Taking Action

Mobilizing Communities to Provide Recreation for Women on Low Incomes

British Columbia
Centre of Excellence
for Women's Health

Vancouver, BC
CANADA

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Contents

We need to make links with those who have long been left out of Canadian sport and physical activity, to learn from their experiences, incorporate them in our way of viewing "sport" and to help them develop appropriate opportunities for themselves. This will require working with the marginalized directly, and forming coalitions with their political representatives in the popular movements. Their active collaboration in research, planning and the dissemination of results will be essential if the presently marginalized are to enjoy genuine opportunities for beneficial physical activity. (Kidd, 1995, p. 16)

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Executive Summary

The Kamloops Women's Action Project (KWAP), funded by the British Columbia Health Research Foundation and completed in 1996, was designed to address health issues of women living below the poverty line by encouraging increased involvement in community recreation. Women on low incomes in Kamloops had identified a lack of access to community recreation as a factor affecting their health and that of their families. Based on principles of feminist action research (FAR), women on low incomes, community partners and the researchers collaboratively identified the research questions, collected data and developed actions, including the implementation of new recreation programs. Multi-level outcomes were achieved, including: improvements in self-reported dimensions of physical and mental health for the women; changes in community recreation policy, program delivery and resource allocation; and the formation of new community partnerships (Frisby & Fenton, 1998).

The purposes of this study were to share the knowledge gained through the Kamloops Women's Action Project with three other communities in British Columbia, and to examine the factors that influenced whether or not action was subsequently taken in these communities to increase the access of women on low incomes to community recreation. The overall goal was to provide some tentative or emergent guidelines regarding "lessons learned" for other individuals, organizations and communities interested in launching similar initiatives. Such guidelines may prove useful in settings throughout Canada.

The methodology consisted of a full-day workshop intervention at each site by original members of the KWAP team using the Leisure Access workbook (Frisby & Fenton, 1998), two return visits to each site and 30 follow-up telephone interviews with workshop attendees over a 12-month time frame.

The factors that enhanced or inhibited dissemination are described as both internal to the working partnerships that were created to tackle the social problems identified and external or more structural in nature.

The identification of the factors that enhance or inhibit community health promotion dissemination will be useful to other women on low-incomes, community groups, the public sector and researchers embarking on similar initiatives. Existing Canadian health policies and programs are frequently based on the assumption that individuals should be responsible for their own health, yet provide little or no opportunities for input from the growing number of women who live below the poverty line and are the most likely to experience poor health. A community development approach helps to ensure that the voices of less powerful segments of society are heard and acted upon in ways that are relevant to them. At the same time, including community leaders and researchers in the process broadens the responsibility for change. Municipal recreation departments are well positioned across the country to play an active role in health promotion; however, there are few documented examples of how these departments are partnering with women on low incomes and representatives from community groups. As well, many have adopted a user-pay system, making programs increasingly prohibitive to Canadians living below the poverty line. The results of this study challenge the traditional direct model of program delivery and the prevailing rational efficiency discourse that emphasizes revenue generation and cost-recovery over social justice. This study demonstrates that the dissemination of successful local health promotion initiatives involving community recreation is more likely to occur when the experience and resources of women on low incomes are pooled with intersectoral community partners around a shared vision of social justice. Additional funding is required to support the dissemination of these types of initiatives.

Background on the Kamloops Women's Action Project

The Kamloops Women's Action Project (KWAP), funded by the British Columbia Health Research Foundation and completed in 1996, was a feminist action research project designed to address the health issues of women living below the poverty line through encouraging increased involvement in community recreation. The project was initiated by a group of women on low incomes, working with a public health nurse, who identified a lack of access to community recreation as a major factor inhibiting the development of healthy lifestyles for themselves and their families. Community partners and a research team were then mobilized to address this community health issue.

Participation was viewed as a positive alternative to traditional medical approaches.

The women on low incomes (a label they used to identify themselves) identified social isolation, a lack of confidence, relationship problems, exhaustion, physical inactivity, stress and depression as major health concerns that could be alleviated through involvement in a physically active form of community recreation. Participation was viewed as a positive alternative to traditional medical approaches, where counselling and medication are often prescribed to alleviate women's health problems.

Using a feminist action research approach (Maguire, 1987; Reid, Dyck, McKay & Frisby, 2000; Reinharz, 1992), the women on low incomes, community partners and researchers worked collaboratively to determine research questions, methods of collecting data and subsequent action strategies. Their aim was to obtain a better understanding of how the social and living conditions experienced by the women, coupled with existing community recreation practices and policies, created barriers to participation. Innovative programs were designed, new approaches to staff training were developed, and the programs were marketed in different ways (e.g., through food banks, job retraining programs and word of mouth). The women reported improvements in fitness levels, weight control and self-confidence, and decreased levels of loneliness, stress and depression following participation in physical activity programs that they helped to design (Frisby & Fenton, 1998).

New community partnerships were formed and increased awareness of the role of physical activity and recreation in health promotion occurred.

The KWAP demonstrated that changes in local government policy, staffing, resource allocation and program delivery were possible when women on low incomes, community partners and researchers collaborated to explore ways of improving women's health (Frisby, Crawford & Dorer, 1997). Another outcome of the KWAP was that new community partnerships were formed and increased awareness of the role of physical activity and recreation in health promotion occurred when the women on low incomes, representatives from the public health unit and family services partnered with the municipal recreation department.

The results of the KWAP were widely publicized and a number of other communities in British Columbia expressed an interest in launching similar initiatives. A workbook based on the project entitled Leisure Access: Enhancing Recreation Opportunities for Those Living in Poverty (Frisby & Fenton, 1998), was subsequently produced to serve as a workshop facilitation tool and to share the lessons learned. The workbook contains a series of worksheets and reference material to assist communities in determining what their priorities are, who their partners could be, how to involve the target group, how to anticipate and deal with barriers, how to develop action plans and how to ensure sustainability. The workbook was not designed as a "prescriptive recipe" to be replicated in other communities because, as Botes and van Rensburg (2000) acknowledge, the need for action grows out of specific situations, and each community, however defined, has its own unique makeup. Rather, the workbook was developed to provide background information, findings and a process that could be adapted by other individuals, community groups and municipal governments.

Purpose

Researchers have long lamented that findings from local health promotion projects, particularly those that are not successful, are rarely published, creating a void in our knowledge regarding the factors that enhance or inhibit dissemination of health promotion initiatives for women from one community to another (Poland, 1996a; Poland, 1996b; Botes & van Rensburg, 2000; Wallerstein, 1999).

The purposes of this study were to share the knowledge gained through the KWAP with three other communities in British Columbia, and to examine the factors that influenced whether or not action was subsequently taken in these communities to increase access of women on low incomes to community recreation as a health promotion strategy. The overall goal was to provide some tentative or emergent guidelines regarding "lessons learned" for other individuals, organizations and communities interested in launching similar initiatives. Other more specific goals were:

• to conduct a related literature review

• to engage in participatory workshops with women on low incomes and practitioners in three other communities that would lead to action plans for promoting health through increased access to community recreation

• to influence municipal recreation policy, resource allocation and programming

• to position community recreation as a local health promotion strategy with community groups who typically work with women on low incomes (e.g., social services, health units, family services, women's centres)

• to provide policy recommendations that might apply to communities across Canada.

IV

Literature Review

A. Contextualizing Poverty, Health and Physical Activity for Women

The risks associated with a number of serious health problems can be reduced through regular activity.

It is well-known that women living below the poverty line are more likely to experience poor health (Doyal, 1995; Evans, Barber & Marmore, 1996; Popay & Jones, 1990) and are less likely to be involved in physical activity and community recreation as a means of offsetting some of the health problems encountered (Frisby, Crawford & Dorer, 1997). According to Hoffman (1995), less than 15 per cent of the female population above 10 years of age in Canada participates in physical activity frequently enough to derive physical health benefits. Yet, there is a growing body of research that demonstrates that the risks associated with a number of serious health problems (including cardiovascular disease, obesity, diabetes, cancer and osteoporosis) can be reduced through regular activity (Barr & McKay, 1998; Pate et al., 1995; Reid, Dyck, McKay & Frisby, 2000; Sallis & Owen, 1999). Increasing activity levels is also effective in the treatment of depression, anxiety, low self-esteem, stress and sleep disorders (Frankish, Milligan & Reid, 1996; Sallis & Owen, 1999). Furthermore, social isolation is reduced when low-income women are connected to their communities through physical activity and recreation programs, especially when they are empowered to be actively involved in decision-making about the content and methods of program delivery (Lord & Hutchinson, 1993; Frisby & Fenton, 1998).

Women living in poverty face a staggering number of challenges that require attention (e.g., poor housing, inadequate child care, insufficient financial resources for food and clothing, domestic violence, disempowerment through the bureaucratic social service systems), so access to community recreation is rarely considered to be a priority. Yet there are compelling reasons why policy makers and practitioners should focus on the role of physical activity and recreation in alleviating health concerns. For example, researchers have demonstrated that health improvements are more striking when the least active persons become physically active, not when those who are already moderately

active increase activity levels by a similar amount (Haskell, 1994). Blair et al. (1996) found that women who are most fit have a 79 per cent lower death rate from all-cause mortality than women categorized as being least fit. In addition, the loss in functioning and muscular strength normally associated with ageing is now thought to be largely due to long-term physical inactivity (Green & Crouse, 1995). Finally, low-income women who participated in the KWAP (Frisby & Fenton, 1998) indicated their children became more active and used their free time more constructively when their mothers served as positive role models by becoming more active themselves.

This evidence suggests that not only can the health and quality of life of women on low incomes and their families be improved, but substantial savings to the health care system could accrue if community physical activity and recreation were positioned as a preventative health promotion strategy for marginalized populations. Unfortunately, little has been done in the areas of policy development, program design or research to address the interconnected social problems of women's poverty, poor health and a lack of involvement in community physical activity and recreation. MacNeill (1999) and Donnelly & Harvey (1999) contend that this omission is because middle-class bureaucrats largely design health and sport policy with little or no input from those who are encountering structural barriers to participation. Consequently,

"in the early 1970s Sport Canada too often funded programs aimed at middle-class individuals for whom such participation was already a meaningful activity. And gender equity programs have also increased the number of athletes in the sport development and high-performance systems without breaking down class barriers. Similarly, the ParticipACTION, Active Living, and other exercise prescription programs have increased the numbers of middle-class participants both male and female, but they have also failed to breach the class barriers." (Donnelly & Harvey, 1999, p. 55)

B. The Feminization of Poverty

Even though Canada is consistently rated as one of the best countries to live in by groups like the United Nations, poverty rates in this country are rising, and it is women who are most likely to live in impoverished conditions (National Council on Welfare, 1998). In Canada, the low-income cutoff for a four-person family is $27,338 per annum in communities with populations between 30,000 and 100,000 and is $27,982 for popula-

tions between 100,000 and 4,999,999.

Currently, the poverty rate for single-parent mothers under the age of 25 is a staggering 91.3 per cent, and the next largest group living in poverty is women over the age of 65 who live alone (National Council on Welfare, 1998). In British Columbia, single mothers, women over the age of 65 and women from visible minority groups have the lowest incomes of all population groups. Almost one quarter of all families in British Columbia are headed by lone parents and approximately 83 per cent of these families are headed by single mothers, a 30 per cent increase from 1991 to 1996 (Women's Health Bureau, 1999). Women continue to be largely responsible for the unpaid care of children and have unequal access to employment opportunities. Further, the gender differences in income levels following separation and divorce are staggering. On average, women experience a 23 per cent loss in net family income, while men gain 10 per cent due to less spending on dependants (Women's Health Bureau, 1999). Twice as many women as men over the age of 65 live below the low-income cutoff (where 70 per cent or more of household income is used for food, clothing and shelter). This gap is expected to widen as the population ages and women's life expectancies continue to exceed those of men. Women from visible minority groups are also more likely to live in poverty as they face additional barriers associated with racism and language.

The poverty rate for single-parent mothers under the age of 25 is a staggering 91.3 per cent.

It is clear that women on low incomes are not a homogeneous group. Their experiences of poverty differ in terms of age, ethnicity, disability, family situation, sexual orientation, geographic location, and so on. However, the health promotion discourse on poverty typically represents the poor as one oppressed group, suggesting that universal policies and programs will be effective (Doyal, 1995; Robertson, 1998). Furthermore, Williamson and Green (1999) have shown that most health care initiatives in Canada are directed at the consequences of poverty (e.g., prenatal programs, food and housing programs), rather than addressing the social, economic and political determinants of inequity. While this study does not tackle these broader social determinants, it does seek change in community structures and policies at a local level in a way that addresses the health issues deemed relevant by women on low incomes.

Health promotion discourse on poverty typically represents the poor as one oppressed group.

C. A Social Determinants Approach to Health

It is generally agreed that it is no

Interventions must target inequalities on a structural level if widespread change is to occur.

longer appropriate to define health only in biomedical terms as the absence of disease. A social determinants approach recognizes that broader social, economic and environmental conditions constrain individual choice and affect health status (Whiteford, 1996). This approach acknowledges that interventions must target inequalities on a structural level if widespread change is to occur, yet behaviorally oriented models and policies of health promotion that place responsibility for health on the individual persist. The problem with the individualist approach to health is that women living in poverty are largely blamed for their situations, while the broader social, political, economic and cultural determinants of poverty and poor health are ignored (Evans, Barber & Marmore, 1996; Fraser & Gordon, 1994; Martin, 1994). The individualist approach absolves governments of responsibility for health care outside the traditional medical system, as individuals are expected to make necessary changes in their lifestyles (e.g., exercise more, stop smoking, eat properly) to achieve optimum health and quality of life (Shiell & Hawe, 1996). MacNeill (1999, p. 217) provides further evidence of how the federal government's approach to the social marketing of active lifestyles has emphasized self-responsibility for health:

"…behaviorist frameworks for public health education (stressing information exchange, attitude shifts, motivation, and behavior modification) and physiological formulas for fitness (e.g., the 'F.I.T.T. Formula' for achieving fitness, requiring attention to frequency, intensity, time and type of activity) have dominated ParticipACTION. These individualist approaches to social marketing have made inequitable power structures in Canada invisible."

Rather than expecting marginalized women to solve their problems in isolation, the approach used in this study was to legitimize the diverse experiences of women and to connect them with those who control local program provision and policy development (Green et al., 1995). Even though community leaders are constrained by their respective personal and professional ideologies (Ristock & Pennell, 1996), developing alliances with those who can share information and influence change at the local level broadens opportunities for sustainable change (Frisby, Crawford & Dorer, 1997; Greenwood & Levin, 1998).

Collaborative community interventions are particularly important in light of evidence that participation itself can be a significant force in improv-

ing perceived control, individual coping and community capacity-building (Baker & Teaser-Polk, 1998; Long & Cox, 2000; Minkler & Wallerstein, 1996).

The starting point in feminist action research is consulting with community members to uncover problems that are relevant to their daily lives and to recognize the systemic forces that contribute to powerlessness (Reid, 2000; Minkler & Wallerstein 1996). However, in a recent review of health research on women living in poverty, Reutter, Neufield & Harrison (1998) were unable to uncover any studies that involved women in the planning and analysis of research. Furthermore, Fugate Woods, Lentz & Mitchell (1993) found that a majority of studies done on women's health focus on health-damaging practices like smoking or substance abuse, rather than on health-promoting practices like exercise. Minkler's (1997) work with low-income seniors is one of the few studies to have addressed self-identified health problems in relation to impoverished living conditions as a preliminary step to action planning. The consequences of not consulting with those living in poverty are that hierarchical power structures are reinforced and the realities of women's lives are either misunderstood or rendered invisible (Morton & Loos, 1995; Redman et al., 1988).

A majority of studies done on women's health focus on health-damaging practices like smoking or substance abuse, rather than on health-promoting practices like exercise.

D. The Context of Community Recreation

Overcoming societal, community and personal barriers to participation in community recreation is daunting. For example, stereotypes that characterize low-income women as adopting unhealthy lifestyles, taking advantage of government services, being lazy or uninterested in community programs are pervasive and shape assumptions that underlie local policies and practices (Fraser & Gordon, 1994).

A lack of community partnerships and a non-holistic approach to the poverty issue are also problematic. For example, community groups which typically work with low-income women (e.g., public health units, family services, women's centres) have restricted mandates and a bewildering array of demands on their time and budgets, so they rarely consider community physical activity and recreation programs as a beneficial health promotion strategy (Frisby, Crawford, & Dorer, 1997).

Furthermore, the social, economic and political contexts that municipal recreation departments (the primary provider of physical activity and recreation programs across the country) operate within create significant barriers to participation

Although women on low incomes typically desire the same physical, social and mental health benefits of participation in physical activity and recreation as middle- and upper-income women, the barriers they encounter on a personal level are much more severe.

for the growing number of Canadians who live below the poverty line. Many departments have moved to market-driven and cost-recovery models of service delivery due to economic constraints and are increasingly charging fees for services provided (Thibault, Frisby & Kikulis, 1999). Because demand remains high among the middle and upper classes who are able to pay for traditional services, and many programs and facilities are already operating at full capacity, those who cannot make a contribution to the "bottom line" are ignored. Some municipal departments have attempted to address this problem by offering "leisure access programs" at a subsidized rate, but few women take advantage of services that stigmatize them and require them to "prove poverty" (Frisby & Fenton, 1998). In some cases, the financial assistance record of citizens must be presented and photocopied before a subsidy is provided. Not surprisingly, few women will subject themselves to this invasive form of treatment.

Proponents of Active Living, a social marketing initiative promoted by the federal government, contend that there are many free activities that citizens can take advantage of, such as walking in the neighborhood or taking children to playgrounds. However, open spaces are often minimal in low-income neighborhoods or are associated with criminal activity, making them unsafe and unappealing to women and their families for recreational purposes.

Although women on low incomes typically desire the same physical, social and mental health benefits of participation in physical activity and recreation as middle- and upper-income women (Frisby and Fenton, 1998), the barriers they encounter on a personal level are much more severe. In addition to the financial costs involved, women who participated in the KWAP indicated that travelling in unsafe neighbourhoods with young children, placing their children's health and activity needs before their own, the loss of dignity associated with asking for subsidies, and a lack of social support are all major barriers to participation. Furthermore, the middle-class culture associated with physical activity and recreation participation (e.g., possessing adequate skill levels, a fit body image, and appropriate equipment and clothing) (White, Young & Gillett, 1995), was also clearly intimidating to the women involved in the KWAP. Literacy, language difficulties and cultural differences were other problems that are often inadequately addressed through existing community recreation marketing and activity programming. Although the following comment was made by

Ingham more than a decade ago, it is still very applicable today:

"What do we have to offer to the currently ill and the about-to-be-ill segments of the populations; those whose illnesses have more to do with workplace rather than lifestyle, with the ravages of unemployment rather than defects of character, with the cumulative effects of impoverishment – impoverishment which is becoming increasingly feminized? Shall we say that they should aerobicize, jazzercise, and jog their problems away?" (Ingham 1985, p. 54)

The changing nature of municipal recreation departments in local government has a direct impact on whether health promotion initiatives for women on low incomes will be supported through community partnerships (Thibault, Frisby & Kikulis, forthcoming). Aucoin (1995, p. 9) describes how the New Public Management ideology that is pervasive in Canadian government is creating major impediments to this type of action because it is increasingly being driven by private-sector values,

"namely a greater need to pay attention to the bottom line in terms of the relationship between revenues and expenditures, on the one hand, and increased demands for quality products and services, on the other. …Confronted simultaneously by declining fiscal capacities and increasing pressures for quality public services, governments have sought to enhance their own productivity, in part by resorting to new management practices. Concerns for economy and efficiency have thus been given a new priority in public management. Enhancing cost-consciousness, doing more with less and achieving value for money [have become] the objectives of this finance-centred perspective on public management reform."

Consequently, investment in public services is being evaluated in terms of efficiency and revenue generation rather than on fulfilling a traditional social mission. This shift in ideology makes public physical activity and recreation services inaccessible to those least able to pay. Attempts to increase participation by lowering fees have been largely ineffective, suggesting that more complex social, cultural, economic, and political factors are at play (Frisby & Fenton, 1998).

E. Factors that Enhance or Inhibit Health Promotion Dissemination

"Far more attention has been directed to knowledge generation than to the dissemination and utlitization of newly discovered knowledge. Difficulty applying this knowledge

coupled with a failure to use it stifles progress in achieving health goals." (Johnson et al., 1996, p. S5)

In 1996, a Special Issue of the Canadian Journal of Public Health was devoted to the dissemination of health promotion research based on a conference hosted by the Institute of Health Promotion at the University of British Columbia in 1995. The focus on dissemination reflects a shift in health policy from institutional health care to prevention and community care. A dissemination research agenda was proposed that called for additional study on the barriers and incentives of adopting new practices, new configurations of community services and partnerships to build greater co-ordination and integration, and the integrative processes that result in better utilization of health promotion information. It was recognized that dissemination research should focus on community organizations, as they exert considerable influence over the choices individuals make, and on individuals who also shape community life (Ness, 1997).

The focus on dissemination reflects a shift in health policy from institutional health care to prevention and community care.

Innovation diffusion theory has traditionally been used to examine how new ideas spread and become adopted by individuals, organizations and communities. According to Orlandi (1996), dissemination is enhanced when early adopters motivate others to act as opinion leaders while remaining sensitive as to how services must be customized given the local context. In the Special Issue, Johnson et al. (1996) suggest that participatory action research holds promise for understanding the process of dissemination because the perspectives of multiple partners and enabling factors are considered while lessons can also be learned from failures.

There is a growing body of literature that identifies the factors that enhance or inhibit the formation of community partnerships to address health and other social issues. Identifying these factors is important because community capacity to take action is heightened when there are high levels of facilitating factors and low levels of hindering factors (Baker & Teaser-Polk, 1998). These factors also influence the degree to which knowledge can be transferred from one community to another (Goodman et al., 1998). Factors that increase the likelihood of success include:

˜• possessing shared values about the need for action

˜• having a least one person to champion the idea

˜• the active involvement of the target group

˜• pooling resources through

intersectoral partnerships

˜• critical reflexivity and involving those with the authority to act as facilitators

˜• integrating research into the process to document outcomes

(Botes & van Rensburg, 2000; Fortin et al., 1992; Johnson et al., 1996; Orlandi, 1996; Wallerstein, 1999).

In contrast, the following factors characterize unsuccessful community partnerships in health promotion:

˜• a lack of broad based participation

˜• inflexible professional cultures and policies that are resistant to change

˜• unresolved power imbalances and conflicts

˜• undervalued capacities of local people

˜• insufficient resources

˜• a lack of trust

˜• excessive pressure for short-term measurable results

(Botes & van Rensburg, 2000; Kanter, 1989; Poland, 1996a).

The inability to take appropriate action is exacerbated when a traditional direct model of community recreation program provision is used where middle-class professionals make assumptions about barriers to participation and are not adequately informed by those who are actually experiencing the barriers. As a result, if programs are offered and registration numbers do not meet predetermined standards, they are cancelled because it is assumed that there is "insufficient interest" (Frisby & Fenton, 1998).

In contrast, a community development approach in which egalitarian power relationships are developed with women to find solutions that will change their life circumstances holds more promise (Dominelli, 1995). This approach requires:

˜• making space for women to discuss the diversity of their realities with other women

˜• promoting egalitarian rather than hierarchical power relations

˜• adopting a facilitator role rather than an expert, professional role

˜• focusing on individual as well as broader social change

(Dominelli, 1995; Ristock & Pennell, 1996).

According to Callaghan (1997, p. 183) feminist community organizing includes all of the traditional activities of community development but focuses more specifically on how

gender, class and race can inform the analysis.

The success of this approach depends not just on the action of one organization but on the development of a complex web of interorganizational networks in a community to deal with social problems that are increasingly complex (Bradshaw, 2000; Selsky, 1991). Otherwise, social problems tend "to fall through the cracks" due to weak systemic capacity, making it difficult to mobilize sufficient resources and political support (Selsky, 1991; Goodman et al., 1998). According to Selsky (1991, p. 101), the advantages of a community development approach based on interorganizational networks are: increased awareness of resources and how to negotiate them; a collective capacity to control the task environment; and a critical mass of relationships needed to sustain the network even when there are fluctuations in specific linkages. Based on this thinking, it was considered important to involve women on low incomes and representatives from a number of community organizations to the workshop interventions that were designed to be the stimulus for the dissemination study.

It was considered important to involve women on low incomes and representatives from a number of community organizations to the workshop interventions.

F. Feminist Action Research

Women living in poverty have been excluded from knowledge production and policy making in health even though they experience the conditions that contribute to poor health on a daily basis. Rahman (1993, p. 89) elaborates on the consequences of this omission:

"Research on oppressed people by external researchers perpetuates the myth of the incapability of people to participate in the research as equals, which alienates them from their own power of generating knowledge relevant for transforming their own environment. Policy recommendations are then sent to outsiders to solve their problems for them, which creates dependence and gives others control over action."

Realigning existing power relationships (e.g., between policy-makers, researchers, practitioners and women) and validating lived experiences are two key tenets of feminist action research (FAR) (Cancian, 1991; Maguire, 1987; Reid, 2000). FAR is a strategy that combines elements of participatory action research (PAR) and feminist theory. Green et al. (1995, p. 4) define PAR as "the systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting social change." While PAR advocates a collaborative approach to knowledge production and action

that gives voice to marginalized groups while attempting to delayer hierarchical power relations, it does not necessarily place women at the centre of the inquiry.

Conversely, feminist theories critique power relations by centring the diversity of women's experiences, but have been criticized for reifying the positions of privileged white academics in the knowledge production process and for not moving beyond critique to emancipatory action (Bowes, 1996; Reid, 2000). Maguire (1987) claims that the limitations of PAR and feminist theory can be overcome when principles from the two are combined:

"Without recognition of, and attention to, its male biases, participatory research cannot be truly emancipatory for all people. By combining feminist research's critique of androcentricism with participatory research's critique of positivism, a feminist participatory research provides a powerful approach to knowledge creation for social and personal transformation." (Maguire 1987, p. 209)

The key features of FAR are:

˜• legitimizing the experiential knowledge of women

˜• democratizing the research process by collaborating with women and community members in all phases of research

˜˜• an action component that leads to personal and social transformation.

The first step in FAR is to identify the issues that are central to the lived experiences of women. In the Kamloops Women's Action Project and the subsequent interventions in three other communities, low-income women talked about their personal situations, meanings of health, their experiences accessing community services, the fears and indignities they had encountered and their hopes for constructive change. Community group representatives and the researchers learned a tremendous amount by listening to the stories of these women and by hearing how involvement in community recreation relates to the broader context of their daily lives. Mutual learning occurred when practitioners explained the constraints that they were working within, and the researchers shared academic and policy-related information. This was the starting point for further dialogue about meaningful social change.

While it was possible for the women to effect change without collaborating with community leaders and researchers, it was clear that their daily struggles were exhausting and left them with little capacity to advocate for themselves and other

women either within or outside existing systems. Creating alliances with caring community leaders who had access to resources and authority channels where policy, program and marketing decisions are made can, in some instances, increase the likelihood that sustainable change will occur (Frisby & Fenton, 1998; Greenwood & Levin, 1998).

It is unrealistic to assume that full collaboration between low-income women, community leaders and researchers is always possible. Rather, the aim is to acknowledge the unique strengths, divergent perspectives and shared responsibilities of all parties involved (Green et al., 1995). As Maguire (1987, p. 45) wrote: "We both know some things; but neither of us knows everything." All participants have a role in negotiating the final meanings of the research.

While the principles of FAR are appealing on a number of levels, the work is complex and is often contradictory:

"We are trying to work the hyphens of theory and research, policy and practice, whitenesses and multiracial coalitions...we are trying to build theory, contextualize policy, pour much back into community work, and help to raise the next generation of progressive, multiracial/ethnic scholars." (Fine & Weis, 1996, p. 271)

Issues of power, collaboration, difference and representation are seldom resolved but must be carefully considered if trust and non-exploitive researcher-subject relations are to be developed (Gatenby & Humphries, 2000; Martin, 1994; Reid, 2000). Nonetheless, principles of feminist action research underpinned the methodology used in this study as described in the following section.

V

Methodology

The methodology consisted of a full-day workshop intervention at each site by original members of the KWAP team using the Leisure Access workbook (Frisby & Fenton, 1998), two return visits to each site, and 30 follow-up telephone interviews with workshop attendees over a 12-month period. To ensure confidentiality, the names of workshop participants are not identified. Ethical approval to conduct the study was obtained through Research Services at the University of British Columbia.

Contact was made with someone in each community who had requested additional information on the Kamloops Women's Action Project, suggesting that there was some readiness to take action. One of the communities was in the Lower Mainland, another was in the Interior and the third was in the Kootenay region of the province of British Columbia.

In all three sites, women on low incomes, municipal recreation staff and representatives from a variety of community groups (e.g., public health units, family services, women's centres) attended the workshops and were subsequently asked questions during return visits or follow-up telephone interviews about the factors that enhanced or inhibited action being taken in their communities. Attendance at the workshops varied from 12 in Community #1, to 24 in Community #2, to 85 in Community #3.

Approval was obtained to tape-record workshop discussions and telephone interviews. Reflective field notes were also recorded. Tape recordings of the workshops, interviews and field notes were transcribed into a word processing file. The data was coded and analysed with the assistance of the computer program Atlis.ti. This program allows researchers to manage large qualitative data sets through the coding of text and analytic memo writing.

VI

Findings

The response to the workshop interventions varied considerably in the three communities. In Community #1, initial plans were developed but were not subsequently implemented. In Community #2, women on low incomes assumed a major leadership role and initiated action plans outside of the existing municipal recreation system because the policies and practices of that department were not community-development oriented and presented a number of obstacles. In Community #3, partnerships emerged between a larger and more diverse group of women on low incomes, community representatives and municipal recreation staff, and more extensive action plans, both within and outside the municipal recreation system, were developed and implemented.

The tracking of the three communities over time revealed a number of factors that influenced whether action was taken and the direction it took. The factors that enhanced or inhibited dissemination were either internal to the working partnerships that were created to tackle the social problems identified or were external or more structural in nature (e.g., the daily experiences of living in poverty, restrictive policies of local government).

A. Internal Enhancers

The use of **a community development approach that actively involved women on low incomes in leadership roles and decision-making** was a key factor that enhanced the likelihood that action would be taken. Women on low incomes were more likely to participate when their voices were heard and valued and when they had responsibility for decisions being made. With this approach, practitioners adopted "facilitator" rather than "expert" roles and gained a much better understanding of the women's diverse situations and the barriers they encountered. However, adopting this type of role was not straightforward, as revealed in the following quote:

"I struggle with my role when I go to meetings because I would like to make suggestions, but I don't want to impose my ideas on the group.

With a community development model, you are supposed to get the group to come up with their own ideas. However, to get things going I did take a leadership role initially, but now the women and other community reps are chairing the meetings on a rotational basis so the leadership is becoming more shared." (Municipal recreation staff)

Respecting difference was key to making women feel welcomed and encouraging their ongoing participation.

The community development approach was most effective when tokenism was avoided by ensuring that an equal or greater number of women on low incomes, in relation to the number of community representatives, was involved. Rotating leadership roles (e.g., chairing of meetings, recording minutes, gathering and reporting information), collectively articulating goals and values, and a consensus decision-making model were other characteristics of the community development approach that led to action. One of the workshop participants elaborated on what consensus decision-making entails:

"When we are not in agreement, we need to voice our concerns as to why consensus isn't being reached. Have we lost our goal here? Do we still understand what the group purpose is where this decision is concerned? Are we getting entrenched in positions? Is that what is going on? Do we have all the information we need? Do we remember what we're trying to achieve here and can we achieve it? Using this approach will help us reduce conflict and ensure that we are all happy with the decisions being made." (Women's center staff)

Diversity of representation was another enhancing factor since broader based plans for action were entertained when a number of different perspectives were considered. While the women shared economic disadvantages, their experiences of poverty and access to services were complex and varied, depending in part on other markers of social identity (e.g., age, ethnicity, presence of children, health status, etc.). Respecting difference was key to making women feel welcomed and encouraging their ongoing participation:

"You respect the other person's knowledge and wisdom in dealing with certain things. And we aren't all good at all things. And somebody might know better how to deal with this particular situation and another person might be better at something else. So, we're bringing together a lot of knowledge and wisdom and we need to respect and trust one another that we're going to do the right things. And we learn that by doing and by having an active part in that." (Older woman on low income)

"The Iranian women can't speak English and are unfamiliar with our concept of community recreation. Why couldn't we show them around the facilities and explain how we do things here?" (Older woman on low income)

Rather than treating women on low incomes as a homogeneous group and assuming that simplistic or universal policies and programs would be effective, diversity of representation helped to ensure that a greater range of actions was implemented. In addition, ensuring diverse representation from local government and community organizations heightened awareness about the health-promotion role of participation in community recreation. This created political pressure which raised expectations that action would be taken.

"This recreation department has not been responsive in the past. But now it is being observed by citizens, other community organizations, and by researchers. With so much scrutiny, it is more likely that some change will occur." (Women's centre staff)

When **a community development approach was accompanied by a social justice discourse** that validated the relevance of the health issue from the women's point of view, a "common ground" regarding purpose, group process and desired outcomes emerged, even though the women and community representatives had very different reasons for participating. Given the diverse backgrounds and social locations of participants, finding a common ground where the rights of women on low incomes and the need for systemic change were acknowledged created space for members to take different types of action. At the same time, group solidarity and a collective passion to tackle the issue were created.

"I'm not alone. Other women are encountering the same problems as me, but they have incredible strengths too." (Single mother)

"Instead of focusing on all my problems, this has given me something positive to focus on…something to look forward to. It's what's getting me out of the house in the morning." (Woman on low income)

"I'm obtaining a much better understanding of the challenges the women face and how I might help." (Municipal recreation staff)

"Women living below the poverty line need housing, food and clothing. I never thought of community recreation as playing an important role in their lives before attending the workshop. There has got to be something we can do to promote

this when the possibilities already exist in our community." (Family services staff)

Identifying and pooling the resources of all participants was an internal enhancer that created collective power and the capacity to act. The resources brought by participants in the various communities differed, as the women brought stories of their experiences of living in poverty, their frustrations trying to access community services, their skills negotiating daily life on limited finances, and their connections to their own social networks in their community. The professionals brought their knowledge of municipal recreation and local community group policies and structures, contacts and support from those in positions of power in their own agencies, and access to facilities, instructors, equipment and child care. Identifying, acknowledging and pooling these varied resources created collective power that would not have been possible if the women or other community members acted independently. As one woman on low income commented, "Together we have power." The women on low income described how working collaboratively with public sector staff differed from their usual encounters with government bureaucracy.

Identifying, acknowledging and pooling these varied resources created collective power that would not have been possible if the women or other community members acted independently.

"I've never had anyone care about what I have to say, but the community reps are listening. They know how the system works and who to go to for help." (Single mother)

In contrast, community members became discouraged when discussions continually emphasized "resource deficiencies" (e.g., a lack of space, equipment or child care) over "resource capabilities" (e.g., finding creative solutions to child care by asking college students in early childhood education programs to volunteer).

Sharing responsibility for action through the community partnerships created stability and reduced stress levels for the women who had multiple responsibilities and for the community representatives who were increasingly feeling overburdened in their public sector jobs. As a result, participants did not feel obligated to attend all meetings or activities, nor were the initiatives dependent on any one "idea champion", as suggested in the health promotion literature. The following quotes illustrate the importance of shared responsibility:

"Being a single parent, I wasn't sure how much I could contribute. But everyone is pitching in what they can to make things work." (Single mother)

"The responsibility is not all on my shoulders, so this is not so over-

whelming. I've been energized by the interest and support from the others. At times in the past I've been the only advocate." (Municipal recreation staff)

B. External Enhancers

When the practitioners communicated information about the initiatives back to the organizations they represented or to other community organizations on a regular basis, community and political support was generated, particularly when the goals of the initiative were communicated in a way deemed compatible with the mandates of the participating organizations (e.g., municipal recreation departments, public health units, family services, women's centres).

"My supervisor and board of directors are very interested in this project and want updates about it on a regular basis. This does fit with our mandate, but we've got limited resources and we do not have the expertise to offer recreation to our clients. Partnering with the municipal recreation department is the obvious way to go." (Family services staff)

Integrating research into the initiative, either by conducting original research to document needs and successes or drawing on existing research to demonstrate the benefits of action, further legitimised the local initiatives. In particular, members of all three communities pointed to the Kamloops Women's Action Project as a stimulus for action, which was probably not surprising as lessons learned from the KWAP formed the basis of the workshop interventions. Nonetheless, the prospects of taking action were deemed to be less overwhelming when there was documented evidence of success from another community, when non-prescriptive guidelines were available to form the basis for planning, and when contact names were provided so that additional advice could be sought.

"When I heard about the Kamloops project I realized that something similar might work in our community and we would not have to reinvent the wheel." (Public health nurse)

"When you showed those statistics that a large portion of women over 65 live in poverty, I knew I would be able to convince others of the importance of this." (Municipal recreation staff)

"I did an informal survey to see if other women like me who were going to the women's centre would be interested in something like this. Many of them were really keen so I know there is a need in our community." (Single mother)

Acknowledging the structural dimensions of poverty, including

women's experiences with bureaucratic institutions and societal stereotypes, the barriers created by poor public transportation and a lack of child care, the numerous physical and mental health problems experienced, body image issues, and the fear of going out in unsafe low-income neighbourhoods, provided a crucial contextual backdrop for discussions and often led to broader scale actions that were unrelated to community recreation per se (e.g., presentations to authorities on public transportation problems). When structural determinants were given inadequate attention, action was more small scale (e.g., the development of a short-term recreation program) and less sustainable because inadequate attention was given to the barriers of participation.

"I think our group arrived at solutions too quickly. The recreation department was willing to put on extra classes, so they just went ahead and did that with little input from us. Then they acted all surprised when hardly anyone showed up. I don't think they will be as willing to do stuff for us in the future because of that." (Woman on low income)

C. Internal Inhibitors

One of the main factors that inhibited action being taken **included power imbalances among collaborators** that were accentuated when practitioners adopted an "expert role" and authoritarian leadership style. This occurred primarily when **a traditional direct model of recreation program delivery** was already entrenched in the community, where policy and program decisions were made with little or no input from citizens. The women on low incomes and other practitioners became disillusioned under these conditions or were forced to find routes for action outside the municipal recreation system, even though these departments have a responsibility, as stipulated in their governmental mandates, to serve all members of their communities. The following quote, taken from field notes following a meeting in one of the communities, reflects a traditional top-down approach to recreation program delivery:

"The municipal recreation programmer announced that the swimming pool could be made available twice a week in the afternoons and an instructor could be provided for the kids. However, it was pretty clear from the discussions that swimming was not something the women wanted to do. They talked about not having the appropriate bathing attire, not having enough money to buy a bathing suit, not wanting to wear a bathing suit in public. They also said the times were not convenient because their children have naps in

When an emphasis was placed on budget cutbacks in local government, fees for service or improving cost-recovery ratios rather than serving the public, the discourse was indistinguishable from that of the private sector and rendered invisible the needs of those who are least able to pay.

the afternoon. The programmer was basically doing what was easiest for her and her department, rather than obtaining input from the woman about their preferences." (Researcher field notes)

The identification and mobilization of resources did not occur when the traditional direct model of program delivery was adopted, because deficiency assumptions (e.g., that women on low incomes are needy rather than capable), underpinned the adoption of the "expert role." In these instances, municipal recreation staff acted independently by controlling resources and searching for "quick fixes" (e.g., by scheduling activities they selected at limited times when facilities were available at a reduced cost). Little effort was made to market these programs in non-traditional ways (e.g., through food banks or through word of mouth via other community partners), and if predetermined quotas of attendance were not met programs were quickly cancelled due to a "lack of interest."

A rational efficiency discourse usually accompanied the traditional direct model of program delivery and stifled creativity and action-oriented decision-making while reinforcing existing policies and practices. When an emphasis was placed on budget cutbacks in local government, fees for service or improving cost-recovery ratios rather than serving the public, the discourse was indistinguishable from that of the private sector and rendered invisible the needs of those who are least able to pay. This discourse was reflected in the following comment made by one of the municipal recreation staff:

"We need to have a minimum of eight participants in a class in order to justify the cost of instructors, space and equipment. We've tried running programs in the past but did not get enough people so it just wasn't worth our while. City council wants us to demonstrate how everything we do contributes to the bottom-line so we have to get those minimum numbers." (Municipal recreation staff)

A lack of diversity of representation was apparent in all these communities as few visible minority women participated. Ongoing attempts to identify more socially isolated women on low incomes or less obvious community partners were lacking as the focus was on creating action with those who had already expressed an interest. Many of the women who did participate indicated they were emotionally "ready" to become more involved in their communities and saw their involvement as a "stepping stone" for more personal forms of action (e.g., learning new skills, furthering

their education or entering the workforce).

"I couldn't have done this a couple of years ago. My husband had left me and I couldn't get a job. I was really stressed out. But now my confidence is coming back. Meeting all these people could open some doors for me." (Single mother)

Contrary to the health promotion literature, if the initiatives relied too heavily on **one idea champion** rather than sharing responsibility, action was less likely to occur. In one community, delays in taking action occurred when the idea champion was overburdened with numerous work responsibilities. When that person subsequently moved out of the community, the initiative ceased. While the idea champions usually assume an important co-ordination and communication role, participants become disenchanted when these tasks are not fulfilled.

"[ ] was the person who got things started with the initial workshop. But when he left town, everyone else was just too busy to pick up where he left off." (School principal)

Conflict is inevitable in any group and **managing conflict** can be more challenging when leadership is shared. If the inevitability of conflict was not acknowledged early on in the community organizing process or was not dealt with in an open way once it did arise, community members either silently dropped out or cliques were formed that drew attention away from the overall goals of the initiative.

"I get really frustrated when people say they are going to do something and then use all types of excuses for not getting it done. But I don't like to confront anyone…it's just not worth the hassle...so I don't know how long I will be able to stick with this." (Woman on low income)

D. External Inhibitors

Problems were encountered when the community partners operated by community development principles when working with women on low income, but then encountered the **rational efficiency discourse** when attempting to garner support from the managers of their organizations or city council. This was due to an oppositional clash in values that pitted the needs and interests of the women against demands for profit making in the public sector. The politicality of community health promotion was apparent when these same managers or politicians used the small-scale initiatives to demonstrate that "the poverty issue is being dealt with," but then **resisted policy changes** that would improve access to services. This dissonance is

apparent when the following two quotes are compared:

"We have a Leisure Access policy that allows all citizens to take part at a reduced rate, but we need proof that they really are on assistance. At the end of the year, I have to show what my revenues are from Leisure Access, just like the other staff in other program areas have to do." (Municipal recreation staff)

"How can I justify spending even three dollars on a recreation program for myself when I don't have enough food for my kids at the end of the month?" (Woman on low income)

Municipal recreation staff saw themselves as "activity programmers" who were not responsible for the poverty issue.

Fragmented community services for women on low incomes contributed to a lack of action because some community group representatives did not view access to community recreation as being within their mandates, while some municipal recreation staff saw themselves as "activity programmers" who were not responsible for the poverty issue.

With a rational efficiency discourse, immediate results that can be measured in quantitative terms take precedence over longer-term outcomes that are difficult to measure. **Demonstrating success** in terms of community capacity-building, empowerment, reduced social isolation and other improvements in women's health is much more difficult than relying on traditional measures such as attendance numbers and profit levels in community recreation programs. Some of the quotes provided earlier attest to this orientation.

The social and living conditions of the women also created major barriers (e.g., child care responsibilities, unsafe neighbourhood, unsupportive or abusive relationships). The women's **past experiences with local bureaucracies and researchers** reduced trust and raised suspicions about what the "real agenda" of the project was.

"I've got a two-year-old and I'm trying to go back to school so I can get a decent job to support him. I'm exhausted at the end of the day and I wouldn't make it to these meetings unless [her friend] picked me up and brought me here." (Single mother)

"If my worker found out that I was spending money on myself for recreation, she would get suspicious. She would be wondering where I was getting the money from and why I wasn't spending it on more important things." (Single mother)

VII

Guidelines for Health Promotion Dissemination

Each community (however community is defined) and the people who comprise it are unique, making the direct transfer of "lessons learned" from one community to another difficult.

It is important to emphasize that the following guidelines, based on the results of this study, are not meant to serve as a "quick fix" or a "ready-made recipe" for community action. Each community (however community is defined) and the people who comprise it are unique, making the direct transfer of "lessons learned" from one community to another difficult. Rather, the guidelines are meant to serve as a starting point for discussions about the types of principles that should guide community involvement in health promotion for women, while pointing out some of the obstacles that may be encountered along the way.

• Ensure that a diverse and representative number of women find the health promotion initiative to be relevant to their daily lives, and invite them to participate in a community planning process in a meaningful way.

• Avoid tokenism by ensuring that women on low incomes outnumber professionals in planning meetings and have the opportunity to assume leadership roles based on their comfort levels.

• Discuss the value of co-generating new knowledge and action strategies through partnerships between women on low incomes, municipal recreation staff and staff from other community groups.

• Acknowledge the structural dimensions of poverty and centre the development of action plans around diversity of women's experiences and understandings. Develop strategies for overcoming child care, transportation and other barriers that will limit participation.

• Ensure that community representatives use a community development approach by adopting facilitator or enabler rather than expert roles.

• Pay attention to process by ensuring that leadership is shared, all voices are heard, a collective rather than hierarchical structure is developed, conflict is acknowledged, and a consensus decision-making model is adopted.

• Develop a vision and value statements that are respectful of diversity and demonstrate passion for the issue.

• Develop short-term and long-term action plans and ensure that they get implemented to energize the group.

• Avoid simplistic solutions that essentialize the experiences of women or require them to "prove poverty" in order to participate.

• Create community partnerships to share responsibility, to reduce the fragmentation of services for women, to pool resources, and to raise awareness about the issues and possible action strategies.

• Collectively assess the resources (including experiences, skills, knowledge, social networks, finances, space and materials) that all members bring early on and mobilize these resources as required to create action.

• Develop a multi-level communication strategy (e.g., word of mouth, newsletters, media coverage, presentations, reports, workshops, academic publications) to share information about the project with other members of the community as well as those in positions of power to garner community and political support and to increase participation.

• Integrate existing and original research into the initiative to demonstrate the relevance of the issue, to increase legitimacy, to evaluate process, and to access short-term and long-term outcomes that are both quantitative and qualitative in nature.

• Develop a social justice discourse to counteract the prevailing rational efficiency discourses in government.

• Document successes and failures to serve as a guide to other communities that may be interested in launching similar initiatives, but ensure that adaptation is encouraged based on the local context and circumstances.

VIII

Recommendations and Policy Implications

A feminist community development approach helps to ensure that the voices of less powerful segments of society are heard and acted upon in ways that are relevant to them.

The identification of the factors that enhance or inhibit community health promotion dissemination will be useful to other women on low-incomes, community groups, municipal recreation departments and researchers embarking on similar initiatives. However, additional funding is required to support dissemination efforts from one community to another (e.g., for resource materials, training of facilitators, travel to other communities, follow-up assistance). Additional research is also required to further our understanding of the factors that enhance or inhibit dissemination.

There are several policy implications arising out of this study. First, existing health policies and programs are frequently based on the assumption that individuals should be responsible for their own health, yet they provide little or no opportunity for input from the growing number of women who live in poverty and are most likely to experience poor health. A feminist community development approach helps to ensure that the voices of less powerful segments of society are heard and acted upon in ways that are relevant to them. At the same time, including community leaders and researchers in the process broadens the responsibility for change when existing community structures, practices and policies, as well as the knowledge production process itself, are critically analysed.

Second, municipal recreation departments are well positioned across the country to play an active role in health promotion. However, there are few documented examples of how these departments are partnering with women on low incomes and representatives from community groups who work directly with them (e.g., women's centres, family services, public health units, multicultural groups) to define and address the complex issues that make participation in programs difficult. In addition, many municipal recreation departments have adopted a user-pay system, making programs increasingly prohibitive to Canadians living below the poverty line. The results of this study challenge the traditional direct model of program delivery and the prevailing rational efficiency discourse that emphasizes revenue generation and cost-recovery values over social justice. Rather, increased participation by

women on low incomes is more likely to occur when a community development model is adopted that encourages their active involvement in action planning and implementation, while respecting the diversity of their situations.

Third, although there have been repeated calls for interventions that address socioeconomic inequalities in health outside the conventional medical system (Mustard & Frank, 1991), medical practitioners and practitioners who work with women on low-incomes seldom consider community recreation as an opportunity for health promotion. This study demonstrates that the dissemination of successful local health promotion initiatives involving community recreation is more likely to occur when the experience and resources of women on low incomes are pooled with intersectoral community partners around a shared vision of social justice.

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Prise de mesures

La mobilisation des collectivités en vue de fournir des activités récréatives aux femmes à faible revenu

Centre d'excellence de la C-B pour la santé des femmes

Vancouver, C.-B.
CANADA

Ce rapport de recherche sur la santé des femmes est offert en francais et sous des formes utilisables par les personnes handicapées. Pour plus de détails, veuillez communiquer avec le Centre d'excellence de la C.-B. pour la santé des femmes

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