CHAPTER 6

Levelling the Playing Field: Promoting the Health of Poor Women Through a Community Development Approach to Recreation

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Over the last four decades increases in differential wage rates for workers, the devolution of publicly funded social services, the development of tax policies favoring the wealthy, and the decline of labour unions have created a period of striking growth in income and wealth inequity in all developed nations (Moss, 2002). The National Council of Welfare (2004: 5) showed that the distribution of personal income in Canada is quite skewed because in 2001, the poorest 20 percent of the population had only five percent of the income compared to the richest 20 percent of the population with 43 percent of the income. Poverty rates in Canada went up after the recession of 1981-82, declined for the rest of the 1980s and rose again with the recession of 1990-91. While the current trend is slightly declining poverty rates, the 2001 rate of 14.4 percent is still higher than the 13.9 percent rate in 1989, the year before the last recession (National Council of Welfare, 2004: 3).

Rising income inequalities have been accompanied by an increase in the number of families living in poverty. In Canada, the number of people living at less than half the poverty line has grown dramatically in recent years, from 143,000 families and 287,000 unattached individuals in 1989 to 277,000 families and 456,000 unattached individuals in 1997 (National Council of Welfare, 2000). Even though Canada is consistently rated as one of the best countries in the world in which to live, poverty dramatically affects the lives of many people and it is women and their children who are most likely to live in impoverished conditions (National Council of Welfare, 2000). Seventy percent of those living in poverty in Canada are women, and single-parent mothers, women over the age of 65, aboriginal women, and visible minority women have the lowest incomes of all

population groups (National Council of Welfare, 1998). In 2001 the poverty rate for single-parent mothers was 42.4 percent compared to 19.3 percent for single-parent fathers, and was 21.2 percent for women over the age of 65 compared to 11.1 percent for men over 65 (National Council on Welfare, 2004: 5).

Women living in poverty face many daunting challenges such as poor housing, inadequate child care, insufficient financial resources for food and clothing, domestic violence, and a sense of disempowerment when dealing with a bureaucratic social service system (Reid, 2004). Given these pressing issues, policy makers and social practitioners rarely consider recreation as a priority -- despite the number of compelling reasons for doing so. As we will show in this chapter, the women on low income with whom we work in the context of our ongoing research see a lack of recreation and social isolation in their communities as major health concerns for themselves and their families (Frisby and Hoeber, 2002; Reid et al., 2002).

Unfortunately, little has been done in the areas of policy development, program design, or research to address the interconnected problems of women's poverty, poor health, and a lack of involvement in physical activity and other forms of recreation. This omission is likely due, in part, to the fact that bureaucrats largely design health, recreation, and sport policy in isolation from one another, and with little or no input from those encountering structural barriers to participation. Another contributing factor is that with increased pressure to produce high performance athletes given Canada's low Olympic medal count, the poor are often rendered invisible when policies and programs are developed, marketed, and evaluated. Similarly, poor women are rarely involved in the planning and analysis of research (Frisby et al., 2005a), and the few studies done on poor

women's health have focused on health-damaging practices like smoking, rather than on health-promoting activities like exercise (Fugate Woods et al., 1993).

The purpose of this chapter is to demonstrate how poverty, combined with prevailing policies in municipal recreation departments, hinders many women from participating in health-promoting forms of recreation and physical activity. To accomplish this aim, we first discuss gendered disparities in income, health, and physical activity. We then critique prevailing policies and practices in municipal recreation, which while ostensibly designed to promote universal access to recreation in Canadian urban centres, often create further barriers to participation (Frisby et al., 2005b). Finally, based on our experiences conducting a five-year feminist participatory action research project involving women living in poverty and a number of public sector partners (including municipal recreation, family services, a women's centre, and community schools), we offer an alternative approach to municipal recreation based on principles of community development (Frisby and Miller, 2002).

Our research project explored what physical inactivity and social isolation meant to a diverse group of low income women including single mothers, older women, recent immigrant women, and women with disabilities. We also examined the community organizing practices that emerged when the women themselves, community partners, and our research team formed an organization called WOAW (Women Organizing Activities for Women) to tackle the social problem of a lack of access to municipal recreation. We regularly attended and kept field notes of WOAW meetings and activities, and conducted focus groups and interviews with the women and partners over time. While, in this chapter, we provide some of our observations based on this research project, we do not

claim to be speaking for all members of WOAW. Given the complexity of the issues addressed, there were often diverse perspectives that were due, in part, to the very different social locations of the various WOAW members.

Box 6.1: Using a Feminist Participatory Action Research Approach

To overcome the problems of excluding poor women in research, we used a feminist participatory action research (FPAR) approach. In a recent article (Frisby et al. 2005a), we describe how this approach is different from traditional research where researchers decide on the research questions and methods and recruit subjects to participate in their studies. The term 'participatory' means that marginalized populations have an opportunity to provide input in all phases of research including determining the relevant research questions and appropriate data collection techniques, analyzing the data, and deciding how to communicate the results. The key assumption is that the research will be more relevant to women on low income if they have a say in its production. A participatory approach is used when we seek to understand the lived experience of those involved in, affected by, or excluded from various types of recreation, especially when that experience is likely to be very different from our own. This process is designed to elicit and combine the lay knowledge of citizens, the instrumental knowledge of practitioners, and the academic knowledge of researchers to improve the human condition. 'Action' is an explicit FPAR goal and the numerous examples of action evident in our project included the organization of dozens of low cost activities; increased participation of women on low income in programs, decision making, and policy change; the formation of new community partnerships; and the development of new theoretical understandings. The 'feminist' dimension of FPAR indicates that we were interested in centering the women's experiences in our analysis, while considering the affects of gendered power relations.

WOMEN, POVERTY, POOR HEALTH, AND PHYSICAL INACTIVITY

Women living in poverty have the poorest health status of all Canadians and are the least likely to participate in physical activity (Doyal, 1995; Raphael, 2001; Reid, 2004). The 'gradient of health' used in the public and population health literatures to capture the pervasive and consistent inverse relationship between socio-economic status and health (Deaton, 2002), also applies to the relationship between socio-economic status (SES) and physical activity participation rates. This social class gradient exists for smoking, dietary

composition, and the amount of leisure-time physical activity that people engage in (Wilkinson, 1996). Several researchers have suggested that the link between social structures and life style patterns can be explained by having differential access to a range of resources in the management of everyday lives (Calnan and Williams, 1991). Material restrictions operate through a number of processes and "unhealthy" behaviours need to be understood in the context of the constraints on everyday life which accompany them (Shaw et al., 2000). Smoking, drinking, poor nutrition, and physical inactivity are socially patterned and represent structural challenges that women face (Walters et al., 1995).

The social class gradient of physical activity participation exists for both men and women, however, men consistently participate more than women over the life cycle (Canadian Fitness and Lifestyle Research Institute, 1998). The notion of the gradient is helpful in conceptualizing the role of gender and income in shaping how we live our lives, what opportunities and resources we have access to, and what risks we are exposed to, as all of these factors influence our health.

There is a growing body of research and increased media attention on the role of physical activity in reducing health problems associated with cardiovascular disease, obesity, diabetes, cancer, and osteoporosis (Sallis and Owen, 1999). Regular physical activity is also thought to be effective in alleviating mental health conditions like depression, anxiety, low self-esteem, and stress (Reid et al., 2000). In the world of health studies, however, health is not only defined in biomedical terms as the absence of disease. An alternative 'social determinants of health' approach recognizes that broader social, economic, and environmental conditions constrain individual choices and affect health status (Ballantyne 1999; Doyal 1995; Marmot and Wilkinson 1999; Wilkinson

2000). This approach acknowledges that interventions must target inequalities on a structural level if widespread change is to occur, thus challenging behavioural models and policies that place responsibility for health on the individual alone. According to behavioural models, individuals are expected to make necessary changes in their lifestyles (e.g., by exercising, not smoking, and eating properly) to achieve optimum health and quality of life. Thus, little consideration is given to how their position on the socio-economic gradient affects their opportunities to make such choices (White et al., 1995). The 'classist' and patronizing message this sends is that "if people would just stop being poor, their health and well-being would improve."

Poverty is usually the product of overlapping and mutually reinforcing sources of disadvantage based on factors such as gender, race, age, education, occupation, and health status. It is also, in part, connected to gendered domestic roles where mothers, particularly those who are single parents, remain largely responsible for childcare. Similarly, marital status is another contributing factor because households with single parents, who are overwhelmingly headed by single mothers, have high poverty rates. Gender differences in income levels are also apparent following separation and divorce where women experience a 23% loss in net family income on average, while men average a gain 10% due to less spending on dependants (Women's Health Bureau, 1999).

Other groups of women are also disproportionately represented below the low-income cut-offs in Canada (where 70% or more of household income is used for food, clothing and shelter). According to the 2001 census data, 48% of the Aboriginal population, 43% of recent immigrants, 30% of visible minorities, and 15% of people with

disabilities live below the low income cut-off (Statistics Canada, 2001). Within each of these groups, more women than men are poor.

Twice as many women as men over the age of 65 live in poverty and this gap is expected to widen as the population ages and women's life expectancies continue to exceed those of men. With the aging population and the de-institutionalization of health services, there will also be greater pressure on women to care for aging relatives (Hankivsky, 1999). Since care-giving performs a vital role in society, and it is estimated that women perform two-thirds of unpaid care-giving work in Canada, this type of intensive responsibility adversely affects women's ability to obtain education and employment (Townson, 2000).

Women with low levels of education are usually restricted to working in minimum waged jobs and often resort to government financial assistance programs because child care costs absorb such large portions of their meagre incomes, leaving insufficient funds for other basic necessities. Labour market inequalities also contribute to gendered differences in the experience of poverty. In Canada, women continue to make less than men with similar levels of education and experience, and the majority of women work in jobs in the lowest earning categories (Townson, 2000). Increasingly, women are working in home-based, part-time, and temporary positions that provide little or no job security, opportunities for advancement, or health care and disability benefits. Those known as the 'working poor' have no discretionary income to pay for the costly fees and equipment associated with participation in physical activity and recreation.

In general, women's roles within the family, the workplace and the community are constrained by gendered patterns of power, authority, and control (Moss, 2002;

Wilkinson, 1996). A simple lack of resources and the shame and stigma associated with living in poverty also shape the ability of poor women to pursue opportunities that others routinely enjoy (Tirone, 2003-2004). Living in extreme material deprivation is tied to high levels of emotional stress and depression, social isolation, poor nutrition, and physical inactivity, all factors that contribute to poor health status (Reid, 2004).

Disparities in income and health are also are rooted in the broader economic, political, historical, cultural, and social arrangements that structure women's lives (Moss, 2002). To illustrate, income and health inequalities have not decreased despite rising national wealth in countries like Canada, the United States, Britain, and Australia. However, these inequities are less pronounced in other wealthy countries like Sweden, Norway, and Finland, where there are stronger social policies promoting citizen health and welfare. In countries where a larger share of resources goes to less well-off persons, life expectancy is higher than in countries where resources are less equitably distributed (Moss, 2002). In Canada, welfare payments per person have been declining and in some provinces they account for as little as 50% of the Low Income Cut-Off, the income level determined by Statistics Canada to be indicative of the poverty line (Health Canada, 1999).

Using a political economy approach, Coburn (2000) argues that the rise of neo-liberalism (sometimes also referred to as 'neo-conservatism'), as reflected in business-oriented practices in government, helps to explain widening income and health inequalities in wealthy nations. The key assumptions underlying neo-liberalism are: i) the market rather than the state produces and makes more efficient use of resources; ii) societies are composed of autonomous individuals motivated primarily by economic

considerations; iii) inequality is an inevitable outcome of market forces; and, iv) state interference leads to unnecessary market distortions (Coburn, 2000). While he acknowledges that there is a complex set of causes contributing to poverty and poor health, Coburn (2000) argues that rapid economic globalization fueled by such neo-liberal ideology contributes to social fragmentation because the need for state intervention becomes undermined by the dominance of market forces. Additionally, social problems are attributed to the failures of individuals rather than to broader social, economic, and political forces. Stereotypes that characterize poor women as adopting unhealthy lifestyles, taking advantage of government services, and being lazy or uninterested in civic affairs are pervasive (Reid, 2004). These discourses 'blame the victim' for their circumstances and serve to absolve governments from making public services, including recreation, more accessible to marginalized citizens.

Box 6.2: Is Reducing Fees Sufficient?

Our research has demonstrated that while women on low income viewed access to local recreation as a way to promote their own health and the health of their families, they encountered numerous barriers that prohibited their participation. The barriers included: costly program fees, equipment, and clothing; a lack of transportation and childcare; a lack of social support; skill and body image issues; disabilities and other health problems; and policies that required them to 'prove poverty' in order to qualify for subsidies. The older women had access to recreation programs and social support through a municipal senior's centre, but poor health, transportation, and mobility issues often limited their participation. Lesbians, Aboriginal, and recent immigrant women on low income faced additional barriers as they were uncomfortable or unfamiliar with the eurocentric, masculinist, and heterosexual norms that characterized the municipal recreation system. Programs were typically promoted in English in written brochures and over the internet and did not take language, literacy, or access into account. Most of the barriers encountered reflected the middle class norms of contemporary municipal recreation service delivery where it was assumed that citizens had adequate financial, social, and cultural capital to participate. Given the range of barriers encountered, our findings showed that simply reducing program fees or offering subsidies is not a sufficient solution in making programs accessible because more complex social, cultural, economic, and political factors are at play.

Hankivsky (1999: 1) has remarked, “Social justice is based on the idea that all members of society should have equal access to societal benefits and opportunities regardless of their position in life.” While health is widely recognized as a fundamental right of citizenship, poor women face many obstacles accessing the Canadian health care system that was designed for middle-class citizens. As a result, for example, many poor women who do not have coverage for dental care and medications see the system as being non-responsive to their needs. They also discover that transportation and childcare costs associated with accessing such services are prohibitive (Hankivsky, 1999).

Municipal recreation departments in Canada are increasingly positioned as a preventive form of health promotion that exists outside the traditional health care system (Canadian Parks and Recreation Association, 2001). As indicated in the next section, our analysis of prevailing policies and practices in municipal recreation illustrates that many of the problems attributed to the health care system apply here as well. We argue that identifying and discussing these problems, based on the input from women on low income involved in our research project, is an important first step in re-visioning the changes required to promote greater social inclusion, social justice, and health (Donnelly and Coakley, 2002; Hankivsky, 1999).

CRITIQUE OF PREVAILING MUNICIPAL RECREATION POLICIES AND PRACTICES

Historically, municipal recreation evolved from the social reform movement and largely targeted disadvantaged youth. By the mid 1980s, government funding for recreation was dropping, the public was resisting further tax increases, and cost recovery strategies (e.g., charging fees) were being implemented, posing serious implications for those least able

to pay for programs. Although a perusal of municipal recreation websites in Canada reveals that most of these departments of local government have mandates to provide recreation programs to all citizens, the reality is that they cater primarily to middle class citizens who can afford the rising costs associated with participation. Today, pressures on municipal recreation departments to be efficient and accountable to city councils and taxpayers through revenue-generating programs must be juxtaposed against claims of universal access and a community development process designed to involve and empower citizens.

Once again, the rise of the neo-liberal agenda is largely responsible for the shift towards NPM strategies in local government. According to Arai and Reid (2003), this has resulted in widespread changes including: dramatic shifts in the role of the social 'safety net' in supporting marginalized citizens, the abandonment of the concept of distributive justice, the movement towards individualism over collectivism, and increased public-private sector partnerships. When a corporatist management model is adopted in local government, discussions regarding the health benefits of participation for marginalized citizens, rising poverty levels, and the need for citizen input become less frequent because the focus is shifted towards competing with the private sector, catering to those who are able to pay, and off-loading services to community groups in order to contain costs (Thibault et al., 2004). With the increased demand for services and the downsizing and restructuring that is occurring in response to financial cutbacks, municipal recreation staff have become overwhelmed with their growing job responsibilities and face risks if they resist the NPM culture in their workplaces (Frisby et al., 2004).

The changing nature of municipal recreation departments in local government has had a direct impact on whether health promotion initiatives for women on low income have been supported through community partnerships. For example, community organizations that typically work with women on low income (e.g., public health units, family services, women's centers, multi-cultural agencies) have restricted mandates and a bewildering array of demands on their time and budgets, and they rarely consider recreation as a beneficial health promotion strategy for their 'clients' (Frisby et al., 1997).

Some municipal departments have attempted to retain elements of the social welfare model through the implementation of 'Leisure Access' policies -- by offering programs at a subsidized rate -- but few poor women take advantage of this policy for a variety of reasons. First, some of the women we worked with were not aware of a leisure access policy because it was not communicated effectively to isolated persons like them (Frisby et al., 2002). Others who were aware of the policy explained that because they had to 'prove poverty' by bringing in their financial records to be reviewed and photocopied by staff. The humiliation, loss of dignity, and invasion of privacy associated with having to prove poverty significantly outweighed the benefits of the Leisure Access policy (Reid, 2004).

Requiring proof of poverty is an exclusionary practice tied to the NPM ideology because it is implemented to deter abusers (e.g., those who are able to pay full price) from taking advantage of the system. This policy is aimed more at achieving accountability than it is at making programs available to low income populations. A related problem is that front-line staff are not always trained to foster an inclusive environment for marginalized citizens. The policing function they must perform when

enforcing leisure access policies actually serves as a further deterrent (Reid, 2004). For poor women with low confidence, who are not sure how the system works, who do not have the right clothes or body shapes, who do not speak English as a first language or have literacy difficulties, the type of welcome they encounter from front-line staff will be a determining factor in deciding to participate.

Additionally, programs offered at a reduced fee are still often unaffordable to many and do not account for other barriers beyond financial costs that prohibit participation (e.g., transportation, childcare, and body image issues). The individualized sign-up procedure is a further hindrance, because some women find the system intimidating when accessing programs on their own. As we will demonstrate later in this chapter, a community development approach that is based on an ethic of collectivism and social support can help overcome this problem.

Proponents of 'Active Living', a social marketing initiative promoted by the federal government and adopted by some municipalities, contend that there are many free activities that people can take advantage of, such as walking in the neighborhood, gardening, or taking children to playgrounds. However, activities like gardening are the preserve of the middle class and 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. Further, the importance of health-promoting social benefits of participation such as social support, decreased isolation, increased social ties are downplayed in the list of activities associated with 'Active Living'. Bercovitz (1998: 323) contends that while the rhetoric of 'Active Living' promotes personal responsibility for health by making individuals less

dependent on professional experts, bureaucrats were really using it to justify budget cuts by having people "doing for themselves." She argues that such top-down initiatives:

> conceal power imbalances between government officials, practitioners and the community … and justify the rapid retreat of the welfare state from social responsibility for fitness and health (1998: 319).

While the emphasis on individual responsibility is problematic, it is equally troublesome when paternalistic assumptions are made that marginalized citizens, who are sometimes portrayed as not adhering to health-promoting messages, are incapable of providing input into policies and programs. Consequently, professionals make decisions about needs and how they should be met from a middle class perspective and design programs in a 'top down' fashion 'for' rather than 'with' citizens (Donnelly and Coakley, 2002). A professionally-driven direct model of program delivery does not serve women on low income well (Frisby and Hoeber, 2002). Rather, it is more likely that women will participate when they have input into the content, location, pricing, instructors, childcare, and marketing strategies devised, making the programs more relevant to their daily realities. For example, some women in our project indicated that word-of-mouth promotions at food banks, low income housing units, and women's centers were much more effective in reaching them than the more commonly used strategies of written advertisements in brochures and on the internet.

We see the revitalization of the community development approach to recreation provision, even though it is fraught with challenges, tensions, and contradictions, as an alternative strategy for beginning to redress some of these exclusionary policies and practices manifested in the rise of NPM in recreation departments in local government.

A COMMUNITY DEVELOPMENT APPROACH TO RECREATION

While community development has a long history in municipal recreation in Canada and there are numerous examples of successful projects (Canadian Parks and Association 2001; Hutchison and Campbell 1996, 1997), it is increasingly being paid 'lip service' by many bureaucrats and politicians at a time when local governments are adopting the business-oriented practices associated with NPM. As Pedlar (1996) acknowledges, some recreation departments see themselves as doing community development when they are really just managing and programming in community settings. The latter approach enables managers and programmers to retain power and expert status, an approach that contrasts sharply with notions of citizen self-determination and empowerment historically connected with the concept.

There is, then, considerable ambiguity and confusion about what community development means (Labonte 1997; Boutilier et al. 2000). Rather than engaging in a definitional debate, we will concentrate on two dimensions that became central to our project, namely *communitarianism* and *feminist community organizing*.

While the individual ethic associated with neo-liberalism favours the market and individual rights, communitarianism stresses collective rights and the important role of the public sector in fostering citizen well-being. At various times, community is associated with a specific geographic region or a group of people who share common characteristics, but lack interconnected social ties. In contrast, Pedlar (1996) contends that being part of a community means people have a sense of place where they have meaningful social interactions that foster feelings of connectedness. Developing social

ties and becoming involved in civic affairs can reinforce a sense of belonging and a desire to become part of collective endeavours.

Pedlar (1996) contrasts communitarianism with the individualistic 'lifestyle enclave' where people express their identities by managing their appearance, consumption patterns, and leisure activities and by not acting interdependently or politically with each other. The rise of individualism over communitarianism contributes to social isolation, fragmentation, and a growing sense of social malaise, especially for those living in impoverished conditions. A return to communitarianism involves identifying with others different from oneself, fostering interdependent social ties, and working together towards both the individual and the public good (Pedlar, 1996).

Box 6.3: A Community Development Approach

In our project several of the women on low income and the community partners described their work as being community development. Some of the women made business cards with the descriptor 'community development consultant' because they believed they were in the best position to encourage participation amongst others on low income in the community. Early on, project members wanted to organize differently to offset hierarchical structures that accentuated and reinforced power differences in their families, workplaces, and communities. This aim was reflected in the following vision statement the group developed at a workshop organized to identify and discuss alternative structures: "We are a group of diverse women working together to enhance quality of life and create positive and sustainable change. Women are empowered, respected, and connected to their communities. All thoughts and feelings are valued and important, and women are treated with dignity." Based on these values, the group decided to work in a collective structure characterized by group decision-making and shared leadership roles designed to distribute power and benefits more equitably. The community development model that emerged included the formation of public sector partnerships to pool resources and build political support. The partners reported how important it was to value the resources brought by the women and to encourage their active involvement, rather than operating in a top down fashion by taking over or telling them what to do. In turn, the women saw the involvement of the partners as adding legitimacy and credibility, and increasing access to resources and knowledge about political structures. While the concept of working within a community development approach was confusing to some members, especially new members who were unaccustomed with it, it remained the preferred way of organizing for the duration of the project. Members claimed that this

model helped reduce their social isolation, increased their skills and confidence, and allowed them to share the workload required to make decisions about programs and policies that had a direct impact on their lives.

Our research has demonstrated how communitarianism arose when some isolated women on low income, a number of public sector partners, and members of the research team came together to address the women's self-defined health problems of physical inactivity and social isolation (Frisby and Millar, 2002; Reid, 2004). This required members of the different groups to become co-learners, to adopt different roles, and to reflect on the power relations inherent in the evolution of the community-based organization that eventually formed (Vanderplaat, 1999). This also encouraged us to consider how we wanted to work together differently. As researchers we drew on the feminist community organizing literature as one source of information about alternative structures and processes.

According to Callaghan (1997), feminist community organizing includes many of the traditional activities of community development, but it is informed by an analysis of how gender, race, class, and other markers of difference affect power relations. Feminist community organizing is also grounded in the realities of women lives and attempts to validate the long history of women's community work that often goes unrecognized (Dominelli, 1995).

Feminist community organizing involves practitioners working directly with women to collaboratively design and implement recreation programs in a way that does not reinforce oppressive power structures. Because it involves respecting and valuing the lived experience of poor women and working with them to redefine issues on their own

terms, it requires a transformation of professional values and relationships (Dominelli, 1995; Reid, 2004).

Empowerment is a key concept connected to community development, feminist community organizing, and health promotion. While the discourses surrounding the use of this term are problematic, Laverack and Wallerstein describe 'empowerment' as:

> a process that promotes capacity building of heterogeneous individuals who have shared interests and concerns, by strengthening their sense of struggle and community activism … along with an increased awareness of the broader social and political causes of their disempowerment (2001: 184).

Ristock and Pennell (1996) emphasize that empowerment is a process one undertakes for oneself, it is not something done 'to' or 'for' someone else. It involves taking control, both individually and collectively, to change the conditions of people's lives. The aim is to redefine issues collectively to transcend the simplistic solutions to social problems often promoted by the media and the state for economic or political reasons.

While it can be a risky process because their voices have often been silenced or misappropriated in the past, the starting point is for women to share their stories. This requires creating a safe space for them to reflect on the nature of their realities by talking to other women, rather than having expert professionals or researchers impose that on them. In the WOAW project, the women on low income talked about both the barriers and benefits of participating in recreation and collectively decided what activities they wanted to participate in. They also took on significant roles in organizing and marketing recreation activities to other poor women in the community.

For practitioners, empowerment means adopting facilitator and collaborative roles instead of prescribing what others should do. For example, in WOAW, the public sector partners offered free facilities and equipment, contacts, and strategies for implementing the ideas agreed upon. Although practitioners are often constrained by professional ideologies like NPM, involving them in community organizing can increase access to resources and knowledge of how to work within existing political structures. The danger of not including them is that community development can become a governmental discourse to justify the off-loading of responsibility for recreation programs to community groups who lack resources (Wharf, 1997).

Organizationally, empowerment means sharing in leadership and decision-making, opening up dialogue, and hearing from those who rarely have a voice in civic affairs (Chinn, 2001). While it is impossible to level the power imbalances that are inherent in working across social divisions, the goal is to shift hierarchical power relations and build collective power to affect change (Ristock and Pennell, 1996; Reid, 2004). Alternative ways of establishing more egalitarian working relations that we attempted in WOAW included rotating the chairing of meetings and committee structures, establishing guidelines for communications (e.g., valuing all voices, no interruptions when others are speaking) and dealing with conflicts, and avoiding 'majority rules' approaches to decision making (Chinn, 2001; Frisby and Millar, 2002).

Tensions will inevitably arise as new structures and processes are evolving but, for the most part, the women and public sector partners we worked with remained committed to exploring new ways of working together. However, a few members found this process confusing and time consuming, and others were more comfortable with

hierarchy because that type of power structure had pervaded their lives. As Dominelli (1995) acknowledges, the work of feminist community organizing is always flawed and unfinished, but searching for more egalitarian relations and sharing skills and resources increases the potential for change that is relevant to the lives of women. In this way, the process of involving women in the planning and organizing of recreation activities becomes just as important as achieving outcomes (Labonte, 1993). It is also important to note that the outcomes desired in community development initiatives (e.g., decreased social isolation and physical inactivity, increased access to publicly funded programs, increased citizen/public sector partnerships) are often diametrically opposed to outcomes sought in a NPM environment (e.g., increased revenues and attendance numbers, decreased costs, increased public/private sector partnerships), and careful thought must be given as how to negotiate this tension.

CONCLUSION

Gendered disparities in income and health exist in Canada and the rise of neo-liberalism and new public management threatens to exacerbate these social inequalities. Although publicly offered recreation programs have historically been designed for all citizens, they are not immune to the powerful discourses of cost recovery and accountability that shift attention away from social problems like women's poverty and poor health. Increasingly, the policies and practices of municipal recreation are creating further barriers to participation. Although implementing alternative approaches will be difficult given the stranglehold of neo-liberalism in local government, the revitalization of community development, based on principles of communitarianism and feminist community

organizing, offers a promising strategy for promoting greater social inclusion, social justice, and health. By including poor women in the policy-making, programming, and research processes they are usually systemically excluded from, local recreation departments can begin to address the significant barriers that accompany poverty. As women's opportunities for participation in recreation increase, so to will the opportunities for improved physical, psychological, social, and community health. Adopting alterative approaches like community development in a meaningful way will also enable the municipal recreation system in Canada to more fully fulfill its societal roles by becoming a more viable site for health promotion.

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Recommended Further Readings

Bercovitz, K.L. (1998). Canada's Active Living policy: A critical analysis. *Health Promotion International* 14(3), 319-328.
The author provides a critique of the discourse of Active Living with its emphasis on lifestyle, empowerment, community and collaboration. The goal was to unpack hidden meanings and political agendas that concealed power imbalances and provided government with a platform for retreating from responsibility for fitness and health.

Canadian Parks and Recreation Association (2001). *Recreation and Children and Youth Living in Poverty: Barriers, Benefits and Success Stories.* Ottawa: The Canadian Council on Social Development.
This report contains a literature review and annotated bibliography of studies related to how children and youth living in poverty participate in recreation. Examples of recreation programs considered to be 'best practices' are also provided.

Donnelly, P. & Coakley, J. (2002). *The Roles of Recreation in Promoting Social Inclusion.* Toronto: The Laidlaw Foundation. (www.laidlawfdn.org)
This working paper delineates the circumstances under which social inclusion might be promoted by recreation programs. Barriers to participation are discussed and recommendations are provided.

Frisby, W., Reid, C., Millar, S. and Hoeber, L. (2005). Putting 'Participatory' in Participatory Forms of Action Research. *Journal of Sport Management* 19 (4), 367-386.
The authors reflect on their experiences conducting feminist participatory research with women on low income. The challenges and strategies used to foster participation in five phases of the research process were considered including setting the research questions, building trust, collecting data, analyzing data, and communicating the results for action.

Reid, C. (2004). *The Wounds of Exclusion: Poverty, Women's Health and Social Justice.* Edmonton, AB: Qualitative Institute Press.
This book is based on Reid's doctoral dissertation that was the winner of the 2002/2003 International Institute for Qualitative Methodology Dissertation Award. Dr. Reid is a co-author of this chapter and was one of the project managers of the WOAW research project described in the case studies. Her book argues that health and access to community services are social justice issues requiring attention.

Relevant Websites

The Canadian Parks and Recreation Association (CPRA) website contains a number of resources related to their Children and Youth Living in Poverty Initiative. www.cpra.ca

The Canadian Research Institute for the Advancement of Women (CRIAW) is a national not-for-profit organization committed to advancing the equality of women through

research about the diversity of their experiences. CRIAW seeks to bridge the gap between the community and academe, between research and action, through its partnerships and activities.http://www.criaw-icref.ca/

The Canadian Women's Health Network (CWHN) was officially launched in May, 1993 by women representing over 70 organizations from every province and territory. The CWHN continues to look to Canadian women as our key sources of information, energy, ideas, direction and inspiration. http://www.cwhn.ca/indexeng.html

The Canadian Centre for Policy Alternatives offers an alternative to the message that we have no choice about the policies that affect our lives. They undertake and promote research on issues of social and economic justice, and produce research reports, books, opinion pieces, fact sheets and other publications, including The Monitor, a monthly digest of progressive research and opinion. http://www.policyalternatives.ca/

Society for Community Development is a British Columbia organization designed to provide leadership and support in helping citizens address common issues, with the goal of working towards a healthier community. This website overviews a number of community development programs that address issues such as family health and violence, and promote public discussion on political, social, and moral issues.
http://www.vcn.bc.ca/scd/

Ten Glossary Terms

Community development: the process of establishing structures of human community within which new ways of relating, organizing social life, and meeting human needs become possible (Ife 1998: 2).

Communitarianism: an ideology where the collective is valued over individual rights and the public sector is thought to play a vital role in citizen well-being (Pedlar 1996).

Empowerment: a process that promotes capacity building of heterogeneous individuals who have shared interests and concerns, by strengthening their sense of struggle and community activism … along with an increased awareness of the broader social and political causes of their disempowerment (Laverack and Wallerstein 2001).

Social Exclusion: a lack of participation in societal activities, alienation from decision-making and civic participation, and barriers to employment and material resources (Raphael 2001).

Feminist Participatory Action Research (FPAR): an approach to research that centers women's experiences in the analysis, involves them in the research process, and has an action component designed to foster social transformation (Frisby et al. 2005a).

Gradient of Health: a line on a graph that indicates that people with the lowest socio-economic status experience the highest rates of mortality and morbidity (Deaton 2002).

New Public Management: the adoption of private sector, market-driven practices by government causing them to become more entrepreneurial and results-focused (Aucoin 1995).

Poverty line: the low income cut-offs (LIOs) established by Statistics Canada to indicate where 70% of household spending is for basic necessities of life such as food, shelter, and clothing.

Recreation: for this chapter we are defining recreation as structured activities offered by municipal recreation departments including physical activities, fitness, art, drama, etc.

Social Justice: "All members of society have an equal access to the various features, benefits and opportunities of that society regardless of their position in life" (Hankivsky 1999: 1).

Critical Thinking Questions

1. Check the website of the municipal recreation department in your home-town or the city where you are studying and locate i) the department's mandate, and ii) its Leisure Access (or fee-reduction) policy. Given what you have learned about poverty, critically assess whether this policy will promote participation of women living on low-income.

2. The new public management ideology (NPM) is pervasive in local government. Identify the key features of this ideology and discuss how it is at odds with a community development approach.

3. What barriers do women on low-income face in terms of recreation participation that are unlikely to be shared by middle and upper class men and women?

4. How would you counter the 'blame the victim' argument that suggests women on low income are responsible for their own situations and poor health?

5. What steps would you take as a recreation programmer to create a community development program? Who would you involve in the creation of the program and why?

When this happens, the playing field for conducting CBPR truly will be leveled. Do you want to read the rest of this conference paper? Request full-text.Â Both partnerships aimed to identify community health needs, develop a community-led intervention to promote positive health outcomes, and evaluate that work iteratively. Although the initial focus for each community was to address obesity and diabetes risk, adherence to the CBPR approach led to different community identified prioritized needs and different pilot projects.Â Abstract Community development attempts to ensure that populations particularly in deprived rural communities have access to basic health services, education, housing, potable water, and food. Levelling the Playing Field: Promoting the Health of Poor Women Through a Community Development Approach to Recreation (2007) In P. White & K. Young (Eds.) Sport and Gender in Canada. (pp. 121-136), Don Mills, ON: Oxford University Press. @inproceedings{Frisby2007LevellingTP, title={Levelling the Playing Field: Promoting the Health of Poor Women Through a Community Development Approach to Recreation (2007) In P. White & K. Young (Eds.) Sport and Gender in Canada. (pp. 121-136), Don Mills, ON: Oxford University Press.}, author={Wendy Frisby}, year={2007} }.Â Bridging the recreation divide: Listening to youth and parents from low income families across Canada, Ottawa. Canadian Parks and Recreation Association, 2005.