researched is less than fully conscious and needs to have her consciousness raised by someone else, the researcher, whose superior consciousness is already raised (Wolf, 1996).

[3] I raised these concerns on numerous occasions. Twice the idea of a suggestion box arose, and a box was always on the table. However, the group was conflicted about the suggestion box's anonymity. Rene said "I think if you haven't got the chutzpah to put your name to it, then it shouldn't be in there.... . I think it's important that persons say what they think, and take charge of it. I'm sorry, I don't like anonymous" (Rene, RTM September 6, 2000). Dismissing the need for anonymity refuted the possibility that being heard and speaking in a group was difficult for some. Conversely, Virginia Dawn felt that anonymity was important in order to provide a safe place to articulate concerns. "I know that there are people that would prefer it to be anonymous, in certain circumstances, it's like a safe area that they can still voice their opinion and not worry, because some people don't have that security" (Virginia Dawn, RTM September 6, 2000).

[4] I distributed a list of free counseling resources to the participants at the first Research Team meeting, and brought the list to every meeting for new attendees. Between meetings I checked-in with Research Team participants over the phone, at Project Team meetings, or at subgroup meetings to get their feedback on the previous Research Team meeting and to learn of anything that may have arisen.

5 Aside from a few comments thanking me for my contributions, over the course of my involvement with the Research Team none of the women commented on my participation. I reflect on my own participation later in this chapter.

6 To my knowledge in 2000 two women withdrew from WOAW as a consequence of conflict. In 2001 two other women withdrew for the same reason. In both years other women withdrew from WOAW; it is possible that some of them withdrew due to a conflict of which I was unaware.

7 Helen, Research Team Meeting, April 17, 2001.

8 The women facilitated their subgroup meetings when there was no researcher or community partner present. Yet at the Project Team or the Research Team meetings, the women felt more intimidated with facilitation. In informal conversations about facilitating, I learned that many felt that they did not know how to facilitate, or they were uncomfortable with writing on the flipchart or chalk board in front of others. I had several discussions with the women about the need for a workshop on facilitation and group process. Though there was considerable interest in this, it has yet to be organized.

8

Women's Health and Social Justice: Implications, Recommendations, and Conclusions

Do unto others as we would have them do unto you.... I see a lot of people putting one another down. Or not taking the time to understand. If they were in that situation they'd want to be understood. And ignorance from authorities in a lot of cases (Rene's interview, June 6, 2000).

The women involved in this dissertation were diverse and had complex lives. Through the lens of my research questions, I learned that exclusion characterized their experiences living in poverty. The women felt culturally excluded as a consequence of their stigmatization (Krieger, 2001). They spoke of being stereotyped and suggested that the stereotype was based on the misperception that welfare recipients choose to be on welfare. The welfare, health care, and community recreation systems enforced and perpetuated stereotypical notions of welfare recipients as intentionally abusing the system, being undeserving and lazy, and needing institutional surveillance. The stereotype of the welfare recipient rationalized institutional policies and practices that forced the women to live in severe material deprivation. Being stereotyped and surveyed contributed to the women's ubiquitous feelings of shame and powerlessness. They had a heightened awareness of their low status and invisibility in society and felt stigmatized and labelled as poor in many (or in some cases all) public arenas.

Exclusion influenced the women's health in several ways. The women discussed their psychosocial health concerns, particularly stress, depression, low self-esteem, and anger, and often used these terms interchangeably to describe their shame. Authorities who controlled the

women's lives cast them as reprehensible through stereotyping and surveying them. These exclusion processes led the women to evaluate themselves negatively – they were shameful and dependent clients of public charity. One woman said she was "less of a person" (Elizabeth's interview, March 20, 2000); another said they were "the rots of society" (Katharine's interview, March 14, 2000). Not only were the women's interactions with authorities shaming, but the very nature of the services that were meant to help them was humiliating. Community recreation's "leisure access" cards, food banks, food vouchers, crisis grants, and other community services that labelled people as "poor" shamed many of the women.

In addition to their experiences of shame, the women's material deprivation influenced their health. All of the women spoke about the challenges of paying for food, housing, clothing, transportation, and recreation. Material deprivation profoundly influenced the women's ability to connect with other individuals or groups in their communities. Absolute poverty imposes constraints on the material conditions of everyday life – by limiting access to the fundamental building blocks of health such as good nutrition, adequate housing, and opportunities to participate in society.

Not only did the women's material deprivation influence their access to the building blocks of health, but the experience of living on low income created uncertainty and feelings of lack of control. All of the women reported that their unrelenting financial worries caused them stress and depression. Budgeting was a major source of stress - learning to juggle expenses, choosing which bills to pay and which to defer to the following month, and determining the exact amount of money to survive on each month. The mothers discussed the physical stress and tiredness of parenting, the worry of adequately providing for their children, and having little security.

When the women did not conform to dominant forms of surveillance and control they felt penalized and punished by authorities who controlled their fate. The women's social location on

263

the margins forced them to actively negotiate their identities through accommodating, resisting, and subverting the dominant discourses of health and poverty that constructed them as the illegitimate Other. Initially the women were divided and their experiences individualized as a consequence of being the Other. Yet the process of meeting as the Research Team, or engaging in feminist action research, enabled some women to move from being divided towards forming a social group. Although working together as the Research Team had its challenges, the processes of feeling included, having a voice, learning, networking, managing conflict, and working towards collective actions were major strengths of the Research Team. Susan said:

> Most of us have always felt that all we did was bitch and complain. So it didn't have value. Now the thing is we've been taught, and been shown, that those are valuable stories. We've learned and grown from those things. It has brought us to this group (Susan's interview, November 9, 2000).

The Research Team organized a series of speakers to address their rights as welfare recipients, and is currently organizing a "welfare grievances workshop" for themselves and other poor women in their communities. The process of meeting as the Research Team, and being guided by a feminist action research framework, has also given rise to important policy implications of this dissertation project.

Implications: Policy and Practice

Women's health involves women's emotional, social, cultural, spiritual and physical well-being, and is determined by the social, political and economic context of women's lives (Phillips, 1995; cited in McComas and Carswell, 1996). In terms of promoting poor women's health, seven broad policy recommendations arose from this dissertation. In the short-term, and in the light of the fact that poverty and exclusion are increasing rather than decreasing, a number of specific actions can be taken to improve poor women's health. Long term solutions, that will have the greatest influence on improving the health of those who are worse off, involve pursuing

economic policies that lead to greater economic equality and a redistribution of wealth. Many initiatives depend upon policy changes that are outside the traditional health sector. In pursuing policy change that would truly influence poor women's health, the leaders for health-promoting public policies must work in complex environments and at those intersections of the domains of influence in which our lives occur (McGinnis, Williams-Russo, and Knickman, 2002). The policy recommendations I gleaned from this research project vary in terms of short or long-term and the extent of change required. For instance, the first three recommendations – supporting community development projects like WOAW, advocating participatory policy development, and finding alternative sites for social justice – are relatively short-term and manageable in terms of implementation. The remaining four recommendations – redressing material deprivation, promoting redistribution and equity, recognizing gender and women's diversity, and politicizing the social determinants of health – are long-term and require more radical societal change.

Support community development projects like WOAW

Social isolation is a major barrier for many women on low income. The research participants reported that they had few opportunities to engage with other women in their communities. Becoming engaged in a social group often reduces isolation and provides an important source of interaction (Lord and Hutchison, 1993). Participation is a key concept on women's health agendas (Lefebvre, 1995), and is an important element and condition of social justice (Young, 1990). If women are not active participants in demanding and using resources, gaps between the resources and the women's health will continue to grow (Jones and Meleis, 1993). Community development projects like WOAW offer opportunities for excluded women to meet others in their community, to engage in decision-making, and to become connected to important community resources such as service providers, programs, activities, educational opportunities, and subsidies. In these ways community development projects can be health promoting for

isolated women.

Advocate participatory policy development

Feminist action research can be used as a framework for innovative and participatory approaches to policy development. Fostering women's participation by adopting a FAR framework can raise awareness and capacity in groups to direct political pressure towards decisions that fit their needs. Through applying FAR values to the policy development process, it is possible to generate policies that are truly responsive to the needs and barriers of marginalized women. It is also possible that inclusion in a collaborative and participatory policy development process may, in itself, be health-promoting for a group of women who have been systematically excluded.

Uncover alternative sites for social justice

Linking health promotion to social justice has the potential to mobilize powerful new constituencies for health (Wallerstein and Freudenberg, 1998). The traditional network of agencies that are typically involved in health promotion endeavours must be expanded to include more politicized organizations working for social change, such as feminist organizations, trade unions, environmental activist organizations, minority rights groups, and third world solidarity groups (Labonte, 1986). WOAW is an example of the ways that working in non-traditional sites for health promotion can have important health benefits for a marginalized population. WOAW was initiated within the community recreation system. Community recreation is not often seen as a site for social justice since recreation is considered a "fringe" activity by the general population and poverty and health activists alike. However, community recreation provided a non-threatening way for over 85 women on low income in the Tri-City area to become involved in community organizing. Community recreation can also be considered as a site for health promotion in terms of providing a space for excluded women to become involved in their

266

communities and to promote their health through accessing regular physical activity (Reid et al., 2002). According to McGinnis et al. (2002), targeting the vulnerable, developing new policy models, and finding new linkages across sectors are essential for promoting equity in health. Involving partners who deal with low-income populations, such as social services, public health, and women's centres, can help to increase participation, pool community resources, and legitimize community recreation as a site for health promotion (Frisby and Hoeber, 2002).

Redress material deprivation

The immediate provision of basic material goods and services for people suffering severe deprivation must be a first priority for any program that seeks to make the world more just (Young, 1990) and to improve health. For instance, income support must provide an adequate standard of living for poor women, and sufficient "living" minimum wages must be provided to protect the working poor. Other resources and services that significantly contribute to promoting health, such as dental and eye care, medications, curative therapies, transportation, childcare, and recreation must be adequately subsidized. Housing policies should aim to provide affordable housing of a reasonable standard (Shaw et al., 2000), and community services, such as welfare advocates and community recreation must exist and be accessible in every community. The provision of such resources and services would enhance poor women's ability to manage and maintain their health.

Although these measures are an important first step towards addressing poor women's health, focusing exclusively on the distribution of material goods and resources "inappropriately restricts the scope of justice and obscures issues of domination and oppression" (Young, 1990). A distributive conception of justice reflects and reinforces a depoliticized public life by failing to bring issues of decision-making power into public discussion. As a consequence, class relations remain invisible because the individualism that is inherent in a distributive justice paradigm

prevents understandings of structural phenomena (Young, 1990). When the original source of the problem remains unchanged and unknown, services and resources have only a limited ability to resolve the problem. Each new problem leads to a demand for additional resources for services to redress the damage that continues to be done. Since the underlying flaw in the system is not addressed, people continue to suffer and demand increasingly more resources and services to meet their needs (Wilkinson, 1996).

Promote redistribution and equity

"In order to decrease socioeconomic inequality, we need to reduce both the proportion of the population who fall behind, and the distance they fall behind" (Wilkinson, 2000, p.267). According to Wilkinson (1996), the real solution is to identify more fundamental changes, such as redistributive taxation, which incur only the initial costs of making the necessary preventive changes in institutional structures. This does not mean relying on economic growth, which improves everyone's material prosperity in parallel while leaving social relations unchanged. Nor does it mean pursuing policies that simply affect which individuals suffer various forms of disadvantage without affecting the total burden of disadvantage in the population. The structural determinants of the social environment must be addressed. Policies need to take aim at reducing the overall burden of disadvantage through tackling the structural sources of inequality. Economic management must aim to increase social cohesion and restore a public sphere that serves and supports poor and working-class adults and families. For instance, graduated policies instituting progressive taxation of income and inherited wealth would reduce inequalities in income and wealth within populations (McGinnis et al., 2002). Policies must be developed to ensure access to educational, training and employment opportunities, particularly for single parents and people with disabilities. Even within a job-rich society there must be a public sphere that supports those who can't work, who haven't worked, and those eager to be educated (Fine

and Weis, 1998).

Other barriers that prevent poor women from accessing services and entitlements, including discrimination and "proving poverty" need to be confronted, examined, and redressed. Legislation to protect the rights of marginalized, minority, and migrant groups, particularly concerning citizenship, employment rights, welfare discrimination, and poor bashing, must be introduced. Institutional policies that condone (and in some cases rely on) discriminatory practices must be rectified so that poor women are treated with respect, consideration, and compassion. In other cases it is not the policy itself that needs to be changed, but how the policy is implemented. Being treated as a liar and a cheat often impedes the poor from accessing a service or entitlement. In these cases training and awareness programs for staff and professionals are required. Importantly, some of the research participants recognized that welfare and health care workers were so overworked that the mistreatment they encountered was inevitable. Therefore, policies that support community workers, including the provision of additional personnel, smaller workloads, and increased work flexibility and support, are needed.

Recognize gender and women's diversity

Policies to redress inequities in health and income must reflect gender and other social constructions which affect resource distribution. Access to political and economic resources is differentiated by gender in most societies (Kaufert, 1996). Fundamental gender inequalities include the division of labour and the segregation of labour markets, the associated inequalities in wages, discrimination in hiring and promotion, and the distinction between paid and unpaid work. Power structures are also in place that systemically disadvantage women, including government and business hierarchies, the regulation and surveillance of sexuality and reproduction, and the power dynamics within domestic relationships (Connell, 1987; cited in Kawachi, Wilkinson, and Kennedy, 1999).

When the specific health interests of women, men, or other groups have not received fair allocation of research attention or resources, a commitment to a just society requires targeted actions. Sometimes, direct policies of preferential treatment toward these specified areas are needed in order to remedy a past injustice and to avoid its perpetuation (Greaves, 2000). For instance, employment and pay inequity and single parent income imbalances must be examined and redressed. The debate about "wages for housework" should be brought into the public health arenas to help highlight the extensive unpaid labour that occurs in privatized homes (Love et al., 1997). From women's perspective, it is essential to consistently examine how new policies affect the equitable distribution of resources. We must become as critically analytical as we can by charting the health implications of regressive government budgets, environmentally degrading industrial "megaprojects," or cost-saving social welfare cutbacks (Labonte, 1986). As well, policies on education, employment, health care, and taxation must be assessed in terms of their impact on social justice and social divisions.

Politicize the social determinants of health

A comprehensive approach that considers the broad range determinants of health is needed to adequately address poor women's health (Raphael, 2001). Through adopting a social determinants of health perspective it is possible to better understand how health care services and resources are two-tiered, and to also understand how societal factors that fall outside of the health care system influence health. The research participants experienced two-tiered health care in terms of access to services and resources; they did not have a full range of services or resources at their disposal to address their health. This means reexamining the rhetoric of "universal" and how the exclusion of the poor from fully accessing health care services and resources.

Some researchers, however, contend that as little as 10 to 15 percent of preventable

270

mortality could be avoided by better availability or quality of medical care (McGinnis et al., 2002), and that health is primarily an outcome of socioeconomic structures (Labonte, 1986). In this vein, it is important to challenge how Canadian health policy and health spending are dominated by a focus on payment for medical treatment (McGinnis et al., 2002). Efforts at shifting government and public awareness away from equating health with health care, towards better understanding the structural causes of ill-health and disease, would ease government pressure to increasingly spend on the health care system. A society which nurtures people's skills and abilities throughout the population, which provides economic opportunities for all, and fosters a cohesive and integrated social environment, would do more for health than curative medical services are able to do (Blane, Brunner, and Wilkinson, 1996, p.12). Although this would enable resources to be diverted to the community and to other government sectors that would have a more significant influence on health outcomes, it does not absolve the government from ensuring that the poor have equitable access to quality health care.

Ideas for Future Research Projects

Recommendations for research on women's health that have been given priority on both Canadian and international research agendas include emphasizing women's social context, women's active participation in the research process, and recognizing diversity among low-income women (McDonough and Walters, 2001). The research implications that arise from this dissertation reflect the priority issues mentioned above. Although my involvement with the women enabled in-depth understandings of the relationship between exclusion and health for a group of primarily White and heterosexual women, future research questions could focus on better understanding the experiences of exclusion across the spectrum of women's diversity. I argued that the health equity field inadequately represented women's experiences in conceptual and methodological frameworks. However, other marginalized groups have been poorly

271

represented (or not represented at all) and continue to be treated in stereotypical ways. Focusing on dimensions of women's diversity, such as race, ethnicity, culture, sexual orientation, and ability, amidst experiences of exclusion, would further understandings of the gradient of health. As well, deepening knowledge on women's experiences as mothers, workers and encounters with violence, abuse, and addictions, are important avenues of research that were not fully explored in this dissertation. Examining the "sub-discourses" within the dominant discourses of poverty and health such as the discourses of stress, depression, self-esteem, dependence, disability, and mothering would provide a deeper understanding of the social contexts of women's experiences and the complex ways they negotiate their day-to-day lives.

Several research recommendations may further women's active involvement in and deepen understandings of the complexities of participation in feminist action research projects. Conducting interviews after the 18 Research Team meetings would have provided important insight into the women's experiences of feminist action research, and in particular, why some women withdrew from the Research Team. Uncovering why some women remained involved and why others dropped out would enable feminist action researchers to better understand who benefits and who is excluded from feminist action research projects. It is also important to develop a theory of action and social change, one that encompasses the notions of intent and agency, in order to advance these complex concepts and to provide meaningful benchmarks for feminist action researchers and others advocating social justice. It would be worthwhile to consider the ways that discourses and individual and collective action are related. For instance, do discourses change over time? What kinds of discourses lend themselves to what kinds of action? What is social change?

Feminist action researchers must collaborate with individuals and groups who are engaged in like-minded work but who do not identify themselves as feminist action researchers. For

instance, insight can be gained from the fields of community development, feminist organizing, popular education, critical theory, and health promotion. Finally, feminist action researchers must acknowledge the challenges of conducting FAR, the toll it takes on the researcher and the researched, and find or develop appropriate support, including, for example, resources on facilitation and group process. Honestly and reflexively coming to terms with the limitations of inclusion, participation, and action, that are inherent in all feminist action research projects, is a necessary task, while striving to develop research processes that enable research participants to participate and collaborate throughout the research process. Collaborative writing is one strategy that may foster greater participation.

A Vision of Health and Social Justice

Health is a social, economic, and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence, and injustice are at the root of ill-health and the deaths of poor and marginalized people. Health for all means that powerful interests have to be challenged, that globalization has to be opposed, and that political and economic priorities have to be drastically changed (The People's Health Assembly; cited in Gittelman, 2002).

We can be healthy only in a healthy society. Health promotion, health equity, and feminist researchers alike assert that we must strive for social justice through seeking the greatest health for the greatest number, protecting citizens who are at the highest risk of ill health, and acting to remove the constraints that prevent individuals from attaining a higher level of health (Labonte, 1986). Health as a social justice issue means the elimination of institutional domination and oppression (Young, 1990). Oppression includes the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions in ordinary interactions, cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms. Envisioning health as a social justice issue makes it possible for all to learn and use satisfying skills in socially recognized settings, to participate in decision-making, and to express feelings,

273

experiences, and perspective on social life in contexts where others can and will listen (Young, 1990). Envisioning health as a social justice issue requires a massive shift in the power structure of society (O'Neill et al., 1994).

In the name of deficit reduction and economic efficiency, however, we are experiencing an attack on programs designed to promote social justice. The deepening of injustices in many societies, including Canada, is a consequence of globalization's trumping of equity and ecology for efficiency and the economy. Globalization trends and conventional economics rely on exclusionary processes that are based largely on maximizing the asocial pleasures of material consumption (Wilkinson, 1996). Exclusionary processes and policies preserve relative and absolute disparities between the rich and the poor, perpetuate harmful stereotypes and discriminatory practices, promote individuation over community, and limit the opportunities people have to pursue their health. Indeed, the directions in which Canadian society is heading are inconsistent with what is known about reducing the incidence of ill-health and disease. These directions, including greater inequality of income distribution and increasingly exclusionary practices and policies, undermine the health of all Canadians and weaken the social infrastructure and safety net (Raphael, 2001). In Canada "there is a missing social economy of wellbeing" (Wilkinson, 1996, p.109). Human social needs must take precedence over demands to maximize individual consumption and economic efficiency (Wilkinson, 1996).

Injustice is how people are excluded, the depths to which they suffer, and the obligations we bear in this regard. "We should not accept social injustice as a given; instead, we should accept the challenge to work toward social justice for all people" (Anderson et al., 1996, p.120). Through redefining what is valid and useful knowledge, using that knowledge to empower the oppressed, and working collectively towards action and social change, feminist action research can contribute to the greater goal of social justice. In our efforts we must "advocate feminism" –

move towards creating political paradigms and radical models of social change that emphasize both collective and individual change (hooks, 1988).

Understanding health as a social justice issue means dropping the crude identification of the quality of life with average level of material consumption, and demoting economic growth from its role as a societal goal. The values of human social and material emancipation must take its place, extending dignity to all (Wilkinson, 1996). Indeed, "unless we make globalization work in the interests of all, we will foster the global spread of illness" (Gro Harland Brundland, the Director General of the World Health Organization (WHO); cited in Hankivsky, 1999). If we used a dose of egalitarianism to turn the idea of civilization into an inclusive rather than an exclusive concept, we would perhaps have an idea of the social conditions for health. The result would be close to something we might call human dignity (Wilkinson, 1996).

> Social justice is the foundation of public health.... It asks us, pointedly, to remember that worldwide dramatic declines – and continued inequalities – in mortality and morbidity signal as much the victories and defeats of social movements to create a just, fair, caring, and inclusive world as they do the achievements and unresolved challenges of scientific research and technology. To declare that social justice is the foundation of public health is to call upon and nurture that invincible human spirit... a spirit that has a compelling desire to make the world a better place, free of misery, inequity, and preventable suffering, a world in which we all can live, love, work, play, ail, and die with our dignity intact and our humanity cherished (Krieger and Birn, 1998, p.1603).

Epilogue

In 2001 and 2002 the Research Team remained a valued meeting place in the WOAW organization; as of June 2002 we had met 23 times. In the spring of 2001 I noticed that the intensity and sense of urgency had subsided and that the Research Team had transformed into a place for discussing collective actions, supporting individual and informal actions, and sharing and learning from one another. During this transition time a more "organic" leadership style emerged (Rahman, 1991). Meetings were relaxed and informal, and organization and facilitation were increasingly shared. My role evolved into one of Research Team member and advocate.[1] At times I advocated for the work of the Research Team or WOAW. For instance, I attended a meeting with the head of Port Coquitlam Parks and Recreation and participated in nominating WOAW for a Promotion Plus Leadership Award.[2]

In 2001 a variety of actions emerged. Two women went back to school, two women joined employment training programs, a group of 10 women developed a "community women's studies course" at a local college, and informal groups of older women became politically active. These informal groups attended an anti-poverty conference, served on the boards of seniors' housing co-operatives, lobbied the government against cuts to B.C. Benefits, and formed a "bus-riders union." The pressure for the Research Team to solely do the work of action shifted towards a recognition that the women had different interests and needs and could informally form groups to pursue their goals. The women began using the resources of the WOAW organization, and not simply the individuals on the Research Team, to pursue their interests. Had the Research Team not enjoyed the support of the WOAW organization, the ways that the women shifted their involvement would have certainly been different. Possibly there would be fewer women

involved today.

This suggests that the work of collective action can place a big burden on a relatively small group of poor women. The structure of the Research Team within the WOAW organization was ideal because WOAW had the material and human resources to support the women's individual and collective actions while enabling them to rediscover the importance of sharing and learning from each other. Indeed, feminist action research projects should be composed of representatives of all elements of the situation that have a bearing on the change (Hall, 1993). In retrospect the Research Team was a place for the women to share ideas, to learn that they were not alone, and to develop an analysis of the "politics of poverty." Significantly, the conscientization of the Research Team members spread to other levels of organizing in WOAW where various forms of action were initiated.

In early 2002 the provincial Liberal party initiated widespread spending cuts to social services and health care. The women's B.C. Benefits subsidies were cut,[3] and many of them said that they no longer felt safe or in control of their lives and feared that they could possibly become homeless. The government cuts that were rationalized under a rhetoric of fostering independence and getting recipients back to work had the opposite effect. They forced the women into more serious material deprivation and crisis, where they could only deal with their basic day-to-day survival. When a single mother with two children has to survive on $909 a month, getting out of the house and finding job is impossible. It was frustrating and saddening to witness the effects of the government cuts on the women in WOAW. Although these cuts influenced the energy and sense of possibility for action and social change, all levels of WOAW continued to meet. In fact, some women suggested that having a meeting to attend, or a reason to leave their homes, contributed to a sense of wellbeing and their ability to cope.[4]

With the current political climate, WOAW's sustainability is uncertain. The SSHRC grant

provided crucial support to many WOAW members, meetings, and activities, and since most community services are struggling for their own survival, it is difficult to envision from where resources to support WOAW will come. Regardless of WOAW's ultimate outcome, I believe that it provided important opportunities for many women on low income in the Tri-City area. Most WOAW women, who were socially isolated prior to their involvement in WOAW, have developed friendships, social support networks, and informal "activist" groups. Other women have pursued educational, training, or work opportunities that may enable them to find secure employment and no longer be subjected to the surveillance and threatening of the welfare system. As one WOAW service provider said, "nothing never happens."

Notes

[1] During this transition time Pam Ponic, the SSHRC Project Manager, was actively involved in the Research Team meetings. I partially attribute her involvement to the ways that my role shifted in that the Research Team members saw a sharing of the "work" of the Research Team meetings.

[2] I was involved with this nomination through my role as a director on the board of Promotion Plus. Sydney Millar, a UBC Working Group member, wrote the application for the award.

[3] In letters to welfare recipients, the government used the word "simplify" to connote the spending cuts.

[4] I would like to acknowledge the tremendous challenges many of the WOAW service providers faced during these government cuts. They encountered increased work responsibilities, decreased support and resources, and job insecurity. Although many were visibly stressed and exhausted, they worked tirelessly to support WOAW.

References

Abood, Doris A. and Conway, Terry L. (1992). Health value and self-esteem as predictors of wellness behavior. *Health Values*, 16(3): 20-26.

Abramovitz, Mimi. (1995). From tenement class to dangerous class to underclass: Blaming women for social problems. In *Feminist Practice in the 21st Century*. Ed(s). N. Van Den Bergh. Washington, DC: NASW Press, pp. 211-231.

Acker, Joan, Barry, Kate and Esseveld, Johanna. (1991). Objectivity and truth: Problems in doing feminist research. In *Beyond Methodology: Feminist Scholarship as Lived Research*. Ed(s). M. M. Fonow and J. A. Cook. Bloomington, IN: Indiana University Press, pp. 133-153.

Acker, Sandra. (2000). In/out/side: Positioning the researcher in feminist qualitative research. *Resources for Feminist Research*, 28(1/2): 189-208.

Adamson, Nancy, Briskin, Linda and McPhail, Margaret. (1988). *Feminist Organizing for Change: The Contemporary Women's Movement in Canada*. Toronto, ON: Oxford University Press.

Adler, Nancy E., Boyce, Thomas, Chesney, Margaret A., Cohen, Sheldon, Folkman, Susan, Kahn, Robert L. and Syme, S.Leonard. (1994). Socioeconomic status and health: The challenge of the gradient. *American Psychologist*, 49(1): 15-24.

Adler, Patricia A. and Adler, Peter. (1994). Observational techniques. In *Handbook of Qualitative Research*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 377-392.

Alvesson, Mats and Skoldberg, Kaj. (2000). Language/gender/power: Discourse analysis, feminism and genealogy. In *Reflexive Methodology: New Vistas for Qualitative Research*. Ed(s). M. Alvesson and K. Skoldberg. London, UK: Sage Publications, pp. 200-237.

Anderson, Joan M. (1987). Migration and health: Perspectives on immigrant women. *Sociology of Health and Illness*, 9(4): 410-438.

Anderson, Joan M., Blue, C., Holbrook, A. and Ng, M. (1996). On chronic illness: Immigrant women in Canada's work force: A feminist perspective. *Canadian Journal of Nursing Research*, 25(2): 7-22.

Anderson, Kathryn and Jack, Dana C. (1991). Learning to listen: Interview techniques and analyses. In *Women's Words: The Feminist Practise of Oral History*. Ed(s). S. B. Gluck and D. Patai. New York, NY: Routledge, pp. 11-26.

Angrosino, Michael V. and Mays de Perez, Kimberly A. (2000). Rethinking observation: From method to context. In *Handbook of Qualitative Research, 2nd Edition*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 673-702.

Anielski, Mark. (2001). Making money or growing poorer? Measuring the genuine health of nations. *The Shift: A Newsletter on Shifting Paradigms in Health and Health Promotion*. 4: 1-2.

Annandale, Ellen and Hunt, Kate. (2000). *Gender Inequalities in Health*. Buckingham, UK: Open University Press.

Audi, Robert (General Editor). (1995). *The Cambridge Dictionary of Philosophy*. Cambridge, UK: Cambridge University Press.

B.C. Ministry of Human Resources. (2002). *Income Assistance Rates*. http://www.mhr.gov.bc.ca/factsheets/2002/iarates.htm.

Ballantyne, Peri J. (1999). The social determinants of health: A contribution to the analysis of gender differences in health and illness. *Scandanavian Journal of Public Health*, 27(4): 290-295.

Barnsley, Jan and Ellis, Diana. (1992). *Research for Change: Participatory Action Research for Community Groups*. Vancouver, BC: Women's Research Center.

Batsleer, Janet and Humphries, Beth. (2000). Welfare, exclusion, and political agency. In *Welfare, Exclusion, and Political Agency*. Ed(s). J. Batsleer and B. Humphries. London, UK: Routledge, pp. 1-21.

Baxter, Sheila. (1988). *No Way to Live: Poor Women Speak Out*. Vancouver: New Star Books.

Becker, Marshall H. (1986). The tyranny of health promotion. *Public Health Review*, 14: 15-25.

Belle, Deborah. (1982). Introduction. In *Lives in stress: Women and Depression*. Ed(s). D. Belle. Beverly Hills, CA: Sage Publications, pp. 11-23.

Belle, Deborah. (1990). Poverty and women's mental health. *American Psychologist*, 45(3): 385-389.

Benzeval, M., Judge, K. and Whitehead, M. (1995). *Tackling Inequalities in Health: An Agenda for Action*. London, UK: Kings Fund.

Bettcher, D. and Lee, K. (2002). Glossary: Globalisation and public health. *Journal of Epidemiological and Community Health*, 56: 8-17.

Blane, D., Brunner, E. and Wilkinson, R.G. (1996). *Health and Social Organization: Towards a Health Policy for the 21st Century*. London, UK: Routledge.

Bloch, Charlotte. (1987). Female unemployment and knowledge of self. In *Unemployment: Theory, Policy and Structure*. Ed(s). P. J. Pederson and R. Lund. New York, NY: Walter de Gruter, pp. 339-353.

Brown, L. David and Tandon, Rajesh. (1983). Ideology and political economy in inquiry: Action research and participatory research. *The Journal of Applied Behavioural Science*, 19(3): 277-294.

Brunner, Eric and Marmot, Michael. (2000). Social organization, stress, and health. In *Social Determinants of Health*. Ed(s). M. Marmot and R. G. Wilkinson. Oxford, UK: Oxford University Press, pp. 17-43.

Calnan, Michael and Williams, Simon. (1991). Style of life and the salience of health: An exploratory study of health related practises in households from differing socio-economic circumstances. *Sociology of Health and Illness*, 13(4): 506-529.

Canadian Fitness and Lifestyle Research Institute. (1998). 1997 physical activity benchmarks report. *Canadian Fitness and Lifestyle Research Institute with Fitness/Active Living Unit, Health Canada and the Interprovincial Sport and Recreation Council*.

Cancian, Francesca M. (1992). Feminist science: Methodologies that challenge inequality. *Gender*

and Society, 6(4): 623-642.

Capitman, John. (2001). Communication: Health-equity-network listserve. <u>Health-Equity-Network@Jiscmail.Ac.Uk</u>.

Chataway, Cynthia J. (1997). An examination of the constraints on mutual inquiry in a participatory action research project. *Journal of Social Issues*, 53(4): 747-765.

Cohen, May. (1998). Towards a framework for women's health. *Patient Education and Counselling*, 33: 187-196.

Cohen, S., Kessler, R.C. and Underwood, L. (1995). *Measuring Stress: A Guide for Health and Social Scientists*. New York: Oxford University Press.

Colantonio, Angela. (1988). Lay concepts of health. *Health Values*, 12(5): 3-7.

Coleman, Gill and Rippin, Ann. (2000). Putting feminist theory to work: Collaboration as a means towards organizational change. *Organization Symposium*, 7(4): 573-587.

Comstock, Donald E. and Fox, Russell. (1993). Participatory research as critical theory: The north Bonneville, USA, experience. In *Voices of Change: Participatory Research in U.S. and Canada*. Ed(s). P. Park, M. Brydon-Miller, B. Hall and T. Jackson. London: Bergin and Garvey, pp. 103-124.

Crawford, Robert. (1977). You are dangerous to your health: The ideology and politics of victim blaming. *International Journal of Health Services*, 7(4): 663-679.

Crawford, Robert. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services*, 10: 365-388.

Crawford, Robert. (1984). A cultural account of "health": Control, release, and the social body. In *Issues in the Political Economy of Health Care*. Ed(s). J. B. McKinlay. New York: Tavistock Publications, pp. 60-103.

Croghan, Rosaleen and Miell, Dorothy. (1998). Strategies of resistance: 'bad' mothers dispute the evidence. *Feminism and Psychology*, 8(4): 445-465.

Deaton, Angus. (2002). Policy implications of the gradient of health and wealth. *Health Affairs*, 21(2): 1-9.

Denzin, Norman K. (1994). The art and politics of interpretation. In *Handbook of Qualitative Research*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 500-515.

Doyal, Lesley. (1995). *What Makes Women Sick: Gender and the Political Economy of Health*. London, UK: Macmillan Press Ltd.

Doyal, Lesley. (2000). Gender equity in health: Debates and dilemmas. *Social Science and Medicine*, 51: 931-939.

Drew, Mary L. and Dobson, Keith S. (1999). The negative self-concept in clinical depression: A discourse analysis. *Canadian Psychology/Psychologie canadienne*, 40(2): 192-204.

Duneier, Mitchell. (1999). *Sidewalk*. New York, NY: Farrar, Straus and Giroux.

Edwards, Rosalind and Ribbens, Jane. (1998). Living on the edges: Public knowledge, private lives, personal experience. In *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives*. Ed(s). London, UK: Sage Publications, pp. 1-23.

Fals-Borda, Orlando. (1991). Some basic ingredients. In *Action and Knowledge: Breaking the Monopoly with Participatory Action Research*. Ed(s). O. Fals-Borda and M. A. Rahman. New York, NY: The Apex Press, pp. 3-12.

Finch, Janet. (1993). "it's great to have someone to talk to": Ethics and politics of interviewing women. In *Social research: Philosophy, Politics and Practice*. Ed(s). M. Hammersley. London, UK: Sage Publications, pp. 166-179.

Fine, Michelle. (1994). Working the hyphens- reinventing self and other in qualitative research. In *Handbook of Qualitative Research*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 70-82.

Fine, Michelle and Weis, Lois. (1998). *The Unknown City: The Lives of Poor and Working-class Young Adults*. Boston, MA: Beacon Press Books.

Fontana, Andrea and Frey, James H. (2000). The interview: From structured questions to negotiated text. In *Handbook of Qualitative Research, 2nd Edition*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 645-672.

Foucault, Michel. (1994). *The Birth of the Clinic: An Archaeology of Medical Perception*. New York, NY: Vintage Books.

Frank, John and Mustard, J. Fraser. (1994). The determinants of health from a historical perspective. *Journal of the American Academy of Arts and Sciences*, 123(4): 1-19.

Fraser, Nancy. (1987). Women, welfare and the politics of need interpretation. *Hypatia*, 2(1): 103-121.

Fraser, Nancy. (1992). The uses and abuses of French discourse theories for feminist politics. In *Revaluing French Feminisms*. Ed(s). N. Fraser and S. L. Bartky. Bloomington, IN: Indiana University Press, pp. 177-194.

Fraser, Nancy. (1997). Multiculturalism, antiessentialism, and racial democracy: A genealogy of the current impasse in feminist theory. In *Justice Interruptus: Critical Reflection on the "Postsocialist" Condition*. Ed(s). N. Fraser. New York, NY: Routledge, pp. 173-188.

Fraser, Nancy and Gordon, Linda. (1997). A genealogy of dependency: Tracing a keyword of the u.S welfare state. In *Justice Interruptus: Critical Reflections on the "Postsocialist" Condition*. Ed(s). N. Fraser. New York, NY: Routledge, pp. 121-149.

Freire, Paulo. (1996). *Pedagogy of the Oppressed*. New York: Continuum.

Friends of Women and Children in B.C. (2002). *July 15, 2002 Report Card*. Vancouver, BC. 1(4): 1-2.

Frisby, Wendy, Crawford, Susan and Dorer, Therese. (1997). Reflections on participatory action research: The case of low-income women accessing local physical activity services. *Journal of Sport Management*, 11: 8-28.

Frisby, Wendy and Hoeber, Larena. (2002). Factors affecting the uptake of community

recreation as health promotion for women on low incomes. *Canadian Journal of Public Health*, March-April: 129-133.

Gamble, Sarah. (1999). *The Routledge Critical Dictionary of Feminism and Postfeminism.* New York, NY: Routledge.

Gaventa, John and Cornwall, Andrea. (2001). Power and knowledge. In *Handbook of Action Research: Participative Inquiry and Practice.* Ed(s). P. Reason and H. Bradbury. London, UK: Sage Publications, pp. 70-80.

Gergen, Mary M. and Gergen, Kenneth J. (2000). Qualitative inquiry: Tensions and transformations. In *Handbook of Qualitative Research, 2nd Edition.* Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 1025-1046.

Gittelman, Martin. (2002). Communication: The people's charter for health. Spiritof1848@Yahoogroups.Com Listserve.

Goffman, Erving. (1963). *Stigma: Notes on the Management of Spoiled Identity.* New York: Simon & Schuster Inc.

Gordon, Gloria Bravette. (2001). Transforming lives: Towards bicultural competence. In *Handbook of Action Research: Participative Inquiry and Practice.* Ed(s). P. Reason and H. Bradbury. London, UK: Sage Publications, pp. 314-323.

Graham, Hilary. (1990). Behaving well: Women's health behaviour in context. In *Women's Health Counts.* Ed(s). H. Roberts. London, UK: Routledge, pp. 195-219.

Greaves, Lorraine. (1996). *Smoke Screen: Women's Smoking and Social Control.* Halifax, NS: Fernwood Publishing and Scarlet Press.

Greaves, Lorraine. (2000). C.I.H.R. 2000: Sex, gender and women's health. *The B.C. Centre of Excellence for Women's Health.* Vancouver, BC. 62 pages.

Green, Lawrence W., George, M.A., Daniel, M., Frankish, C.J., Herbert, C.J., Bowie, W.R. and O'Neill, M. (1995). Study of participatory research in health promotion: Review and recommendations in the development of participatory research in health promotion in Canada. *Institute of Health Promotion Research, The University of British Columbia.* Vancouver, BC.

Greenwood, Davydd J. and Levin, Morten. (1998). *Introduction to Action Research: Social Research for Social Change.* Thousand Oaks, CA: Sage Publications.

Guba, Egon G. and Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In *Handbook of Qualitative Research.* Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 105-117.

Hall, Budd. (1981). Participatory research, popular knowledge and power: A personal reflection. *Convergence*, 14(3): 6-17.

Hall, Budd. (1992). From margins to center? The development and purpose of participatory research. *The American Sociologist.* 15-28.

Hall, Budd. (1993). Introduction. In *Voices of Change: Participatory Research in the United States and Canada.* Ed(s). P. Park, M. Brydon-Miller, B. Hall and T. Jackson. Toronto, ON: OISE Press, pp. xiii-xxii.

Hankivsky, Olena. (1999). Social justice and women's health: A Canadian perspective. *Maritime Centre of Excellence for Women's Health*, Halifax, NS. http://www.medicine.dal.ca/mcewh/oct-synthesis/hankivsky-justice.htm.

Harding, Sandra. (1986). The instability of the analytical categories of feminist theory. *Journal of Women in Culture and Society*, 11(4): 645-664.

Harding, Sandra. (1987). Introduction: Is there a feminist method? In *Feminism and Methodology: Social Sciences Issues*. Ed(s). S. Harding. Bloomington, IN: Indiana University Press, pp. 1-14.

Harvey, Jean. (2001). The role of sport and recreation policy in fostering citizenship: The Canadian experience. *Canadian Policy Research Networks Discussion Paper NO. F/17*. Ottawa, ON.

Health Canada. (1997). Final table June 26, 1997: Determinants and lifespan n.D.G. *Health Canada*. Ottawa, ON.

Health Canada. (1999). Statistical report on the health of Canadians. *Federal, Provincial, and Territorial Advisory Committee on Population Health*. Charlottetown, PEI. 345 pages.

Herbert, Carol P. (1996). Community-based research as a tool of empowerment: The Haida Gwaii diabetes project example. *Canadian Journal of Public Health*, 87(2): 109-112.

Hertz, Rosanna. (1996). Introduction: Ethics, reflexivity and voice. *Qualitative Sociology*, 19(1): 3-9.

hooks, bell. (1984). *Feminist Theory From Margin to Center*. Boston, MA: South End Press.

hooks, bell. (1988). *Talking Back: Thinking Feminist, Thinking Black*. Toronto, ON: Between the Lines.

hooks, bell. (1990). Choosing the margin as a space of radical openness. In *Women, Knowledge and Reality: Exploration in Feminist Philosophy*. Ed(s). A. Garry and M. Pearsall. New York, NY: Routledge, pp. 48-55.

Hunt, Kate and Annandale, Ellen. (1999). Relocating gender and morbidity: Examining men's and women's health in contemporary western societies. Introduction to special issue on gender and health. *Social Science and Medicine*, 48: 1-5.

Ingham, Alan G. (1985). From public issue to personal trouble: Well-being and the fiscal crisis of the state. *Sociology of Sport Journal*, 2: 43-55.

Israel, Barbara, Checkoway, Barry, Schulz, Amy and Zimmerman, Marc. (1994). Health education and community empowerment: Conceptualizing and measuring perceptions of individual, organizational, and community control. *Health Education Quarterly*, 21(2): 149-170.

Janesick, Valerie J. (2000). The choreography of qualitative research design: Minuets, improvisations, and crystallization. In *Handbook of Qualitative Research, 2nd Edition*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 379-399.

Jarvis, Martin J. and Wardle, Jane. (1999). Social patterning of individual health behaviours: The case of cigarette smoking. In *Social Determinants of Health*. Ed(s). M. Marmot and R. G. Wilkinson. Oxford, UK: Oxford University Press, pp. 240-255.

Jones, Patricia S. and Meleis, A.I. (1993). Health is empowerment. *Advances in Nursing Science*, 15(3): 1-14.

Jones, Wanda K., Snider, Dixie E. and Warren, Rueben C. (1996). Deciphering the data: Race, ethnicity, and gender as critical variables. *Journal of American Medical Women's Association*, 51(4): 137-138.

Kaufert, Patricia A. (1996). *Gender as a Determinant of Health: A Canadian Perspective*. Canada-U.S.A. Women's Health Forum, Ottawa, ON.

Kawachi, Ichiro, Wilkinson, Richard G. and Kennedy, Bruce P. (1999). Introduction. In *Income Inequality and Health: The Society and Population Health Reader*. Ed(s). T. N. Press. New York, NY, pp. xi-xxxiv.

Kelly, Deirdre M. (1996). Stigma stories: Four discourses about teen mothers, welfare, and poverty. *Youth and Society*, 27(4): 421-449.

Kemmis, Stephen. (2001). Exploring the relevance of critical theory for action research: Emancipatory action research in the footsteps of Jurgen Habermas. In *Handbook of Action Research: Participative Inquiry and Practice*. Ed(s). P. Reason and H. Bradbury. London, UK: Sage Publications, pp. 91-102.

Kirby, Sandra and McKenna, Kate. (1989). *Experience, Research, Social Change: Methods from the Margins*. Toronto, ON: Garamond Press.

Klein, Renate Duelli. (1983). How to do what we want to do: Thoughts about feminist methodology. In *Theories on Women's Studies*. Ed(s). G. Bowles and R. D. Klein. London, UK: Routledge, pp. 88-104.

Krieger, Nancy. (2001). A glossary for social epidemiology. *Journal of Epidemiology and Community Health*, 55(October): 693-700.

Krieger, Nancy and Birn, Anne-Emanuelle. (1998). A vision of social justice as the foundation of public health: Commemorating 150 years of the spirit of 1848. *American Journal of Public Health*, 88(11): 1603-1606.

Krieger, Nancy and Fee, Elizabeth. (1994). Man-made medicine and women's health: The biopolitics of sex/gender and race/ethnicity. In *Women's Health Politics, and Power: Essays on Sex/Gender, Medicine, and Public Health*. Ed(s). E. Fee and N. Krieger. Amityville, NY: Baywood Publishing Company, pp. 11-33.

Krieger, Nancy and Zierler, Sally. (1995). Accounting for health of women. *Current Issues in Public Health*, 1(1): 251-256.

Labonte, Ronald. (1982). Half-truths about health. *Policy Options*, 3: 54-55.

Labonte, Ronald. (1986). Social inequality and health public policy. *Health Promotion*, 1(3): 341-351.

Labonte, Ronald. (1994). Health promotion and empowerment: Reflections of professional practise. *Health Education Quarterly*, 21(2): 253-268.

Lahelma, Eero, Martikainen, Pekka, Rahkonen, Ossi and Silventoinen, Karri. (1999). Gender differences in illhealth in Finland: Patterns, magnitude and change. *Social Science and Medicine*, 48: 7-19.

Lal, Jayati. (1996). Situating locations: The politics of self, identity, and "other" in living and

writing text. In *Feminist Dilemmas in Fieldwork*. Ed(s). D. L. Wolf. Boulder, CO: Westview Press Inc., pp. 185-214.

Lather, Patti. (1991). *Getting Smart: Feminist Research and Pedagogy With/in the Postmodern*. New York, NY: Routledge.

Lather, Patti. (2001). Postbook: Working the ruins of feminist ethnography. *Signs: Journal of Women in Culture and Society*, 27(1): 199-227.

Lefebvre, Yvonne. (1995). *Women's Health Research in Canada*, Ottawa, ON: Canada-USA Women's Health Forum.

Lincoln, Yvonna S. (1995). Emerging criteria for quality in qualitative and interpretative research. *Qualitative Inquiry*, 1(3): 275.

Lincoln, Yvonna S. and Denzin, Norman K. (2000). The seventh moment: Out of the past. In *Handbook of Qualitative Research, 2nd Edition*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 1047-1065.

Lofland, John and Lofland, Lyn. (1984). *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis, 2nd Edition*. Belmont, CA: Wadsworth Publishing Company.

Lorber, Judith. (1997). *Gender and Social Construction of Illness*. Thousand Oaks, CA: Sage Publications.

Lord, John and Hutchison, Peggy. (1993). The process of empowerment: Implications for theory and practice. *Canadian Journal of Community Mental Health*, 12(1): 5-21.

Lorde, Audre. (1984). *Sister Outsider*. New York, NY: The Crossing Press Feminist Series.

Love, Rhonda, Jackson, Lois, Edwards, Richard and Pederson, Ann. (1997). Gender and its relationship to other determinants of health. *Department of Behavioral Science, University of Toronto*. Toronto.

Lunman, Kim. (2002). Welfare reform comes to B.C. *The Globe and Mail*. Vancouver: A4.

Macintyre, Sally, Ford, G. and Hunt, Kate. (1999). Do women 'over-report' morbidity? Men's and women's responses to structured prompting on a standard question on long standing illness. *Social Science and Medicine*, 48: 89-98.

Macintyre, Sally and Hunt, Kate. (1997). Socio-economic position, gender and health: How do they interact? *Journal of Health Psychology*, 2(3): 315-334.

Madriz, Esther. (2000). Focus groups in feminist research. In *Handbook of Qualitative Research, 2nd Edition*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 835-850.

Maguire, Patricia. (1987). *Doing Participatory Research: A Feminist Approach*. Amherst, MA: The Centre for International Education, University of Massachusetts.

Maguire, Patricia. (1993). Challenges, contradictions, and celebrations: Attempting participatory research as a doctoral student. In *Voices of Change: Participatory Research in the United States and Canada*. Ed(s). P. Park. Westport, CT: Bergin and Garvey, pp. 157-176.

Maguire, Patricia. (2001). Uneven ground: Feminisms and action research. In *Handbook of Action Research: Participative Inquiry and Practice*. Ed(s). P. Reason and H. Bradbury. London, UK: Sage Publications, pp. 59-69.

Marmot, M.G. et al. (1991). Health inequalities among British civil servants: The Whitehall II study. *Lancet*, 8(June): 1387-1393.

Marmot, M.G., Shipley, M.J. and Rose, G. (1984). Inequalities in death-specific explanations of a general pattern? *Lancet*, 5(May): 1003-1006.

Marmot, Michael. (2000). Introduction. In *Social Determinants of Health*. Ed(s). M. Marmot and R. G. Wilkinson. Oxford, UK: Oxford University Press, pp. 1-16.

Martin, Jane Roland. (1994). Methodological essentialism, false difference, and other dangerous traps. *Signs: Journal of Women in Culture and Society*, 19(3): 630-657.

Martin, Jane Roland. (1996). Aerial distance, esotericism, and other closely related traps. *Signs: Journal of Women in Culture and Society*, 21(3): 584-614.

McAuley, E. and Rudolph, D. (1995). Physical activity, aging and psychological well-being. *Journal of Aging and Physical Activity*, 3: 67-96.

McComas, Joan and Carswell, Anne. (1996). A model for action in health promotion: A community experience. *Canadian Journal of Rehabilitation*, 7(4): 257-265.

McDonough, Peggy and Walters, Vivienne. (2001). Gender and health: Reassessing patterns and explanations. *Social Science and Medicine*, 52: 547-559.

McGinnis, J. Michael, Williams-Russo, Pamela and Knickman, James R. (2002). The case for more active policy attention to health promotion. *Health Affairs*, 21(2): 1-8.

McHoul, Alec and Grace, Wendy. (1993). *A Foucault Primer: Discourse, Power and the Subject*. New York, NY: New York University Press.

McWilliam, Carol L. (1996). Creating understanding that cultivates change. *Qualitative Inquiry*, 2(2): 151-175.

Mies, Maria. (1991). Women's research or feminist research? In *Beyond Methodology: Feminist Scholarships as Lived Research*. Ed(s). M. M. Fonow and J. A. Cook. Bloomington, IN: Indiana University Press, pp. 60-83.

Mikhail, Anis. (1981). Stress: A psychophysiological conception. *Journal of Human Stress*. 9-15.

Miles, Matthew B. and Huberman, A. Michael. (1994). *Qualitative Data Analysis: An Expanded Sourcebook*. Thousand Oaks, CA: Sage Publications.

Millar, Sydney. (2002). Multiple discourses of community development: Addressing the implications for a community-based partnership. *Unpublished Master of Arts thesis in Human Kinetics*. Vancouver, BC, The University of British Columbia.

Morris, William, Ed. (1982). *The Houghton Mifflin Canadian dictionary of the English Language*. Markham, ON: Houghton Mifflin Canada Limited.

Naples, Nancy A. (1996). A feminist revisiting of the insider/outsider debate: The "outsider

phenomenon" in rural iowa. *Qualitative Sociology*, 19(1): 83-106.

National Council of Welfare. (2000). Justice and the poor: A national council of welfare publication. *Minister of Public Works and Government Services Canada*. Ottawa, ON.

National Council of Welfare. (2000). Poverty profile, 1998. *National Council of Welfare*. Ottawa, ON.

Nicoloff, G. and Schwenk, T.L. (1995). Using exercise to ward off depression. *Physician and Sportmedicine*, 23: 44-56.

Nyden, Philip and Wiewel, Wim. (1992). Collaborative research: Harnessing the tensions between researcher and practitioner. *The American Sociologist*, 24: 43-55.

O'Connell, Dorothy. (1988). Poverty and the common woman. In *No Way to Live: Poor Women Speak Out*. Ed(s). S. Baxter. Vancouver, BC: New Star Books, pp. 76-82.

O'Neill, Michel, Rootman, Irving and Pederson, Ann. (1994). Beyond Lalonde: Two decades of Canadian health promotion. In *Health Promotion in Canada: Provincial, National and International Perspectives*. Ed(s). A. Pederson, M. O'Neill and I. Rootman. Toronto, ON: W.B. Saunders Company Canada, pp. 374-386.

Park, Peter. (1993). What is participatory research? A theoretical and methodological perspective. In *Voices of Change: Participatory Research in the United States and Canada*. Ed(s). P. Park. Toronto: OISE Press, pp. 1-19.

Park, Peter. (2001). Knowledge and participatory research. In *Handbook of Action Research: Participative Inquiry and Practice*. Ed(s). P. Reason and H. Bradbury. London, UK: Sage Publications, pp. 81-90.

Parker, Ian. (1992). *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*. London, UK: Routledge.

Poland, Blake. (1998). *Social Inequalities, Social Exclusion and Health: A Critical Social Science Perspective on Health Promotion Theory, Research and Practice*. Conference Presentation, Bergen, Norway.

Pollock, Kristian. (1988). On the nature of social stress: Production of a modern mythology. *Social Science and Medicine*, 26(3): 381-392.

Rahman, Muhammad Anisur. (1983). The theory and practice of participatory action research. In *The Challenge of Social Change*. Ed(s). O. Fals-Borda. Geneva, Switzerland: International Labour Organisation, pp. 108-132.

Rahman, Muhammad Anisur. (1991). The theoretical standpoint of PAR. In *Action and Knowledge: Breaking the Monopoly with Participatory Action Research*. Ed(s). O. Fals-Borda and M. A. Rahman. New York, NY: The Apex Press, pp. 13-23.

Rahman, Muhammad Anisur and Fals-Borda, Orlando. (1991). A self-review of PAR. In *Action and Knowledge: Breaking the Monopoly with Participatory Action Research*. Ed(s). O. Fals-Borda and M. A. Rahman. New York, NY: The Apex Press, pp. 24-34.

Raphael, Dennis. (2001). Inequality is bad for our hearts: Why low income and social exclusion are major causes of heart disease in Canada. *North York Heart Health Network*. Toronto, ON. 71

pages.

Raphael, Dennis. (2001b). Communication: Losing the forest for the trees. Health-Equity-Network@Jiscmail.Ac.Uk .

Razavi, Shahra. (1998). Gendered poverty and social change: An issue paper. *United Nations Research Institute for Social Development.* Geneva.

Reason, Peter. (1994). Three approaches to participative inquiry. In *Handbook of Qualitative Research.* Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 324-339.

Reason, Peter. (1998). Political, epistemological, ecological, and spiritual dimensions of participation. *Studies in Cultures, Organizations and Societies,* 4: 147-167.

Reay, Diane. (1996). Dealing with difficult differences: Reflexivity and social class in feminist research. *Feminism and Psychology,* 6(3): 443-456.

Redman, Selina, Hennrikus, Deborah J., Bowman, Jennifer A. and Sanson-Fisher, Robert W. (1988). Assessing women's health needs. *Medical Journal of Australia,* 148: 123-127.

Regehr, Cheryl. (2000). Action research: Underlining or undermining the cause? *Social Work & Social Sciences Review,* 8(3): 194-206.

Reid, Colleen. (1997). Women organizing for women: Disjunctures in the consumption and provision of health and wellness services for single mothers. *Unpublished Master of Arts thesis in Human Kinetics.* Vancouver, BC, University of British Columbia: 162 pages.

Reid, Colleen. (2000). Seduction and enlightenment in feminist action research. *Resources for Feminist Research,* 28(1/2): 169-188.

Reid, Colleen. (2002). A full measure: Towards a comprehensive model for the measurement of women's health. *The B.C. Centre of Excellence for Women's Health.* Vancouver, BC. 35 pages.

Reid, Colleen and Dyck, Lesley. (2000). Implications: Future research, program and policy development. In *The Health Benefits of Physical Activity for Girls and Women: Literature Review and Recommendations for Future Research and Policy.* Ed(s). C. Reid, L. Dyck, H. McKay and W. Frisby. Vancouver, BC: British Columbia Centre of Excellence for Women's Health, pp. 201-205.

Reid, Colleen, Frisby, Wendy, Millar, Sydney and Pinnington, Beth. (2000). W.O.A.W. Phase 1 report: An overview of initial research findings and reflections. *W.O.A.W.: Women Organizing Activities for Women,* funded by the Social Sciences and Humanities Council of Canada. Vancouver, BC. 29 pages.

Reid, Colleen, Frisby, Wendy, Millar, Sydney, Pinnington, Beth and Ponic, Pamela. (2001). W.O.A.W. Phase 2 report: An overview of research findings, reflections and recommendations. *W.O.A.W.: Women Organizing Activities for Women,* funded by the Social Sciences and Humanities Council of Canada. Vancouver, BC. 41 pages.

Reid, Colleen, Frisby, Wendy and Ponic, Pamela. (2002). Confronting two-tiered community recreation and poor women's exclusion: Promoting inclusion, health, and social justice. *Canadian Women's Studies, Special Issue "Women and Sport,"* 21(3): 88-94.

Reinharz, Shulamit. (1983). Women as competent community builders. *Issues in Mental Health*

Nursing, 5(1-4): 19-43.

Reinharz, Shulamit. (1992). *Feminist Methods in Social Research*. New York, NY: Oxford University Press.

Repetti, Rena L. and Wood, Jenifer. (1997). Families accommodating to chronic stress: Unintended and unnoticed processes. In *Coping with Chronic Stress*. Ed(s). B. H. Gottlieb. New York, NY: Plenum, pp. 191-220.

Richardson, Laurel. (1994). Writing: A method of inquiry. In *Handbook of Qualitative Research*. Ed(s). N. K. Denzin and Y. S. Lincoln. London, UK: Sage Publications, pp. 516-529.

Richardson, Laurel. (2000). Writing: A method of inquiry. In *Handbook of Qualitative Research, 2nd Edition*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 923-948.

Ristock, Janice L. and Pennell, Joan. (1996). *Community Research as Empowerment: Feminist Links, Postmodern Interruptions*. Toronto, ON: Oxford University Press.

Robertson, Ann. (1998). Shifting discourses on health in Canada: From health promotion to population health. *Health Promotion International*, 13(2): 155-166.

Rootman, Irving and Raeburn, John M. (1994). The concept of health. In *Health Promotion in Canada: Provincial, National and International Perspectives*. Ed(s). A. Pederson, M. O'Neill and I. Rootman. Toronto, ON: W.B. Saunders Company Canada, pp. 56-71.

Rose, Gillian. (1997). Situating knowledges: Positionality, reflexivities and other tactics. *Progress in Human Geography*, 21(3): 305-320.

Ruspini, Elisabetta. (2001). The study of women's deprivation: How to reveal the gender dimension of poverty. *International Journal of Social Research Methodology*, 4(2): 101-118.

Ruzek, Sheryl Burt, Clarke, Adele E. and Olesen, Virginia L. (1997). Social, biomedical, and feminist models of women's health. In *Women's Health: Complexities and Differences*. Ed(s). S. B. Ruzek, A. E. Clarke and V. L. Olesen. Columbus, OH: Ohio State University Press, pp. 11-28.

Ruzek, Sheryl and Hill, Jessica. (1986). Promoting women's health: Redefining the knowledge base and strategies for change. *Health Promotion*, 1(3): 301-309.

Ryan, Gery W. and Bernard, Russell. (2000). Data management and analysis methods. In *Handbook of Qualitative Research, 2nd Edition*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 769-802.

Scheff, Thomas J., Retzinger, Suzanne M. and Ryan, Michael T. (1989). Crime, violence, and self-esteem: Review and proposals. In *The Social Importance of Self-esteem*. Ed(s). A. M. Mecca, N. J. Smelser and J. Vasconcellos. Berkeley, CA: University of Berkeley Press, pp. 165-199.

Schlicht, W. (1993). Mental health as a consequence of physical exercise: A metal-analysis. *The German Journal of Psychology*, 17: 88-92.

Schroeder, Carole and Ward, Debbie. (1998). Women, welfare, and work: One view of the debate. *Nursing Outlook*, 46: 226-232.

Schur, Edwin M. (1980). *The Politics of Deviance: Stigma Contests and the Uses of Power*. Englewood

Cliffs, NJ: Prentice-Hall Inc.

Sedgewick, Eve Kosofsky. (1993). *Tendencies*. Durham, NC: Duke University Press.

Shaw, Mary, Dorling, Danny and Smith, George Davey. (2000). Poverty, social exclusion, and minorities. In *Social Determinants of Health*. Ed(s). M. Marmot and R. G. Wilkinson. Oxford, UK: Oxford University Press, pp. 211-239.

Shiell, Alan and Hawe, Penelope. (1996). Health promotion community development and the tyranny of individualism. *Health Economics*, 5: 241-247.

Spivak, Gayatryi C. (1990). *The Post-colonial Critic: Interviews, Strategies, Dialogues*. New York, NY: Routledge.

Standing, Kay. (1998). Writing the voices of the less powerful: Research on lone mothers. In *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives*. Ed(s). J. Ribbens and R. Edwards. London, UK: Sage Publications, pp. 186-202.

Statistics Canada. (1996). *1996 census nation tables*. Statistics Canada. www.statscan.ca/english.

Stein, Jane. (1997). *Empowerment and Women's Health: Theory, Methods and Practise*. London, UK: Zed Books.

Swanson, Jean. (2001). *Poor-bashing: The Politics of Exclusion*. Toronto, ON: Between the Lines.

Tandon, Rajesh. (1988). Social transformation and participatory research. *Convergence*, 21(2/3): 5-18.

The Globe and Mail. (2001). A special interest supplement "Women's Health" September 24, 2001: W1.

Thibault, Lucie, Frisby, Wendy and Kikulis, Lisa. (1999). Interorganizational linkages as a strategic response to institutional pressures. *Managing Leisure*, 4: 125-141.

Tierney, William G. (2000). Undaunted courage: Life history and the postmodern challenge. In *Handbook of Qualitative Research, 2nd Edition*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 537-553.

Tom, Allison. (1993). Women's lives complete: Methodological concerns. In *Women, Work and Coping*. Ed(s). B. C. Long and S. E. Kahn. Kingston, ON: Queen's University Press, pp. 32-50.

Tom, Allison. (1997). The deliberate relationship: A frame for talking about faculty-student relationships. *The Alberta Journal of Educational Research*, 43(1): 3-21.

Tom, Allison and Herbert, Carol. (2001). The near miss: A story of relationship. *Qualitative Inquiry*, 8(3): in press.

Van Den Bergh, Nan. (1995). Feminist social work practice: Where have we been...Where are we going? In *Feminist Practice in the 21st Century*. Ed(s). N. Van Den Bergh. Washington, DC: NASW Press, pp. xi-xxxix.

Vertinsky, Patricia, Batth, Indy and Naidu, Mita. (1996). Racism in motion: Sport, physical activity and the Indo-Canadian female. *Avante*, 2(3): 1-23.

Vio Grossi, Francisco. (1981). Socio-political implications of participatory research. *Convergence*,

14(3): 43-51.

Wall, Naomi Binder. (1993). The beautiful strength of my anger put to use. In *And Still We Rise: Political Mobilizing in Contemporary Canada*. Ed(s). L. Carty. Toronto, ON: Women's Press, pp. 279-298.

Wallerstein, Nina. (1999). Power between evaluator and community: Research relationships within New Mexico's healthier communities. *Social Science and Medicine*, 49: 39-53.

Wallerstein, Nina and Freudenberg, Nicholas. (1998). Linking health promotion and social justice: A rationale and two case stories. *Health Education Research*, 13(3): 451-457.

Walters, Vivienne, Lenton, Rhonda and Mckeary, Marie. (1995). Women's health in the context of women's lives. *Health Promotion Directorate, Health Canada*. Ottawa, ON.

Weedon, C. (1987). *Feminist Practice and Post-structuralist Theory*. Oxford, UK: Basil Blackwell.

Weitzman, Eben A. (2000). Software and qualitative research. In *Handbook of Qualitative Research, 2nd Edition*. Ed(s). N. K. Denzin and Y. S. Lincoln. Thousand Oaks, CA: Sage Publications, pp. 803-820.

Wendell, Susan. (1996). *The Rejected Body: Feminist Philosophical Reflections on Disability*. New York, NY: Routledge.

West, Candace and Fenstermaker, Sarah. (1995). Doing difference. *Gender and Society*, 9(1): 8-37.

Westkott, Marcia. (1998). Culture and women's health. In *Behavioral Medicine and Women: A Comprehensive Handbook*. Ed(s). E. A. Blechman and K. D. Brownwell. New York, NY: The Guildford Press, pp. 816-820.

White, Paul. (1998). Urban life and social stress. In *The New Europe: Economy, Society and Environment*. Ed(s). D. Pinder. Chichester, UK: John Wiley & Sons, pp. 305-321.

White, Philip, Young, Kevin and Gillett, James. (1995). Bodywork as a moral imperative: Some critical notes on health and fitness. *Society and Leisure*, 18(1): 159-182.

Whiteford, Linda M. (1996). Political economy, gender and the social production of health and illness. In *Gender and Health: An International Perspective*. Ed(s). C. F. Sargent and C. G. Brettell. Englewood Cliffs, NJ: Prentice-Hall Inc., pp. 242-259.

Whitemore, E. and Kerans, P. (1988). Participation, empowerment and welfare. *Canadian Review of Social Policy*, 22: 51-60.

Wilkinson, Richard G. (1992). Income distribution and life expectancy. *British Medical Journal*, 304(6820): 165-8.

Wilkinson, Richard G. (1996). *Unhealthy Societies: The Afflictions of Inequality*. London, UK: Routledge.

Wilkinson, Richard G. (2000). Putting the picture together: Prosperity, redistribution, health, and welfare. In *Social Determinants of Health*. Ed(s). M. Marmot and R. G. Wilkinson. Oxford, UK: Oxford University Press, pp. 256-274.

Williamson, Deanna and Green, Lawrence W. (1999). *The Role of the Health Sector in Addressing*

Poverty. Annual Conference of the Canadian Public Health Association, Winnipeg, MB.

Wolf, Diane L. (1996). Situating feminist dilemmas in fieldwork. In *Feminist Dilemmas in Fieldwork.* Ed(s). D. L. Wolf. Boulder, CO: Westview Press, pp. 1-55.

Woodman, Marion with Jill Mellick. (2001). *Coming Home to Myself: Daily Reflections for a Woman's Body and Soul.* Berkeley, CA: Conari Press.

World Health Organization. (1998). Gender and health: Technical paper. *The World Health Organization.* Geneva, Switzerland.

Young, Iris Marion. (1990). *Justice and the Politics of Difference.* Princeton, NJ: Princeton University Press.

Zola, Irving Kenneth. (1972). Medicine as an institution of social control. *Sociological Review,* 20: 487-504.

Appendices

Appendix A – Overview of SSHRC Project

1999	
June 1999	• First workshop at Poirier Centre (Leisure and Parks, Coquitlam); over 85 women and their children attend. • "Women Organizing Activities for Women" named for the first time; four WOAW subgroups determined.
June – Aug. 1999	• The four WOAW subgroups meet regularly – PoCo WOAW, Aged to Perfection, SWCo WOAW, Iranian Mutual Support Group. • Dr. Frisby receives a $5000 Seed Grant from SSHRC to complete the second stage research proposal.
Sept. 1999	• Colleen hired as Project Manager for the research component of WOAW; begins attending subgroup meetings, writing a monthly newsletter, and attending Project Team meetings. • 1st Annual WOAW Picnic
Oct. 1999	• Dr. Frisby submits the larger research proposal to SSHRC
Nov. 1999	• The Iranian Mutual Support Group disbanded; 3 subgroups remaining.
Dec. 1999	• WOAW receives 3 years of funding from SSHRC • Colleen submits her "Second-Stage Research Proposal" to her committee; determines that her data collection will occur through the formation of a "Research Team."
2000	
Jan. 2000	• The official beginning of the research component of WOAW
Mar. 7, 2000	• 1st Research Team meeting held at Hyde Creek Recreation Centre, Port Coquitlam.
Mar. – Apr. 2000	• 1st round of interviews with women in WOAW conducted by Colleen (n=20) • 1st round of interviews with WOAW community partners conducted by Dr. Frisby (n=10).
Apr. 2000	• Formation of CoPoMo WOAW. • Increased involvement of 3 more community partners due to formation of CoPoMo WOAW
May – Jun. 2000	• 2nd round of interviews with women in WOAW conducted by Colleen (n=12)
June 7, 2000	• Phase 1 Research Party (5th Research Team meeting)
July 1, 2000	• Beginning of Phase 2 of SSHRC research project (July 1 – December 31, 2000)
Sept. 2000	• 2nd Annual WOAW Picnic
Nov. 9, 2000	• 11th Research Team meeting, only one attendee.
Dec. 12, 2000	• Phase 2 Research Party (12th Research Team meeting)
2001	
Jan. 1, 2001	• Beginning of Phase 3 of SSHRC research project (January 1 – June 30, 2001) • Decreased role as Project Manager (Colleen) and gradual integration of Pam Ponic as the Project Manager.
Feb. 6, 2001	• 13th Research Team meeting
Apr. 3, 2001	• 14th Research Team meeting. • Louise (community service provider) attended to help group devise welfare grievances workshop.
May 29, 2000	• Research Team data analysis potluck (15th Research Team meeting)
June 19, 2000	• DERA Workshop at 17th Research Team meeting
June 21, 2000	• Phase 3 Research Party (18th Research Team meeting)
July 1, 2001	• Beginning of Phase 4 of SSHRC research project (July 1 – December 31, 2001) • Pam Ponic as Project Manager, Colleen no longer working regular hours on SSHRC project

October 19-21, 2001	• WOAW retreat at Sasamat Outdoor Centre
November 8, 2001	• 19th Research Team meeting
December 4, 2001	• Phase 4 Research Party (20th Research Team meeting)

2002

January 1, 2002	• Beginning of Phase 5 of the SSHRC research project (January 1 – June 30, 2002) • Colleen filling in as Project Manager while Pam away
February 4, 2002	• 21st Research Team meeting
May 2, 2002	• 22nd Research Team meeting – discussion of BC government welfare cuts • Thank you letters and quotations sent to all of Colleen's research participants
May 16, 2002	• Research Analysis meeting (for Phase 4 WOAW report); focus on social isolation
June 13, 2002	• Research Party (23rd Research Team meeting)
July 1, 2002	• Beginning of Phase 6 of the SSHRC research project (July 1 – December 31, 2002) • CIHR community recreation policy grant submitted

Appendix B – Detailed Overview of Research Team Meetings

	Attendance; new attendees	Topics Discussed, Decisions Made, and Important Notes*
RTM #1 – **March 7, 2000**	15	• Discussed purpose of the Research Team; tape recording, consent, confidentiality; honoraria • Engaged in unexpected discussion around stereotypes associated with welfare and poverty honoraria*
RTM #2 – **April 4, 2000**	13; 6	• Discussed health and poverty; stress, depression, isolation; common barriers • Shared experiences with judging and stereotypes honoraria*
RTM #3 – **April 26, 2000**	10; 1	• Discussed stress and depression as major health issues • Reviewed data from previous meeting – the relationship between stress, depression, social isolation, and poverty • Discussed the label of welfare recipient • Divided into 2 groups to brainstorm possible group actions honoraria*
RTM #4 – **May 16, 2000**	16; 0	• Divided into 4 groups to discuss welfare grievances and recommendations • Data analysis – distributed handout with data from previous meetings & direct quotes honoraria*
RTM #5 – **June 7, 2000** *Phase 1 Research Party*	13; 2	• Discussed hopes and dreams of the Research Team • Engaged in group discussion around celebrating successes • Guided through resources exercise (Beth) • Socialized with catered lunch
RTM #6 – **June 29, 2000**	8; 0	• Future hopes and dreams for the RT • Discussed actions of the Research Team • Decided to focus on working towards registering WOAW as a non-profit society and organizing a welfare grievances workshop • Data analysis – distributed handout with hopes and dreams for the Research Team honoraria*
RTM #7 – **August 17, 2000**	10; 0	• Had a 45 minute check-in, discussing group activities and challenges • Conflict arose between PoCo WOAW and Aged to Perfection subgroups • Determined that 2 members get information about non-profit and non-governmental organizations • Data analysis – discussed handout with hopes and dreams for the Research Team
RTM #8 – **Sept. 6, 2000**	9; 4	• Discussed group process, including values, principles and roles • Amanda (co-op student) attended and discussed the resource book • Discussed ideas for a welfare grievances workshop • Distributed handouts on group process
RTM #9 – **Sept. 27, 2000**	7; 0	• Reviewed group process values, principles, and roles • Research Team member distributed information on non-profit society • Distributed handouts to group on group process, welfare grievances workshop, and photocopies from "Educating For A Change"
RTM #10 – **October 19, 2000**	7; 2	• Community health nurse attended; discussed the role of community health nurse with WOAW and identified health policy areas to address • Discussed welfare grievances • Discussed ways for the Research Team to be more effective; being organized, doing the work, taking responsibility, setting goals and deadlines • Distributed handout for tracking "action items" from the meetings

	Attendance: new attendees	Topics Discussed, Decisions Made, and Important Notes*
RTM #11 – **Nov. 9, 2000**	1; 0	• Conducted an impromptu interview on the strengths and limitations of the Research Team. • Discussed body weight as an issue for many WOAW members
RTM #12 – **Dec. 12, 2000** *Phase 2 Research Party*	12; 1	• Discussed challenges the groups are facing; specifically PoCo WOAW's challenges • Celebrated successes of WOAW and the Research Team • Catered lunch and socializing Tape recording blocked* honoraria*
RTM #13 – **February 6, 2001**	9; 0	• Meeting initiated by ATP member (Wanda) • Group decided to focus on welfare grievances workshop; each group to come up with key issues they would like to have addressed • Decided to work together and to write key questions on a flip chart
RTM #14 – **March 6, 2001**	12; 0	• Discussed key questions from each group; participant took notes on flip chart • Data analysis - distributed analysis categories for "poverty"; though little discussion was generated • Decided to make calls to find speakers and locations; tasks divided among the women
RTM #15 – **April 3, 2001**	14; 0	• Louise Hara attended and discussed particulars of community forum • Determined to have two meetings – one with Downtown Eastside Residents' Association (DERA) and one with B.C. Benefits regional coordinator
RTM #16 – **April 17, 2001**	5; 0	• Booked DERA for June 19, 2000 • Decision to have Regional Coordinator visit after DERA workshop, in fall 2001 • Booked "Data analysis potluck" for May 29, 2000 • Decision to investigate joining the "bus riders union"
RTM #17 – **May 29, 2001** *Data Analysis Potluck*	15; 4	• Data analysis led by Colleen, with flip chart and handouts • Discussion of major categories for Colleen's dissertation • Pam Ponic took fieldnotes honoraria*
RTM #18 – **June 19, 2001** *DERA Workshop*	17	• A representative from DERA attended this meeting and discussed the rights and entitlements of B.C. Benefits recipients – both disability benefits and social assistance. Colleen absent*

Informed Consent Form

I understand that my participation in the study entitled "The health of women on low-income: ideologies, experiences and health through a frame of feminist action research" is entirely voluntary. I may refuse to participate or withdraw from the study at any time without jeopardy of participation in community recreation programs. I have received a copy of the letter of initial contact for my own records and I understand what is asked of participants in this study.

I CONSENT to participate in this study.

Signature_____ Date: _____

I CONSENT to having the interviews tape recorded.

Signature_____ Date: _____

I CONSENT to having the Research Team meetings tape recorded.

Signature_____ Date: _____

Page 2 of 2

Appendix D – Schedule #1 Interview Questions March 2000

How and when did you get involved in WOAW? How are you currently involved?

What were your reasons for getting involved? What do you hope to gain from your involvement? Have your reasons changed from the beginning?

What is your assessment of how WOAW is going? Are you encountering any difficulties in staying involved? What challenges have your WOAW group been encountering? How are these challenges dealt with?

What are the most appealing activities that are being developed and why? How do you see yourself benefiting from these activities? Do you have any concerns about these activities?

This project is a partnership with other women, service providers, and researchers. What are the advantages of partnering with a) other women, b) service providers, and c) researchers? What are the challenges of partnering with a) other women, b) service providers, and c) researchers?

Do you consider yourself to be healthy? What are your main health concerns? What do you think is/are the cause(s) of this/these health concern(s)? Do you think that your living situation (family, environment, support, financial situation, etc.) has an impact on your health? Why or why not?

Physical inactivity, stress, and social isolation are three health issues that WOAW members have identified as priorities that should be tackled through this project.

Is physical inactivity a health issue for you? Why is this the case? What barriers do you encounter that make it difficult to be physically active?

Is stress a health issue for you? What is causing stress in your life? How have you been dealing with it?

Is social isolation a health issue for you? What is causing you to feel socially isolated? How have you been dealing with it?

What changes would help to reduce physical these particular health issues (physical inactivity, stress, social isolation, or the ones previously identified)?

Are physical inactivity, stress, and social isolation interconnected issues? In what ways?

Is your involvement in WOAW helping you deal with these health issues? Is it contributing in any other ways that we have not already discussed?

Appendix E – Schedule #2 Interview Questions June 2000

How have you been involved in WOAW? How many hours per week do you spend on WOAW activities and meetings?

To you, what is the image of good health? Where does this image come from?

It has been raised in the Research Team meetings that the experience of living in poverty is one of the group's biggest health concerns. Is this the case for you?

What in particular about living in poverty is a health concern for you?

How long have you lived in poverty for? What do you think causes you to live in poverty?

What is the stereotype/label/stigma of people living on welfare?
(Probes if necessary: men versus women; single mothers; older women; middle-aged single women)

Does the stereotype exist? In which cases?

What are the consequences of the stereotype? How has the stereotype affected you?

Is there a connection between the stigma of welfare and your health? Do you think that dealing with the stereotype affects your health? In what ways?

What would an ideal community look like? What does a healthy community look like?

What is your community? Do you have more than one?

Do you feel like you have a voice in your community? Why or why not?

In what ways do you feel excluded from the community you would like to be a part of? What do you think are the effects of your exclusion? Does your exclusion affect your health? In what ways?

Is there a connection between your community/lack of community and your health? Why or why not?

Do you think that the Research Team is an important aspect of WOAW?

What have been the main activities at the RT meetings (learning, sharing, networking, collaborating, research)? How could the RT be changed to better suit your needs?

Is there value in discussing your grievances with welfare? Why or why not? Where should the RT go from here?

Appendix F – Interview Face Sheet

Name: _____   Age: _____

Domestic status:
☐ single
☐ divorced
☐ separated
☐ widowed
☐ common-law partner
☐ other?

How would you describe your ethnicity/race? _____

Do you have children?
☐ yes
☐ no

If yes, how many children do you have and what are their ages? _____

_____

Where do your children live? _____

What is your education level?
☐ elementary school
☐ some high school
☐ completed grade 12
☐ some college
☐ completed college diploma
☐ some university
☐ completed university degree
☐ other: _____

Do you receive social assistance?
☐ yes
☐ no

Are you on disability benefits?
☐ yes
☐ no

If yes, are they:
☐ public
☐ private
☐ both public and private

For how long have you been receiving social assistance and/or disability benefits?

_____

What was your family income as you were growing up? (estimate)
☐ below $10 000
☐ between $10 000 and $20 000
☐ between $20 000 and $30 000
☐ between $30 000 and $40 000
☐ over $40 000

What kind of neighborhood did you grow up in? _____

What was your parents' education level? _____

What is/are your biggest health issue(s)?

_____

What are your future aspirations? Do you have a career or goals in mind for the future?

_____

_____

Appendix G – Fieldnote Guidelines for Observations of Research Team Meetings

Throughout the data collection process, observations will be made and recorded as fieldnotes. I will document my "personal history" of the research process, reflecting on barriers, difficulties and constraints encountered, challenges in linking with the "community", and power dynamics throughout the process. As well, my role as the researcher and my "conceptual baggage" (Kirby and McKenna, 1989) will be thoroughly documented in my journal. Observations of the Research Team meetings, Project Team meetings and subgroup meetings for the "Women Organizing Activities for Women" (WOAW) were informed by the following guidelines:

- Logistical information (e.g. date, time, location, and attendance);

- Meanings and understandings of health (e.g. meanings of good health, meanings of poor health, decision-making about health, health concerns, responsibility for health);

- Experiences and understandings of the stereotype of low-income women, low-income mothers, and low-income elderly women (e.g. specific anecdotes of incidences and stories, confrontations and challenges with the stereotype, critiques of this stereotype, experiences with authority figures, evidence of internalizing the stereotype, evidence of dismissing the stereotype);

- The relationship between the stereotype and the women's health (e.g. does the stereotype result in anxiety, stress, guilt, low self-esteem, shame, denial, or social isolation for the women?);

- Evidence of action plans for addressing stereotyping and health for this group of low-income women (e.g. individual action such as overcoming the stereotype of the low-income woman by becoming visible and active in decision making, organizational action such as challenging evidence of the stereotype in practices and policies in community services, and community-level action, including press releases or seeking media attention to debunk the stereotype).

Appendix H – Code Book

ACTION
Action - (1) WOAW
Action - (2) Individual
Action - (3) Systemic
action - action-oriented WOAW members
action - activities & workshops
action - activities for kids
action - childcare
action - fundraising
action - health sector
action - housing
action - importance of both
action - individual
action - individual - career
action - individual - helping other women
action - networking
action - non-profit society
action - recreation
action - resource book
action - societal "big A" change
action - transit
action - welfare
action - welfare - homecare
action - welfare - treatment
action - WOAW
action - WOAW - advertising

BARRIER
barrier - individual - ex partner
barrier - individual - health
barrier - individual - motivation
barrier - individual - poverty
barrier - individual - self-esteem
barrier - individual - shame
barrier - individual - time
barrier - individual - voice
barrier - recreation - economic
barrier - societal - daycare
barrier - societal - isolation
barrier - societal - women's roles
barrier - WOAW - belonging
barrier - WOAW - childcare
barrier - WOAW - cliques
barrier - WOAW - group process
barrier - WOAW - location
barrier - WOAW - numbers
barrier - WOAW - transportation

COMMUNITY
community - acceptance & openness
community - accessibility
community - church
community - cliques
community - defined
community - family
community - food banks
community - friends
community - having a voice
community - health/ideal
community - helping/working together
community - housing
community - inclusion/exclusion
community - non-WOAW
community - parks
community - priorities
community - recommendations
community - recreation centre
community - safety/policing
community - stereotype
community - transportation
community - Tri-City area
community - WOAW
community - women's centre

GROUP PROCESS
group process - attendance
group process - attitude towards hierarchy
group process - confidentiality & anonymity
group process - conflict
group process - doing a round
group process - doing the work
group process - domination
group process - group energy
group process - organization & structure
group process - participation
group process - roles
group process - speaking in public
group process - speaking one at a time
group process - tape recording
group process - women facilitating
group process - working together

306

HEALTH
health - age
health - body image
health - eating
health - general comments
health - medications/counseling
health - mental health
health - smoking
health – television

HEALTH - BELIEFS
health - beliefs - experience & understandings
health - beliefs - having hope
health - beliefs - image of good health
health - beliefs - judging
health - beliefs – media

HEALTH - CONNECTION
health - connection - depression & self-esteem
health - connection - depression & SI
health - connection - stress & depression
health - connection - stress & SI
health - connection - stress, depression, SI
health - connection - stress, depression, SI, PA

HEALTH - DEPRESSION
health - depression - actions
health - depression - anger
health - depression - bc of WOAW
health - depression - defined
health - depression - diagnosed "clinical"
health - depression - eating
health - depression - fears
health - depression - judging
health - depression - living in pain
health - depression - low income
health - depression - men
health - depression - motivation
health - depression - parenting
health - depression - tiredness/sleep
health - depression - TV
health - depression - vitamins
health - depression - weather

HEALTH - DISABILITY
health - disability - govt standards
health - disability - poverty
health - disability - stigma
health - disability - transportation

HEALTH - NEGATIVE
health - negative - addictions
health - negative - affect lifestyle
health - negative - alcoholism
health - negative - anger
health - negative - arthritis
health - negative - back
health - negative - body weight concerns
health - negative - breast cancer
health - negative - bunions
health - negative - carpal tunnel syndrome
health - negative - chronic fatigue
health - negative - diabetes
health - negative - eating/eating disorders
health - negative - elephantitis
health - negative - endometriosis
health - negative - falling/loss of balance
health - negative - fibromyalgia
health - negative - headache (migraines)
health - negative - heart
health - negative - high blood pressure
health - negative - hyperthyroidism
health - negative - IBS
health - negative - loss of memory/confusion
health - negative - low energy
health - negative - osteoporosis
health - negative - pain
health - negative - parenting
health - negative - scoliosis
health - negative - sharps box
health - negative - shingles
health - negative - sinusitis
health - negative - sleep
health - negative - smoking
health - negative - social anxiety disorder
health - negative - surgery
health - negative – tendonitis

HEALTH - PHYSICAL ACTIVITY
health - physical activity - barrier - ability
health - physical activity - barrier - financial
health - physical activity - barrier - friends
health - physical activity - barrier - laziness
health - physical activity - barrier - physical access
health - physical activity - benefit
health - physical activity – involvement

HEALTH - POSITIVE
health - positive - housing
health - positive - inspiration
health - positive - social network
health - positive - transportation

HEALTH - POVERTY
health - poverty - affordability
health - poverty - barriers
health - poverty - bureaucracy
health - poverty - decision making
health - poverty – shame

HEALTH - SELF-ESTEEM
health - self-esteem – poverty

HEALTH - SOCIAL ISOLATION
health - social isolation - domestic status
health - social isolation - education
health - social isolation - fear/intimidation
health - social isolation - friends
health - social isolation - health reasons
health - social isolation - loneliness
health - social isolation - low self-esteem
health - social isolation - parenting/family
health - social isolation - poverty
health - social isolation - WOAW
health - social isolation - women's roles

HEALTH - STRESS
health - stress - actions
health - stress - cause of stress
health - stress - children/parenting
health - stress - community
health - stress - eating
health - stress - effects of stress on health
health - stress - family
health - stress - fear of dying
health - stress - finding work
health - stress - friendships
health - stress - govt bureaucracy
health - stress - headaches (migraines)
health - stress - health concerns
health - stress - income tax
health - stress - judging/labeling
health - stress - life changes
health - stress - no time for self
health - stress - pain
health - stress - physical effort day-to-day
health - stress - poverty
health - stress - poverty - worry/helplessness
health - stress - use of word "stress"
health - stress – WOAW

IDENTITY
identity - feminist
identity - represent women on LI
identity - WOAW members
identity - women
identity - work

MOTHERHOOD
motherhood - parenting
motherhood – poverty

PERCEPTION
perception - community & society
perception - couples society
perception - diverse & diversity
perception – TV

PERSONAL EXPERIENCE
pers. exp. - abuse
pers. exp. - children/childcare
pers. exp. - comm. involvement
pers. exp. - criminal minded
pers. exp. - education
pers. exp. - ethnicity
pers. exp. - family
pers. exp. - invisibility & no voice
pers. exp. - judging
pers. exp. - length of time in poverty
pers. exp. - motivation
pers. exp. - partner (ex, husband, etc)
pers. exp. - school/bullying
pers. exp. - sexual orientation
pers. exp. - shame
pers. exp. - smoking
pers. exp. - suicide
pers. exp. - support & understanding
pers. exp. - trust
pers. exp. - women friends
pers. exp. - work

POVERTY
poverty - accessibility of services
poverty - analysis & critique
poverty - banking
poverty - barriers and challenges
poverty - benefits/plusses
poverty - children/child benefits/childcare
poverty - fear, intimidation & threatening
poverty - health care - medications
poverty - health care - personnel
poverty - health care services
poverty - housing
poverty - identity - adapting/resourceful
poverty - lack of information
poverty - media - treatment
poverty - men
poverty - money - budgeting
poverty - money - food
poverty - money - level of financial support
poverty - money - school expenses
poverty - powerlessness
poverty - pride
poverty - recreation
poverty - recreation staff
poverty - services & entitlements
poverty - spousal support
poverty - transportation
poverty - treatment
poverty - unseen poor
poverty - welfare - personnel
poverty - welfare - policy
poverty - welfare office
poverty - work & training

RACISM - prejudice - description
RESEARCHER ROLE
researcher role - arranging childminding
researcher role - asking questions
researcher role - communications with women
researcher role - driving
researcher role - facilitating
researcher role - food for meetings
researcher role - logistics
researcher role - organizer & instigator
researcher role - outsider
researcher role - project manager
researcher role - questions about group process
researcher role - reactions
researcher role - representation
researcher role - resource person
researcher role - role of interviews

ROLE OF RESEARCH TEAM
role of RT - action
role of RT - connectedness
role of RT - diverse women together
role of RT - doing work for WOAW
role of RT - getting work done
role of RT - knowing you're not alone
role of RT - learning and consciousness raising
role of RT - overwhelming & difficult
role of RT - registering as a non-profit
role of RT - resource sharing
role of RT - sharing
role of RT - transit
role of RT - venting problems
role of RT - welfare grievances
role of RT - working for the community
role of RT - working in a group

STEREOTYPE
stereotype - age
stereotype - bad mother
stereotype - children
stereotype - disability
stereotype - reaction
stereotype - researcher
stereotype - researcher reflections
stereotype - shame
stereotype - single mother
stereotype - weight
stereotype - welfare recipient

SUPPORT OF SSHRC
support of SSHRC - assistant (Beth)
support of SSHRC - relationship to dissertation

WOAW
WOAW - activities
WOAW - benefit
WOAW - budget
WOAW - commitment
WOAW - community partners
WOAW - cost of childminding
WOAW - honoraria
WOAW - level of involvement
WOAW - newsletter
WOAW - researchers
WOAW - subgroups
WOAW - sustainability
WOAW -- vision

WORK