

The Social Determinants of Health: Equity Across the Lifespan

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EXECUTIVE SUMMARY

Over the last decade, the study of women's health has recognized that health is influenced not only by biological mechanisms and medical models but by a range of socio-cultural, physical, and psychological factors (Cohen & Sinding 1996). Broadly categorized as the multiple determinants of health, these factors can include such influences as income and social status, social support networks, education, employment and working conditions, physical and working environment, biology and genetic predisposition, personal health practices, healthy child development, gender, and culture (Cohen 1998; Women's Health Strategy 1999). When discussing the factors that affect health, it is necessary to recognize gender as a key social determinant. Although both women's and men's health is affected by social and economic factors, the interaction of gender with the other determinants of health creates different experiences of health and illness for women and men. The compounding and interconnected impacts of race, sexual orientation, gender, age, class, and disability influence social support networks, access to education, access to quality employment, risk of violence, and other resources affecting health. This paper explores several social factors affecting women's health. These reflect common themes in women's health literature and comments from interviews conducted with community group representatives, policy makers, and researchers in St. John's, Newfoundland.

RECOMMENDATIONS

Finding #1: Concern that the shift from acute care to community care will not be adequately resourced, thus women will have to provide "free" caregiving that will negatively impact their mental and physical health.

Recommendation #1: Recognize caregiving as "real" work and financially compensated it. In places where community organizations or informal networks are expected to participate in care-giving, appropriate resources must be available to those doing such work.

Finding #2: Women's health does not occur in a vacuum. Women are part of families and communities. When communities suffer, women's health usually deteriorates.

Recommendation #2: Job creation, nutrition, housing, and health promotion programs need to be accessible to all members of the community. Care must be taken that the special needs of certain groups, for example, women, persons with disabilities, older people, and aboriginal people are taken into consideration.

Finding #3: Communities already have many of the skills and resources needed to cope with change and difficult situations.

Recommendation #3: Although access to counselling services and social workers is important, it is equally important that lay people work with others in their community who are going through difficult times.

Finding #4: Although access to services, hospital beds, and quality health care can influence health, poverty and lack of jobs is a major health determinant.

Recommendation #4: It is necessary for policy makers, community workers, researchers, and service providers to examine and treat the root of problems that exist in their communities. It is not enough to provide "band-aid" solutions that only treat problems such as stress, anxiety, and depression that may be symptomatic of larger-scale problems such as poverty.

Finding #5: Women living in rural and geographically isolated areas often do not have access to counsellors, support groups, mammograms, breast screening, and abortion services.

Recommendation #5: Governments should strive to make equal access to services and health care a reality (bring services to remote communities and bring people living in remote communities to services).

Finding #6: Social support plays a pivotal role in health and well-being. Community organizations provide many free support services and help for people who have nowhere else to turn. A move away from core funding to project based funding hampers community-based organizations ability to provide these services.

Recommendation #6: Community-based organizations must have the option of applying for operational and core funding to support vital services (referrals, peer counselling, organizing support groups, etc.).

INTRODUCTION

Our understanding of women's health and what affects women's health has evolved significantly over the last century (Cohen 1998). Traditionally, discussions of women's health focused on reproductive and gynecological health, however in the last two decades there has been a shift in our understanding of women's health. There is now some understanding that women's health concerns extend across the life cycle and are not limited to reproductive and gynecological problems. Women's health is related to the social, political, cultural, and physical conditions under which women live. The factors and conditions affecting women's health include inter-connected physical, mental, social, and spiritual dimensions (Cohen 1998).

In this paper I examine the social determinants of health and what they mean specifically to the health of women. Because women do not constitute a homogenous group, when addressing the factors that influence women's health, I have tried to represent women's diversity with regards to race, age, socio-economic class, ability/disability, and sexual orientation. The second half of this paper is devoted to women's health and community health issues identified by several community groups, researchers, and policy makers in St. John's, Newfoundland. I also outline some of the projects, programs, and models that have contributed to women's health in this province.

THE DETERMINANTS OF HEALTH

One of the major developments to emerge in the study of women's health over the last decade in particular has been the recognition that health is influenced not only by biological mechanisms and medical models but by a range of socio-cultural, physical, and psychological factors (Cohen & Sinding 1996). Broadly categorized as the multiple determinants of

health, these factors can include influences such as income and social status, social support networks, education, employment and working conditions, physical and working environment, biology and genetic predisposition, personal health practices, healthy child development, gender, and culture (Cohen 1998; Women's Health Strategy 1999). The Report on the Health of Canadians (1996) also lists behaviours that enhance or create risks to health, such as individual capacities and coping skills, and decision-making. The Ottawa Charter for Health Promotion (1986) describes peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity as fundamental conditions and resources essential for health (Cohen 1998).

THE SOCIAL DETERMINANTS OF HEALTH

To create models, programs, and methodologies that will improve health, the full spectrum of the determinants must be considered. The National Forum on Health (1997) recognized the particular importance of the social and economic determinants of health. The Canadian Institute for Advanced Research has also proposed that stable and satisfying employment, the availability of social support, equitable income distribution, and a social environment that allows an individual to have a sense of control and security are factors essential to good health and well-being (Kaufert 1996). While detection of disease and quality of services can affect health, employment, poverty, quality of housing, and access to education can have an even greater impact (Cohen 1998; Minister of Public Works and Government Services 1997).

Although shifting funds away from sickness care to social programs that lead to improvements in housing, employment, and education can better employ societal resources to prevent illness, some caution is necessary. Livingstone

(1998) outlines two possible problems that can come as a result of focusing on the social determinants of health. First, it is problematic when shifts from hospital care and health services to community care and social services are not accompanied by an appropriate shift in resources. Simultaneous funding cuts from health care and other social programs make it difficult for Canadians to become and stay healthy (Livingstone 1998). Second, certain discussions about the social determinants of health have minimized the “social” and have laid responsibility for health primarily with the individual. Focusing on behaviour such as smoking, exercise, and diet can deflect attention from macro problems such as pollution, workplace safety, and poverty that are often not under individual control. Cohen (1997) states, “It is essential that we understand that the factors influencing the development of unhealthy behaviours can be broadly categorized as those that reside within individuals and in our immediate environment and those that occur at the socio-cultural level” (p. 194).

When discussing the factors that affect the health, it is necessary to recognize gender as a key social determinant. Gender is a social construct that consists of a range of personality traits, values, and attitudes that society ascribes to men and women on a differential basis (Cohen 1998). According to Kaufert (1996), gender influences access to political and economic resources. Although both women’s and men’s health is affected by social and economic factors, the interaction of gender with the other determinants of health creates different experiences of health and illness for women and men. Although women are disadvantaged relative to men on many measures of equity that effect health, some women are doubly or triply disadvantaged (Kaufert 1996). The compounding and interconnected impacts of race, sexual orientation, gender, age, class, and disability influence social support networks,

access to education, access to quality employment, risk of violence, and other resources affecting health. Historically, systemic bias also permeated mainstream health research and health care provision and this has influenced which aspects of health have been researched and where health priorities lay.

HOW DO SOCIAL FACTORS INFLUENCE WOMEN’S HEALTH?

There are many inter-connected factors influencing women’s health. It is necessary to recognize that factors such as job loss, poverty, stress, and isolation may influence women differently and may interact to produce different effects. For example, a woman who has many social supports may cope better with job loss than a woman who has very few social supports and is stigmatized in her community because she is a lesbian. Below, I outline some of the social and economic factors that often affect women’s health.

MULTIPLE ROLES

A study by Denton and Walters (1996) showed that women of different ages and at different stages of their lives experience different kinds of stressors and have different health concerns. For example, women under the age of 45 were more likely than women over 65 to list stress as a major health concern. Women over 65 report fewer health concerns and worries, yet experience greater life-threatening and chronic health problems (Denton and Walters 1996). Women who experience stress are less likely have time for themselves, they may be experiencing work or money problems, or they may be taking care of children or an elderly parent (Denton and Walters 1996). In Canada, a burdened health care system, along with a shift in the delivery of services from the acute care setting to the community has necessitated that women increasingly bear the brunt of juggling

work demands with multiple family roles. Not only do women often take the majority of the responsibility for childcare, daughters are three times more likely than sons to be primary caregivers to their elderly parents. Half of those caring for family members with disabilities are full-time workers and also spend an average of 16 hours per week caring for parents (Ruzek 1998). Such caregivers have shown to be eight times more likely to suffer symptoms of stress and depression than the population at large (Ruzek 1998). Because managing full-time work and caregiving is so difficult, many women are forced to leave paid work to care for others, resulting in reduced social security benefits, pensions, and medical insurance. This in turn can have a deleterious effect on women's physical and mental health status.

WOMEN'S WORK

Women's paid work is also often mediated by family responsibility (Walters, Lenton and McKeary 1995). For example, a woman working outside of the home who has support in terms of shared parenting or access to child care will have different demands on her than a woman who is a single parent or someone who cannot afford child care. Despite the multiple demands women face, work outside of the home tends to have positive effects of women's health. Work outside of the home can offer financial rewards, social support, and greater self-esteem (Walters, Lenton and McKeary 1995). However, some literature highlights problems that women face in the workplace (Messing 1991). Women tend to be concentrated in areas such as nursing, teaching, and sale and service occupations. Clerical work, factory work, and sales are often repetitive and offer little control over immediate work environment. Workers in these occupations are often not involved in decision making. These kinds of work environments tend to increase stress and decrease job satisfaction (Kaufert

1996). Further, women are often faced with work conditions that negatively impact their well-being. Messing (1991) outlines a series of social problems, such as discrimination and harassment, and physical problems, such as mal-adjusted equipment and poor working conditions, that influence women's health.

Many studies that examine how work affects health do not include older adults (Arber 1996). However, there are health benefits to older adults (over 60) who continue in full-time or part-time work. Occupational class has a strong effect on self-assessed health of older adults even after they stop working. For example, those who worked in semi-skilled occupations report worse health than those who worked in higher middle-class occupations even after they have retired (Arber 1996). Unemployment is another major problem faced by women that negatively affects health. Unemployed women and women doing only housework tend to have higher levels of ill-health (Arber 1996).

INCOME DISTRIBUTION

The relationship between poverty and ill health is well-documented and well-known (The Working Group on Women's Health, Department of Health, Government of Newfoundland and Labrador 1994). In all societies, including Canadian society, women constitute a larger proportion of the poor and they lag behind men in almost every social and economic status indicator (Cohen 1998). Canadian aboriginal women are more likely to be living below Statistic Canada's low-income cutoffs than other Canadian women. Kaufert (1996) has identified some of the social and economic conditions resulting from racism and poverty that influence women's well-being. "Factors such as poverty and racism determine women's access to education, the type of occupation available to them, their actual or potential dependence on welfare payments, the

quality and affordability of their housing, the quality of their health care and its ease of access, the availability of quality child care, the safety of their neighbourhood, and their access to affordable nutrition” (p. 6). Poverty also seems to be associated with a slough of chronic health conditions such as heart disease, arthritis, stomach ulcers, and migraines (Statistics Canada 1994). Income affects lifestyle, quality of housing, and nutrition. To a large extent, income can determine access to health care, for example treatment, medication, counselling and rehabilitation (The Working Group on Women’s Health, Department of Health, Government of Newfoundland and Labrador 1994). In fact, not only do Canadians in higher income brackets live longer, there is a gradient in health status: health increases at each step up the hierarchy in income, education and social status.

SOCIAL SUPPORT

According to a recent report considering gender as a health determinant, there is considerable evidence that social support influences health status, health behaviour, and the utilization of health services (Davidson, Holderby, Stewart, vanRoosemalen, Poirier, Bentley, and Kirkland 1997). The authors of the report allude to recent research that highlights distinct differences in men’s and women’s support. First, women tend to have multifaceted networks and more friends/confidantes, they give more types of support, and benefit more from supportive interactions. However, many women, because of the discrimination associated with differences in cultural, ethnic, sexual, or socio-economic circumstances, experience isolation in the context of their lives, and may be severely limited in their access to social support (Davidson et al. 1997). The importance of friendships was frequently cited by Newfoundland women in a report on women’s health issues (Williams 1989). When

asked to identify factors which facilitated their health, women listed ‘friends’ as the third most important social determinant of health. Although quality interpersonal relationships are vital, the supports found in the larger community are also important (Walters, Lenton and Mckeary 1995).

The extreme opposite of supportive environments and relationships is the violence that many women are faced with in interpersonal relationships and in the workplace. Violence has direct influence on both physical and mental health and is an index of social support (Walters, Lenton and Mckeary 1995). Women with low incomes, immigrant women, and Aboriginal women have rates of physical abuse higher than the national average. Women with disabilities are also vulnerable to abuse (Nova Scotia Advisory Council on the Status of Women 1995). In one study, 39% of ever-married women in Canada with a disability or a disabling health problem reported physical or sexual assault by a partner. Although violence in lesbian relationships is not widely discussed in the lesbian community or the anti-violence movement (Muzychka 1992), 32.4% of lesbians in Nova Scotia indicated that they had been abused in a same-sex relationship (Nova Scotia Advisory Council on the Status of Women 1995).

THE SOCIAL DETERMINANTS OF HEALTH THROUGH THE EYES OF COMMUNITY WORKERS, SERVICE PROVIDERS, ACADEMICS AND POLICY MAKERS IN ST. JOHN’S, NEWFOUNDLAND

Many of the issues outlined above were identified in the early 1980s by Newfoundland and Labrador women during the Women’s Health Education Project (WHEP). WHEP was organized to identify key women’s health issues in communities across Newfoundland and Labrador, to share strategies for coping, and to work

toward realistic change. In total 123 workshops were conducted with approximately 2234 women (Women Health Education Project, Newfoundland and Labrador 1984). At the time of WHEP, women identified issues such as stress, supportive relationships, geographic isolation, economic factors, unemployment, discrimination, and having multiple roles as key to their health and well-being.

Knowledge about these women's health issues has been a catalyst for some individuals, community organizations, service providers, researchers, and policy makers to work on strategies to improve women's health and community health in Newfoundland and Labrador. Often models, projects, and services that have been successful in improving women's health are not widely publicized and are only documented in informal reports.

For this reason, I chose to talk to some key informants working in different sectors about some of the factors that determine women's health in Newfoundland and Labrador, their efforts to improve women's health and well-being, and about some of the barriers to achieving better health for the women and communities in this province. I interviewed two researchers/professors from Memorial University of Newfoundland, Shirley Solberg from the School of Nursing and Joan Scott from the Biology and Women's Studies Department. I interviewed three women from community groups that also have a service component, Jane Robinson from the St. John's Women's Centre, Moyra Buchan from the Canadian Mental Health Association, Newfoundland and Labrador, and Yvonne Jacobs from the Senior's Resource Centre. I spoke to Dorothy Robbins from the Women's Policy Office and Joyce Hancock from the Provincial Advisory Council on the Status of Women. I also spoke with one service provider, Ann Kearney, from the Breast Screening Program, Newfoundland and Labrador.*

Many of the people that I talked to work with organizations that play many different and over-lapping roles. For example, the Provincial Advisory Council on the Status of Women informs policy by working with government, participates in community development, and works with other groups on issues such as mental health, violence against women, and employment. Although some of the people I spoke with could not name all of the social determinants of health and may not have been familiar with that terminology, conceptualizations of health that they articulated were holistic, multi-faceted, and complex.

It seemed that all of these organizations based their work, projects, and services on the premise that health – women's health, family health, and community health – are affected by interconnecting, socio-economic factors. In the following section I will outline some of the key issues that were identified.

ECONOMIC DEPRESSION

Unemployment and underemployment were issues mentioned by almost all of the women I spoke to. For example, Jane Robinson, from the St. John's Women's Centre said that low income resulting from unemployment and underemployment can lead to low self-esteem and poor mental health. The Women's Centre often gets calls from women who are having difficulty coping with a family or work related problem that is, in part, caused by unemployment and a lack of money. In December 1998 the Women's Centre conducted a study exam-

* It is important to note that I chose to speak to women who worked in St. John's but had contact with communities across the province. Although I do not assume that I am representing the views of women working in rural or small urban centres across the province, the women I spoke to have much insight into various important issues for women across the province. I also recognize that women working with different organizations may have identified different issues and/or projects as important.

ining the housing concerns of low income women, survivors of abuse, women with disabilities, unemployed women, and women on social assistance. Some of the main concerns expressed by women were safety and health issues, inadequate repairs to housing by owners, violence or fear of violence from other tenants, substandard living conditions, and discrimination (St. John's Women's Centre 1998).

Poverty issues also seem to be making their way into the classroom. Joan Scott, professor in Women's Studies and in Biology said that in certain classes students are now talking about how poverty affects their lives, including their health. Some aboriginal women especially have made the connections between how a lack of jobs and resources can contribute to a wide variety of problems such as violence, drug and alcohol abuse, and depression.

Moyra Buchan, from the Canadian Mental Health Association, Newfoundland and Labrador said that people are often shut out from participation in mainstream society because they are dealing with stress, depression, or anxiety as a result of job loss, job insecurity, or poverty. She thinks it is important to recognize that empowerment and participation are essential to positive mental health and community involvement. The Canadian Mental Health Association, Newfoundland and Labrador organized a program called "Speaking for Ourselves". This program trained individuals to sit and participate on the boards of the Family Resource Centres across the province that were opened in high unemployment and high social assistance areas. The program worked on self-esteem building and demystifying and clarifying governing boards. This training program resulted in a high rate of participation of parents on the Family Resources Centre Boards and a video/manual being produced that could be used as a guide for other groups.

SOCIAL SUPPORT

Many of the women I spoke to identified social support as a major factor affecting health and well-being. For example, Yvonne Jacobs at the Senior's Resource Centre noted that, older women are often left taking care of their male partners because men have a shorter life-expectancy and tend to be older than their female partners. This puts physical stress on caregivers, because taking care of the physical needs of a person, such as washing and feeding, can be physically demanding. The caregiver may feel distress because their partner is not well and a caregiver may be isolated in the home if she cannot leave a sick partner alone. Dorothy Robbins, Women's Policy Office, identified the impact of deinstitutionalization and early release on paid and unpaid caregivers who are primarily women as one issue that needs further examination in the area of women's health. To respond to the calls for support and information that the Senior's Resource Centre was receiving through their information line, a caregiver's support group was created. Although the support group is aimed at people over 50, Yvonne acknowledged the need for such a group for younger caregivers.

It seems that one of the key goals of the Senior's Resource Centre is to provide seniors access to social support and to decrease isolation among seniors. The centre offers many programs for seniors that provide support through education and building of social networks. Yvonne Jacobs described the effort that is made to encourage seniors to participate in the Friday Friendship Club. Each member is called and told about the event happening that week (a movie night, a talk, an outing, etc.). The person is then called again to see if they would like to participate and they are provided with transportation if necessary. First time participants are also paired with a buddy who introduces them to others and acquaints them with the program. The goal is to remove some

of the barriers that make it less likely for seniors to participate, such as lack of transportation and minimal outreach.

GEOGRAPHIC ISOLATION

One of the identified problems facing Newfoundland and Labrador women was geographic isolation. Shirley Solberg from the School of Nursing said that there exists a gap in research on women who live in small, isolated areas and on women who are geographically scattered and do not have access to services. The challenge is getting services to those areas and getting women to those services. Women in rural areas also may not have access to appropriate services. For example, a woman who has been sexual assaulted may not receive abortion counselling or the appropriate tests. Health service providers may not know the protocol for examination and counselling. Women may not go to health care providers if they have been assaulted because they may worry about not receiving confidential treatment. Shirley told me about a recent project that allowed women with breast cancer in different locations in Newfoundland to teleconference with each other to provide support and information. This project helped cancer patients/survivors deal with lack of contact with other cancer patients/survivors that comes with being in a small, isolated community.

Ann Kearney of the Newfoundland Breast Screening Program, mentioned some of the barriers to receiving breast screening faced by women in this province:

Mammography utilization is affected by income and education ... so women who are less educated and lower income tend to use the services less than women of a higher socio-economic status. Women are also really strongly influenced by their physician in terms of screening ... Another determinant of health

is geographic location, so women who live further away from a screening centre or a hospital are less likely to come for screening.

Clearly, many women living in geographically isolated areas may experience difficulty getting the services and support needed for continued good health.

COMMUNITY HEALTH

Several of the women I spoke to indicated that it is important to examine the context of women's lives to improve health and well-being. Women are part of families and larger communities. When those families and communities suffer because of inadequate health services, economic depression, and lack of social support, women's health suffers as well. This does not negate the fact that women may have specific needs within families and communities or that certain women who are socially or economically disadvantaged may be more vulnerable to violence, discrimination, and isolation – factors that can contribute to ill health. It is important to strike a balance between what is good for the community as a whole and what is good for women in a community. For example, although jobs in technology and the natural resource sector may provide opportunities and economic sustainability for communities, Dorothy Robbins from the Women's Policy Office noted that it is necessary to include women in training programs in these sectors, institute fair hiring policies, and make the workplaces woman-friendly.

Several of the women I interviewed spoke about using resources already present in the community to deal with mental health issues and to provide social support to each other. Moyra Buchan described the response to the close of the fishery and the ensuing crisis:

... the process of adjustment to major loss, it's a human process that people usually go through with the support of people around

them. What struck me was the way we had over-professionalized. Our expectation that when you think you have a problem you need a professional to fix it, while in our history, people support each other through change.

Both the Canadian Mental Health Association, Newfoundland and Labrador and the Senior's Resource Centre have developed training programs that help people within communities across Newfoundland and Labrador hone their helping and listening skills so that they can help those who need support or information.

LINKING WITH OTHER GROUPS

Linking with groups in other sectors is important because it combines a variety of skills and strengths to create effective and innovative projects. Almost all of the women interviewed mentioned the importance and need of linking with people working on health issues in other sectors. Both Shirley Solberg, School of Nursing and Joan Scott, Biology and Women's Studies discussed ways in which the university and the community could work together. Shirley Solberg said that community organizations sometimes approach university researchers when they want a particular piece of research done or when they want to evaluate an existing program. Other times, university researchers approach community organizations in order to create projects that are representative of community needs. Community organizations and university researchers have also come together in the past to create coalitions like the Women's Health Network, Newfoundland and Labrador. This network was developed with a goal to start a dialogue and create links between researchers, community organizations, policy makers, and service providers working in the area of women's health in Newfoundland and Labrador.

Work with a variety of groups also takes place at the government level. Dorothy Robbins

described some of the work of the Women's Policy Office that involves working with many government departments at the provincial level, examining new policies that are being developed and their effect on women. The Policy Office has come up with a Gender Analysis Guide to help various departments consider the impact of policies on all women inclusive of age, sexual orientation, colour, race, ethnicity, ability/disability and socio-economic status and to identify these policies early on in the policy formulation process (Women's Policy Office 1998). The goal of gender inclusive analysis is achieving a society in which both men and women are equally valued and in which people's choices are not limited because of their gender, social positions, or non-relevant characteristics (Women's Policy Office 1998: 9). The Women's Policy Office hopes that this guide will lead to the development of policies that take into account the life-experiences of all women in this province.

A DIVERSITY OF WOMEN

Each woman I interviewed was asked if they tried to address the needs of women of different ages, lesbian/bi-sexual women, women of colour, women living in various locations across the province, and women with disabilities. There were several ways in which needs were addressed. Both Dorothy Robbins from the Women's Policy Office and Joyce Hancock from the Provincial Advisory Council on the Status of Women felt that when developing policies it is important to consider the effects of policies, models, or programs on *all* women. It is necessary to consider how a program or policy would affect women living in different economic situations, women from a variety of family structures (i.e., single moms), women with different abilities, women from different cultures, and so on. Some organizations also initiated projects that highlighted and ad-

dressed the needs of certain disadvantaged women. Yvonne Jacobs from the Senior's Resource Centre told me about a program, called the Senior's Bridging Cultures Club that links seniors from different cultures in social activities, informational talks, and involves them in light exercise. This program aims to decrease isolation for new immigrants and increase social support networks between men and women from different cultures.

Another project that came as a result of setting sexual orientation and the status of lesbians in Newfoundland and Labrador as a research and lobbying priority by the Provincial Advisory Council on the Status of Women, was a book about the lives of lesbians in this province (Muzychka 1992). The book was titled "Out of the Closet and Into the Light, Improving the Status of Lesbians in Newfoundland and Labrador (Muzychka 1992). Martha Muzychka did in-depth interviews with lesbians across the province and the ensuing report painted a picture of some of the legal, social, and health issues faced by the women interviewed. In terms of health, some of the issues highlighted were kin rights when a partner is hospitalized, heterosexism or lack of sensitivity to sexual orientation, and inability to disclose sexual orientation to a health care provider (Muzychka 1992).

Other organizations have tried to make an effort to include a diversity of women on their governing boards or memberships. The hope is that a diverse governing structure and membership will lead to the prioritization of a variety of issues that affect women of different ages, life situations and backgrounds. Other groups have tried to link with others working on projects that addressed the needs of women with disabilities, lesbian women, and women from different cultures. It seems that lack of adequate funding, lack of human resources, and difficulty linking with groups outside of St. John's, were some barriers to developing a

variety of programs and conducting research that would be inclusive of all women.

SUMMARY

This paper examined some of the social and economic factors influencing the health of women. Discussed were the effects of women's multiple roles, income distribution, women's paid and unpaid work, and social support on health and well-being. The second half of this paper highlighted some of the issues identified by interviewed community group representatives, policy makers, and university researchers in St. John's. Several factors affecting the health of women living in Newfoundland and Labrador were emphasized and some of the projects and programs that have been developed to address the needs of women and the communities they live in. It is vital that social, cultural, and economic factors are considered during the development of policies, programs, and models that are aimed at improving women's health and well-being.

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