

Women and Healthy Living in Canada

Fact Sheet Number 1 Fall 2012

PHYSICAL ACTIVITY

RETHINKING WOMEN AND HEALTHY LIVING IN CANADA

Rethinking Women and Healthy Living in Canada: Challenging the Discourse, Evidence and Practice examines the sex, gender, diversity and equity dimensions of healthy living among women in Canada by conducting sex-and gender-based analyses of the healthy living discourse, key healthy living topics and selected healthy living strategies.

Fact sheets on women and healthy living have been prepared on physical activity, sedentary behaviour, self-injury, food insecurity, sodium, tobacco, alcohol, sexual behaviour and condom use.

Learn more at www.womenshealthdata.ca



Women and girls are less active than men and boys at all age levels in Canada and many women are not sufficiently active to attain the health benefits of physical activity.

Physical activity has been shown to have positive impact across a wide spectrum of health issues for girls and women, including reduced risk of several chronic conditions and improved emotional and social well-being. Physical activity also represents one of few modifiable factors that can reduce breast cancer risk, which makes it particularly important for women to be physically active [1].

Measuring physical activity is a challenge due to the lack of clear definitions and categories, but usually include leisure-time activities, occupational activities, active transportation (walking, cycling), and domestic work.

The Canadian Physical Activity Guidelines recommend adults to engage in at least 150 minutes of moderate-to-vigorous intensity physical activity per week, in bouts of 10 minutes or more, to achieve health benefits [2]. It is estimated that only 14% of Canadian women met these recommendations in 2007-2009 [3]. The current physical activity guidelines do not include sex- and gender-specific recommendations despite research suggesting that women are less physically active than men and they may experience different barriers to physical activity.

Sex- and gender-based analysis

Sex- and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

1. **Sex** refers to the biological characteristics that distinguish male from female bodies. Sex differences include different chromosomal patterns, reproductive organs, hormones and proportions of fat to muscle.



2. **Gender** refers to socially constructed roles, relationships, attitudes, behaviours, relative power, etc., that shape and describe what it means to be male or to be female in a society.

3. **Diversity** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.

4. **Equity** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should

ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [4].

Sex issues

Canadian women are less physically active than men, regardless of age group [3]. In 2010, 50% of women and 56% of men reported being moderately active or active in their leisure-time [5]. Physical activity has shown to have positive effects on depression and anxiety, both of which are more common among women.

Gender issues

Physical activity is a gendered experience and the differences in physical activity rates for men and women are at least partially caused by the role of gender in the social, economic and health realities of women's lives. Women and men tend to engage in different types of physical activities; the most common activities among women include walking, gardening, home exercises, swimming and dancing [6]. Family responsibilities and lack of time are commonly reported barriers to women's physical activity [7-9]. Some women may also experience barriers to physical activity because of culture, socioeconomic status and the physical environment.

Diversity issues

Differences in physical activity rates exist in terms of socioeconomic status, ethnicity, immigrant status, age and geography. Women with low socioeconomic status and recent immigrant women are less likely to be as physically active as the Canadian average. Aboriginal women and older women are also less likely to be physically active. Across Canada, women in British Columbia, Alberta, Nova Scotia and the Yukon are more likely to report being active or moderately active in their leisure time compared to women in Quebec, Nunavut, Ontario, Newfoundland and Labrador and the Northwest Territories [5].

Equity issues

Not all women have the same opportunities to be physically active. Women with low income may not have the resources required to join exercise programs or clubs, and may not be able to get to recreational facilities due to transportation costs. As women are more likely to be in low-paying and precarious employment, their time may also be more constrained and they may be disproportionately less likely to have jobs that provide access to fitness facilities at the workplace [6].

High income neighbourhoods often have more community resources for recreational facilities and may thus provide girls and women with more options for being physically active [10]. Neighbourhood safety is another factor that influence girls and women's physical activity and there is a need for strategies that ensure that neighbourhoods are safe for walking, cycling and other forms of physical activity. There is also a need for strategies to ensure equitable access to resources [11], including access to suitable physical education classes and/or organized sports which may be subject to gender-related inequities.

Critique

Data on physical activity is often collected through self-report surveys, which can result in reporting bias. Activities performed by women with young children are often unstructured

(e.g. carrying children while performing household chores), and are often less memorable and more difficult to categorize compared to planned physical activities [12]. Physical activity is often measured as moderate-to-vigorous activity, conducted during leisure-time, and therefore does not capture light-intensity activities and activities that are performed at the workplace, in schools, in the household or through active transportation (walking, cycling) [13]. Women's and girls' actual physical activity can therefore be underestimated or misclassified [14].



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Women and Healthy Living in Canada

Fact Sheet Number 2 Fall 2012

SEDENTARY BEHAVIOUR

RETHINKING WOMEN AND HEALTHY LIVING IN CANADA

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Women and men are equally sedentary but their behaviours differ and may be associated with different health effects for women and men, effects that are independent from physical activity.

Sedentary behaviour has become a distinct field of inquiry with its own logic, origin and impact on health, separate from too little physical activity [1]. Health effects associated with sedentary behaviour include increased risk of weight gain, type 2 diabetes, some cancers, cardiovascular disease and poor mental health [2-4].

Sedentary behaviour include television viewing, computer and handheld device use, reading, occupational sitting, motorized transportation and other behaviours that involve sitting. Although the definitions are not consistent in the literature, in Canada, sedentary behaviour has been defined as a distinct class of behaviours characterized by little physical movement and low energy expenditure (≤ 1.5 metabolic equivalent units) [4].

The Canadian Sedentary Behaviour Guidelines recommend that children and youth spend no more than 2 hours per day on recreational screen time and that time spent on sedentary transportation and extended sitting should be limited throughout the day [5]. There are currently no Canadian guidelines suggesting limits to the amount of time that adults spend sedentary, despite research suggesting that sedentary time increases with age.

Sex- and gender-based analysis

Sex- and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

1. **Sex** refers to the biological characteristics that distinguish male from female bodies. Sex differences include different chromosomal patterns, reproductive organs, hormones and proportions of fat to muscle.



2. **Gender** refers to socially constructed roles, relationships, attitudes, behaviours, relative power, etc., that shape and describe what it means to be male or to be female in a society.

3. **Diversity** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.

4. **Equity** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should

ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [6].

Sex issues

Girls and women's sedentary behaviours differ from boys and men and their behaviours have been associated with different health effects. For men, sedentary behaviour has been associated with an increased risk of colon cancer, while for women there may be increased risk for endometrial cancer and ovarian cancer [4]. Despite these differences, current sedentary behaviour guidelines do not include sex- and gender-specific recommendations.

Gender issues

It is estimated that men and women spend approximately equal hours per day sedentary [7]. However, women and men engage in different sedentary behaviours. For example, more men than women report being frequent users of computers and television, while women are more likely to report frequent reading [8]. Girls and women also spend time in communication-based sedentary behaviours such as talking on the phone, texting and instant messaging [9], and also while 'hanging around' and socializing [10].

Diversity issues

Differences in sedentary behaviour exist in terms of sex, age, marital status, education and immigrant status. Frequent leisure-time computer users (11 or more hours per week) are often younger, have not been married and are often men. Unemployment is also associated with frequent leisure-time computer use for both women and men.

Frequent television viewers, on the other hand, are more likely to have lower levels of education (less than secondary education), be in the lowest household income quintile and be living in rural areas. Recent immigrants are more likely to report frequent computer use than people who are Canadian-born, but less likely to report watching television [11]. Canadian girls are more likely to watch TV and use computers, than to play video games or read [8].

Equity issues

Inequities can influence time spent in sedentary pursuits, including inequities related to power, gender and income. Neighbourhood safety is an important factor for sedentary behaviour and children's television time has been linked to their mother's perception of neighbourhood safety where children in the least safe neighbourhoods tend to spend more time watching TV [12]. It is possible that girls and women may have less power and entitlement to move with safety in their neighbourhoods and may therefore spend more time sedentary. Women may also be more likely to have jobs with limited ability to change the structure of their workplace and, as a result, have fewer opportunities to reduce the amount of time spent sitting.

Critique

The relationships between sedentary behaviour and morbidity and mortality have not received as much research and policy attention as the relationship between physical activity, morbidity and mortality. Most studies to date focus on a limited number of sedentary behaviours, such as watching television and computer games,

and therefore exclude other behaviours that women may be involved in. Measuring sedentary behaviour is a challenge as these behaviours are often engaged in sporadically throughout the day and may be harder to remember than scheduled physical activities. Self-reports, a common measure of both physical activity and sedentary behaviour, may therefore not be a reliable measure of sedentary behaviour [4,11].



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Women and Healthy Living in Canada

Fact Sheet Number 3 Fall 2012

SMOKING TOBACCO

RETHINKING WOMEN AND HEALTHY LIVING IN CANADA

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Smoking rates are decreasing in Canada but there are groups of women where smoking rates are higher, including women living with low income and Aboriginal women.

In 2011, 17.9% of women reported current smoking in Canada [1]. Overall smoking rates are decreasing but there are groups of women where smoking rates are higher including young women, women living with low income, single mothers, Aboriginal women [2] and women who have survived sexual and physical abuse [3].

Women are also exposed to other people's tobacco use. In 2010, 5% of non-smoking girls and women (aged 12 years and older) reported being exposed to second-hand smoke at home and 15% in vehicles and/or public places [1].

Sex- and gender-based analysis

Sex- and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

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3. **Diversity** can be identified as variations in culture, ethnicity,

sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.

4. **Equity** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [4].



Sex issues

Research suggests that girls and women may be particularly vulnerable to the effects of smoking and exposure to second-hand smoke. Women who smoke are at risk of developing heart disease, chronic obstructive pulmonary disease, cervical cancer, lung cancer, and breast cancer [2, 5]. Smoking may also have detrimental effects on women's reproductive function including decreased fertility and early menopause [6].

There are delayed sex-specific effects of second-hand smoke that

may put girls and women at particular risk of certain health outcomes such as breast cancer [5, 7].

Smoking during pregnancy can result in health risks for both the women and the fetus, including increased risk of preterm delivery, spontaneous abortion, growth restrictions for the fetus and could potentially increase the risk of long-term behavioural and psychiatric disorders for the child [8].

It has also been suggested that women metabolize nicotine differently than men [9] and that nicotine replacement therapy may be less effective for women [7, 10].

Gender issues

Several gender-related factors can influence women's smoking behaviour and exposure to second-hand smoke, including unequal power and income differences. For example, some women may not feel comfortable, or have the power, to implement smoke-free policies in the home or in the car if their partner smokes. Women are also more likely to work in the service-industry or in private homes where they may be exposed to second-hand smoke [11]. Fear of weight gain is a barrier for many women to stop smoking, as women encounter tobacco marketing which brand cigarettes as a means to achieve cultural ideals of thinness [12].

Diversity issues

Smoking rates in Canada tend to vary depending on where women live, their income and education level, by age and Aboriginal identity. Results from the Canadian Community Health Survey (CCHS) 2009/2010, suggest that daily smoking rates are higher among women with low income and low levels of education. Young women are also more likely to smoke and rates tend to decrease with age. The largest proportion of daily and occasional smokers can be found in the three territories (Yukon, Nunavut and the Northwest Territories) and it has been estimated that smoking rates in the Aboriginal population could be more than twice as high as in most Canadian provinces [13].

Equity issues

Female smokers in Canada often occupy marginalized social positions in relation to socioeconomic status, Aboriginal status, sexual orientation and/or experiences of trauma or mental illness. Although smoke-free policies have been effective in reducing smoking rates in the general population, these declines have not been equitable across population subgroups [7] and it has been suggested that smoke-free policies may contribute to inequities. For example, the 'denormalization' of tobacco use may result in smokers having difficulty finding housing and they may be discriminated against at work. Feelings of shame may also prevent smokers from seeking health care and accessing smoking cessation services [14]. Some argue that smoke-free policies have had particularly limited impact on girls and women with low socio-economic status [7].

Pregnant women may also be particularly vulnerable as the social stigma attached to smoking during pregnancy may cause additional delays in treatment and prevent many women from seeking cessation assistance.

Critique

Smoke-free policies have been largely gender-blind [7] and have not considered socio-economic disparities [15] despite that fact that the large majority of female

smokers occupy marginalized social positions and often have low income. Smoke-free policies should therefore adopt a health and social justice approach to reduce inequity, and it has been suggested that smoke-free policies should be accompanied with cessation programs [11]. There are currently no detailed, large-scale surveys or surveillance initiatives focusing specifically on Canadian women's tobacco patterns and more research is needed to accurately understand why women start and continue to smoke, in light of evidence of the harmful health effects.



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Women and Healthy Living in Canada

Fact Sheet Number 4 Fall 2012

DRINKING ALCOHOL

RETHINKING WOMEN AND HEALTHY LIVING IN CANADA

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Alcohol is the most commonly used substance by women in Canada and is an emerging issue among some girls and women where rates of heavy drinking are increasing.

Alcohol is the most commonly used substance by women in Canada [1]. In 2010, 73.9% of women reported that they had consumed alcoholic beverages in the past 12 months [2]. While the majority were considered light drinkers, 10% of women in Canada reported being heavy drinkers, defined as 5 drinks or more on one occasion [3]. Recent evidence, however, suggest that the threshold for what is considered heavy drinking for women should be lowered to 4 drinks or more as the health impacts of alcohol use have shown to be more severe for women compared to men [4,5]. A preliminary analysis suggests that the prevalence of heavy drinking may increase by 50% if this new threshold is used [5].

The pan-Canadian low-risk drinking guidelines, released in 2011, define low-risk drinking for women as no more than 2 drinks on most days, up to a total of 10 drinks per week, in order to reduce long-term health risks; and no more than 3 drinks on one occasion to reduce the risks of harm and injury [6,7].

Sex- and gender-based analysis

Sex- and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

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3. **Diversity** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.

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Sex issues

Women may be particularly vulnerable to the effects of alcohol due to their body size, genetics and life circumstances [9]. Because women often have smaller body size and weigh less than men, they reach higher blood alcohol levels than men for the same quantity of alcohol consumed. Women also tend to have less water in their bodies to dilute alcohol, which makes the blood alcohol concentration higher. Additionally, it has been found that women have less alcohol-metabolizing enzyme (gastric alcohol dehydrogenase) that breaks down alcohol in the stomach [9,10]. As a result, women's alcohol absorption may be slower [11] and more alcohol absorbed in the bloodstream and sent to the brain. Research also suggests that women may "experience a more rapid progression to addiction or dependence on alcohol than men" [9].

Gender issues

Some women report using alcohol and other substances to cope with problems, stress and to increase confidence. It has been suggested that women may have more stressors due to their high workload associated with family responsibilities, caregiving and other unpaid, domestic labour as well as paid labour, which could affect their drinking behaviour [11].

Girls and women are also more likely to experience physical and sexual abuse, which has shown to be associated with substance use. Women's alcohol use is heavily stigmatized, especially among pregnant women, which may prevent women from seeking care [12].

Diversity issues

Women living with high income are more likely to be daily drinkers than women in lower income groups. Heavy drinking is more common among younger women, never married women, Aboriginal female youth and women living in Quebec and the Atlantic provinces, compared to other areas in Canada [2]. Women who have unstable housing or who are homeless may be at particular risk of heavy alcohol use and other risks associated with their substance use.

Equity issues

Women in high socioeconomic groups tend to drink more frequently but are often considered light-to-moderate drinkers, while women in lower socioeconomic group tend to engage more in heavy drinking. These patterns of consumption among groups with lower socioeconomic status tend to result in a higher burden of alcohol-attributed disease even though overall alcohol consumption may be lower than among women with a higher socioeconomic status. These health inequities may be further exacerbated among women if they are viewed more negatively for having alcohol problems and/or receive less attention from health professionals regarding potential alcohol problems [13].

Critique

The pan-Canadian low-risk drinking guidelines have considered the differential impact that alcohol may have on women and men but before these guidelines were created, measures of alcohol use and heavy drinking were identical for men and women, a practice that ignored a number of important biological and social differences between men's and women's alcohol use patterns.

The emergence of a dialogue and guidelines targeted specifically to women's alcohol use is a promising direction in alcohol and health policy.



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Women and Healthy Living in Canada

Fact Sheet Number 5 Fall 2012

CONDOM USE

RETHINKING WOMEN AND HEALTHY LIVING IN CANADA

Rethinking Women and Healthy Living in Canada: Challenging the Discourse, Evidence and Practice examines the sex, gender, diversity and equity dimensions of healthy living among women in Canada by conducting sex- and gender-based analyses of the healthy living discourse, key healthy living topics and selected healthy living strategies.

Fact sheets on women and healthy living have been prepared on physical activity, sedentary behaviour, self-injury, food insecurity, sodium, tobacco, alcohol, sexual behaviour and condom use.

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Most women in Canada who are at risk of acquiring sexually transmitted infections use condoms. However, many women find it difficult to negotiate safer sex and condom use with their partners, pointing to a need for greater sexual equality for women.

Condoms are widely available and inexpensive contraceptives that also provide the best available barriers to sexually transmitted infections (STIs), such as chlamydia, gonorrhea, syphilis and HIV [1]. Preventing STIs is critical because viral and incurable infections (as well as the occurrence of bacterial STIs) have been steadily increasing in Canada [2]. Condoms are the only barrier protection against HIV transmission during vaginal and anal intercourse [1]. Male condoms are most commonly available and used for mutual protection in vaginal and anal intercourse and are sometimes used by partners for oral sex. When used correctly, male condoms are 87%-98% effective in preventing pregnancy. Female condoms have been available for some time in North America and are the most effective women-controlled prevention against STIs.

Sex- and gender-based analysis

Sex- and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

1. **Sex** refers to the biological characteristics that distinguish male from female bodies. Sex differences include different chromosomal patterns, reproductive organs, hormones and proportions of fat to muscle.

2. **Gender** refers to socially constructed roles, relationships, attitudes, behaviours, relative power, etc., that shape and describe what it means to be male or to be female in a society.



3. **Diversity** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.

4. **Equity** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [3].

Sex issues

Fewer than half of women report using condoms as their primary form of contraception, although 31% of women aged 18-19 and

34% of women aged 20-24 reported using condoms as their birth control of choice [4]. Young males (15-24) were less likely to report using a contraceptive. About one-third of young adults in Canada have had sex with more than one partner in the past year [2, 5]. In Canada, fewer than 35% of women at any age between 15 and 49 who were at high risk for STIs (users with more than one sexual partner in the past 12 months) reported using a condom during the last time they had sexual intercourse [4]. In every age group, women were less likely to report using a condom during last intercourse than men. For females, but not for males, earlier first intercourse was associated with reduced likelihood of using condoms [2, 5].

Gender issues

Condoms as the primary choice for contraception declines as women get older, which presumably coincides with women being in more stable relationships where the risk of disease transmission is lower. Despite their effectiveness as contraceptives and in preventing STIs and HIV/AIDS, many women considered high risk for STIs do not use condoms, particularly after the age of 25. Women may not be able to negotiate safer sex and condom use because men decide whether or not a male

condom is used. Power differences and potential or real threats of violence may prevent women from protecting themselves [6, 7]; condom use can often be a point of contention between partners [8]. Female condoms have not been well received by women because they are difficult to use and expensive [9].

Diversity issues

Young women with more education and more income were more likely to report regular use of condoms. Condom use declines dramatically with age. Women over 30 years with more than one sexual partner in the past year were half as likely to use condoms as women aged 15 to 29 years [2, 4]. Older women may be more likely to believe that they are not at risk from unprotected sex. Fewer women used condoms in 2002 (18%) than in 1995 (25%) [10]. The decline in condom use was not accompanied by increased abstinence nor was it balanced by corresponding numbers of women and their partners testing for STIs. However, the prevalence of sexually transmitted infections - including chlamydia, gonorrhoea, syphilis and HIV/AIDS - has increased [2, 4, 10]. A survey of injecting drug users found that women varied in their use of condoms, depending if their sexual encounters were with regular partners, casual partners or paying clients [11]. Women in the sex trade, women who engage in survival sex and others who are vulnerable to poverty and violence are disproportionately likely to acquire HIV although specific rates of condom use in these populations is unknown.

Equity issues

Women with more education have a greater likelihood of using condoms during high-risk encounters, particularly women with at least some post-secondary education [3]. Researchers have found that young women and men were less likely to engage in risky behaviour if they were motivated to pursue their education [12]. As noted, women's ability to negotiate condom use can be compromised by threats of violence and other power differences with their partners. Early tests of an "Invisible Condom", an applicator with spermicidal gel, have been favourable [13]. If it becomes commercially available it

may be an effective contraceptive and preventative for women whose male partners refuse to wear a male condom [13].

Critique

Survey data available on contraceptive use, and condom use specifically, are limited, despite the fundamental importance to individual and population health. The Canadian Community Health Survey asked about contraceptive use among 15-24 year olds but only asked high-risk survey respondents under 50 years of age about condom use [14]. Given that condom use declines with age, while the risks of unprotected sexual intercourse remain unchanged across the life span, it would be valuable to ask about unprotected high-risk sex among all respondents [2, 4]. Other limitations to the survey include that respondents may only have replied about male condom use, "sexual intercourse" was not defined in the question, and respondents who are asked about personal behaviour may not be fully forthcoming about high risk behaviour [15].



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Women and Healthy Living in Canada

Fact Sheet Number 6 Fall 2012

RETHINKING WOMEN AND HEALTHY LIVING IN CANADA

Rethinking Women and Healthy Living in Canada: Challenging the Discourse, Evidence and Practice examines the sex, gender, diversity and equity dimensions of healthy living among women in Canada by conducting sex- and gender-based analyses of the healthy living discourse, key healthy living topics and selected healthy living strategies.

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SEXUAL BEHAVIOUR

Most women in Canada are sexually active and in a variety of ways. Sexual norms and double standards persist but education programs have not necessarily kept up.

Healthy sexuality and sexual health are both components of healthy living, as well as access to contraception (e.g., condoms), prevention of sexually transmitted infections (STIs) and HIV/AIDS, and deciding when and how to be sexually active.

Canadian sexual behaviour data are fairly limited as the focus of national health surveys is on risky behaviours related to STIs and HIV/AIDS and only women under the age of 50 were surveyed [1]. Although women's definitions of being sexually active vary [2], most women in Canada report being sexually active with over 80% of women 20 years and older reporting having ever engaged in sexual intercourse [1]. The Public Health Agency of Canada (PHAC) is developing a new survey on sexual health and healthy sexuality, which will provide additional information on sexual behaviour for Canadians [3].

Sex- and gender-based analysis

Sex- and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

1. **Sex** refers to the biological characteristics that distinguish male from female bodies. Sex differences include different chromosomal patterns, reproductive organs, hormones and proportions of fat to muscle.

2. **Gender** refers to socially constructed roles, relationships, attitudes, behaviours, relative power, etc., that shape and describe what it means to be male or to be female in a society.

3. **Diversity** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.



4. **Equity** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [4].

Sex issues

Most women report engaging in sexual behaviours, but a number of health issues (e.g., anxiety, depression, diabetes, hypertension) may affect women's sexual desire and subsequent levels of sexual activity [5]. Younger women with chronic heart disease exhibit lower rates of sexual behaviour compared to healthy peers [6]. Women who have recently given birth may be cautious about resuming sexual intercourse, including feeling

concerned about healing, discomfort, sleep disruption, and general fatigue [7]. Changes in estrogen levels during menopause may affect women's enjoyment of sex [5].

Gender issues

Young women report that they are judged more harshly than young men if they transgress the sexual norms of their social circles [8]. A recent study of young women found that sexual compliance (defined as willingly engaging in sexual activity that one does not desire) is a common behaviour among young people in committed relationships [9]. Negotiating condom use may be difficult for many women due to fear of violence and concerns that a partner may become suspicious about a woman's HIV serostatus or STI infections [10]. In one study, women with older partners (>4yrs older) were more likely to report sexual behaviours that were risky [10].

Diversity issues

In a study of US young women, a significant portion of straight-identified youth reported engaging in some type of same-sex activity [11]. Sexual minority youths (who identify themselves as gay or lesbian, bisexual, or unsure of their sexual identity) may be less likely to use condoms or other birth control methods [12]. Sexual minority female adolescents have a significantly higher odds ratio of



having an STI than female adolescents who are attracted only to males [14].

More than 1 in 4 female adolescents aged 15-17 in Canada reported having sexual intercourse in the previous year although the proportion of sexually active teens varied across the country [1]. The potential risks for 15 years olds are mainly linked to the emotional characteristics of this developmental stage [15]. A number of American studies confirm that drinking alcohol precedes unplanned sexual intercourse among young women [16]. Alcohol use may be more likely to be a factor in new, compared with repeat, sexual behaviours [16].

Most women reported having one sexual partner in the previous 12 months in the 2009/2010 CCHS, which did not differ by income, geographic location or education level [1]. Women who are intravenous drug users may have multiple partners if they are trading sex for survival, including for housing and drugs. One reason women give for their involvement in sex work is the lack of other employment and education opportunities.

Older women's sexual activity may be restricted due to a lack of same-age partners.

Equity issues

Street-involved youth participate in more sexually risky behaviours than their peers who are not homeless [17]. Women in Vancouver who lived on the streets or were street-involved were pressured into having unprotected sexual intercourse for a number of reasons, such as working away from the main streets because of fear of police, borrowing used crack pipes, violent clients, and servicing clients in public spaces or cars [18].

Women with higher levels of education may have greater confidence to negotiate condom use with their partners [19]. One study found that young women were less likely to use condoms if they were getting low grades in school, English was not their first language, or they were part of a visible ethnic group [20].

Critique

Data on the sexual activity of women aged 50 years and older are limited, as the focus of national surveys has commonly been on

risky sexual behaviours among young people. Exploring society's broader views on various sexual behaviours and their relation to sexual health will allow researchers to move beyond outcomes that are based solely on individual behaviours, characteristics, and qualities [21]. The new survey from PHAC may provide research on some of these issues [3]. Exploration of policies and attitudes regarding sexual violence, adolescent sexual expression, and the "risks" of sexual behaviours among older women is needed. Sexual and reproductive health education programs that include information on relationships and present sex in a positive light, rather than only inherently risky, may be the most beneficial for all ages .



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Women and Healthy Living in Canada

Fact Sheet Number 7 Fall 2012

RETHINKING WOMEN AND HEALTHY LIVING IN CANADA

Rethinking Women and Healthy Living in Canada: Challenging the Discourse, Evidence and Practice examines the sex, gender, diversity and equity dimensions of healthy living among women in Canada by conducting sex-and gender-based analyses of the healthy living discourse, key healthy living topics and selected healthy living strategies.

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Learn more at www.womenshealthdata.ca



FOOD INSECURITY

In low income households, food expenditures can be constrained and healthy foods may be sacrificed for lower cost (and unhealthy) foods.

Food insecurity was originally defined as the simple lack of adequate amounts of food, but it is now understood as a broader concept that includes lack of access to high quality and quantities of food as well as worry about having enough food. Health Canada considers households to be experiencing food insecurity if “at times during the previous year, these households were uncertain of having, or unable to acquire, enough food to meet the needs of all their members because they had insufficient money for food” [1]. The Canadian Community Health Survey (CCHS) focuses on income in its definition of food insecurity, determining that households being unable to afford adequate food during the previous 12 months are food insecure.

According to the 2007-2008 CCHS, approximately 6.6% of women in Canada live in food insecure households [1]. Of these women, 4.2% experience mild food insecurity (insecurity without hunger), 2.0% experience moderate food insecurity (insecurity with moderate hunger), and 0.4% experience severe food insecurity (insecurity with severe hunger).

Sex-and gender-based analysis

Sex-and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

1. **Sex** refers to the biological characteristics that distinguish male from female bodies. Sex differences include different chromosomal patterns, reproductive organs, hormones and proportions of fat to muscle.



2. **Gender** refers to socially constructed roles, relationships, attitudes, behaviours, relative power, etc., that shape and describe what it means to be male or to be female in a society.

3. **Diversity** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.

4. **Equity** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [6].

Sex issues

Food insecure women are more likely to experience both poor physical health (e.g., nutrient deficiencies, heart disease, high blood pressure, cancer) [2-4] and mental health (e.g., stress, depression, anxiety) [5-6]. Food insecurity is particularly risky for women with pre-existing chronic conditions that require special diets for health management, such as diabetes [7-8].

Gender issues

In many cultures and societies, women are responsible for food, including planning, purchasing, and preparation [9]. As a result, women are often blamed when diets are inadequate and they will often cope with food insecurity by compromising their own diets in order to feed their children [3, 10, 11].

Mothers living in low-income households typically eat last and eat food of lower quality [3]. Lone parent households (most often led by women) have the highest rates of food insecurity in Canada [1]; over 20% of lone mothers experience food insecurity.

Diversity issues

Lone mothers, Aboriginal women, visible minority women, immigrant women, and senior women in Canada are at particular risk of low income and thus, food insecurity [1, 12].

Aboriginal women living off-reserve in Canada experience over twice the rate of mild food insecurity, over three times the rate of moderate food insecurity, and over four times the rate of severe food insecurity compared to non-Aboriginal women [13]. In Arctic Canada, the affordability of grocery store food and accessibility to hunting and fishing are major factors affecting Aboriginal women's food security as well as overall cultural health and survival [14-15].

Equity issues

Low income is associated with a variety of social inequities and food insecurity is one result of these inequities. Women are more likely than men to experience poverty and lone mothers, Aboriginal women, visible minority women, immigrant women, and senior women in Canada are at particular risk of low income due to marginalization and discrimination [12]. Women living on low income may have poor access to healthy food options as these are often more expensive than unhealthy food. In Canada, it has been found that women whose household income falls in the lowest income quintile experience food insecurity rates more than twice the national averages. Food budgets for low income individuals can often be the only flexible part of their budgets, therefore food expenditures can be constrained [4] and healthy foods may be sacrificed for lower cost (and unhealthy) foods [18].

Critique

Women experiencing food insecurity report that they often know what constitutes a healthy diet, but simply do not have the resources for or access to healthy foods. Healthy living strategies tend to present a healthy diet as a choice that is within the reach of anyone and everyone in Canada, but for women in food insecure households, healthy "choices" are not an option. Promotion of policy reform at local, regional, and national levels that will lessen economic constraints on low-income households has been proposed as a direction for combating food insecurity [19].

The CCHS focuses on income-related food insecurity, which is critical, but it ignores

other influences, such as rural, remote, and suburban living, distribution of income within households, and the costing and quality of foods available. This kind of data would help to provide a more nuanced understanding of food insecurity in Canada.



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Women and Healthy Living in Canada

Fact Sheet Number 8 Fall 2012

RETHINKING WOMEN AND HEALTHY LIVING

Rethinking Women and Healthy Living in Canada: Challenging the Discourse, Evidence and Practice examines the sex, gender, diversity and equity dimensions of healthy living among women in Canada by conducting sex-and gender-based analyses of the healthy living discourse, key healthy living topics and selected healthy living strategies.

Fact sheets on women and healthy living have been prepared on physical activity, sedentary behaviour, self-injury, food insecurity, sodium, tobacco, alcohol, sexual behaviour and condom use.

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SELF-INJURY

“I think all, every woman, our feelings all stem from the same. It’s hurt. It’s a loss of control. It’s hopelessness. And however you self-injure, it’s all just coping mechanisms”
(Study participant)

Non-suicidal self-injury (NSSI) refers to bodily injury without the purpose of suicide, but results in tissue damage [1]. According to the Canadian Institute for Health Information (CIHI), the primary mode of NSSI is poisoning (85%), followed by cutting/piercing (10%), and suffocation/strangulation (2%) [2]. Small scale studies continue to identify cutting, scratching and burning as common forms of NSSI [3]. In Canada, in 2009/2010, approximately 140 women per 100,000 were hospitalized for NSSI [2]. Although these rates appear to have decreased over the last decade by about 15% [4], hospitalization rates do not record those who are not admitted to hospital for their injuries. It is estimated that NSSI data may be underestimated by about 60% as emergency department data is often coded as “un-determined” [5].

Sex-and gender-based analysis

Sex-and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

1. **Sex** refers to the biological characteristics that distinguish male from female bodies. Sex differences include different chromosomal patterns, reproductive organs, hormones and proportions of fat to muscle.

2. **Gender** refers to socially constructed roles, relationships, attitudes, behaviours, relative power, etc., that shape and describe what it means to be male or to be female in a society.

3. **Diversity** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.



4. **Equity** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [6].

Sex issues

The onset for self-injury among females is typically between the age of 14 and 24 years [3]. According to hospitalization data from 2009-2010, 58% of self-injury hospitalizations were for

females [2]. Self-injury among women is more likely to result in inpatient hospitalizations and emergency department visits than for men [2, 7]. Women are more likely to engage in self-injury, whereas men are more likely to complete suicide [2]. The rate of self-injury among those with mental illness comorbidities is common [2], however, some researchers have identified the importance of viewing self-injury as a coping response to certain social contexts rather than as symptom of any particular disorder [8].

Gender issues

Emergency department visits for cutting/piercing or poisoning injury are more likely to be coded as self-injury in women compared to men of the same age group (under 65 years) [5]. Between the ages of 12 and 17 years, the number of self-injury cases among females was more than four times (1,536) the number of male cases (368).

In addition to a history of mental health issues, self-injury may be the result of stressful life events, an environment characterized by abuse or low self-esteem, family or friends' suicides or self-harming, and/or difficulty with interpersonal relationships (e.g., social isolation) [9, 10].

A history of abuse or other invalidating experiences may result in low self-esteem and

self-loathing for women, which have been identified as important factors in self-injury.

As a result of feeling powerless, women may engage in self-injury to gain a sense of control. Women have talked about self-inflicted injury as a way to cope in a life over which they otherwise have little equality [9].

Diversity issues

Adolescence is a particularly sensitive period during which self-injury may begin due to societal pressures to fit in with peers and/or general difficulties with family, friends or school [7, 8].

Rates of self-injury vary from province to province, with lower provincial rates in 2009/2010 in Prince Edward Island (55 per 100,000) and Ontario and Manitoba (58) compared to New Brunswick and Newfoundland and Labrador (81). Compared to the provinces, self-injury rates were substantially higher in the Yukon (192) and Nunavut (379) [4].

According to data from CIHI, individuals from less affluent neighbourhoods have twice the rates of self-injury compared to individuals from affluent neighbourhoods [2].

New forms of social media may provide a manner for women to communicate and compare their self-injuries via blogs and videoblogs [11] which may glamorize the behaviour(s). In one study, 15% of participants stated that their self-injury was motivated because of television and/or movies [3].

Equity issues

Self-inflicted physical pain may give women a sense of power in light of the powerlessness they feel in the rest of their lives. A history of sexual or physical abuse is common among women who engage in self-injury. Engaging in self-injury may help women cope with the stress and emotional pain of past or present distressing or oppressive conditions in their lives. Punitive methods and approaches to women who engage in self-injury may further exacerbate the women's distress levels and lead to additional self-harming behaviour.

Women from low income neighbourhoods may exhibit high rates of self-injury due to additional stressors, such as violence and family poverty, which may also contribute to women's overall feelings of powerlessness [2].

Critique

The National Ambulatory Care Reporting System (NACRS), which tracks emergency department data and can provide useful information on self-injury, has not been implemented across Canada. Further, Canada does not have a national strategy to address self-injury [2]. Implementation of such a strategy and using the NACRS would help identify and track self-injury related behaviour more effectively and help improve the existing research and subsequent prevention education on self-injury in Canada. In particular, additional education and awareness is needed for various health care professionals (e.g., family physicians) as women often seek out health services prior to presenting for acute medical care as a result of self-injury.



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FOR MORE INFORMATION

BC Centre of Excellence for Women's Health:
www.bcccewh.bc.ca

Atlantic Centre of Excellence for Women's Health:
www.acewh.dal.ca

Prairie Women's Health Centre of Excellence:
www.pwhce.ca

The Source:
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Fact Sheet Number 9 Fall 2012

SODIUM CONSUMPTION

Most women in Canada consume eight times the dietary requirements for sodium. Much of the salt in their diet comes from processed and pre-packaged foods, making it a challenge to reduce the salt content in their diets.

Sodium chloride (NaCl) is predominantly consumed as table salt that is present in processed food or added during food preparation [1]. Only a small portion of sodium is consumed from adding salt to foods during mealtimes. Many people who report eating foods already high in sodium report adding extra salt to their food [2]. Although a small amount of sodium is required for cellular metabolism, many Canadians exceed recommended daily sodium intake levels.

Specifically, most women and girls are consuming 75% more than the recommended upper sodium intake levels [2].

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cardiovascular diseases [5-8]; osteoporosis [9-11]; kidney stones and kidney disease [7, 11]; stomach cancer [11], and severe asthma [5,12]. Additionally, Canadians do not get enough potassium (found in fruits, vegetables, dairy products), which works in tandem with sodium to regulate metabolism and fluids [13] and may be implicated in hypertension.

Gender issues

According to data from the 2009-2010 Canadian Community Health Survey (CCHS), 60% of women reported that knowledge of salt content influences their food choices [14]. Women's food choices may subsequently affect the food their families consume given that women are often responsible for planning, purchasing, and preparing food for their families [15]. Using less healthy pre-packaged foods for meal preparation may be a convenient, less expensive option for many women.



Sex issues

The diets of Canadian women mirror those of many other high-income countries: a calorie-rich diet that is deficient in essential nutrients [4]. Excessive salt is associated with hypertension and

Diversity issues

The amount of sodium contained in women's diet increases with age, particularly during the teen years and at age 40 and older [14]. In a detailed analysis of data from the 2004 CCHS, adults (between the ages of 50 and 69)

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diagnosed with hypertension had higher salt intake compared to matched age controls without hypertension [16].

For Inuit women, traditional diets (when available and feasible) provide women with more protein and protein-related micronutrients and a lower intake of saturated fats, carbohydrates, and sodium [17].

Equity issues

“Food deserts” (city areas with few or no grocery stores) may be problematic for women with low income who lack regular access to stores where fresh groceries are readily available [18]. Fast food restaurants and/or small expensive local grocers may be the only local option for these women, resulting in them frequenting convenient and less expensive places to shop, with fewer healthy food choices available. Urban women, who have access to large grocery shops with fresh produce, may have more healthy food choices when it comes to reduced salt content .

Critique

Adequately measuring sodium consumption is difficult given that many pre-packaged foods contain varying levels of sodium. The 2004 CCHS, which focused on nutrition, asked individuals about their efforts to reduce salt intake, but did not measure whether or not people add salt to their food while cooking or at the table. Nationally representative research is required to further examine Canadians’ sodium consumption behaviours.

There are many reasons why it is not possible for individual women to consistently make healthy food choices. Additional research on these food choices could be used to create female-specific messaging and healthy eating education programs regarding sodium consumption.



FOR MORE INFORMATION

BC Centre of Excellence for Women’s Health:
www.bccewh.bc.ca

Atlantic Centre of Excellence for Women’s Health:
www.acewh.dal.ca

Prairie Women’s Health Centre of Excellence:
www.pwhce.ca

The Source:
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