

WOMEN, LOW INCOME, AND HEALTH:  
AN ETHNOGRAPHY OF A HOUSING CO-OPERATIVE

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF  
MASTERS OF SCIENCE IN NURSING  
in  
FACULTY OF GRADUATE STUDIES  
School of Nursing

We accept this thesis as conforming  
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

April 1996

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### Abstract

The purpose of this study was to describe the health beliefs, values, concerns, and health practices of women living on low income in a specific housing co-operative. The choice of this context controlled for some of the diversity which exists amongst poor women. The effect of a co-operative housing environment on the health of these women was also examined.

Initially, an ethnographic method was proposed. When access for participant-observation was denied, the method was modified to include intensive interviews only. Ten volunteers were recruited out of the total population of thirty-six women. These women were interviewed individually (with one exception), using an unstructured format. The interviews were audio-taped, transcribed, and analyzed for common themes.

At the time of the study, the participants saw themselves as a diverse group lacking a common identity. They did acknowledge, however, that they shared a common history of "hard experiences." The findings revealed that, for these women, inherent in the experience of living on a low income is a sense of a lack of control. Limited finances result in fewer choices and decreased feelings of control over one's life. Consequently, health was defined for these women in terms of meeting basic needs such as safety and security.

The participants identified their new environment as having both positive and negative health consequences. Acquiring stable, subsidized housing had reduced, although not eliminated, the stress of coping with limited finances. Initially, however, the new responsibilities associated with managing the co-operative, combined with adjusting to a community lifestyle, provided enough added stress that several women identified a significant deterioration in their health following the move.

Since no research could be found which addresses the health of mature, unattached, low income women, this descriptive study represents a starting point for further research.

**TABLE OF CONTENTS**

Abstract	ii
Table of Contents	iv
Acknowledgement	viii
CHAPTER ONE: INTRODUCTION	1
Background of the Study	1
Research Questions and Purpose	5
Statement of the Problem	5
Purpose	5
Research Questions	6
CHAPTER TWO: LITERATURE REVIEW	7
Introduction	7
Poverty and Health	9
Conceptual and Methodological Issues	10
Women, Poverty, and Health	11
Housing, Poverty, and Health	20
Gaps in the Research on Women and Poverty	22
Conclusions	25
CHAPTER THREE: METHOD	28
Introduction	28
Definition of Terms	29
Assumptions	29
Limitations	30
Sample	30
Setting	30
Gaining Access	31

	v
Sampling	32
Data Collection	34
Procedures	34
Recording of the Data	35
Length of Fieldwork	36
Analysis	37
Protection of Human Rights	39
Summary	40
CHAPTER FOUR: FINDINGS	42
Introduction	42
The Housing Co-operative	43
The Concept of Co-operative Housing	43
The Physical Space	44
Administrative Structure	48
The Women of the Housing Co-operative	50
Common Backgrounds	50
Dysfunctional/Abusive Histories	51
Previous Housing Experiences	54
Experiences Living on a Low Income	57
Diversity of Poorness	57
Coping Strategies	60
Emotions and Low Income as Identity	64
Definitions of Poverty	68
Building a Co-operative Living Environment	69
Diversity	70
The Move	72

	vi
Boundary Issues	74
Building Support Networks	80
What is Health for These Women?	86
Summary	91
CHAPTER FIVE: DISCUSSION	94
Introduction	94
Discussion of the Findings	94
Identity and Self-Concept	96
The Environment	101
The Neighbourhood	102
The Housing Co-operative	103
Social Support	105
Control	108
Implications for Nursing	113
Nursing Practice	113
Nursing Education	115
Nursing Research	116
Discussion of Method	117
Rigor	118
Significance of the Study	123
Summary of the Study	123
References	125
Appendix A	132
Appendix B	134
Appendix C	136

## Acknowledgement

First and foremost, I would like to express my deep appreciation to my thesis committee, Dr. Joy Johnson, Dr. Joan Bottorff, and Dr. Sally Thorne. They have generously shared ideas, resources, critical feedback, and encouragement. Joy and Joan have impressed upon me that maintaining a sense of fun is essential, and that even writing a thesis can be enjoyable. Without Joy's assistance in preparing the many drafts of "the official shedule," I am not sure if I would have ever reached the end.

To my parents, Patricia and Joseph, for having impressed upon me the value of an education and supporting all the endeavours I have ever undertaken, I express my love and appreciation.

Many friends and colleagues provided support during the course of my graduate studies. I am especially grateful to Gail Gleason and Lona Lonergan whose practical assistance and encouragement were always available. Special mention needs to be made of Murphy who stood by me through it all without ever complaining.

To the Langara College Research Committee, I am grateful for the generous financial support provided for this study.

Finally, I thank the women who participated in this study. Not only did they generously share of themselves and their experiences, but they also provided a tremendous amount support and encouragement for this project. Of special note is Cleo Pawson's assistance and inspiration. Without it, the idea for this study never would have been born.



## CHAPTER ONE

### INTRODUCTION

#### Background of the Study

Health promotion is a major focus in health care today. It has been defined by the World Health Organization (1984) as "the process of enabling people to increase control over, and to improve, their health" (p. 3). Health promotion has been operationalized primarily through efforts to change the health-related behaviours of individuals via education. An emphasis on health education alone, however, fails to take into account the social and economic barriers to behaviour change (Nelson, 1994).

The determinants of health are emphasized in a health promotion approach. For example, Butterfield (1990) encourages nurses to "think upstream" which means considering and addressing the economic, political, and environmental factors that are the precursors of poor health. Many of these factors are beyond the control of the individual. Research has shown that the relationship between the determinants of health and health itself is very complex (Williams, 1990). Furthermore, the modification of environmental risk factors is extremely difficult (Epp, 1986).

Of the many determinants of health, socioeconomic status (SES) is the single most reliable predictor of health

status (Nelson, 1994). Health is clearly related to wealth (Health & Welfare Canada, 1992) and conversely, poverty exerts a devastating effect on one's well-being (National Council of Welfare, 1987).

While there is ample evidence of a direct relationship between SES and health, this relationship is not well understood (Williams, 1990). Due to the complexity of the relationship between poverty and health, research is fraught with many confounding variables. Even defining SES by indicators such as income, occupation, social class levels, or education is problematic (Nelson, 1994). Development of effective health promotion strategies cannot be accomplished until the relationship between poverty and health is better understood.

Within the body of literature that addresses the relationship between health and poverty, women's health needs have received very little attention (Doyal, 1991). Indeed, a major criticism of the research on poverty and health is the absence of an analysis of the confounding effects of gender. It is very important to include women in this analysis since they are especially vulnerable to poverty and its effects. For example, women comprise the majority of the poor in Canada (National Council of Welfare, 1990) and some evidence exists to indicate that women, by placing the needs of others ahead of their own, are more likely to experience deprivation and its negative

consequences while living in poverty (Payne, 1991).

It was not until 1970 that the differential effect of poverty for women was identified in Canada (National Council of Welfare, 1979). Many mortality and morbidity studies included men only or failed to analyze gender differences (McElmurray et al., 1987). Women who do not work outside the home are excluded from statistics on employee absenteeism and workers' compensation (Doyal, 1991), and when included in statistical data are often classed according to their husband's occupation (Marmot, Kogevinas, & Elston, 1987).

Since 1970, some research has been completed specific to women's experience in poverty, but many gaps remain. The majority of this research has focused on reproductive issues such as prenatal care, breast-feeding, and cervical and breast cancer. Very little research has addressed the issues of poverty for single parents or elderly women, and unattached poor women seem to have been completely ignored. This omission is puzzling when one considers that the majority of poor Canadian women live alone or with non-relatives (National Council of Welfare, 1990).

There is a need for research that addresses both women's concerns as they relate to health and poverty and that explains the relationship of poverty to health. To date, a few studies have demonstrated links between SES and stress (Williams & House, 1991), hierarchical position

(regardless of income) and health, and meaningful social relationships and health (Lindheim & Syme, 1983). However, a simple relationship between only one of these variables and health seems unlikely.

Inadequate housing is an especially important factor associated with poverty and poor health for women. (Doyal, 1991; Payne, 1991). Payne states that housing serves as an indicator of both deprivation and health status for poor women. Public housing projects are often associated with stigmatization which has negative health effects (Lindheim & Syme, 1983). Housing co-operatives, however, have been identified as a means of enhancing women's health via a supportive community environment (Wekerle, 1988) which fosters the development of new skills and an sense of control over the environment (Morisette, 1987).

Nurses are confronted with the health consequences of poverty in almost every work setting. Furthermore, statistical projections indicate that the number of poor people will continue to increase (Moccia & Mason, 1986). In order to serve this growing clientele, nurses can no longer treat economic impoverishment as an unmodifiable risk factor. Instead, nurses need to enhance their awareness of the relationship between poverty and health, increase their understanding of people's experiences with poverty and health, and increase knowledge of strategies which can be used to assist the poor to improve their health.

Qualitative research methods seek a depth of data that enlarges our view by attempting to see human experience "in the complexity of its context" (Munhall & Oiler, 1986, p. 57). There are numerous references in the literature on poverty and health that call for qualitative studies that address the health practices and health needs of the poor. Nelson (1994), for example, concluded that "nursing investigations describing the processes through which the health practices of the socioeconomically disadvantaged are shaped by the larger social environment are urgently needed" (pp. 8-9).

#### Research Questions and Purpose

##### Statement of the Problem

Effective health promotion strategies are limited by the lack of knowledge regarding how factors such as SES affect health. There are large gaps in our knowledge of the relationship between the environment, poverty, and health, especially concerning women and their experiences. Virtually no research has been conducted on the health of unattached, low income women. Specific aspects of living in poverty, such as inadequate housing, and the relationship with health need to be addressed.

##### Purpose

The purpose of this study was to develop an understanding of how living on a limited income affects the health of women. Women living in poverty, however, are a

very diverse group. In order to narrow the focus of the research and to examine the possible health-enhancing effects of one proposed social intervention, the residents of a housing co-operative built exclusively for unattached, low income women were selected for study. The choice of this subgroup of poor women allows for the study of the influence of this environment on their health and helps to control for some of the diversity amongst poor women by eliminating variations in housing.

#### Research Questions

The main question addressed was:

How does living in a housing co-operative influence the health and health practices of women living on low income?

Subsidiary questions were:

- (a) How do the women living in a specific housing co-operative construct health in their lives?
- (b) What are the beliefs, values, concerns, and practices of low income women in relation to their health?

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

No written account can even come close to portraying the damage to physical health and the scars to psychological well-being that can come from living at standards below those deemed absolutely minimal for basic subsistence. What can be said of a life which consists of a daily struggle merely to survive? (National Council of Welfare, 1987, p. 82).

Despite the fact that socioeconomic status (SES) is the single most reliable predictor of health status (Nelson, 1994), the actual mechanisms of the relationship between poverty and poor health are not well understood (Williams, 1990). Although these causal mechanisms have not been clearly demonstrated, there is arguably little doubt that the manifestations of poverty, including inadequate housing and nutrition, are associated with poor health. Payne (1991), for example, contends that "poor housing, an inadequate or erratic income and poor nutrition all suggest levels of stress which may result in a threat to mental as well as physical health" (p. 155). Similarly, based on her observations of women in India, Beckett (1994) concluded that women's shorter lifespans and poorer health were a result of endemic stress, that is, the consequences of

deprivation, inadequate resources, limited role opportunities, and oppressive cultural forces.

While the connection between the negative forces of poverty and poor health seems intuitively logical, the actual study of these mechanisms is very difficult. Research on poverty and health is complicated by many confounding variables. For example, those in lower socioeconomic groups tend to have higher rates of smoking (Williams, 1990), and it is challenging, at the very least, to separate out the effects of poverty per se. As the following literature review illustrates, there are at least three reasons for the gaps in our knowledge of poverty and health: the nature of the relationship between poverty and health is very complex, the empirical evidence is limited primarily to morbidity and mortality statistics, and there has been a failure among researchers to adequately address gender in relation to poverty and health.

In that there are a limited number of empirical studies available on women, poverty, and health, the following review of the literature includes opinion papers and review papers. The literature reviewed arises from the disciplines of nursing, medicine, and the social sciences. A brief review of selected, classic studies on poverty and health places the literature on women, poverty, and health into context. The literature review has been organized into four sections: poverty and health; women, poverty, and



health; housing, poverty, and health; and gaps in the research on women, poverty, and health.

### Poverty and Health

Williams (1990) conducted an extensive review of the literature on socioeconomic differentials and health. He concluded that while there is "clear abundant evidence for a strong causal relationship between socioeconomic position and health status" (p. 81), there is little information to explain this association. Many studies have examined the relationship of SES to mortality and morbidity. For example, Marmot et al. (1987) reviewed the national mortality and morbidity statistics for England and Wales between 1922 and 1971 and analyzed them according to social class and gender. They found social class to be a "robust" predictor of mortality and suggested that social inequalities in mortality have probably increased in recent years. They concluded, however, that the links between social class and disease and death are not understood.

The Alameda County Study (Haan, Kaplan, & Camacho, 1987) attempted to examine the reasons for the association of low SES with poor health. A sample of 1,811 adults over age 35 were followed for nine years. The researchers found that residents of a designated poverty area had higher mortality rates than a similar group living in non-poverty areas despite adjustment for multiple variables including employment, income, education, age, race, gender, and

alcohol and tobacco use. This study proves to be very important as the results suggest that environmental factors in a designated poverty area contribute to mortality. Unfortunately, a significant gap remains in our understanding of how the factors associated with poverty affect health.

### Conceptual and Methodological Issues

Much of the recent literature on poverty and health addresses the conceptual and methodologic issues that create difficulty for researchers. For example, merely defining the level of economic adequacy becomes problematic. "Education, occupation, and income are commonly used indicators of SES, and each of these has particular strengths and weaknesses" (Nelson, 1994, p. 4). Statistics Canada reports reveal that 16-24 year olds experience the greatest depth of poverty among all age groups, although these figures should be viewed with caution. Many people in this age group are likely to be students who receive money from parents not reported as income (National Council of Welfare, 1990). As another example, occupation is a better measure of social class for men, while type of housing and access to cars seems to be a better measure of social class for women (Marmot et al., 1987).

The way in which poverty is defined is an important issue because it affects how poverty is measured, who is considered poor, and has implications for identifying the

underlying causes of poverty (Payne, 1991). Payne raises the issue of deprivation and notes that one cannot assume that resources are allocated equally within a household. Women may do with less to ensure that the needs of other family members are met or may be denied access to "family" resources such as an automobile.

### Women, Poverty, and Health

There is very little known about women's health in general (Doyal, 1991), and even less about the effects of poverty on women's health. There are a number of reasons for this "oversight." Women, and especially poor women, tend to be afforded lower status and importance in society. Zambrana (1988) indicates that the health of poor and minority women remains a low research priority. In many studies concerning poverty, the population has been considered homogeneous and researchers have not analyzed their results in ways that would emphasize the "gender factor" (World Health Organization, 1992). Based on their review of the literature, McElmurray et al. (1987) assert that there are gender differences in health. These differences need to be explored.

Most of the literature reviewed in this section consists of theoretical and opinion papers due to the dearth of empirical research on women, poverty, and health. Much of the information that is available is in the form of demographic data. This information has been very helpful in

illuminating women's situation in regards to poverty. For example, it was not until the 1970 report by the Status of Women Commission that the extent of poverty among women was brought to national attention (National Council of Welfare, 1979). The fact that a national study of poverty conducted at the same time failed to identify women's predominance among the poor (National Council of Welfare, 1979) highlights how researchers' lack of attention to gender may influence results.

Many opinions have been put forward to explain the lack of attention to women's health needs. Thomas (1988) explains the insensitivity to women's needs as a bias within the medical system that considers men as normal and female differences are aberrant. Daly (1989) blames the "medicalization" of health care for producing a picture of women's health dominated by a specific view of reproductive health and under-estimating other aspects. McBarnette (1988) seems to agree that women are viewed as important primarily for their reproductive value. Based on a review of the literature and American statistical data (mostly from New York state), she concluded that poor women are at higher risk for unplanned pregnancy, sexually transmitted diseases, maternal mortality, and cervical cancer. McBarnette asserts that "the health gap for poor women is significant to the larger society since the health status of women directly affects the health status of future generations" (p. 76). A

computer search of the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Medline for references regarding women, poverty, and health supports the view that women's reproductive health is emphasized. The majority of articles concerning women's health, especially empirical studies, primarily deal with the topics of prenatal care, breast-feeding, and breast and cervical cancer screening.

While reproductive issues have been the major focus, Payne (1991) identifies "role strain" as the second obsession of researchers studying women and health. Recent studies have indicated, however, that role strain is not the health hazard it was anticipated to be. In one study, Aston and Lavery (1993) measured the physical and psychological well-being of women in paid employment. Studying 120 women in the work force, they used three scales to measure psychological well-being, including a self-reported inventory of physical symptomology, a social support scale, and a cynicism scale. Their findings support the view that paid employment is generally rewarding for women. Given the additional responsibilities and exposure to hazards in the workplace, however, it is surprising to find that the health of working women is better (Payne, 1991). "The fact that the health of women in paid work is better than women who are full-time housewives indicates perhaps the disadvantages in terms of staying at home, in a job which is unpaid, isolated, and undervalued" (Payne, p. 128).

While paid employment seems to be good for women, it is not an easy answer to the problems of poor women. Unfortunately, the jobs available to the majority of women do not pay a wage sufficient to overcome women's vulnerability to poverty. Smith (1986) examined the relationship between the increase in the number of women in paid employment and growth in the service sector in the United States (US). She explained the cause of women's poverty as twofold. First, increasing numbers of women are self-supporting or dependent on social assistance and the low wages provided by most new jobs available to women offer little opportunity to "climb out of poverty." Second, there is an assumption in our society that women will be supported financially by men despite growing numbers of women who are not.

Few researchers have examined poor women's perceptions of their situations. Calnan and Johnson (1985) explored the relationship of English women's social class to two dimensions of health beliefs. A trained interviewer conducted two sets of unstructured interviews with 60 women from two social classes. Interview transcripts were analyzed for concepts of health and perceptions of vulnerability to disease. The researchers found little class difference and questioned whether the importance of personal health beliefs in patterns of health behaviour have been overestimated. They also suggest that the social

context acts as a barrier to preferred choices of action. Williams (1990) labels the failure to address the structural elements of inequality, while focusing on health education, as "blaming the victim" for failure to follow healthier lifestyles.

In one of the few empirical studies of poverty and women's health, Schrijvers et al. (1995) analyzed the data from a cancer registry in southeast England in order to examine the association between deprivation and breast cancer. Deprivation was defined by rating the electoral districts where the women lived at the time of diagnosis according to four variables: overcrowding, male unemployment, social class, and car ownership. The Carstairs Index gave a single score for these four variables. A multivariate analysis was used to compare the relative survival rate, expressed as a ratio, with the deprivation score. Findings showed a better survival rate for women from more affluent areas, even after adjustments were made for stage at diagnosis, morphology, and treatment category. The investigators speculated that the possible causes of this gradient were earlier detection, referral, and treatment for the more affluent women, and decreased nutritional status, less social support, negative psychological factors, and decreased ability to cope with a diagnosis of cancer for the women in the lower income groups. Once again, support for the association between SES

and health has been demonstrated, without any explanation of this relationship.

The general lack of understanding of the mechanisms by which poverty leads to poor health has many negative consequences. From a health care perspective, economic impoverishment often is treated as an unmodifiable risk factor, such as age or heredity (Nelson, 1994); or the structural elements of inequality are ignored while health education is emphasized (Williams, 1990). This attitude impedes the development of effective interventions or health promotion strategies. For example, Makuc, Freid, and Kleinman (1989) analyzed changes in US national trends in the use of preventive health care by women between 1973 and 1985. Existing data from the National Health Interview Survey were categorized according to age, race, income, and year of the interview. They found that, with the exception of blood pressure testing among older women, the poor remained less likely to have recent preventive care. The researchers recommended increased efforts to encourage preventive care. However, one must question the effectiveness of "encouragement" when potential barriers, such as a lack of transportation, the absence of child care, or other concerns exist in the lives of poor women.

In McBarnette's (1988) previously cited report of poverty and reproductive health, her first recommendation calls for more health education stating that "much of the



observed health gap is related to lifestyle and knowledge" (p. 77). Rowe and Miles (1994), however, in their daily experience with poor single mothers in a British preventive health project, found that the women were already familiar with the health information they had to offer.

McElmurray et al. (1987) studied the effectiveness of trained inner-city volunteers as community health advocates in an eight week program. The 30 trainees, all except two of whom were women, were between 16 and 21 years of age. They received health information and advocacy training, which included developing their communication skills and conflict resolution skills. The advocates were expected to act as liaisons between health care experts and women in the community. Although the time limitation imposed by the funding source was a major drawback to the study, both trainees and project staff evaluated the program positively. The staff found, however, that the advocates had repeated questions regarding how to apply the health information to their specific cultural contexts. Providing information that women already have or cannot use is obviously an ineffective health promotion strategy. Nurses and other health care professionals need to learn more about the barriers to utilizing this information.

Edwards (1993) conducted a qualitative study of African American women living in poverty in order to explore their health problems and health management behaviours. Each of

22 women, recruited from an urban low income housing project, were interviewed three times. Data were analyzed by constant comparative analysis. Coping with stress emerged as the basic health problem. The main sources of stress were identified as raising children alone, lack of money, and transportation. Active mastery was identified as the process these women used to successfully manage their daily stressors. Many of the women who were able to manage stress successfully had a strong belief in God, clearly identified goals, and networked with church members and neighbours. While these findings are not widely generalizable, they do suggest the importance of social support for successful stress management for this group of low income women.

The plight of homeless women is beginning to receive some recognition in the nursing literature. Kline and Saperstein (1992) describe a shelter for homeless women run by nurses in order to draw attention to the issues related to women's homelessness. They describe homelessness as the result of "a complex series of social, economic, and interactional issues" (p. 887). Kline and Saperstein also emphasize the dearth of research on this topic.

A few recent studies have addressed homeless women. Nyamathi and Flaskerud (1992) conducted a series of studies to refine and evaluate a tool to measure the concerns of minority women who were homeless and/or drug-addicted. A

comprehensive literature review and qualitative focus groups were used to refine the tool, which consists of an inventory of current concerns. The inventory was then administered to 978 American Black and Hispanic women who were in drug recovery programs or who were homeless. The researchers found the concerns of these women to be "complex and multidimensional" with competency (the ability to function optimally in the personal, social, or religious domains) as a major concern. The instrument, however, requires further assessment of its reliability and validity.

Montgomery (1994) interviewed seven women identified by a shelter's staff as having overcome homelessness. Her intent was to study the strengths and personal resources of these women. She also volunteered for two to six hours per week at the shelter during this time. The majority of the women (six of the seven) had grown up in "deplorable" conditions. Using grounded theory to analyze her data, Montgomery found that homelessness, at least in this instance, was a "temporary state of disruption" in an attempt to break away from an abusive and oppressive situation in order to start a better life. These studies represent only a beginning in our efforts to understand the causes and effects of homelessness.

All the empirical studies cited to this point have been American or British. The applicability of their results to the Canadian environment must be viewed cautiously,

particularity because of the major differences in the health care systems. The paucity of empirical studies on Canadian women, poverty, and health highlights the need for them. In the only identified Canadian work, Thomas (1988) reports the results of a key informant survey. Unfortunately, the report of this survey contains very little information regarding its method. Structured interviews were conducted with 55 participants residing in the five regions of Canada. Mental health was the chief concern affecting all women, but of special concern for rural, isolated, disabled, or poor women. Thomas asserted that economics is probably the most important factor affecting women's health and suggests that there are financial barriers to health care for poor women despite the principle of universal access to health care in Canada. While this survey is important, the sample consisted of persons considered experts on women's health (from community, academic, medical, and government settings) and therefore the findings may not represent poor women's concerns.

#### Housing, Poverty, and Health

Housing is a particularly important issue for poor women. For example, Payne (1991) cited a survey of living standards in London, England that showed environmental factors, including dampness in the house, to be linked to poorer health. In addition, Payne suggested that the quality of housing is both an indicator of a woman's overall

level of deprivation and an indicator of her health status. Because there are differences in the climate and in the central heating systems between Canada and Britain, these results may not be directly generalizable to a Canadian population.

In their literature review, Lindheim and Syme (1983) discuss the stigmatization associated with public housing projects. They suggest that constant reminders of one's lower rank may cause anger and lowered self-esteem, which may result in higher rates of disease. Other authors discuss the importance of housing in relation to SES. Doyal (1991) states that the cost, design, and location of housing all affect women's health.

Co-operative housing environments, however, provide affordable, secure housing with stable rent (Morissette, 1987). Wekerle (1988) conducted in-depth case studies of ten women's housing co-operatives in eight Canadian cities. She noted that co-operative housing is more than just an affordable place to live. It can provide a supportive community environment, and experience on committees can provide co-operative housing residents an opportunity to improve skills such as decision-making. Morissette, who reviewed statistics on the Canadian housing situation, also acknowledges the positive benefits of co-operative housing for residents, including the provision of greater control over the environment.

Nairne (1991), based on a review of the literature on women's housing needs and information from Statistics Canada, concluded that women often must spend more on housing than their male counterparts because of their concerns about neighbourhood safety. Women as renters also pay a larger proportion of their total income on housing. For example, in 1986, approximately 46% of Canadian women in one-person households spent 30% or more of their income on housing, and 23% of the women spent 50% or more (Nairne, p.43). These statistics have implications for defining poverty because a woman spending a high proportion of her income on rent has less remaining for the other necessities of life.

#### Gaps in the Research on Women and Poverty

Zambrana (1988) identified several gaps in the research on women, poverty, and health. "The quality of life of poor and minority women, with specific reference to their health, mental health, and family roles, has been a low research priority" (p. 138). Class and cultural variables are poorly understood, despite evidence that "poor and racial/ethnic women are at a disadvantage in terms of their health status" (p. 142). There is even limited data on low-income Caucasian women. Zambrana calls for research on the effects of aging, on chronic life stress and its effects, and that addresses the qualitative experiences of poor and minority women.

In her demographic overview of American women in poverty, Wilson (1988) advocates for recognizing and exploring the diversity amongst poor women. "By ignoring the diversity in the population of poor women and the changes in this population over time, policy makers and others fail to develop and advocate for policies that address the needs of all types of poor women" (p. 21). Wilson states that "by 1984, almost one in five poor people lived alone or in a household where they were unrelated to other individuals, and more than half of these poor were women" (p. 25). In her discussion of the diverse groups of poor women, Wilson devotes several pages each to poor married women, female heads of households, and teenage mothers, but only three paragraphs to unattached poor women. She does indicate that poor women who live alone or with non-relatives are a diverse group that constitute an increasing percentage of the "poverty population."

A similar "oversight" is observed in Women and Poverty Revisited, a report by the National Council of Welfare (1990). In this document, the following facts are provided. The largest group of poor Canadian women (40%) live alone or with non-relatives. The fastest growing group of women are the unattached. In terms of depth of poverty, the second poorest group is unattached men and women between the ages of 25 and 64 with an average income at only 58% of the poverty line. [Women consistently have lower incomes than

men in any category. For example, the average annual income for unattached men 45-54 years is \$27,654 and only \$21,881 for women (Lindsay & Devereaux, 1991, p. 35).] In contrast, the income of poor seniors averages 82% of the poverty line. Despite the evidence above, detailed analysis focuses on only three age groups: 16-24, 55-64, and the elderly.

The reasons for unattached poor women between 25 and 54 being virtually invisible, even in discussions concerning women and poverty, are not explicit. As mentioned already, women are valued largely for their reproductive potential. A woman who is neither wife nor mother, in addition to being economically disadvantaged, is afforded very low status in our society. The World Health Organization (1992), however, asserts that "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, economic or social condition (p. v)".

It is anticipated that mature, unattached, low-income women, like others who are economically disadvantaged, suffer negative health consequences as a result of their poverty. These women fall within a category that has been virtually ignored in the literature, that is, unattached, low income women below retirement age. Rowe and Miles (1994) observed that poor, single mothers have little social support due to the emotional and financial costs of a social life. This observation raises the question of whether other



groups of low income women suffer from a lack of social support. Unattached poor women may be prone to social isolation due to a lack of family supports. "The economic and social consequences of living alone must not be underestimated" (Nairne, 1991, p.38).

Mature, unattached, low-income women have a basic right to have their specific health needs identified and addressed. In this search of the literature, no evidence was found suggesting that any work in this area has been done.

#### Conclusions

Poverty results in poor health. This relationship has been firmly established by empirical research. The number of empirical studies concerning SES and health, however, seems small when one considers that SES is the single most reliable predictor of health status. A large number of conceptual and methodological issues make studying this relationship difficult, which may dissuade investigators from addressing this important topic. Merely defining "poverty" may be problematic, and the number of confounding variables may be overwhelming. As a result, the majority of available research regarding poverty and health consists of morbidity and mortality studies. These studies confirm the relationship between SES and health, but the mechanisms of how SES and health interact remain poorly understood.

In the general literature on poverty and health, the

gender factor has been largely ignored. In regards to women, poverty, and health, demographic information has revealed that the majority of the poor are women, the female gender experiences a greater vulnerability to poverty, and women, once economically disadvantaged, tend to stay poor for longer periods of time. We also know that poor women are a diverse group in terms of age, marital status, racial and ethnic backgrounds, and living situations. Despite women's predominance among the poor, very few empirical studies have addressed this topic.

Nurses need a better understanding of the effects of poverty on health from the individual's perspective, as well as how the effects may be moderated by living in a housing co-operative. This understanding is essential for implementing effective health promotion strategies, that is, measures that address the needs identified by those who are poor.

Authors of the opinion papers reviewed all advocate for the use of qualitative methods to study women, poverty, and health. Qualitative methods can be used to study people within the rich contexts of their lives, thus providing a large amount of descriptive data regarding a small sample. This approach, to an extent, overcomes the problem of confounding variables as the controlled environment of an experimental study is not required.

The investigator chose a qualitative method to study a

small, discrete group of low income women living in a specific housing co-operative. Unattached, low income women below retirement age is a group that has been overlooked in the literature, even in discussions regarding women and poverty. Knowledge of these women's beliefs, values, concerns, and health practices and how they are affected by living on a low income within this specific housing environment will be a starting point in understanding the complex relationship of poverty and health for women.

## CHAPTER THREE

### METHOD

#### Introduction

Moccia and Mason (1986) recommend that qualitative research methods be employed to examine the effects of poverty on health.

Nursing's knowledge base could be extended and enhanced tremendously by qualitative, descriptive studies using such methods as ethnography and phenomenology to study the lives of the poor, their experiences in relation to their health status, the successful and unsuccessful ways they have attempted to influence their communities and the health care system (p. 22).

In order to discover what health means for low income women, and to determine how they construct health in their lives, an ethnographic study of the women in a specific housing co-operative was undertaken.

Ethnography is the study of culture, which is defined as "the acquired knowledge that people use to interpret experience and generate social behaviour" (Spradley, 1979, p. 5). The goal of ethnography is to discover such cultural knowledge. "Ethnographers seek understanding of the customary actions, beliefs, knowledge, and attitudes of a social group as reflected in the ways of engaging in everyday life" (Zaharlick & Green, 1991, p. 207). In this

study, the everyday life of a group of low income women in a co-operative housing unit was examined in order to acquire an understanding of their knowledge, beliefs, and practices related to health. Although ethnography provides a holistic perspective (Munhall & Oiler, 1986), it may be topic-oriented (Zaharlick & Green, 1991), and in this instance, health is the central focus.

#### Definition of Terms

A definition of health was not be predetermined for this study as the women's own definitions of health were explored by looking at their beliefs, values, concerns, and health practices. Defining socioeconomic status is often problematic (Nelson, 1994). For the purposes of this study, however, it is practical and appropriate to use the definition of the co-operative housing society. Low income, therefore, is defined as an annual income of \$25,500 or less. Unattached is defined as living alone or with unrelated adults. During the course of the study, all residents of the co-operative housing development lived alone.

#### Assumptions

This study is based on the following assumptions:

1. Women living in poverty have a shared culture.
2. The women living in this housing co-operative have a shared culture which is not static but continually evolving.

3. The women have concerns regarding health which are related to their income level.
4. The co-operative housing environment has a effect on the women's health and health concerns.

#### Limitations

This study is limited primarily by its size and scope. The women studied represent only one small sample of poor women who live in co-operative housing complexes. Since there is great diversity amongst poor women and their needs, the results cannot be generalized to other groups of women living on low incomes.

The women selected for this co-operative housing project require special abilities in order to fulfil their duties as members of the co-operative. An interview and selection process was used to bring together this particular group of women. Therefore, caution is suggested in looking at these particular women as representative of unattached low income women as they may possess a higher level of skills and abilities than the average woman who finds herself economically disadvantaged.

#### Sample

##### Setting

The setting for this study was a newly-opened housing co-operative for mature, low income women. While the co-operative's target range for the women is 40-64 years of age, younger women with disabilities are eligible. The co-

operative's regulations do not stipulate that the women must be single. The small size of the suites, however, and the criterion that the combined income of all occupants must be less than \$25,500 annually make it unlikely that any women will choose to share their accommodation. During the course of this study, all residents lived alone.

This housing co-operative is the first one in the city built exclusively for low income women 40-64 years. The study, in a sense, has been "opportunistic research," because the recent opening of the co-operative presented a unique opportunity to study a clearly defined group of women living on low income.

#### Gaining Access

Access for this project was facilitated by one of the residents of the housing co-operative. Informal contact was made initially with the society responsible for the co-operative's development. In addition to the members of the society, this group included three original members of the board of directors for the co-operative and a number of residents of the co-operative. (Membership in the society and in the co-operative are not mutually inclusive.) The entire group's initial response to the proposed study was very positive.

The three board members agreed to distribute a one and one-half page outline of the proposed study (Appendix A) to all members of the co-operative. The members were asked to

review the outline and discuss it amongst themselves. The investigator had hoped to attend a general meeting of the membership to discuss the proposal and to answer any questions. The directors, however, reported that due to the large volume of business to be discussed at the meeting, permission could not be granted for the investigator to attend.

Upon the advice of one board member, a written request was sent to the board of directors outlining the access required for the study. Following a general membership meeting, one woman reported to the investigator that some of the residents had serious reservations about the observation portion of the study. Since consensus could not be reached by the membership, permission for observation and participant-observation was denied.

As an alternate plan, women were recruited to participate on an individual basis. One enthusiastic member, disappointed that full access had not been approved, recruited nine volunteers and supplied the investigator with their names and telephone numbers.

### Sampling

In an ethnographic study, sampling must take place on three levels according to time, people, and variations in context in order to provide a full and representative picture (Hammersley & Atkinson, 1983). Sampling time was no longer possible once participant-observation was denied.



The sampling of persons was simplified by the recruitment of volunteers. Women were selected mainly at random from the volunteer list and interviewed according to their availability. For example, one woman had expressed interest in being interviewed as soon as possible, and two women were not available when contacted and were interviewed in the latter part of the study. One of the volunteers did not return any of the investigator's calls and was, therefore, not interviewed. One participant invited a second woman to her interview, and one additional participant was recruited, for a total sample of ten women. As the study proceeded, it became apparent that the women of the co-operative were not as homogeneous a group as anticipated. Instead, the participants were characterized by a great deal of diversity. For example, the women varied considerably in age, ranging from those in their thirties to those in their sixties. Many of the sub-groups identified by the women were well-represented in the volunteer sample. When it became apparent, however, that some sub-groups, such as working women, were not well-represented, attempts were made to recruit more volunteers. One woman advised against obtaining the names of all the working women and contacting them directly as she believed they might consider this action to be an invasion of privacy. Instead, a notice was posted in the laundry room specifically requesting working women to volunteer for the

study. There was no response to this request.

The women interviewed were also asked to suggest others who would be valuable participants. It is encouraging to note that some of the suggestions included women who had already been interviewed. Most of the women of the co-operative are Caucasian, and the name of one "woman of colour" was put forward as possibly having a different perspective. A note was left under her door, but she did not respond. As Hammersley and Atkinson (1986) indicate, sampling is always subject to access. Some people do not want to share their thoughts and the right to refuse to participate must be respected always.

#### Data Collection

Initially, the intent was to gather data via observation, participant-observation, intensive, interviews, and focus groups. Due to lack of permission for general access, data collection was limited to intensive open-ended, unstructured interviews.

#### Procedures

A total of eleven interviews were completed. Two of the women were interviewed twice. At the beginning of each session, the investigator reviewed the purpose of the study, encouraged and answered any questions, and obtained written consent (Appendix B). A list of proposed questions (Appendix C) provided a starting point for the initial interviews.

For the early interviews, the women were asked to describe life in the co-operative. Questions and prompts, both verbal and non-verbal, were used to encourage the women to expand on points of interest. The subjects of health and living on a low income were introduced as appropriate to the flow of the interview.

In later interviews, the participants were asked to imagine the investigator as a new member of the co-operative in order to determine what procedures and information would be given to help a new member "fit in." As data collection proceeded, questions arising from the review of the transcripts were included. As the study progressed, more and more of the data from previous interviews was introduced for validation.

The interviews were completed in three "clusters": three interviews at the beginning, three interviews at the midpoint, and five interviews (including the two repeat interviews) towards the end of the data collection phase. Each taped interview lasted sixty to ninety minutes.

#### Recording of the Data

Ten interviews were audio-taped, but only nine were transcribed due to technical problems which resulted in one "blank" tape. One of the repeat interviews was conducted over the telephone so it was not taped, but detailed notes were taken. The audio-tapes were transcribed verbatim to provide an accurate record of the dialogue. Each transcript

was reviewed with the tape to ensure accuracy.

Field notes were recorded following the interviews. They included a brief description of the participant and the setting, and the investigator's thoughts, ideas, and reactions to the interview. Usually three separate types of fieldnotes are used: a condensed account of descriptive data made during or immediately following the period of observation, an expanded account made later which fills in detail, and a journal of the ethnographer's experiences, feelings, reactions, problems, insights, and decisions (Spradley, 1979). Due to the absence of participant-observation sessions, these three types of records were condensed into one.

#### Length of Fieldwork

Ideally, active fieldwork continues until data saturation is reached, or no new data, patterns, themes, dimensions, or insights are revealed (Munhall & Oiler, 1986). In this instance, data collection spanned a period of seven and one half months. The first interview took place nearly eight months after the women moved into the co-operative. When the final interview was conducted, the women had been living in the co-operative for fifteen months. Several themes were revealed during the course of this study and were validated by the participants. It is suspected that new themes may have emerged if the study had continued, as the culture of the co-operative is in the

process of evolution. As many ethnographers emphasize, however, no ethnography is ever complete (Spradley, 1979).

### Analysis

Data collection and analysis proceeded concurrently. This process is essential in ethnography as the on-going analysis directs further data collection by raising new questions (Spradley, 1979).

After each interview, field notes were written, the audiotape was reviewed, and notes were made from the tape before transcription. Each transcript was reviewed a minimum of six times. Transcripts were examined for any information which related to the concepts of health and poverty. Notations were made in the margins. Sections or phrases which seemed especially significant were underlined or highlighted.

Following the first three interviews, themes appearing in all three transcripts were identified. Some of the topics that began to recur even at this early stage were conflicts within the co-operative, boundary-setting, concerns for safety, and strategies for living on a low income. A chart was made to outline how the three different women had commented on the common topics. New questions arose from an examination of these associations. Examples of some of these questions are as follows: What do these women have in common?, What are positive aspects of life in the co-operative?, and What does the word "poor" mean to the

women?

After the completion of six interviews, all six transcripts were colour-coded line by line for the following categories: health, health problems, poverty, co-op life, previous housing situation, family, and work/life's purpose. Some lines had multiple colour codes if more than one category was applicable. The data were then completely reorganized in order to compile all references from each category. These categories of data were reviewed and coded again, allowing new themes to emerge. For example, within the category of health, sub-categories such as safety, boundaries, control, self-esteem, support, skills, work, absence of symptoms, pets, and environment were identified. Each main category was sub-divided in this manner. A final reorganization was completed. The data were literally cut and pasted one more time and new categories were established.

The benefit of organizing and reorganizing the data is the promotion of data analysis. As one tries to reorganize pieces of data, questions arise as to where this segment best fits, such as, "Does comparing oneself to others less fortunate constitute a strategy for coping with a low income, or does it fit better under self-esteem?" Notations were made of these questions and ideas.

Major themes, key ideas, and questions were shared with the participants in the latter interviews, particularly

those women being interviewed for a second time. This sharing of information resulted in validation of the themes, or the generation of new data. Two participants were asked to review the second draft of the findings chapter and they provided feedback.

Analysis continued throughout the process of writing the findings. Attempting to communicate the data in a logical sequence continued to raise ideas and questions as to how the data fit together.

#### Protection of Human Rights

The rights of the participants were ensured in several ways. The proposal for this study was reviewed and approved by the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects. The issues of consent and confidentiality were addressed as follows.

Consent for each taped interview was obtained and a consent form (Appendix B) was signed by each participant. Prior to each interview, it was emphasized that the participant was under no obligation to answer any specific questions or to discuss any particular topics. On at least two occasions, participants exercised this right to refuse to discuss a specific subject.

The anonymity of the housing co-operative has been maintained. Although members of the society for the co-operative's development expressed an interest in and a need

to document the benefits of this type of housing for low income women, the women who actually live there specified that they did not want the co-operative named. The descriptions of the building and the participants has been done with the intent of preventing identification of either the co-operative or the individuals who participated.

Data will be made available for secondary analysis. This intention is made clear in the consent form (Appendix B). All data, however, will have all information which may identify the participants removed. Pseudonyms for the participants have been used in all field notes, transcripts, and findings to maintain confidentiality. A list of codes for the pseudonyms has been seen by the investigator only and will be destroyed upon completion of the project.

#### Summary

Due to the complexity of the relationship between poverty and health, the little that is known regarding the experience of living in poverty, and the diversity amongst poor women, a qualitative research method was deemed to be most appropriate for this topic. An ethnographic approach has provided detailed information on one small, clearly defined group of low income women living in a specific housing co-operative and has explored their beliefs, values, concerns, and practices related to health. This study provides a starting point for research in this area and has uncovered questions for further study. The details of these



findings are presented in the next chapter.

## CHAPTER FOUR FINDINGS

### Introduction

In this study, the experiences of a discrete group of women living on a low income are explored. The findings provide a glimpse into the women's daily struggle to cope with limited means, and the stress and frustration which accompanies this challenge. The women's strength, courage, and creativity are also captured.

A new housing co-operative for mature, low income women was the setting for the study. Due to the recent nature of the women's move into the housing co-operative, the adjustment to this new way of life was found to exert a far greater effect on the women's health concerns than originally anticipated. The initial difficulties of creating a community out of a group of thirty-six strangers was central to many of the interviews. The benefits of living in a co-operative environment are highlighted, and out of their descriptions of daily life, an understanding of what health means for these women emerges.

The findings have been organized in the following manner. To provide the reader with context, the chapter begins with a description of the physical space, the administrative structure, and some general descriptions of the women themselves. In the next section, the women's experiences of living on a low income, including previous housing situations, are described. Subsequently, the major

themes of "co-op life" are outlined: boundary issues and building support networks. In the final section, health as defined by these women is described. As much as possible, the women's own words have been used to convey meaning.

### The Housing Co-operative

The housing co-operative which provided the context for this study is unique in that it is the first in the province designed and constructed specifically for unattached, low income women. It exists largely as a result of the efforts of an organized group of women committed to the development of affordable housing for mature, single women. Stable, reasonable rent is extremely important for low income women. In addition, housing co-operatives have the potential to provide many other benefits for their residents, including a sense of community.

### The Concept of Co-operative Housing

A sense of community is, in many instances, absent in today's large urban centres. Current Canadian culture emphasizes individual achievement over co-operative efforts. In addition, the average urban dweller often lives, works, shops, and plays in different parts of the city, and may not have any associations with neighbours. These two factors combine to create an environment which may become fragmented and impersonal.

Many efforts are being made to recapture this lost sense of community. Governments and citizen groups are

undertaking projects such as neighbourhood houses, community crime prevention offices, Block Watch, community art projects, festivals, and others to try to re-establish community identities and the benefits of community life.

The "creation of community" within the urban environment is one of the main goals of co-operative housing (Cooper & Rodman, 1994). Members of a co-operative purchase shares, providing them with joint ownership and shared control over their living space. The residents of the building are not merely neighbours due to geographical proximity, but they are partners in the operation of their home. In this particular co-operative and during the period of the study, the residents were not only required to participate in the functioning of the co-operative, but shared the additional challenge of setting up the initial structures and laying the foundation for future operation.

In order to understand the experiences, challenges, and accomplishments of this group of women, some background information is needed. There are three elements of this co-operative: the physical space, the administrative structures, and the women who live there. These three elements are described in the following sections with the intention of placing the findings of the study within their context.

#### The Physical Space

The housing co-operative is based in a new, four-

storey building located in a major Canadian city. The building itself is situated in an upper middle class neighbourhood between a fast food restaurant and a financial institution. Its pink stucco exterior is commonly found in the area. There is a sign above the front entrance with the name of the co-operative on it.

The street is a busy thoroughfare, and the bus stops almost at the door. Along the street are many small restaurants, produce stores, and a mix of small businesses and shops. For many of the women, this new neighbourhood was a drastic change from the ones to which they had become accustomed.

The co-operative's main floor space houses the lobby, the laundry room, and the main common area, or "community room." There is a controlled entrance to the co-operative and opposite most of the suite numbers on the panel reads "occupied." Very few of the women have requested to have their names displayed.

Behind the clear glass of the double doors is the lobby. It is open and spacious, furnished only with an upholstered couch, one painting, a small sculpture, and a plant. These items have been donated. The floor is tiled with large brown and white linoleum squares. The mailboxes are on the wall facing the door. Below the mailboxes are neat piles of free community newspapers and magazines.

As one moves through the lobby, it narrows to a

hallway. To the left are the elevator, the laundry room, and the common room. The stairway to the upper floors is on the right. There is a large bulletin board opposite the elevator and two more bulletin boards in the laundry room. They are organized into sections for specific types of information and have always appeared very neat and tidy. Apparently there has been a problem with notices being taken down prematurely.

The community room has kitchen facilities (cupboards, sink, and a dishwasher) at one end and windows at the other. Next to the windows, a door opens onto the patio. When no events are in progress, the room is sparsely furnished with a beige upholstered couch, and metal stacking chairs lean against the wall. During events, this room can be dramatically transformed. For example, a cafe atmosphere was created for one of the parties.

The hallway runs alongside the common room and leads to the patio, adjacent to the back lane. The small patio is a very pleasant spot with raised flower beds containing small trees and shrubs, and in summer, flowers and vegetables. A white patio table with an umbrella and chairs provides a place to sit.

The thirty-six women live in one-bedroom suites on the second, third, and fourth floors. Access to the upper floors is via the elevator or stairwell. The inner wall of the stairwell is clear glass which creates a feeling of

openness. The elevator has large buttons mounted low on the wall for easy access by those in wheelchairs. There is a small bulletin board in the elevator with notices for things such as the change of a meeting time.

The halls are painted throughout in off-white with a hint of pink and the trim is a dark "dusty rose" pink. The carpets in the hallways and stairwells are an industrial quality and are also of a "dusty rose" hue. One woman questioned the architect's view of low income women given the overwhelming "pinkness" of the decor.

The hallways give a perception of brightness, cleanliness, and newness. One participant, however, indicated where the hallway carpets are already beginning to show signs of wear. Several women have personalized the doors to their suites with small decorations, pictures of pets to be rescued in case of a fire, receptacles for "inside" mail, and small carpets. One "welcome mat" reads "go away."

In approximately the middle of the second floor is an office. The co-operative's manager/book-keeper works in the office one day per week. On the third and fourth floors, this space is a common area. To date, there is little furniture in these small, bare rooms. On the fourth floor, this common room opens onto a garden patio. There is also common space in the basement with lockers for storage.

The one-bedroom suites are not large, ranging from 546

to 712 square feet. They are bright with patio doors leading onto small balconies. When windows are open, the traffic noise is considerable, especially in those suites which face the street. Despite this fact, two women commented on how much quieter it is than their previous neighbourhood.

The kitchens and bathrooms are tiled, and the remaining floor space is covered with hard twist carpet similar to the hallways. The suites come in four levels of adaptability for the disabled. Features include wide doorways for wheelchair access and low closet railings. The walls of the suites are painted in a neutral tone. At the end of one year, the women are allowed to decorate with paint and wallpaper, providing they return the suite to its original condition when they move.

#### Administrative Structure

Prior to acceptance, qualified applicants were interviewed by a panel and given information about co-operative living. After being asked a series of standard interview questions, women were recommended to the board of directors for acceptance based on their apparent willingness and ability to live and work in a community. (Nine units, however, are set aside for British Columbia Housing, and although these candidates were also interviewed, they could not be rejected unless fraud could be proven.) Upon acceptance, the women were informed that their participation



in the operation of the co-operative was a condition of acceptance, and they signed an agreement to that effect. They were told to expect participation to be approximately ten hours per month, which is a standard for most housing co-operatives. Very few of the women knew each other before they moved in, although a few long term friendships did exist.

The women are responsible for the operation and maintenance of the co-operative, and a number of committees have been set up to achieve these ends. Members of the board of directors are elected for a one year term, but half of the board changes every six months to provide continuity. Other committees address finances, maintenance, membership, safety, and pets. Consensus decision-making is used by all committees and has been described by some of the women as time-consuming, and at times, frustrating. The amount of work required in the early phase of the co-operative's development has greatly exceeded everyone's expectations.

Assistance in learning to run the co-operative has been provided by an organization that assists with the establishment of new co-operatives, the management company's paid, part-time employee, and the Co-operative Federation of British Columbia. The consultant from the former has facilitated this process by setting up workshops to help the women develop administrative skills. For example, she has led workshops on topics such as taking minutes at a meeting.

All the women who have mentioned these support personnel speak very highly of them and the assistance they have provided.

#### The Women of the Housing Co-operative

To qualify for the co-operative, women must have annual incomes below \$25,500, be residents of the province, be paying more than 30% of their income for rent or live in poor or inaccessible accommodation, and be at least forty years old or have a permanent disability. The women's actual ages range from mid-thirties to seventies. All the women interviewed have some level of disability, whether it be physical, mental, or emotional. The women have diverse backgrounds in terms of education and work experience, and a minority are currently employed.

The ten women who participated in the study comprise 28% of the total population of the co-operative. In many ways, they are representative of the women in general. For example, their ages span the complete age range within the co-operative. The study participants were all highly involved in the work of the co-operative. It is impossible to say, however, if this sample is truly representative.

#### Common Backgrounds

There was complete consensus amongst those interviewed that the women of the co-operative share a common history. Although each woman's experience was acknowledged as unique, it contained "hard experiences" that the women had endured.

Their common backgrounds included three elements: a dysfunctional or abusive past, difficulties with previous housing, and the experience of living on a low income. This common history, particularly a dysfunctional or abusive past, was identified as their reason for being in the co-operative.

#### "Dysfunctional"/Abusive Histories

The "hard experiences" or "rough upbringings" shared by the women were, for many of them, childhoods spent in dysfunctional or abusive families. For women with supportive families, "hard experiences" included sexual assault, chronic health problems, or permanent disabilities. These common pasts were referred to by several women as "fear-based backgrounds" and were characterized by a lack of trusting relationships.

These past hardships have made "survivors" of the women. While they believed that it is their common backgrounds that brought them together, the personal qualities that have allowed them to survive are also shared. Their histories, and the coping mechanisms they have developed to deal with them, were identified by some of the women as negatively affecting their day-to-day lives in the co-operative, specifically in the ways in which they communicated with one another.

Doris described how she could "sense" other women's abusive pasts by their "over-sensitivity to flippant

remarks":

Maybe I'm making assumptions. It's just my sense of the people I meet. I feel I have to be careful what I say.

This need to be careful was characterized by another woman as "walking on tippy-toes." Lydia also "sensed" that many of the women had lacked trusting relationships by their confrontational and demanding behaviour. Alice stated the "fear-based backgrounds resulted in a lot of paranoia."

Several women commented that some of the others had not progressed beyond their pasts. Alice believes that it is unhealthy to dwell on one's dysfunctional past:

A lot of people to me here want to get into this real depth of problems and past history, what your parents were like and all. That's okay, but come on, it doesn't have to be all doomsday either. That's what I was feeling...all of these women have all these issues and problems and that's why we live in this co-op and, oh, we've got to have a committee and find out how we can better ourselves. It just got to be too much, it was just too [much] analyzing everything.

From her comments, it is clear that beliefs about a common history are not based on an intuitive sense alone, but also result from open discussions of these matters.

Doris drew a connection between these "dysfunctional" backgrounds and the high percentage of health problems

amongst the women.

A lot of them have emotional problems and someone told me the other day 97 or 96% of women have physical problems and or both...It's probably as a consequence of [coming] from dysfunctional families and...they were abused as children or [by] husbands.

Her comments point to the possibility of a cycle in regards to abusive histories, health problems, and poverty. One woman actually articulated a desire to "break out of this pattern."

Despite the current difficulties related to their dysfunctional histories, the women did believe that they had achieved some positive outcomes in regards to their health. Eve believes that the women have progressed beyond these "hard experiences" and have learned to take care of themselves:

I think that a lot of the women here have had quote, unquote, hard experiences in their lives and have done some amount of work in getting to here because I think getting to here has meant that we're taking care of ourselves somehow.

Several women confirmed this perspective by commenting on the courage displayed by many of the women in the face of various challenges. One participant indicated that all the women of the co-operative have learned to advocate for themselves, and even those who say they do not value

themselves do, at least enough to seek out good quality, affordable housing.

Observations confirm this view. The women were seen as assertive and articulate in presenting their viewpoints, politically astute, and did show evidence of valuing themselves. For example, one woman recognized the lack of respect she has received from her family in the past and the age discrimination she currently faces from society at large. She showed self-respect and an awareness of self-worth by describing herself as a more interesting person now than she has ever been.

Several of the women interviewed believe they share a common past described as "fear-based backgrounds" and now live in the co-operative as a result. These experiences have had negative consequences for their health, ranging from a lack of trusting relationships and difficulties communicating to physical and emotional disabilities. Despite these hard experiences, the women have learned to value and take care of themselves, at least enough to make improvements in their previously unsatisfactory housing accommodations.

#### Previous Housing Experiences

In terms of the more recent past, the women also shared some common difficulties with their housing situations prior to moving into the co-operative. The women have come from a variety of housing situations including individually-rented

apartments, shared accommodation with one or more roommates, living in someone's home in exchange for caregiving services, and one woman had even lived in a co-operative. The instability of these housing arrangements is best exemplified by one woman who had moved four times in the previous year.

The difficulties with previous housing identified by the majority of women related to finances, personal safety, and social isolation. The most obvious positive outcome resulting from these shared experiences is the women's genuine appreciation for how the co-operative has improved their living situations.

Finances represented the most frequently mentioned concern. The women discussed how rent had consumed a disproportionate amount of their total income; in some instances, as much as three-quarters of it. Very little was left for other expenses. Although these high rents posed tremendous difficulty in and of themselves, they were also accompanied by feelings of insecurity and instability. One woman described how she felt "trapped" by her previous landlord due to her physical disability and the difficulty finding accommodation which accepted pets. Several others also described the fear of sudden, unaffordable rent increases.

Doris: ...Living in rented apartments, they can go up anytime. You don't feel secure. I was in one very

reasonable, quite nice apartment and, phew, the rents went sky high.

All but two of the women mentioned financial difficulties associated with previous housing, and these two women have familial financial resources upon which to draw.

Single women are believed to spend a larger portion of income on rent due to a greater need for a safe environment (Nairne, 1991). Amongst these women, however, concern for personal safety in the former neighbourhoods was frequently mentioned despite them spending a substantial percentage of income for rent.

Kathryn: When I walked down the street, I would look behind me and around me...not during the day but in the evening when I was walking home so there was a sense of insecurity.

Not "feeling safe" was linked not only to a fear of crime in the neighbourhood at large, but also to social isolation. For Betty, living alone meant an absence of social support, no one to call on in times of need:

Betty: You're living in situations where it's only you that's going to do it and nobody else, nobody around to care if you fall. There's nobody around to come and knock on your door and see if you're okay.

Another woman, self-sufficient in most respects, did not require practical assistance, but was in great need of social contact.



Doris: I certainly wouldn't go back to my rented apartment after living here, definitely not, no, I was very lonely.

Conversely, for some women living alone was not an option as shared accommodation was all they could afford.

Out of this shared experience of difficulties in previous housing situations comes an appreciation for what the co-operative has to offer:

Kathryn: It's not home, but it's better than where I was before, in many ways. I mean, it's better than where I could be.

These women did not choose to live in the co-operative primarily for the benefits of an alternative lifestyle; they chose it out of a pressing need for stable, affordable housing. Several of the women did not view the co-operative as a permanent home, but rather as a "stepping stone" to something better. When they do leave the co-operative, however, it will be by their choice. While it does not completely eliminate the problems these women faced in their previous living situations, the co-operative certainly does reduce some of the stress of living on a low income. It gives these women a sense of control, something severely lacking when one lives on a low income.

#### Experiences Living on Low Income

##### Diversity of Poorness

Some diversity was apparent in regards to the women's

experiences of living on a low income and their perceptions of that experience, but there were also common themes. Not all of the women described themselves as "poor." In order to try to describe the experience, however, all the women began by describing coping strategies they used to manage on a low income, and two main types of coping strategies emerged. The women shared many similar emotions in the struggle to get by on a low income, and some agreement on the definition of poverty emerged.

Interestingly, the women did not identify strongly with one another despite their common socioeconomic status. In fact, the low income status may have been a deterrent to identifying with one another. While they were very open to discussing personal finances in the interviews, the women stated that generally they do not talk to each other about these matters. Lydia attributed this fact to the values of the larger society. Money equals success, and to acknowledge one's low income is, in a sense, to admit to failure.

Although all the women must have an annual income of \$25,500 or less to be eligible for the co-operative, there exists a range of "poorness" and differing perceptions of poorness amongst the women. There were women who do not identify themselves as poor:

Alice: I'm not really poor, no, I don't see myself as poor at all. I just need more money.

Others described graphic accounts of living in poverty. One woman believes that "quite a few of the people" in the co-operative are "poor." She does not consider herself to be poor at present, but described her experience as a child to illustrate that she knows what it is like to be poor:

Doris: I have been poor as a child, we were on welfare, and we hated it. We just lived for the day and she [mother] would talk about when we got off welfare. It was terrible to be on welfare, and we had to wear welfare clothes. You know, they gave you the clothes you had to wear and your shoes, and gaudy, horrible colours...So I know what it's like to be poor.

Another woman readily described herself as "poor," stating she had been poor all her life. She identified this factor as making her different from some of the women in the co-operative, although she stated, "I would imagine that some of the women here have also been poor their entire lives."

On several occasions, the women gave clues that the values, biases, and assumptions of society towards the poor also operate within the co-operative. For example, some of the women with hidden disabilities believed that other women looked at them and wondered why they were not working. In another instance, someone put forth a strong argument that poor women deserve a nice place to live, then proceeded to defend her right to be there, stating she had worked hard for it.

### Coping Strategies

When asked what it was like to live on a low income, the women typically began by describing the coping strategies they used to manage with limited finances. Out of this small sample of women, general coping strategies for dealing with a low income seemed to vary between two drastically different methods. Several women talked about careful budgeting, "counting pennies," and "having to scrimp," and the stress and frustration that accompanied those measures.

A very different coping style was described by one woman who spends relative to what she has at the moment and deals with the consequences later:

Eve: I'll go out and spend money because I don't want to sort of spend five dollars here and there along the way and not, and deny myself something. I'll go out for dinner and spend too much money, even just fifteen dollars is too much money and then I'll just go, okay, well I deal with that on the other end of it and I'll do without something.

This woman's experience of growing up poor was one of continually running out of basic necessities such as food and hot water. She explained her behaviour in terms of her father's role modelling. "My father has been the same way...he sort of spends relative to what he has in his pocket and then he'll do without." She also related it to a

need to avoid a constant sense of deprivation:

Eve: Always around food I don't really want to deny myself that much because it's always been an issue in my life having enough food.

Trying to budget with an inadequate income is an impossible task, as evidenced by Nancy who previously received a welfare cheque of \$550 per month and had five dollars left after basic expenses were met. Perhaps, for this depth of poverty, spending relative to what is in your pocket, rather than hopelessly trying to budget, is a means of reducing stress, at least temporarily.

Coping strategies centred around the basic necessities of food and clothing. Recreational activities, or limitations on them, were also mentioned frequently. An inability to afford social activities such as "eating out" seemed to be a measure of "poorness."

Doris: A lot of them just don't have the money to go out for dinners.

One woman who did not consider herself "poor" had several coping mechanisms for being able to eat out on her limited budget. Her strategies included sharing a bottle of wine with friends before going out and drinking only water with her meal as even non-alcoholic beverages could equal the price of the food.

Eating at home also involved measures to reduce costs, such as "watching prices" and "buying whatever they have on

special." One woman, on a partial vegetarian diet for health reasons, acknowledged that "it's cheap." Several women mentioned food allergies and described the challenge of buying more expensive specialty foods, necessary for health, on a limited budget.

Clothing was frequently mentioned in regards to managing on a low income. Several women described shopping at "second hand stores" most or all of the time. For other women, however, even second hand stores were not an option. Instead, they coped by not buying any clothes at all for long periods of time.

Eve: I will just go without for so long, you know, for years without new clothing.

These descriptions of deprivation stand in stark contrast to the consumerism of our society.

Recreational activities are limited for these women due to income, although not all of them identified this as stressful. One woman said she could not afford to go to movies, but did not mind watching television at home instead. "Window shopping" is a popular activity. No one expressed any resentment regarding the contrast between the visible affluence of the neighbourhood and their limited incomes. Instead, many expressed enjoyment of the pleasant ambiance.

There were strategies such as walking or bicycling instead of taking the bus, exchanging services versus paying

for them (such as peer counselling), and making one's own furniture. Some of the women have been very creative in decorating their suites with inexpensive items. One woman described the pleasure she obtained from "creating something out of nothing." Overall, the residents of the co-operative seemed to have a high percentage of creative or artistic people. At first this creativity seems born of necessity. Or, perhaps, it is these women's innate creativity that sets them apart from other poor women who have not fared so well.

The majority of women interviewed compared themselves to others less fortunate, including the homeless. Identifying others in worse circumstances can be a mechanism for making one's own situation appear better. These women, however, acknowledged the real possibility of ending up on the street themselves.

Eve: I've always been, up until now, a step away from living in the street.

The recognition of this possibility was accompanied by fear:

Alice: I would be petrified to be out there trying to live in Stanley Park or on the street, no one should have to live like that.

Ironically, a "bag lady" had been sleeping in the doorway of the co-operative. In reference to her, Betty commented:

Without this place we could all be her, although some people don't want to be helped.

Overall, the strategies used to cope with a limited

income were not careful plans. Instead, they were a means of working within very limited options. For example, if you have no money for the bus, you walk. Comparison to others less fortunate, although thought to be a coping strategy, seemed to engender more fear than comfort. In addition to fear, many other emotions were described as integral to their experiences of living on a low income.

#### Emotions and Low Income as Identity

The emotions associated with life on a low income included fear, anger, frustration, guilt, shame, and despair. They give some perspective of what it "feels" like to struggle in this way. The word "frustrating" and others such as "stressful" or "strain" were used repeatedly. Frustration was related to not having enough.

Eve: It's very frustrating and it's always sort of felt like it's just over there,...that the access to these things is just over there, somewhere, just out of my reach, but close.

Several of the women expressed frustration at being limited socially by their incomes.

Kathryn: There isn't a slush fund to just play.

Alice: That's too bad that money is such a problem sometimes, when you want to go out to dinner or go rent a boat or do some fun things, but it takes money so I try to find other things that don't take it.

The women emphasized that they were not talking about



luxuries or extravagances, but things that are necessary for health. Several women used the expression "basic comforts," things that more affluent Canadians take for granted. For example, one woman mentioned such a basic, but inaccessible, thing as a rack for drying clothes.

Anger and frustration were also closely linked to the structure and administration of social services. Some of the participants raised their voices, one becoming very flushed in the face, when discussing how they wanted only "the basics," but asking for extra money from Social Services was a dehumanizing experience.

Nancy: The financial aid worker made me feel so vulnerable because you're at their mercy in a way...

(later) You are not human when you are in the social service. You're just a number, or just like a little puppet. It's very demeaning, it's very cruel to me.

This woman compared her relationship with Social Services to a parent-child situation where she had to "get permission for everything." Eve used a similar analogy when she said, "I've never really lived in an adult world, the world of money." It is no wonder the women described this dependent position with limited control over their own lives as frustrating.

The women were sensitive to the discrimination which exists towards those of lower income levels. One affirmed, "I'm not a lazy bum." On a collective level, the women

disagreed as to whether or not the co-operative itself faced discrimination within the neighbourhood. Betty believes it does:

We all know what housing co-op means. It's a stigmatism that has been put on social housing for decades.

Others disagree that "co-op" is equivalent to social housing, and believe the neighbourhood to be generally supportive of this type of housing project. The sign with the name of the co-operative became the focus for this disagreement as some of the women believed it advertises the presence of social housing and they wanted it removed. The sign, however, remains.

The women are also divided in their opinions regarding the quality of the building. One participant believes that the co-operative is under social pressure to conform to a particular image:

Doris: I think it was the architect that told us originally that we have to keep it modest. A lot of people said, "Well, that's social housing, how come they got such a nice looking building?"

Another woman describes the construction of the building as "a piece of shit." These perceptions are difficult to understand in light of the information that the building meets earthquake standards and was rated highly by a building inspector at the end of the first year. Are the

views of some of the women clouded by the expectation that they will never have anything nice? Or, are these perceptions related to the shame of living on a low income?

The shame of living on a low income was acknowledged several times. Part of one woman's strategy for avoiding the discrimination that exists towards the poor was to avoid specific aspects of stereotypes. She makes a conscious effort to speak and appear in a manner which prevents others from recognizing that she is someone who has been poor all her life.

It was revealing to hear the women talk about their "relationship to money" very explicitly. Some of them described it in varying degrees of shame, guilt, and confusion. One woman obviously blames herself for her current situation:

Alice: I wanted money. I was greedy. That's what was wrong with me. I paid the price, I'll tell you, of being so into money.

This relationship to money was also tied to some of the women's identities:

Eve: I wasn't allowing myself to believe that I could make money because a lot of that is ingrained, [that] to make money is to try and be something you're not.

The point was reinforced by a member of the finance committee who said it "felt very strange to suddenly have all this money," even though it was not personally hers.

### Definitions of Poverty

One participant very clearly defined being poor as "having no options." Certainly the women's descriptions of coping strategies show they are working with limited resources and have fewer options. This idea is supported by the observation that the women who find their income level less of a strain, or do not consider themselves "poor," have outside resources upon which to draw. For example, some of the women have been able to afford extra comforts due to gifts of money from family or the ability to obtain credit. Compared to those who consider themselves poor, these women do have options.

In describing the experience of life on a low income, the women invariably discussed coping strategies they use to manage financially. These strategies involve food, clothing, and recreational activities. The two main types of coping methods were "counting pennies" and "spend now, do without later." Both types of strategies were accompanied by feelings of fear, anger, and frustration.

Out of these descriptions of coping strategies emerged definitions of poverty. For some of the women, pooriness is measured by the inability to afford basic comforts which go beyond the necessities of survival such as food and shelter, yet do not constitute luxuries. Poverty was also articulately defined by one participant as having no options.

### Building a Co-operative Living Environment

For these women, the journey to a co-operative living environment has been along a very bumpy road. As previously mentioned, urban Canadian culture does not properly prepare people for living in a community. The women were faced with the challenge of building a co-operative living environment from an all-female group. According to the participants, the women have survived abusive or dysfunctional pasts and some of them are still struggling to overcome them. This group of women from diverse backgrounds have lived through the initial difficulties and are beginning to enjoy some of the benefits of community existence, although they have not reached the freeway yet.

These women all share the experience of living in this building and this neighbourhood, and, with a few exceptions, participate in the operation of the co-operative. Creating a community in a new building with thirty-six strangers has been very challenging and "a lot of work." In the initial interviews, the women focused on the tremendous amount of work involved in learning to run the co-operative. Consensus decision-making is used by all committees which is time-consuming and, at times, frustrating. As time progressed, however, the women acknowledged the growth of support networks and a sense of community. One woman describes what they have accomplished in the first year as a "miracle." Part of the "miracle" has been the development of a sense of

community from such a diverse group of women.

### Diversity

One might anticipate that a group of mature, single, low income women interested in a co-operative lifestyle would have much in common. The women, however, have repeatedly emphasized their differences rather than their similarities. At approximately the midpoint of the interview process, one woman was emphatic that the women of the co-operative have only two things in common: living in the same building, and living on a low income, "nothing else."

Throughout the interviews, the women have identified many categories which highlight their diversity. For example, there are working and non-working women, disabled (with the sub-categories of visible and hidden disabilities) and non-disabled women, age categories (less than forty years, forty to sixty years, and greater than sixty years), those who identify themselves as poor and those who do not, always poor versus newly poor, previously married and never married, and gay and heterosexual women. One woman even characterized women in terms of their involvement in the co-operative: over-involved, involved, and those who have "stepped back."

The participants frequently pointed to their diversity as a source of actual or potential conflict. One woman, when asked if there is a division between working and non-

working women within the co-operative, responded with an emphatic "yes." She stated she believes the working women are less involved in the running of the co-operative and expect the non-working women to "take care of everything." The one working woman interviewed, however, did not see this difference. She did imply, however, that she believes the non-working women to be generally less productive by her statement, "I couldn't stand to just do nothing." In another example, one woman identified previously married women as having greater difficulty adjusting to life in the co-operative.

Betty: There are a few like that, widowed or divorced, used to male influence to help take care of them, not used to standing on their own two feet, but they'll adjust to looking after themselves.

The women also differ in opinions which has led to conflict during committee work:

Doris: Sometimes the meetings in particular get very volatile and we all have different view points.

Another participant described her resignation from one of the committees. While she enjoyed the work very much, a "personality conflict" with another member made it impossible for her to continue.

To an outside observer, the women do not appear dramatically different from one another. Lydia used this analogy to explain the contrast between apparent

similarities and the vast diversity described by those interviewed.

Perhaps it's like an artist's monochrome palette. From a distance, it all looks like one colour. But when you get up close, you can see all the different shades and tones.

For whatever reason, these women see their differences first. The women of the co-operative are demographically very similar, and to the casual observer would appear to have much in common. The women themselves, however, have repeatedly focused on the diversity which exists within the group.

As hypothesized earlier, the women may be resisting identification with one another due to the low status associated with being on a low income. Perhaps, too, the emphasis on differences is a means of retaining one's uniqueness in the face of a collective identity as the women move in together and begin building a community.

### The Move

The first aspect of life in the co-operative that the women shared was the experience of the move. Moving to new accommodation can be both exciting and stressful. Participants described their anticipation upon moving into a brand new building, each of them with an individual suite. There was relief in having security and stability related to housing, and excitement regarding meeting new people. One



woman described how she was so grateful for the co-operative that she "kissed the carpets and the walls." Unfortunately, for many of the women, the problems of the first few months seemed to overshadow the positive aspects. One woman describes the "horrors" of the move very articulately:

Doris: It was very traumatic moving in here. It was absolutely hell. We were like lost sheep and it took a long time to get over that, months, and I can't really explain why.

Another woman described the move as a "disaster." Some of the problem seemed tied to unfulfilled expectations:

Kathryn: I hated the co-op as soon as I moved in. I mean I was ready to move out. I absolutely despised it because it wasn't what I wanted in terms of physical space. It's an absolute piece of shit in terms of the design, in terms of the construction.

The limited physical space was a concern for many of the members interviewed. One woman pointed to her dresser which is in the living room because there is not enough space for it in the bedroom. She considered herself better off than others whose beds would not fit and they had to "send them out" and get single beds.

Another factor which affected the move was the number of problems which occurred in the first few months. Kathryn describes it well:

When I moved in there was one thing after another that

happened. I slipped and fell. The power was blowing out in the neighbourhood, two, three times. We were having false alarms. The pipes blew. It was like there was all this stuff happening and I thought, you know, I don't think this is a very good move.

All these problems seemed to create an atmosphere of crisis for the women who were already fully occupied setting up an administrative structure and learning how to run the co-operative. For some women, however, successfully managing the crises strengthened alliances and contributed to a sense of accomplishment. One woman described her involvement in one emergency situation with pride.

The move to a more affluent neighbourhood required an adjustment in one's identity.

Eve: When I first moved in here I felt really out of place in the neighbourhood because it's a pretty affluent neighbourhood and I've never really lived in that kind of a community.

The move was fraught with many problems, and required the women to make adjustments on many levels. Setting boundaries was the next challenge following the move.

### Boundary Issues

Living together, working together, and possibly socializing together make it essential to be clear about boundaries. All women interviewed mentioned "boundary issues" and, for most of them, it was a major concern. The

boundary issues related to three main problem areas: reaching agreement about the use of common areas, separating the work of the co-operative from one's personal life, and setting limits on interpersonal relationships with the other women.

The problems related to common space seem to be the least complex, and actions are being taken to resolve them. The issues have revolved around noise, use of alcohol, and competing interests for the available space. This particular boundary issue was described by a woman who thinks of her suite as her "room" and believes many other women think of the entire building as "home."

Doris: I think we all think of this, the whole place as our home and it's just, as you would in your own home, you don't like somebody else mucking around, messing around. Somebody takes it upon themselves to put something somewhere and you don't like that.

Not everyone agrees with this view. One woman suggested that considering the entire building one's home may be indicative of boundary problems.

Task forces have been set up to examine the issues of common space and to set up policies for use of them. When a task force is struck, however, "things just slow right down," so the problems have not yet been solved, but the women seemed satisfied that they are being addressed.

Separating the work of the co-operative from one's

personal life begins by making distinctions between interactions that occur as part of the work of the co-operative from ordinary interpersonal relationships of a social or neighbourly nature:

Doris: Sometimes you might have different opinions and then if you're socializing as friends it could [cause] conflict. What I try to do is if I lose my temper or I have a disagreement with someone that's got a different opinion, I leave it behind at the meeting.

The problem of drawing a line between the work of the co-operative and one's personal life is compounded by the amount of work involved which exceeded everyone's expectations. One woman said the amount of work felt more like ten hours per week instead of ten hours per month. She describes the overflow of the work into her personal life and space this way:

Alice: This place became an office. I mean, I had paperwork [everywhere]. I was like committee here or committee there. I felt like I didn't have a life.

Not only is there a huge volume of work, but its distribution has been uneven. While some women have "worked their butts off," others have contributed much less. Some women believe they have done "too much," with detrimental consequences attached to becoming "over-involved" in the work of the co-operative:

Eve: A lot of people got close to being very sick here

in the beginning because they just thought they had to keep giving and giving because no one else was going to do it.

In a trial and error fashion, the women learned techniques to separate the work from the rest of their lives, with acceptable standards of behaviour emerging. For example, it is generally unacceptable to knock on someone's door to discuss co-operative business. Any complaints or problems, unless emergencies, are to be addressed in written form to the chairperson of the appropriate committee.

A few members have responded to the conflict and boundary issues by withdrawing completely from co-op life, and non-participation has become another major issue. When asked what form this withdrawal takes, one woman described others who have not attended any meetings for months and are seldom seen around the building as they "sneak in the back door." While temporary withdrawal is acceptable when one "needs a break," to withdraw totally is not. One woman blames those, herself included, who have made it easy for some not to contribute by doing everything for them. In any case, a task force has been set up to try to "get back" these non-participating members.

Several of the women talked about the need to set limits on their interpersonal relationships to maintain personal space, privacy, and mental health:

Alice: This is probably my own perception that I had to

almost befriend these 35 other women and it's just unrealistic.

Doris: Some people have found that they...get too friendly with somebody and they're tapping on their door all the time and losing their privacy.

One participant identified the women's "dysfunctional" backgrounds as contributing to the challenge of negotiating interpersonal boundary issues.

Lydia: You can get really entangled in each others' lives here if you don't have good boundary skills. It can be scary because some people here really have a huge amount of need. I feel like if I took that upon myself to start trying to fulfil all the things I see they need then maybe I wouldn't have any more time for myself ever again.

Another woman concurred that it is both unhelpful and unhealthy to respond to the "tell me what to do" aspect of another's neediness, hence falling into old patterns of co-dependency.

Over the course of the first year, the women began to come to terms with the boundary issues. Sometimes a move towards the opposite extreme was needed to achieve balance. The words "stepped back," "stayed back," or "backed away" were used repeatedly, in regards to their involvement in the operation of the co-operative:

Eve: I guess my strategy here has been a little bit to

stay back, just to be involved to a degree that doesn't jeopardize those boundaries but also keeps up with my commitment to the co-op;

and in regards to interpersonal relationships:

Alice: ...And then I was like too much, too many, too much company, so I just back away and I back away.

Although the women indicate they are making progress with the boundary issues, it remains a very difficult task. Some of the women expressed feelings of guilt or concern that others would be offended by this setting of limits on interpersonal relationships:

Alice: I've got this thing that they won't like me or that they'll think that I don't want to have anything to do with them.

There is, however, satisfaction in setting limits and finding the consequences more positive than anticipated:

Alice: I'm quite content and now that I've set these boundaries for myself, it's much better.

Setting appropriate boundaries means "drawing the lines" between friends, acquaintances, colleagues in committee work, and those with whom one does not associate at all. Determining who is similar to and different from herself assists each woman to find where she "fits in," the first step in the development of a support network. Boundary-setting also requires that each member takes care of herself first, and finds a balance in honouring her commitment to

the co-operative without doing too much.

### Building Support Networks

Building support networks requires a number of steps for these women. First, the women found they need to accept the fact that you cannot be "best friends" with all thirty-five other women. Since that is not possible, one needs to seek out others, sometimes by trial and error, with whom you are compatible and can "fit in." Within these smaller groups of like-minded individuals, "support happens."

Negotiating boundary issues seems closely tied to the tasks of "fitting in" and building support networks within the co-operative. Participants discussed the issue of "fitting in" within the co-operative's structures, both formal and informal. For many of them, it did not seem to be a new concern. For example, one woman described herself as having always felt "different." In regards to the co-operative, not "fitting in" was often described within the context of the diversity of the members. Factors such as age differences were an issue:

Eve: There's always that sense of I'm younger than most of the people here so I do have that sense of not quite fitting in the way others fit in.

None of the women interviewed actually expressed a sense of "fitting in," instead many emphasized feelings of separateness with phrases such as "I don't feel fully involved" or "the co-op isn't my life." There were



indications, however, that some resolution of the "fitting in" issue is occurring:

Betty: I've always been that half-a-step out of step all my life. I think now it's not so odd but now I stand aside from people and I'm not the only one that's half out of step. I've got company now, especially in here.

Betty's comments indicate that the women of the co-operative are discovering some common ground, even if it is in terms of them all being "different" in some way.

Several women have made a clear distinction between the formal and informal structures within the co-operative. The conflict, work overload, and "burnout" associated with committee work has, for some women, resulted in a negative connotation to the word "co-op." The word has come to be associated with the formal structures. While many positive aspects were associated with the informal relationships the women had developed, they were considered by many as separate from the co-op. It is interesting to note that some of the women denied a sense of community or downplayed their involvement in the co-operative, yet their actions contradicted their statements. One woman described herself as "not really involved in the co-op," yet she is both the acting chairperson and recorder for a major committee and an active participant on a new task force. When asked, another woman stated there was no sense of community, yet later

described how much she enjoys "chatting" to the other women when she meets them in the hall, in the laundry room, or on the bus.

There are indications that a sense of community does exist despite some participants' statements to the contrary. Many participants referred to the "outside world" or the "larger community." Mary describes how the concepts of "insider" and "outsider" were clearly illustrated at a recent general meeting. A visitor was present at the meeting and Mary described how one could "sense a ripple pass through the group" as people recognized the presence of an outsider and questioned why she was there.

In later interviews, the women readily acknowledged the presence of support systems within the co-operative. Some participants defined the first step towards building a support system as identifying others who are similar to you or share common interests.

Lydia: People can usually tell through instinct who they're going to be similar to and comfortable with. One participant said "it is a matter of not forcing connections." Another woman described it as a process of "clicking or not clicking" with others. She described how she has satisfying conversations with some women and yet does not speak to others at all.

The support networks developing within the co-operative are mostly of an informal nature. Efforts to formalize

support networks have been unsuccessful. In one instance, an attempt was made to institute a formal "buddy system" for women with disabilities. The plan was met with complete resistance.

Lydia: Someone had this plan. You'd be assigned to a neighbour to go to [for help] and so many of us resisted that and said, "No way, we want to go to whoever we've established trust with."

In another example, a support group for women with hidden disabilities, initiated by one woman, dissolved due to decreasing participation and lack of a clear purpose.

All other support described in the interviews was of an informal nature.

Lydia: I've seen a lot of support happen here and it's not usually organized. It's just the neighbours sort of taking it on themselves to reach out to the person. This informal support takes a variety of forms and seems to fall into the following categories: concrete or material support, informational support, inspirational support, and emotional support.

Concrete support, described by one of the women as "a thing support" encompasses money, material goods, and physical assistance. Cards of sympathy or support are circulated for signatures and given to women who are ill or have experienced a recent loss of a family member. One woman emphasized that no one in the co-operative is in a

position to provide monetary support to another in need. She described an agreement she has with a neighbour for a \$20 loan at the end of the month when one of them is "caught short," a tentative arrangement at best, as neither of them can depend on the other to have an extra \$20 when it is needed.

Kathryn spoke enthusiastically about the "freebie box" in the laundry room. In this box, insiders or outsiders discard clothing and other items which can be claimed by others on a "first-come, first-served" basis. Not only has Kathryn found several desirable items of new clothing for herself, but a neighbour has claimed a number of items for her which she has greatly appreciated.

Informational support was described by several participants. For example, one person mentioned a notice for a food bank posted on the bulletin board as being a better way to help someone than actually giving them food. Another woman described "healing information" which has been extremely helpful to her, such as the name of an exceptional physiotherapist that several of the women are now visiting. Information on nutrition, food allergies, and recipes is also exchanged.

Inspirational support takes a number of forms. Some women described how the courage seen in others as they struggle with various challenges is inspiring. Conversely, another woman described how she felt "sorry for herself"

when she lived alone, but seeing the difficulties faced by others in the co-operative, she has recognized her own strengths and abilities, and has seen her work progress as a result.

While organized social events are enjoyed ("We have wonderful parties"), they do have their awkward moments.

Lydia: Everyone is kind of shy so maybe only one person is speaking and you're aware of thirty other people paying attention to your every word so it's kind of inhibiting.

Even many of the "organized" events are relatively informal, such as the video nights where a group gets together to watch a movie.

The greatest social and emotional support develops as the women discover others with whom they "click" and friendships are established. Dyads or small groups of women "get together for coffee" or go out together. It is within these informal structures that the women listen to one another, offer emotional support, and share information. Betty's comments best illustrate the type of support available:

I rely on the people in here as friends, just people to talk to. They help me a lot. I have a friend. She stops always before she goes outside. She says do you need anything, she always stops to see if I'm okay.

The support within the co-operative is mainly a result of

informal networks, and it is growing.

Kathyrn: I can see that there is a community building and developing, that some people are really there for other people, and there is a support system created which is very nice to see and to be around.

The energy expended by the women in seeking out connections and establishing trusting relationships with select individuals or groups is beginning to reap tremendous benefits in terms of the support gained.

#### What is Health for these Women?

The women discussed their many and varied health problems, from food allergies to cardiac arrest. It was not, however, from their individual stories of illness that the meaning of health for these women emerged. Instead, the shared beliefs, values, and concerns regarding health arose from their descriptions of daily life.

Safety and security figure largely in the definition of health for these women, and were mentioned by everyone interviewed. When asked to define health, one woman describes health as contentment, then directly links it to safety:

Alice: [Health is] a lot of peace of mind...being content quite a bit, feeling safe in your environment. "Feeling safe" seems to encompass three areas, which are physical safety, financial security, and emotional security. Although the trauma of "the move" and the difficulties

relating to the operation of the co-operative, setting boundaries, and fitting in have taken a toll on the women to some extent, overall this measure of health, "feeling safe", seems to be enhanced by living in the co-operative. First, the issues of physical safety are examined.

After a sexual assault at a young age, one woman says she still never goes out at night, but discussed the increased feeling of safety in this new neighbourhood due to the number of shops and stores. Her former neighbourhood lacked these amenities and was comprised of hotels, pubs, and large businesses such as an automobile dealership, all on a very busy thoroughfare:

Julia: If someone follows you, you just go into a [fast food restaurant] and stay there and pretend you're ordering something.

Another woman described a feeling of safety in having neighbours close at hand. "I like living alone in this suite but I like knowing that I have the neighbours here." This same woman called me shortly after her interview to report that during the night someone had climbed up the side of the building to the fourth floor, and she been very relieved that others, in addition to herself, heard the intruder and called the police.

Connections were drawn between income and health. Nancy expressed her wish to return to the work force, but due to her food allergies, groceries consumed a large

portion of her income. Without sufficient income to buy the special foods, however, she says she will not be strong enough to go back to work.

Health practices were directly influenced, in many instances, by the women's financial situations. Several participants described frustration at being limited in their preferred health practices by a lack of money. These women suggested that vitamins and alternative therapies such as acupuncture should be covered by medical insurance plans. Another limitation to healthy choices was the high cost of organic foods. One participant questioned whether the stress of being able to afford only produce which might be high in chemicals adversely affected health in and of itself. All of the women interviewed have special health concerns ranging from food allergies to emotional problems. It is unfortunate that, for many of them, a limited income interferes with their ability to address these concerns in the manner they would prefer.

In terms of financial security, some of the women were quick to emphasize that their lives are not easy now, but that financially things have improved considerably.

Kathryn: I don't have to worry about the finances so much because of being on subsidy and that's a great relief. There's a sense of being able to have a bit more and there's a sense of security.

All of the women seemed to make a clear distinction



between physical and emotional health. Emotional health (or emotional security) for these women encompasses self-esteem, healthy boundaries, and feelings of control. In terms of self-esteem, there were many references to ways in which the co-operative improved the women's self-esteem. Enhanced self-worth accompanied merely living in a "nice" building in a good neighbourhood.

Doris: I think it [the co-op] would give them a feeling that they're worthwhile, that they do deserve something nice. I think it helps their self-esteem.

Opportunities to learn new skills also promoted self-esteem. One woman admitted that she had not known how to write a cheque until a year ago. Participating on the various committees, although stressful at times, provided many positive experiences:

Betty: I was very surprised when I got voted in [to the Board of Directors]. I was dumbfounded. I never thought that I was that popular. I was very shocked.

Kathryn: I'm now the minute-taker of one of the committees. The chairperson acknowledged how good the minutes were and I thought, ooh, I felt good, I feel really good about that acknowledgment.

In addition to the individual skills and accomplishments, there is an overall sense of achievement in being able to operate the co-operative:

Eve: The fact that we're all women, I mean that's great

in itself because that builds self-esteem, too, because we're not depending on anybody from the male gender to come and save our co-op or make our co-op function or rescue us from anything happening here. We have to do it ourselves and when we do that, it builds esteem. Inherent in this description of enhanced self-esteem is an element of control. In discussing the positive aspects of co-op life, many of the women used phrases such as "a sense of control" or "being empowered":

Kathryn: There's more a sense of being in control of my life and I like that.

Eve: It's the first time I've ever lived in a place that everything works, and also that I have some control over, that I don't have to go look to somebody else, you know, to fix things or to organize things, so in that sense it's really good.

This sense of control contrasts sharply with the women's experiences of living on a low income where they struggle with limited options and feel at the mercy of social services.

Health was even defined in terms of community. For Nancy, "a healthful environment is one where people are learning to live with one another." She questioned whether many of our society's problems are a result of this inability to live together in community.

The challenge with boundaries, gaining control, and

establishing helpful relationships also seems to involve gaining perspective:

Eve: People are finding out where they fit and what their role can be, and not everybody is panicking about the small things anymore because I think we've stepped back and seen the overall picture.

#### Summary

The participants of this study believe that the women of this housing co-operative, although diverse in many ways, share significant common experiences. These experiences include dysfunctional or abusive backgrounds, living on low income, and the difficulty of finding adequate, affordable housing.

They are engaged in the challenge of building a community out of thirty-six women who were initially strangers. This challenge is intensified in that many have not had experiences controlling their own environments. While they have identified many stresses associated with the tasks of learning to operate the co-operative, setting boundaries, and fitting in, they are also beginning to identify positive aspects of co-operative life.

Subsidized rent in a permanent home has increased feelings of security and reduced some of the strain of living on a low income. The better quality neighbourhood and living in community have increased feelings of physical safety. As boundaries are negotiated and support networks

emerge, the women identify the potential for a healthier way of life.

The women in this study are seen to construct health in terms of basic needs. They define health in terms of safety, security, adequate shelter, and having basic comforts. The women's beliefs and values regarding health mirror those of the larger society. Unlike women in higher income brackets, their incomes restrict their options for health practices. Some of the women, however, have developed creative strategies for carrying out these health practices within the constraints of their income.

The housing co-operative, even for those women who are committed to the ideals of community life, is first and foremost a place of secure, affordable housing. The women vary greatly in their attitudes towards the co-operative as a home. Some of the women view it as a long term residence, while others see it as a "stepping stone," allowing them an opportunity to strengthen their health and develop new skills, with the ultimate goal of returning to the workforce. In this regard, the co-operative is a temporary refuge. It provides the women with hope for a better future.

The co-operative is somewhat of a "mixed blessing" for the women in terms of their health. While living there has reduced the financial stress and provided a sense of stability, the demands of participating in its operation has

created new stresses. Sadly, several of the participants believe their health has deteriorated since moving into the co-operative. Perhaps, in time, as the administrative aspects of the co-operative stabilize, and the women develop the new skills needed for this new way of life, health benefits will become evident.

## CHAPTER 5

## DISCUSSION

Introduction

To date, virtually no research has been completed on the health of unattached women living on a low income. This study provides descriptive information on the everyday experiences of this discrete group of women living on low income in one co-operative housing project. The purpose of this study was to develop a beginning understanding of how living on a low income in this context affects the health of these women, by exploring how they construct health in their lives. The results are not generalizable to other groups of low income women, but they do raise questions for further research.

In this chapter, the most significant aspects of the findings are discussed in light of relevant research. Due to the dearth of studies on unattached low income women, references to the literature include references to opinion papers and related research. The implications of the findings for nursing practice, nursing education, and nursing research are contained in the following section. Subsequently, the method of the study and its limitations are discussed. A summary of the study concludes this chapter.

Discussion of the Findings

Initially, the effects of living in a housing co-

operative was not anticipated to be the major focus of this study. As the interviews proceeded, however, adjusting to this new way of life was found to be the most pressing health concern for the majority of the participants. For this reason, the most significant findings of the study are related directly or indirectly to life in this housing co-operative.

Three of the most interesting aspects of the findings of this study are discussed in this chapter. The first aspect is that the women were found to perceive themselves as a diverse group without a common identity. This lack of a common identity seemed to interfere with the interpersonal interactions the women had with one another to the extent that the social environment was identified as a major source of stress. The second significant aspect of the findings is that the environment exerted both positive and negative effects on the women's health, with the physical environment having many positive consequences. The final aspect of the findings to be discussed is the women's construction of health. Health was defined as "feeling safe" and was underlined by a theme of control. These findings have been organized around the following concepts: (1) identity (2) the environment (including both the physical and social contexts) and (3) control. An examination of the findings in relation to these concepts demonstrates they are closely inter-related and all affect the women's health.

### Identity and Self-Concept

Identity, or a coherent sense of self, is important for health. Without "that sense of selfhood, only retreat and entrenchment are the viable alternatives to a schizophrenic and disturbed existence" (Rutherford, 1990, p. 24). While identity provides a stable core to a person's individuality, it is about belonging, as well as being different from others (Weeks, 1990). Nozick (1992) describes how identifying with one's peers leads to self-knowledge by providing a "mirror" that reflects back to us who we are and what we might be.

One of the most striking and unexpected findings of this study was the women's lack of a sense of belonging to one another. The women interviewed perceived themselves as a diverse group without a common identity. Although the literature supports the view that low income women are a diverse group with varying needs (National Council of Welfare, 1990; Wilson, 1988), the women of this sample are demographically very similar, yet they repeatedly emphasized their differences.

The women's reluctance to identify with the co-operative as a whole was explained by the participants. They gave reasons for this outlook as having been different all their lives, or suggesting they did not want to lose their individuality within the collective whole. The literature regarding co-operative housing supports the idea



of this tension between community identity and individualism (Cooper & Rodman, 1994; Ley, 1993). Within our society, with its emphasis on individual growth and achievement, it is not surprising that members of any group would have difficulty developing a group identity. As Moccia and Mason (1986) suggest, an outlook focused on community welfare rather than rugged individualism requires a major philosophical shift.

While a sense of community or belonging is lacking in society at large, there seem to be other reasons the women have not been able to readily identify with one another. The women interviewed agreed that they share a common history of abuse, dysfunction, or other "hard experiences." Nevertheless, some of them pointed to this commonality as the source of their differences. One participant suggested that holding onto uniqueness could be a strategy for maintaining self-worth and surviving abusive or dysfunctional relationships. Justice (1992) confirms that family violence, whether physical or emotional, damages one's sense of identity or separateness. McEvoy (1990), a feminist counsellor working with victims of abuse, concurs that childhood abuse creates "a sense of isolation, of being freakishly different" (p. 63).

Recollections of the quality of childhood experiences have been positively correlated with psychological adjustment and coping, and negative childhood experiences

have been correlated with increased symptoms of emotional distress, increased social introversion, and decreased ego strength in low income single mothers (Olson, Kiechnick, Banyard, & Ceballo, 1994). Although abuse has been shown to cross all income levels (Justice, 1992), the findings of this study are consistent with reports in the literature that those in low income brackets more frequently report living in dysfunctional families (Cohen, 1994). Montgomery's (1994) study of homeless women also found the majority of participants (six of seven) had grown up in "deplorable" conditions.

The histories of abuse and/or dysfunction have most likely affected the identities of the women in this study. There are, however, other possibilities as to why the women do not readily identify with one another. Low income women hold very little status and power in society, and as a coping strategy, these women may have chosen not to identify with this undesirable image. As one participant stated so succinctly, to identify with other low income women is equivalent to admitting failure. Cohen (1994) discusses how, in our society, women's self-esteem is often linked to appearance which includes wearing the right clothes, the right makeup, and "participating in a lifestyle that is beyond the reach of those who live in poverty" (p. 952). There is an absence of positive role models and positive media images to which poor women can relate. According to

Hall, Stevens, and Meleis (1994), "differentiation" is one of the properties of marginalization. "The edge is thus an experiential place in which peripheralized persons are distinct and isolated not only from the centre, but also from one another" (p. 26).

A strong sense of self, combined with a sense of connectedness, is important for health. In a study of older women's images of health, Perry and Woods (1995) found that a "core inner self" that grows and adapts is one aspect of being healthy. Developing that inner core requires identification with others. Nozick (1992) concurs stating that personal empowerment begins with self-knowledge which does not develop in isolation, "but is usually sparked by an interactive process of identifying with other people in a common struggle" (p. 101). Similarly, in her study of women's experiences of empowerment, Shields (1995) found that two of the themes of empowerment are a core sense of self and one of connectedness. Saltonstall (1993), in a study of conceptions of health, also found a sense of self to be one aspect of being healthy.

Conversely, lacking a sense of connectedness results in feelings of isolation. This perception of being different can lead to stigmatization, low self-esteem, and decreased personal power (Hall et al., 1994). In a review of twenty-three studies of the determinants of health-promoting behaviour, Gillis (1993) found self-efficacy and self-

concept to be among the strongest predictors of health-promoting behaviour. Lacking a strong self-concept and personal power may negatively affect one's health practices.

In summary, identifying with peers is important to the development of a healthy sense of self. The women who participated in this study lack a common identity for a number of possible reasons. The women's histories of abuse and dysfunction have resulted in feelings of being "different." Living in a low income bracket reinforces the sense of isolation because it is one of the properties of marginalization. Finally, our society's emphasis on individualism is a barrier to the development of a sense of community and belongingness. Whatever the causes, however, the absence of a common identity has potentially negative consequences for health, including low self-esteem, increased feelings of powerlessness, reduced or absent health-promoting behaviours, and increased vulnerability to illness.

Living on the periphery, however, does carry the potential for some positive outcomes. They are worth mentioning because these positive characteristics were evident in some of the women interviewed. Marginalization almost forces one to reflect on the situation, and qualities of resilience may be promoted (Hall et al., 1994). Many of the women discussed the amount of "personal work" they have done in terms of counselling and group work, evidence of

reflection. Several of the participants identified themselves as "survivors," indicating an awareness of their inner strength and resilience. Furthermore, society looks to the margins for innovation and creativity relative to cultural change (Hall et al., 1994). It is not likely a coincidence that many of the participants referred to themselves as artists or discussed their need to express themselves creatively.

Despite the potential for positive outcomes, marginalized persons do have an increased vulnerability to negative health consequences. This vulnerability is related not only to their perceptions of themselves and their situations, but is also dependent on the contingencies of the environment (Hall et al., 1994). For this reason, the elements of the environment identified by the women as affecting their health are discussed in the following section.

#### The Environment

Kleffel (1991) has encouraged nurses to broaden their concept of the environment and to pursue research which addresses the precursors of health problems. Treating the health problems of individuals without consideration of the effects of the environment is doomed to failure. The findings of this study pertinent to the concept of the environment are interesting for several reasons. The women frequently mentioned aspects of the environment in regards

to their health. Due to the recent nature of their move into the housing co-operative, the women were able to make comparisons with their previous housing situations, including the effects of changing neighbourhoods. The co-operative itself is an interesting environment which holds the potential to reduce the women's sense of isolation. The social context of the co-operative, however, was often cited as a source of stress rather than a support. In the next sections, both the physical and the social environments are discussed in relation to the literature.. The discussion has been organized into three sections: the neighbourhood, the housing co-operative, and social support networks.

#### The Neighbourhood

Living in a designated poverty area has a negative effect on health as shown by the Alameda County Study (Haan et al., 1987). The majority of the women interviewed identified negative aspects of their previous housing situations, including crime, safety concerns, and social isolation. These concerns do not address the invisible health risks inherent in poorer neighbourhoods such as increased exposure to pollutants and greater stress related to stigmatization (Lindheim & Syme, 1983).

Not only are poor neighbourhoods detrimental to health, but Anderson and Armstead (1995) suggest the "the residential environments of the affluent may even be health enhancing" (p. 222). Schrijvers et al. (1995) found

increased survival rates following the diagnosis of cancer for women from more affluent neighbourhoods. Studies have shown that merely being able to look upon pleasing, natural scenes can speed healing after surgery (Ulrich, 1984). Several participants of this study identified the positive aspects of their new neighbourhood, specifying such things as parks, proximity to the beach, interesting shops, and increased feelings of safety as contributing to enhanced well-being.

The women of this study identified several aspects of their previous housing situations which may have had negative health consequences. In addition, many of them mentioned factors in the new neighbourhood considered to be health-enhancing. Their reports are consistent with those in the literature and emphasize the importance of the environment to health.

#### The Housing Co-operative

Housing co-operatives are designed and built to provide affordable housing, to allow residents greater control over their environments, and to provide a sense of community (Cooper & Rodman, 1994; Ley, 1993). While all of the women interviewed acknowledged feelings of increased security and reduced financial strain since moving into the co-operative, the increased sense of control and social support inherent in community life were not immediately apparent. Ironically, almost all participants reported increased

stress levels associated with living in the co-operative and participating in its operation. In fact, several participants reported a significant deterioration in their physical and/or mental health following the move into the co-operative.

The adjustment to a new way of life may have created additional stress, resulting in this negative effect on health. Previously, major life change events, such as change in place of residence, were thought to increase stress and precipitate health problems. More recently, it is the element of loss within these changes that is considered to create pathogenic stress (Williams & House, 1991). Cultural change to an extent that alters cultural values and rules of behaviour, and impacts on traditional ways of coping with stress, is also potentially damaging to health (Corin, 1994). The women's move into the co-operative has resulted in several losses related to their former lifestyles, including, in some instances, previously successful coping strategies. They moved into somewhat of a cultural "vacuum" until new rules and values could become established, and new methods of coping developed.

Studies of housing co-operatives illustrate their potential to provide increased social support, especially for women (Wekerle, 1988). The development of community, and the social support that accompanies it, is not a smooth process due to differing views on the definition of



community and the challenge of achieving a balance between social support and privacy (Cooper & Rodman, 1994). These problems are consistent with those identified by the women in this study. The topic of social support is discussed in the following section.

### Social Support

Social support, like poverty, is a complex and multi-dimensional concept and, until recently, it has been reported as having only a beneficial role in regards to health (Ducharme, Stevens, & Rowat, 1994). Social support has also been considered synonymous with social networks (Malone, 1988). One of the problems faced by low income women is the absence of adequate support networks. Two of the women in this study reported social isolation as a problem prior to moving into the co-operative. In the limited literature on women, poverty, and health, the absence of social support has been noted. Nairne (1991) suggests that unattached poor women may be prone to social isolation due to lack of family supports. Family members, however, are not necessarily a person's main support system (Lackner, Goldenberg, Arrizza, & Tjosvold, 1994).

Although social support is acquired through one's social network, the presence of social relationships does not guarantee support. Rowe and Miles (1994) observed that poor, single mothers are lacking in social support due to the financial and emotional costs of a social life. Other

studies have shown that for low income women, social relationships may be a source of greater stress than for women with more resources (Peznecker, 1984). Most notable in this study is that the women interviewed, including those previously isolated, identified social relationships as a major source of stress, particularly in the early phase of establishing the housing co-operative. Almost everyone mentioned negotiating boundary issues as challenging and problematic. This negative aspect of social relationships has recently been acknowledged and labelled "dissupport" (Malone, 1988).

In oppressed groups, it has been observed that those who feel powerless tend to identify with the oppressor and respond negatively towards peers, resulting in what has been called "horizontal violence" (Heide, 1988). The participants often linked the problems with interpersonal relationships to communication difficulties and boundary issues that were rooted in their common pasts. The women interviewed discussed the lack of trust evident in some of their interactions. Mistrust is the one lesson learned by almost all survivors of family violence (Justice, 1992). Some of the women described the barriers to communication as "paranoia" and "over-sensitivity." McEvoy (1990) says that survivors of childhood abuse are hypersensitive to their environment and the people in it.

White (1992) maintains that boundaries are constructed,

negotiated, and maintained to give some sense of orderliness to human interaction. An interpersonal boundary is defined as "a dynamic line of demarcation separating an individual's internal and external environments, and varying in permeability and flexibility" (Scott, 1988, p. 26).

Boundaries are an important part of cultural norms, regulating our interactions with others (McEvoy, 1990).

McEvoy (1990) substantiates that childhood abuse constitutes repeated invasion of boundaries, leaving the individual with boundaries that are too permeable, resulting in a blurred sense of self and decreased personal power. Women, in general, tend to have more permeable boundaries and are at greater risk of "over-commitment" in social relationships (Stewart, 1993; Williams & House, 1991). In this study, problems with boundary issues were evident in the women's difficulty setting limits on interpersonal relationships, their degree of involvement in the co-operative, and their fear of becoming "entangled" in one another's lives.

Over the course of data collection, the women interviewed provided more and more examples of how social support was developing, and how this support was viewed as a very positive aspect of life in the co-operative. The concepts of identity and boundaries are important to the development of social support. One needs sufficient boundaries to gain a clear sense of self, and one needs to take care of oneself first. Next, one needs to find others

similar to oneself with whom to identify. The participants described this step as "fitting in." Once a woman finds others with whom she "fits in," the stage is set for these like-minded individuals to provide support to one another.

The women's descriptions of this process are consistent with the findings of Shields (1995) whose study of empowerment found all of these aspects (a sense of self, commitment to self, and a sense of connectedness) as necessary ingredients for empowerment. The missing aspect of empowerment, a sense of choice or control, is discussed in the following section.

### Control

In addition to social relationships and social support, a sense of personal control can affect health (Williams & House, 1991). Control has been positively correlated with social status, and the accompanying self-esteem and sense of mastery can buffer the impact of stressful life events (Williams & House, 1991). Conversely, chronic poverty leads to the perception that much of the world has control over the individual (Humphry, 1995). In this study, control emerged as a major theme underlining the women's perceptions of health. When asked to describe their lives, the women invariably began discussing coping strategies they used to manage on a low income. These strategies, such as "counting pennies," can be seen as attempts to gain control over their lives. One woman actually made the connection between

poverty and control by defining poverty as "having no options."

The findings of this study indicate that living on a low income, and the associated decreased sense of control, has had a significant impact on the women's definitions of health, concerns regarding health, and health practices. In an exploratory study, Calnan and Johnson (1985) found that health beliefs have little relationship to social and material circumstances. They did find, however, that the lower class women interviewed had more functional definitions of health such as "getting through the day." In this study, the women's definitions of health and associated concerns focused on meeting basic needs on a day-to-day basis, hence illustrating a more functional and practical view of health. Control over basic needs is less likely to be reflected in the health concerns of women in higher economic strata. More resources mean more choices, and hence, more control.

Safety and security featured largely in the women's definitions of health and were mentioned by all participants. The focus on safety and security as an important component of health may be related to the shared "hard experiences" and previous loss of control over personal safety. For example, the women who had been sexually assaulted at an early age were still very much concerned with physical safety. Saltonstall (1993) reported

that definitions of health were guided and constrained by social norms and situations, and that gender was integral to one's concept of health. In part, this was reflected in the frequency with which issues of safety and danger were evident in the women's narratives. Interestingly, the women in Saltonstall's study were white, middle-class, and between 35 and 55 years. Considering that safety concerns were also prominent for the women who lived in the co-operative, it is possible that this issue is related more to being female than to income level.

It has been observed that women attempt to gain some control over safety by spending a larger proportion of their income on rent in order to live in better neighbourhoods (Nairne, 1991). For low income women, this strategy results in fewer resources remaining to meet other basic needs, thereby resulting in reduced control over other aspects of their lives. While the theme of safety and security did not arise in a study of older women's images of health (Perry & Woods, 1995), the themes of independence and energy, both necessary for control, did.

Limited finances and reduced control over one's life can lead to feelings of insecurity. The women in this study described the increased stress of struggling to manage on an inadequate income. This finding concurs with those of Edwards (1993) whose participants, African American single mothers living on low income, described coping with stress

as their primary challenge. Many of these women listed raising their children alone as the greatest source of stress, followed by lack of money and transportation difficulties. These two groups differ significantly in terms of nationality, race, and parental status. The results do suggest, however, that the greatest threat to health for low income women is living under constant stress. These results are consistent with Beckett's (1993) observations of endemic stress for women in India and the subsequent effects on their health.

Several participants clearly articulated how a lack of money directly affected their ability to carry out preferred health practices. This finding is consistent with a growing body of literature which supports the idea that social and economic barriers, and not a lack of information, exert most influence on health behaviour (Nelson, 1994; Gillis, 1993; Williams, 1990). This idea is contrary to the health-belief model (Rosenstock, 1974) where beliefs, values, and knowledge are considered to form the basis of behaviour change. This conclusion is indirectly supported by Gillis (1993) who found that one of the most frequently studied determinants of a healthy lifestyle, health value, emerged as an inconsequential determinant of health behaviour.

It is noteworthy that the women in this study believed their health practices were limited by income, despite a policy of universal access to health services in Canada.

Several women voiced frustration over their inability to carry out preferred health practices such as buying vitamins, purchasing organic fruits and vegetables, or seeking therapies such as counselling which are not covered by health insurance. In Keith's (1987) study of postponement of health care by older unmarried women, financial concerns were found to be the prime reason for delays in seeking medical treatment. Although this study is American and differences in the health care systems need to be taken into account, these results should not be overlooked. In one Canadian study, Thomas (1988) also identified economics as a barrier to health care.

In addition to the direct effect of limiting health practices, financial status also increases stress due to feelings of loss of control over personal health. Living in the co-operative has, however, provided the women with opportunities to learn to new skills and gain more control over their environment. For many, this has been a very positive experience, identified by some of the women themselves as empowerment.

While research has shown that a sense of control enhances health (Williams & House, 1991), Jones and Meleis (1993) have actually defined health as empowerment. In their model, health is conceptualized as the interaction of three variables: stressors, resources (internal and external), and energy (or power). When the findings of this



study are examined in terms of this model, the challenges to health for low income women become readily apparent. These women have many stressors and potentially fewer resources (both internal and external) to cope with them. A considerable amount of energy is required to meet basic needs. This draining of energy depletes one's power, thus resulting in a sense of decreased control.

Control has emerged as an important theme in this study of low income women's construction of health. Limited resources lessen one's choices in all aspects of life, including health practices. Fewer choices result in a lack of a sense of control, increased stress, and negative effects on health. When the women of this study identify the co-operative as providing them with a sense of greater control over their lives, they are, in essence, describing an improved state of health.

#### Implications for Nursing

The findings of this study have implications for nursing practice, nursing education, and nursing research. The implications for each of these areas is discussed separately in the sections that follow.

#### Nursing Practice

The women's lack of a common identity has implications for the nurse working with clients living on a low income. The nurse cannot assume that demographic similarities mean women will relate to one another, and this has implications

for strategies such as support groups. When attempting to bring women together for mutual support, nurses need to look at factors such as age, employment status, and marital status as influencing group cohesiveness.

When working with clients living in housing co-operatives, the nurse needs to recognize both the benefits and stressors inherent in this type of lifestyle. The nurse may assist the client to identify sources of stress and the skills needed to manage them. Referrals to community resources where these skills can be developed might be made. Identifying and supporting effective coping mechanisms already in place is also beneficial. In general, nurses also need to take measures to support and foster increased self-esteem in low income clients. One way to do so is to provide positive feedback on the effective coping strategies the client is using to manage stressors successfully (Rowe & Miles, 1994).

Providing positive role models for women living on a low income may present a challenge. There are, however, organizations whose leaders and members have strived to improve the situation for those living on low income. Introducing clients to these organizations achieves two purposes. It provides the client with additional resources, and also introduces the woman to persons who may serve as positive role models.

Finally, nurses must have an increased community focus.

Attention to the environmental determinants of health is crucial. It is no longer acceptable to use the nursing diagnosis "knowledge deficit" without considering the barriers to carrying out preferred health practices. When working with clients living on a low income, nurses need to assess the barriers to health that exist for each client, and work with this person to develop measures to overcome them.

Nurses also have an important role beyond their immediate practice. Nurses are in an excellent position to identify the social and environmental precursors to poor health. Once socially-embedded health risks have been found, nurses must work both individually and collectively, via their professional associations, to influence changes in social policy.

#### Nursing Education

The findings of this study underscore the need for nursing education to address the fact that barriers to health practices are a focus for nursing intervention. This education needs to be carried out at all levels including basic education programs, graduate programs, and continuing education for all practising nurses. Students at all levels need to learn assessment skills that enable nurses to assess entire communities and which lead to the identification of environmental determinants of health problems. Students and nurses alike need encouragement to become politically active

and to lobby for social changes that will have positive health benefits.

### Nursing Research

The results of this study raise many questions for further study. For example, what is the incidence of abuse and dysfunctional family experiences for women living on low income? What is the relationship between these experiences and both the women's income levels and health later in life? Most importantly, what are the mechanisms which enable an individual to overcome these experiences?

Nursing research needs to encompass a broader conception of the environment (Kleffell, 1991). In particular, more research on the subject of safety as a health concern for women is needed. Housing is another aspect of the environment appropriate for nursing research. For example, social housing has typically been developed in low income areas (Ley, 1993). The evaluation of social housing projects in "better" neighbourhoods may reveal long term health and social benefits. This change might help decrease the stigmatization that Lindheim and Syme (1983) identify as being associated with public housing. They suggest that it is the stigmatization that leads to anger, decreased self-esteem, and consequently negative health outcomes. More research is needed before any firm conclusions can be made.

The study participants have been able to improve their

situation by gaining access to a housing co-operative. What qualities set them apart from other low income women who have not fared so well? Can these qualities be fostered in others, and if so, how? Anderson and Armstead (1995) also questioned whether there are coping skills that can be taught to the poor to enable them to better manage their many stressors. Of particular importance is the evaluation of measures that may help to support the coping measures of these women or reduce some of the stress. Furthermore, what are the long term health benefits of living in a co-operative style of housing? Can these principles be applied to other aspects of society for health-enhancing effects?

Given that very little research has been conducted regarding women, poverty, and health, and virtually none pertaining to mature, unattached, low income women, there are numerous possibilities for investigation. This study, however, has indicated that the concepts of identity, the environment, and control are suitable places to begin.

#### Discussion of Method

The method proposed for this study was ethnography. Unfortunately, permission for participant-observation was denied and this has limited the data collection for the study. In the next sections, the measures taken to ensure rigor are described, the limitations to the study are discussed, and the significance of the findings, in light of the study's limitations, are reviewed.

### Rigor

The essential differences between qualitative and quantitative research methods make it inappropriate to use the criteria of reliability and validity, associated with a quantitative approach, when evaluating qualitative research (Sandelowski, 1986). For this reason, strategies to achieve rigor in qualitative research were used.

Auditability has been identified as an important strategy to achieve rigor in qualitative research (Burns, 1989; Sandelowski, 1986). It requires that a clear "decision trail" is documented, which means reporting all decisions that were made and the rationale for them. In this study, auditability has been ensured in two ways. As mentioned earlier, the investigator maintained a journal record of thoughts, feelings, reactions, insights, and decisions. In combination with the written analyses that focuses on the data, this record provides a clear decision trail. In addition, the faculty committee members reviewed the data and analyses on a regular basis and provided suggestions as necessary.

A second aspect of rigor is achieving credibility and fittingness (Sandelowski, 1986). The first strategy to achieve this criterion is to ensure for representativeness of the data. The procedures listed under sampling were directed towards this aim. For example, selecting participants that hold different roles within the co-

operative prevents the presentation of only one particular view. "Elite bias" can occur when only the most visible and articulate members of a group are interviewed or observed (Burns, 1989). It is a limitation of this study that participant-observation did not take place. Nevertheless, intensive interviews were conducted with a sample of volunteers. These women comprise 28% of the residents of the co-operative, and were seen to represent the diversity of the membership in many ways. For example, the volunteers included women from all age groups, newly poor and always poor, and those who consider themselves poor and those who do not. It is likely, however, that their willingness to participate may set them apart in some way. In addition, some groups were known to be under-represented, such as the working women and those women not actively participating in the operation of the co-operative. Measures were taken to recruit some of these women, but they were unsuccessful. To compensate for this limitation in data collection, women participating in the study were asked to compare themselves with women who were not well represented. In addition, through their stories of life in the co-operative, it was possible to gain at least some understanding of the dynamics that affected all residents.

It must be kept in mind that accounts of one's behaviour do not always coincide exactly with one's actual behaviour. Jarrett (1993), in discussing the use of focus

groups with low income minority populations, acknowledges the potential for "idealized" accounts of one's life. This potential arises from the poor's acceptance of mainstream values while recognizing that their behaviour diverges from that of the larger population. This type of "impression management" is, however, not limited to low income groups but is seen as a factor affecting the data collected by an ethnographer in any context (Hammersley & Atkinson, 1986).

Even in the absence of participant-observation, the women were seen, at times, to contradict themselves. For example, several women described themselves as not very involved in the co-operative, when, in fact, they were participating on more than one committee. There were also aspects of their lives that the women were reluctant to talk about. In one instance, a participant mentioned a "major conflict" occurring within the co-operative, but declined an invitation to discuss it. This obvious reluctance to talk about certain circumstances limited data collection, and may have been evidence of trust issues. Participants from vulnerable groups, such as these women, may find it difficult to trust the investigator (Abbott, Blair, & Duncan, 1993). Participant-observation would have provided an added dimension to the data, and the denial of this aspect of the study perhaps signals the concerns of some of the women regarding trust. Measures were taken to foster trust and a sense of control on the part of the



participants. For example, the investigator ensured that discussions with the women remained confidential and was respectful of women who exercised their right to not answer any specific questions or discuss particular topics.

Another strategy to ensure rigor involves looking at the data from different viewpoints, known as triangulation. Respondent validation and sampling from different participants and at different points in time are forms of triangulation (Hammersley & Atkinson, 1986). One way sampling in time was accomplished was by completing the interviews in three clusters over a period of several months. Another example of sampling in time involved interviewing two of the earlier participants for a second time later in the study. This procedure showed a decrease in reports of stress and conflict as the study progressed, although these themes did not disappear entirely, and an increase in reports of positive aspects of co-op life was observed. The time limits on this study were a drawback because an on-going evolution of the culture in the co-operative is to be expected. The completion of a longitudinal study, however, was not the original intent of this study.

Rigor is also maintained by checking for typical and atypical elements. When a conclusion has been reached, the researcher deliberately tries to disprove it to strengthen its validity. For example, when the data were organized and

seemed to fit in a particular way, they were reorganized again to see if a better fit could be found. Finally, obtaining validation from the subjects themselves was built into the data collection process by presenting ideas from earlier interviews to new participants. Participants indicated validation by comments such as "Yes, that's it exactly." While validation by participants is generally considered a measure of rigor in qualitative research (Sandelowski, 1986), this technique does not necessarily apply to ethnography. While respondent validation may be useful due to the respondent's greater knowledge of the context, the investigator cannot be assured that the participants have conscious access to the beliefs, values, and cultural norms that influence behaviour (Hammersley & Atkinson, 1986).

A clear example of how respondent validation is not always successful with ethnography occurred when two participants were given a report of the results of this study to review. One participant strongly disagreed with some of the findings, including some quotes from her own interview. When this discrepancy was identified to her, she expressed her concerns that the findings presented the women and the co-operative in a negative light. It is possible that both her closeness to life in the co-operative and her own needs influenced this participant's evaluation of the results.

### Significance of the Study

It was never the intent for the results of this study to be generalizable to any other population. The study does, however, provide descriptive information on the experiences of one group of women living on a low income, and gives some insights into the construction of health for these women. It explores the health beliefs, values, concerns, and practices of these women, and how living on a low income in this particular environment affects them. Since the women have only recently moved into this housing environment, they were able to provide comparisons with their previous living arrangements. The concepts of identity, environment, and control have been shown to have particular significance. The project has generated several questions for further study.

### Summary of the Study

Economic impoverishment has been clearly linked to poor health, although the mechanisms of this relationship is not well understood. This study has been an initial attempt to address the gaps in the literature on women, poverty, and health. The purpose of this study has been to examine how low income women construct health in their lives within the context of a specific housing co-operative. It has explored the women's beliefs, values, concerns, and health practices by studying their everyday lives.

An ethnographic approach was chosen to provide

descriptive data on the daily lives of these women. Unfortunately, access for participant-observation was denied. As an alternative, intensive interviews were conducted with a sample of ten volunteers. The interviews were audio-taped, transcribed, and analyzed for common themes.

There were several interesting findings. The women perceived themselves to be a diverse group without a common identity. They did, however, see themselves as sharing a number of common experiences which included a history of abuse, dysfunction, or other "hard experiences."

Living in the housing co-operative was identified initially as a major source of stress by the majority of the participants. The reasons given included learning new skills required in the operation of the co-operative and negotiating boundary issues. As time progressed, the women identified more success in managing interpersonal relationships. As each woman learned to "fit in," social support systems developed. The most significant findings of the study relate to the concepts of identity, the environment, and control. These areas all provide opportunity for further research.

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## Appendix A

Research Proposal Outline for XXXXXXXXXXby Chris Wasylishyn, MSN Student, UBCOctober 26, 1994.Research Questions:

1. What is it like to live in a housing co-op for low income women?
  - a) How do low-income women construct health in their lives?
  - b) What are the beliefs, values, concerns, and practices of low income women in relation to their health?
  - c) How does living in a co-op influence a woman's health and health practices?

Purpose:

The purpose of this study is to learn about how living on a limited income affects the health of women. I also expect to learn something about how living in a housing co-op affects health. To date, virtually no research has been done on the health of unattached, low-income women. This study is anticipated to be a starting point for research in this area and will likely generate questions for further study.

Method:

The method I plan to use is called ethnography. Using it, the researcher learns about shared beliefs among a particular group. The main technique for ethnography is participant-observation. Using this approach, I hope to observe and interact with members of the co-op at meetings, social events, and while just spending time around the building. Other techniques I propose to use are individual taped interviews and focus (discussion) groups of two to three participants.

Ethical Issues:

The study must be approved by the University of British Columbia ethics committee before I begin. All information provided by individuals will be kept confidential. I will continue to negotiate permission on an on-going basis. For example, I will obtain permission to attend each social

event and prior to each taped interview. Anyone who does not want to participate in a taped interview will be under no obligation to do so. (I expect I will need to do only six to ten individual interviews.) I will be working under the direct supervision of two experienced researchers.

Consequences of Participating in the Study:

Many people find the opportunity to participate in a study rewarding and enjoy expressing their concerns. The personal consequences of participating are minimal. At times, you may feel the effects of having an "outsider" present. If, however, at any time you feel your privacy is being invaded, you will be able to ask me to leave.

There has not been enough research on women's health in general and especially on the health of low-income women. This study will contribute in a small way towards correcting that deficiency. I am committed to having the results of the study published so they will be accessible to others.

Appendix B

(UBC LETTERHEAD)

Page 1 of 2

CONSENT FORM: Interviews

Project Title:

Women, Low Income & Health: An Ethnography

Student Investigator:

Chris Wasylishyn

Master of Science in Nursing Student

University of British Columbia

Telephone: XXX-XXXX

Graduate Thesis Supervisor:

Dr. Joy Johnson

Telephone: 822-XXXX

The following aspects of this research study have been explained to me to my satisfaction:

1. The purpose of this research project is to explore the beliefs, values, concerns, and health practices of low income women.
2. A maximum of three interviews will be conducted with me.
3. Each interview will last approximately 60 minutes.
4. Each interview will be audiotaped by the investigator and transcribed by a typist.
5. A summary of the research report will be available to me upon request.

I understand that there may be no direct benefits to me for participating in this study, but it is hoped that the knowledge gained will help to improve health care for low income women.

I hereby give permission to be interviewed and for those interviews to be audiotaped and transcribed. I understand that the tapes and transcriptions will be identified only by code numbers, that my name and address will be kept in a separate locked file, and that this file will be destroyed upon the completion of this investigation. I understand that any identifying information will be deleted from the transcriptions.

I understand that after the project is finished, the information collected may be used by this or another investigator to answer another research question. This investigator will obtain ethical approval according to standard procedures before beginning such research. The audiotapes are the property of the investigator and by consenting to participate in this project, any rights to these tapes are waived.

I understand that I am free to refuse to participate in this study, to refuse to answer any questions, and to withdraw from the study at any time without consequences to myself.

I have had opportunity to ask questions and these questions have been answered to my satisfaction.

This is to certify that I, \_\_\_\_\_, hereby voluntarily agree to participate in the above named project. I have received a copy of this consent form.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Investigator

Date: \_\_\_\_\_

## Appendix C

SAMPLE INTERVIEW QUESTIONS

Both the individual interviews and the focus groups will address the following questions. Broad, open-ended questions are used to elicit the participants' perspectives.

I am interested in the effects of living on a low income on your lifestyle choices and health. Tell me about your day to day life.

What does it mean to you to be healthy?

What is important to you in regards to your health?

What are the things you do to for your health?

How does living on a limited income affect your health?

How does it affect those things you do or would like to do to be healthy?

In what ways has living in this housing co-operative affected your life in general, and specifically, your health?