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OVERCOMING SYSTEMIC BARRIERS TO ACCESS IN ACTIVE LIVING*

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The Centre for Sport Policy Studies (CSPS), in the Faculty of Kinesiology and Physical Education at the University of Toronto, is engaged in empirically-based research in the service of sport policy, monitoring and evaluation studies, and education and advocacy for the two most important ambitions of Canadian sport: 'sport for all' (widespread grassroots participation) and healthy high performance in elite-level sports. The Working Papers represent an important part of the work of CSPS.

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CSPS WORKING PAPER NO. 1:
Editor's Introduction

Although this paper preceded the foundation of the Centre for Sport Policy Studies (CSPS) in 1999, it is work that, in many ways, led to the formation of the CSPS and the Research Centre for Sport in Canadian Society (RCSCS) under the Directorship of Jean Harvey. The two research Centres were the first of their type in Canada, and the work outlined in this paper continues to inform at least part of the work of the two Centres.

The 1996 discussion paper, prepared under contract for the Fitness Branch, Health Canada and Active Living Canada, represents the first comprehensive review in Canada of 'barriers' to participation in physical activity, together with a series of recommendations for overcoming those barriers. In more up-to-date terminology, it may be better to think of those barriers as *social determinants of (non)participation*.

Since the paper was first written two major things have happened. First, research continues to affirm that the barriers identified by Donnelly and Harvey still exist. Second, there is now widespread evidence of declining rates of participation and the increasing incidence of diseases related to inactivity in Canada. The evidence and recommendations presented in the paper still stand, and they only await the political will to overcome barriers to participation.

Editor's Introduction, May 2011

CONTENTS

1. INTRODUCTION

Introduction

There is a now a large body of knowledge identifying systemic barriers to access in education and in the workforce – barriers that contribute to the reproduction of poverty, crime, and other social problems. Such barriers may take the form of tangible discrimination, based on ignorance and / or prejudice. They may result from limitations based on cost, transportation, or physical access. But frequently, and in their more subtle form, barriers tend to be based on the assumption that all individuals have a similar background – which results, for example, in the provision of similar educational opportunities to children from enriched middle class homes and those from homes where there are no books, computers, or educational toys, and where even the level of nutrition may be compromised; or which results in the assumption that all individuals, no matter what their class or heritage, will feel comfortable in surroundings where white, middle class norms prevail. Faced with such barriers, many individuals will naturally assume that they do not belong in such surroundings, or that they have no chance of success in a system where they are treated in the same way as those from more privileged backgrounds; and, they may begin to act in ways that confirm prejudices and actually begin to conspire in their own subordination. The cycles of poverty and unemployment, the reasons that “working class kids get working class jobs” (and middle class students tend to move into middle class careers) (Willis, 1977) despite their apparently having the same educational opportunities, are a consequence of such systemic barriers. This foundation paper represents a preliminary attempt to begin to understand such systemic barriers to involvement in physical activity.

Purpose and Scope

The purpose of this foundation paper is to begin to develop an understanding of the ways in which systemic barriers may work to prevent access to active living. Given:

- the growing understanding of the importance of physical activity to the overall health of Canadians,

- the potential cost-saving to health care systems, and other positive benefits to the economy and community that may result from improvements in the health status of Canadians, and
- the growing awareness of the existence of systemic barriers which restrict access to work and education opportunities,

it is important to begin to understand the ways in which such systemic barriers to active living might account for survey results showing limited levels of physical activity among Canadians.

Active living is defined as “a way of life in which physical activity is valued and integrated into daily life” (Fitness Canada, 1991, p. 4). “Active living encourages Canadians to be active in a way that suits their schedules, personal interests, needs and abilities. Thus a wide array of physical activity [may be included]: formal exercise programs, leisure-time pursuits such as walking and dancing, recreational and competitive sport participation, domestic activity such a gardening, housework, as well as paid physical labour” (O’Brien Cousins, et al., 1995, p. 23).

The notion of systemic barriers is developed in Chapter 2, where we propose a model incorporating *infrastructural*, *superstructural*, and *procedural* barriers. In Chapter 3 we review a number of studies and reports identifying various systemic barriers to active living for various populations classified according to social class (including ‘youth at risk’), heritage, age (including both youth and aging populations), gender, and different abilities. The systemic barriers for these populations are charted according to the model developed in Chapter 2, and a general, overlapping category of systemic barriers is developed. Chapter 4 provides a series of recommendations based on the model that has been developed, and on the systemic barriers identified and classified according to the model.

Importance of Access

Numerous studies have demonstrated a variety of benefits that result from being

involved in physical activity; a few studies have shown some negative consequences of such involvement; and several studies have produced equivocal results. The most comprehensive examination of the benefits of physical activity has recently been produced by Craig, Russell and Cameron (1995). In their in-depth review of the research in this area they note the benefits of exercise for:

- ***General Health*** – reduced risk of premature death; reduced absenteeism; increased general health status
- ***Biological Health*** – beneficial effects of exercise for coronary heart disease, diabetes, several types of cancer, back problems, osteoporosis, high blood pressure, and obesity
- ***Mental Health*** – physical activity may reduce anxiety, stress and depression, and increase emotional well-being and satisfaction
- ***Community Health*** – physical activity may reduce juvenile delinquency and other forms of crime and substance abuse, and increase productivity
- ***Human Development*** – exercise may improve self-esteem and self-efficacy, and increase learning and cognitive function.

The relevant parts of the Executive Summary of the report are reproduced in Table 1.

Table 1. The Benefits of Active Living: Reducing the Risks of Sedentary Living

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1. Reduced risks of premature mortality and disease:

- Risk decreases as activity level increases
- One hour of moderate activity spread over the course of the day adds as much as two years to men's lives
- Risk of coronary heart disease decreases if physical activity of even a low to moderate level is performed regularly
- The risk of cardiovascular disease is up to three times greater for persons with

diabetes; physical activity helps to reduce this risk

- Risk of developing Type II diabetes is reduced; protective benefits is highest for those persons most at risk – those with high body mass index, history of arterial hypertension, or a family history of diabetes
- Reduced risk of colon cancer, and possibly the risk of breast cancer and lung cancer
- Reduced risk of back problems; back problems are related to sedentary living, infection and rheumatoid disease; being moderately active at work reduces the risk of lower back problems; the risk is higher among those performing heavy physical work
- Reduced risk of osteoporosis; active people have greater bone mass than inactive people; regular weight bearing or resistive exercise is essential for bone health
- Reduced risk of obesity, a key risk factor in coronary heart disease

2. Reduced acute health problems:

- Those who are inactive report more reductions in daily activities as a result of acute health problems
- Those who are inactive in their leisure time are more likely to report days lost at work
- Those who have low fitness levels may lose up to 2.5 times as many days off work as their very fit counterparts
- Trunk flexion and pelvic tilt exercises reduce the recurrence of acute lower back problems

3. Reduced mental health problems:

- Reduced anxiety and stress
- Reduced depression
- Increased psychological well-being
- Positive association with a person's satisfaction with their physical shape, appearance and weight

- For older adults, regular physical activity including interaction with others is more likely to increase life satisfaction, owing to increased feelings of social integration

4. Increased economic activity:

- Reduced absenteeism
- Significant savings; even slight decreases in days off work attributable to becoming more active can lead to significant savings across the entire workforce
- Increased productivity
- Reduced turnover, hiring and training costs
- Reduction in accidents

5. Enhanced human development:

- Increased self esteem; self esteem is positively associated with better adjustment, less defensive behaviour, less deviant behaviour, and general well-being
- Positively affects self-efficacy; physical activity influences individuals' perceptions of their physical capabilities and personal efficacy
- Moderate to high association between academic performance and motor performance; physical education is associated with academic performance – students with high grade point averages perform better on selected physical skill tests – and those with daily aerobic programmes tend to have higher levels of reading, language and mathematics than those without
- Positive effect on the cognitive skills of children with learning disabilities • possible improvement in, or maintenance of, cognitive-neuro psychological functioning in aging

Adapted from: Craig, Russell & Cameron, (Executive Summary), 1995, pp. 1-2.

The numerous, almost miraculous claims for the benefits of physical activity lead us to wonder why it has not been patented by an innovative company. Such widespread

claims should serve as a warning that the claims need to be accepted with caution, and that the context of the claims needs to be examined carefully. It should be borne in mind that the Ontario report is a highly selective analysis of literature, conducted with the specific aim of identifying studies that show the positive benefits of physical activity. And while each of the topics identified by Craig, et al., includes reflections on "qualifications and limitations of the current data" and "research gaps," there are a number of other qualifications that must be noted:

- In some cases, while there appears to be a relationship between physical activity and some attribute, the cause is not apparent (i.e., the mechanism by which physical activity may have such an effect)
- This inability to interpret the way in which physical activity might have an effect may be a result of the effect being caused by an intervening or co-acting factor - e.g., there is a strong positive relationship between social class and health status and longevity, even for inactive individuals; there is also a strong positive relationship between social class and involvement in physical activity; few studies have included clear controls for social class
- In some cases the direction of effect is not apparent – for example, do people who are physically active gain more self esteem, or are people with high self esteem more likely to be physically active?
- In many cases the effects of physical activity, while statistically significant, are not strong – e.g., in the best study of the relationship between physical activity and psychological well-being (McTeer & Curtis, 1990), a positive relationship was found for men but not for women; and, even for men, physical activity only accounted for approximately 5% of the variance in psychological well-being
- Everyday experience suggests that health status and cognitive ability are the result of a great deal more than physical activity – we can all think of inactive but healthy individuals, and active but unhealthy individuals; and we can also think of inactive individuals with a great deal of cognitive ability, and active individuals with rather low cognitive ability
- The Ontario report has not taken into account a number of partial results (e.g.,

positive findings limited to a particular gender or social class) (e.g., McTeer & Curtis, 1990); has not addressed some equivocal results (e.g., regarding the relationship between physical activity and juvenile delinquency) (e.g., Snyder, 1994); and has not reviewed some contradictory results (e.g., the cardiovascular benefits but musculoskeletal costs of physical activity) (e.g., Lüschen, et al., 1996)

Despite these qualifications, it is apparent that there are positive benefits to be derived from physical activity, but that the relationship between those benefits and physical activity is far more complex than we might have expected.

Similar qualifications must be applied to estimates of the economic effects of increased physical activity. In a recent Ontario study (Staines, Prince & Oliver, 1995) an attempt was made to determine the economic impact of an increase in participation rate in physical activity to 58% (from the current 33%). The microeconomic impact was determined as follows:

- Government health costs would have been $778 million lower in 1995
- The number of person-years lost to death and disability in 1995 would have been lower by 5,653 (0.07% of the population of Ontario)
- Labour productivity in the whole economy would have increased between 0.25% and 1.5% in 1995
- Local government expenditures related to physical activity would have been $237 million higher in 1995

(Adapted from: Wood (Executive Summary), 1995, p. 1).

Not only are these estimates based on the unqualified assumptions of the type of work reviewed by Craig, Russell & Cameron (1995), but they also introduce a new set of assumptions (e.g., that health care costs are patient costs rather than physician and system costs; that increased attendance at work leads to an increase in productivity,

etc.). It is far more likely that the economic impact would be real, but rather less amenable to measurement. If increased physical activity leads to an increased quality of life, it is likely that such a change would have a powerful positive impact on the economy.

A Note of Caution

It is apparent that there are significant public health benefits to be derived from increasing the activity level of the population. But there are several caveats to be borne in mind when developing a strategy for increasing activity levels:

- It is extremely important not to overstate the benefits of exercise (people are well aware that exercise is not the universal panacea, and overstating the benefits may lead people not to believe any of the benefits);
- There are clear limits to the use of fear as a strategy for encouraging people to become more active (e.g., "if you don't exercise you will die of a heart attack!"), and there are clear limits to the medicalization of exercise; these strategies have not worked very well in the cases of exercise prescription[1] or smoking and they are, in the final analysis, victim-blaming strategies;
- There are some clear indications that the social benefits of exercise may be at least as significant in terms of public health as the psychological and somatic benefits; these should not be underestimated in any strategies to increase participation in physical activity;
- A strategy for increasing the activity level of the population cannot be conceived in isolation from other public health strategies, and it is doomed to failure if that is the case; in other words, attempts to encourage individuals to increase their activity levels must take into account all of the circumstances of their lives – nutrition level, homeand work environments, etc.

This report is concerned with systemic barriers to involvement in physical activity, and with overcoming those barriers. The tangible barriers – cost, transportation, access to facilities, programme development, security, etc. – although involving some expense to

overcome, may in fact be easier to eradicate than those existing in the minds of individuals, but are a consequence of the structures in which they live. For example:

- Feeling that physical activity is inappropriate or undignified for a person of one's age, heritage, or gender,
- Feeling that one is not competent or able to participate,
- Feeling or fear that exercise might promote illness or injury (e.g., heart attacks, falling, etc.),
- Feeling that because of one's size, appearance, religious beliefs, skin colour, etc., one cannot comfortably show one's body in an exercise situation.

While these points have been expressed in terms of individual attitudes and feelings, this should not be taken as evidence that we are advocating an individualistic-psychologistic approach. Such attitudes and feelings are a powerful expression of social constructs and circumstances (e.g., social myths, and various forms of discrimination and prejudice) that have a powerful impact on individual feelings and actions (cf., C. Wright Mills (1959) notion of "personal troubles and public issues"). As Mills notes, "We study the structural limits of human decision in an attempt to find points of effective intervention, in order to know what can and what must be structurally changed if the role of explicit decision in history-making is to be enlarged" (1959, p. 174). This approach leads to the clear understanding that, as Labonté (1995, p. 166) states, strategies for health promotion must begin by "starting where the people are" – geographically, physically, socially, and mentally – and not by imposing them from above. These caveats and conditions guide the recommendations made in this foundation paper.

Notes

1. There is an ongoing debate among exercise physiologists and fitness specialists regarding the regimentation and medicalization of exercise, and the threshold levels for obtaining optimal health benefits from exercise (i.e., three times per week, 20 minutes per time, at 70% maximum heart rate). Those aware that such a prescription has done little to change the exercise habits of the population have begun to advocate a programme of active living in which a minimal level of exercise is considered to be of more benefit than remaining sedentary. The former are concerned that minimal levels of exercise will be considered sufficient, while the latter insist that people must begin to become active before they can work up to the optimal level. Unfortunately, this debate tends to isolate exercise from the wider social structures in which people live. This discussion paper, while closer to the active living position, shows that the debate is taking place largely without consideration of the broader context, and fails to take into account alternative notions of activity, and the social benefits of becoming involved.

2. THE MODEL

Introduction

The purpose of this Chapter is to present a model for a systemic approach to equity and access in active living. The first section focuses on key concepts as well as on the main issues at stake with regard to equity and access in general. The second section presents an overview of barriers to access and equity and initiatives to overcome these barriers in domains other than active living. A third section presents the model itself. The model represents a systemic approach to equity and access. By systemic approach we mean a comprehensive view of barriers that exist as a result of dominant structural characteristics of our society, as opposed to attitudinal barriers that focus on individual characteristics (motivation, etc.). Barriers prevent people from participating in terms of aspects of active living for which they are qualified and to which they are entitled. The model constitutes a comprehensive view of common barriers as they are experienced by individuals or groups who are different from those who define the norm. However, the model also recognizes that some barriers may apply more to certain groups than others. Moreover, certain individuals and groups live several forms of differences. As a result, some of the barriers may be even more difficult to overcome.

Definitions and Clarification of Concepts

It is common knowledge that in democratic societies such as Canada, opportunities are not equal for everyone. Advanced democratic societies are divided by social class, gender, heritage, age and ability differences. Moreover, lack of education, economic resources and meaningful work experiences are well documented sources of the social reproduction of inequality of opportunities, as well as determinants of the ways in which individuals serve to conspire in their own subordination (Willis, 1977). However, even if historical discrimination is commonly acknowledged with regard to gender, heritage, age and mental or physical disability, persistent social inequalities are still too often overlooked, especially in time of economic strife.

In Canada, **equality** rights are constitutionally guaranteed by sections 15 and 28 of the

Canadian Charter of Rights and Freedoms. Section 15[1] prohibits discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability. Section 28[2] ensures that the rights and freedoms described in the *Charter* are guaranteed equally to women and men:

> In *Andrews vs. the BC Law Society*, the Supreme Court of Canada affirmed that the purpose of the purpose of the equality provision in the *Charter* is to protect from discrimination, groups that suffer social, political and legal disadvantages in our society. […] The Court firmly rejected the "same or identical treatment" standard of equality, recognizing that "…every difference in treatment between individuals under the law will not necessarily result in inequality, and as well that identical treatment may frequently produce serious inequality (Status of Women Canada, 1995, p. 5).

This approach to equality, which takes into account differences as they pertain to the interdependent dynamics of formal-legal equality and substantive-social Equality, can be referred to as promoting equity. In other words, **equity** is about recognizing differences and taking actions to make sure these differences do not result in differential access [see Article 15(2) in Note 1]. Equity can be defined as the belief in and practice of just treatment. **Access** is the principle and practice of ensuring opportunities for all to participate fully. In concrete terms, this would suggest that, for example, citizens' right to vote (formal equality) is necessary, but in itself is insufficient to the democratic process.

Certain conditions must be met in order for citizens to exercise that right (e.g., time, place, transportation, information… must be accessible to all). The simple act of casting a ballot may present complications for persons with physical disabilities who may have specific transportation requirements; for persons with hearing impairments who may not have heard the public debates surrounding the campaign; or for a single mother who may not have someone to look after her children while she goes to vote. On the one hand, these specific conditions (or substantive-social equality) are to be met (e.g., para-transportation; sign language communications; child care) for these citizens to fully exercise their legal right to vote. On the other hand, elected legislators, who are responsible for ensuring that these resources are accessible to all citizens and that they

are relevant to everyone, must be sensitized to these issues and act upon this awareness in their representational role. In short, formal and substantive mechanisms that are equitable, yet specifically designed to meet particular needs or situations, must be accessible for the full participation and representation of all citizens in political, economic, social and cultural institutions – the leaders of which must see to the development and fair allocation of these means. "This notion of 'substantive' equality acknowledges the systemic and structural nature of inequality. It recognizes that both freedom from discrimination and positive action are required to arrive at equal outcomes" (Status of Women Canada, 1995, p. 11).

The concept of equality, with its formal/substantive dimensions as well as its underpinnings in terms of homogeneity/diversity, is a theoretically and politically delicate one. For example, Gayle MacDonald distinguishes between "absolute equality" founded on sameness, "sex specific equality" founded on difference, and a "sex-neutral gender specific" concept of equality. In practical terms, these may be translated by proclaiming maternity leave for mothers (in a sex specific representation of equality) or advocating a policy on parenting leave for both sexes (in a sex-neutral gender specific conception of equality):[3]

> As for an absolute standard of equality, it would only reinforce the belief that equity exists in the reality of women's lives. […] *The illusion that women have achieved equality is almost as pervasive as the reality of the oppression* (Brodsky & Day, 1989: 11). Men and women are not equal, not in socio-economic status (Mies, 1986), not in wage scales (McDermott, 1991), not in career opportunity nor advancement (Armstrong & Armstrong, 1983; Pask, et al., 1985), and certainly not in the home (Delphy, 1984; Luxton,, 1980; Rosenberg, 1986) (MacDonald, 1992, p. 9).

For Rioux, theoretical constructs of equality fall under three main categories: "One is the formal theory of equality, that is the equal treatment model. The second is the liberal theory of equality, incorporating both the ideals of equality of opportunity and special treatment. The third is the equality of outcome or equality of well-being model" (Rioux, 1994, p. 128). She argues that only the third model is able to fully address inequalities.

In the context of this paper, dealing with situating barriers to accessibility and presenting practical recommendations, perhaps a seemingly more moderate conception of social justice is required:

> Gender equality means that women and men have equal conditions for realizing their full human rights and potential and to contribute to national political, economic, social and cultural development and benefit equally from the results. Equality is essential for human development and peace. […] Attaining gender equality demands a recognition that current social, economic, cultural, and political systems are gendered; that women's unequal status is systemic; that this pattern is further affected by race, ethnicity, and disability; and that it is necessary to incorporate their specificities, priorities and values into all major social institutions (Status of Women Canada, 1995, p. 10).

Although this definition focuses on gender equality, it is sufficiently comprehensive to be applicable and sensitive to issues of race, heritage, ability and age differences. An attractive feature of this definition is that it underlines the dialectic relationship between accessible conditions (material, perceptual and procedural) for participation in political, economic, social and cultural development, and equal benefit from the results by virtue of representation.

It is acknowledged that systemic discrimination or barriers call for systemic remedies. **Systemic** (discrimination or remedies) refers to conceptions, practices and procedures that are inherent to systems and are perpetuated by them (Abella – Report of the Royal Commission on Employment Equity, 1984; quoted in Mallette, 1989, p. 148).
We should also note that the term **minority** is to be considered in qualitative rather than quantitative terms. Minority refers to the historical and socio-political "inferiorization" or "unrecognition" of certain groups taken as incapacitated "minors" with regard to citizenry. By definition, minorities are also all groups that have limited access to either wealth, status or power. For example, people with different abilities are a minority, not because they represent a limited number of citizens but "…because their differences tend to stem from a deficiency in those characteristics on which participation in the social structure and determination of equal status have been designed" (Rioux, 1994, p. 128); i.e., for one citizen's capacity to exercise his or her conventional rights. From this perspective, one must ask: In which institutions, at what level, and why are certain

segments of society (un)involved? (e.g., the predominance of women in low-paying, low-skilled, low-security jobs; or the over-representation of incarcerated Native peoples versus their serious under-representation in institutions and positions of prestige and power). How had the norm been defined, and by whom? Thus, several groups are minorities because of their differences.

Heritage is used in this paper to designate groups with different ethnic backgrounds. An ethnic group is "…a group whose members share a common belief that they have a common heritage, culture, racial background and traditions" (Heritage Canada, 1993). Aboriginal people, which includes status and non-status 'Indians', Inuit and Métis are included in this category.

Overview of Access and Equity Barriers and Initiatives in Other Domains

This section considers examples of studies or reports that focus on identifying barriers, as well as initiatives taken or proposed to overcome to overcome these barriers for different groups, touching on issues other than active living. The aim here is not to provide an extensive review of these studies or reports, but rather to present telling examples in order to develop a model of systemic barriers to active living.

Our examples touch on the following issues: heritage, women, people with different abilities, and the aging population. These examples are the results of over 30 years of initiatives to overcome inequalities. In the 1970s, new social movements and emerging welfare states were mainly focused on the principle of equality as a means and an indicator of universality, and democratization of services and institutions. Since that time, the question of sameness which underlies the notion of equality, has been a subject of theoretical and practical controversy (Greene, 1989; in McDonald, 1992, p. 11).

Within the current context of growing globalization and neo-liberalism, concern over the respect for differences and identities has come to the fore. The concept of equity, which takes into consideration particularities in its appreciation of equality, has marked most of

the organizational discourse in the 1980s. During this period, pay and employment equity legislation were introduced in the Canadian Parliament as well as in provincial legislatures and the US Congress. In both the Canadian and US experience, employment equity is considered by some to have had meager results. In the US case, bold affirmative action programmes created a serious 'backlash' among "angry able bodied white males." In Canada, the *Employment Equity Act* is now to be given more scope and more teeth with its pending reform (Bill C-64) by which employment targets for under-represented groups are to be extended to para-public institutions; numerical goals and timetables are to be established and systematically audited by the Canadian Human Rights Commission which would have the authority to ensure employer compliance. That is not to say that this piece of legislation, and others like it, are not without their share of contestation and resistance among some segments of the Canadian population as well as their political and economic leaders (Report of the Standing Committee on Human Rights and the Status of Disabled Persons, 1995). Elsewhere, among various activist groups, employment and pay equity legislations considered to be necessary, but only as a transitional means until full access to participation and representation in private and public sectors is made possible by dismantling insidious systemic barriers (Dumas & Mayer (eds.), 1989).

The first half of the 1990s, characterized by a recession, a growing realization of the financial bankruptcy of welfare states, dialectics of globalization and regionalization, and increasing support for the devolution of powers, has been accompanied by the "discourse of empowerment." In general terms, the notion of **empowerment** refers to the control of means and ends by and for groups concerned. In the minds of conservatives, empowerment is seen as a means for diminishing state responsibilities and attaining greater fiscal efficiency, without necessarily questioning the existing structures and distribution of power. However, in the minds of people concerned with social justice and welfare, the term empowerment has close to 'revolutionary' implications since it is viewed as the process by which people act in concert to gain power and exercise it at their will. From this perspective, an empowerment approach to increasing the participation and representation of minority groups would imply a

transformation of mainstream political, economic and social institutions from without (Parsons, 1991; Staples, 1987; Torre, 1985; Zippay, 1995).

Heritage

This section draws from a study on the accessibility of health and social services to minority ethnic groups: *A Study of Minority Ethnic Group Access*, conducted by the Social Planning Council of Ottawa-Carleton and the ACCESS Committee of Ottawa-Carleton (Bergin, 1988).

The study identified several barriers to access and provided solutions to overcome these barriers. In the following, we summarize some of the key points underlined in the report. The most important barrier identified was language. The next was availability of information.

The report emphasizes that certain members of the designated groups may encounter difficulties understanding and completing forms required by health and social service organizations. The individuals rely heavily on those who accompany them (e.g., other family members and aid workers) to overcome these difficulties. It is assumed by the service providers that the accompanying persons will not only translate the information, but will also explain its content and the implications of signing. The establishment of a coordinated and multi-organizational system was proposed in order to provide accessible and adequate second (or third) language training to service providers and recipients, as well as the provision of translation and interpretation services.

The inability to communicate because of linguistic, cultural or interpretive impediments, was a cause for great concern. Interpreters or facilitators must be competent, available and sensitive to their role in mediating information between the service provider and the person for which the service is provided.

Cultural appropriateness of services was also seen as a barrier. Cultural differences such as family structure, male – female and parent – child relationships may arise as

barriers in intercultural understanding. There needs to b an ongoing diffusion of information and dialogue between mainstream service providers and cultural minorities, as well as among the various cultural minorities, in order to find some common ground.

The training of personnel has also been pointed to as an issue, namely with regard to referrals to other services. In referring their clientele to other services (hospitals, financial assistance, day care centres, or housing), aid workers need to be adequately trained, informed, and able to communicate.

Particular needs have been identified for minority ethnic groups with regard to health and social services. They include: mental health services; employment; short term financial assistance; adequate affordable housing; day care services; family support services; dental care; and prenatal and postnatal care.

One of the key features of this report is the distinction it makes between two forms of access: client access, which refers to individual opportunities to access services; and organizational access, which refers to representation within the service delivery system, including the decision making process. Thus, the report, recognizing that participation of designated groups in the planning, development, delivery and administration of mainstream health and social services as board members, volunteers and/or staff is necessary, made several recommendations to that end. For example, that health and social service organizations ensure that their boards of directors and volunteer contingents reflect the composition of the community in terms of gender; ethnic, cultural and linguistic origin; physical, mental and psychological ability; and age.

Recently the Canadian Ethnocultural Council (1994, pp. 32-36) provided a series of recommendations for groups of different heritages. Following are some of the key recommendations:

- Foster a sense of belonging for newcomers;
- Public education must be provided to eliminate racist and discriminatory attitudes

with workshops and training sessions in schools, workplaces, television and newspapers;

- Citizenship and Immigration Canada must recognize the learning needs of each ethnocultural sub-group and offer language training that is tailored to their specific needs;
- More information on the Canadian work culture, employment conditions, business regulations, licensing requirements and job searching techniques must be available to newcomers;
- Workshops and resources regarding other countries' educational and work systems must be made available to Canadian employers, managers, professional bodies and union leaders to promote a fair assessment of the qualifications of ethnic minority candidates;
- Mainstream institutions must be prepared to provide culturally sensitive essential services to every group within society on an equitable basis;
- More interaction, communication and cooperation among different ethnocultural groups and associations must be promoted;
- Workshops and seminars on community development and leadership training must be available to ethnocultural communities; the associations must be able to improve their ability to respond to the needs of their members, to deal with the media and lobby the government;
- Ethnocultural associations must provide more information and services that
- encourage members to become independent and participate in every aspect of Canadian life;
- Federal agencies must increase funding for diverse groups to deliver services that foster integration of ethnic minorities into Canadian society;
- Ethnocultural associations must provide more resources, group activities and support groups for seniors who may require services in their own language;
- The Canadian government should make pension agreements with other countries to enable ethnic minority seniors to have their pension plans transferred to Canada;
- All women must be provided with language instruction regardless of their

employment choices;

- A national child care program must be implemented to allow women freedom to work or attend school;
- Support groups and services for newcomer women must be available;
- Funds should be increased to support public education, programs, and training that fosters cross-cultural and racial understanding;
- More resource material is needed to help newcomers to understand and function within the Canadian system;
- Print and electronic media must receive cross-cultural training in order to portray fairly and accurately Canada's changing cultural composition;
- School boards must review their curriculum to adapt to the growing cultural and racial diversity of Canadian schools and make it more responsive to the needs of ethnocultural communities;
- Schools must increase the hiring of ethnic minorities in management and teaching positions;
- School boards must promote religious accommodation and allow students and staff to observe holidays of ethnocultural groups represented in the school population;
- School boards must review the assessment procedures used to place students;
- School boards must increase the availability of culturally sensitive youth support groups and counseling services to help ethnic minority youth deal with problems;
- Universities and colleges must include a mandatory cross cultural component to the curricula that train teachers, health care professionals, police officers, judges and journalists;
- Ethnocultural minorities must be encouraged to apply to the faculty of education.

Even though its final report has not been released at the time of writing, the Royal Commission on Native Peoples has already formulated several interesting recommendations on systemic barriers to access to a wide range of services and life opportunities:

- Create and enforce environmental management regimes to conserve lands and resources for traditional uses and practices;
- Alter the definitions and opportunities for traditional uses and practices;
- Eliminate government's traditional role as the adversary of Aboriginal interests;
- Harmonize federal, provincial, territorial roles in development;
- Vastly expand educational opportunities, through existing institutions, partnerships and joint ventures;
- Clarify and stabilize fiscal context, especially taxation, financial capacity, and jurisdiction in matters of land and resource use;
- Modify and refine local political capacities;
- Ease and increase access to capital;
- Encourage mutually beneficial relations between Aboriginal organizations, communities and businesses and non-Aboriginal organizations, communities and businesses;
- Enrich self-government;
- Vastly improve facilities for the flow of information. Establish an Aboriginal information and research facility to co-ordinate information on a wide range of initiatives;
- Eliminate barriers to liaison between Aboriginal peoples (in Canada) and economic efforts made by Aboriginal peoples internationally;
- Make funds available for the development that builds on tradition;
- Create a neutral dispute-solving mechanism and joint problem-solving mechanism;
- Recognize urban populations as capable of self-government, holding land and jurisdiction over taxes;
- Governments must emphatically support Aboriginal people's cultural objectives;
- Eliminate gender barriers in and out of Aboriginal communities;
- Redefine some topics as economic, rather than social activities such as hunting, fishing and trapping, daycare, micro-enterprise and cottage industry;
- Overhaul school curriculum to educate Aboriginal children about the real contributions and capabilities of Aboriginal people. Overhaul the Canadian

curriculum to facilitate the understanding of Aboriginal culture;

- Provide the ways and means to reconstruct local political and social environment that promotes development of gender relations, ethical politics, and an appreciation of success and wisdom;
- Restructure the entire inventory of services to Aboriginal people.

Women

Women's rights are one of the domains where numerous studies can be found. Given the limitations of this report, we will refer only to initiatives proposed for eliminating gender and other forms of discrimination in schools. For elementary and secondary schools proposals have been made to sensitize young children to discrimination (relating to sex, culture, origin, age, ability) and to make young children aware of discrimination: e.g., asking young boys and girls what they will do when they grow up, and what would they do if they were of the opposite sex; encouraging them to reflect on their responses and directing them in adopting a critical approach to discriminatory conditions, perceptions and practices in their immediate environment; implementing activities that enable them to act upon their increased awareness.

An initiative launched at the Young Women's Club at an inner city Toronto elementary school has been identified as a good example. The Club is run as a voluntary extra-curricular activity, with meetings held at lunch time and after school. It has a membership of about 30 girls between the ages of 9 and 12, from grades 4 to 6. Its goal is to discuss issues of gender equity and to study the impact of gender on the socialization of adolescent girls. Although the focus is on the school system, the girls also deal with events in the family and in the broader culture. Meetings are informal, they are animated by the Club's founder, and activities have included: discussions about a movie or television show, daily experiences, sharing of journal entries, assemblies, campaigns, media studies, clipping files, writing poetry, plays and stories about women's issues and making the public (Naveau, 1992, pp. 85-88).

Another form of initiative that has been proposed was a pedagogic guide for the

creation of new women-men gender relations:

> On its own, the school setting would not be capable of achieving such social change as to permit real gender equity. It can, however assume a leadership role in this area by creating an environment which incites children to take on the necessary changes in values and perception. It can also form one of the core settings around which the community will organize different cultural and socio-political activities which will lay the foundations of a new society (Ferrer & LeBlanc Rainville, 1988, pp. 79-92, *our translation*).[4]

There are indeed several barriers to women's full participation and representation. First and foremost the role of women as primary caregivers results in limited access. Women's labour in the family (as caregivers for dependent members – children and the elderly) translates into "feminized" sectors of the labour market (nursing, teaching, clerical work, responsibility for social issues such as a health or environment portfolio or ministry at the executive levels). The sexual division of labour must be addressed first within the family in order to attain gender equity in the labour market (Stoddart, 1989, p. 47). The non-recognition of domestic work within the family also results in limited access. Tasks such as feeding, cleaning, and raising children are not considered as work, are not remunerated, and are not accounted for in the GNP when they are performed by a wife or mother. However, when the same tasks are performed and offered as services on the labour market by (mostly female) individuals selling their labour, they are remunerated (although minimally) and accounted for in the GNP. It is, therefore, not the domestic tasks which go unnoticed, but rather the social relationships in which they are set.

The establishment of a national child care system is considered as one of the major solutions to access for women:

> In order to insure affordability, quality and convenience of child care services, a national policy would have to be implemented. The existing system (with Child Care Expense Deduction under CAP) largely benefits higher income earners; cost sharing between the federal government and provinces under CAP is inoperative; and work related child care serving employees in the public sector is

a limited, individual and discretionary response to a societal problem…

Child care in Canada is largely a patchwork series of services, established in an *ad hoc* manner by non-profit organizations, parent groups, commercial operators, employers, and to a limited degree, local municipalities. This has resulted in a fragmented delivery system, which is unaffordable and unavailable to the majority of working families…

Child care is the ramp that provides equal access to the work force for mothers…

Child care is important for a number of reasons: it allows women to work; high quality child care programs promote healthy child development for all children regardless of their parents' socio-economic or employment status; absenteeism, turnover and tardiness can all be reduced when parents do not have to deal with the stress of all too often having to place their children in unsatisfactory situations…

Key components to quality child care include: staff training, staff wages and working conditions (NB child care workers are among the worst paid workers in the work force), child/staff ratios, limits on group sizes which vary according to children's ages, developmentally appropriate curriculum, physical environment, parental involvement and non-profit status (Cook, 1986; Doherty, 1991; Lero & Kyle, 1986; Phillips & Howes, 1986).

In order to meet the needs of parents, programs should also: be affordable, available, and conveniently located either near a parent's place of work or study, or a residential community; provide a range of services which are available on the days and times they are needed, in a variety of settings; provide integrated services for all children regardless of socio-economic situation or ability; be responsive to local community and cultural needs and have a non-profit orientation (Beach, 1992, pp. 64-66).

Persons with different abilities

The Social Planning Council of Ottawa-Carleton (1993) has put forward a list of formal recommendations to overcome systemic barriers for people with different abilities. Some of them are:

- Improved access to buildings and its facilities: public transportation; parking sports for disabled persons; signage; good air quality; automatic doors;
- Orientation on the organization and its activities: orientation outreach is critical… people don't even know they can participate… the jargon and terminology used by an organization is often a barrier;
- Disability awareness training for staff and volunteers: difficulties that people with disabilities experience are related more to professionals (particularly in the medical field) than with diagnosis… stigma;
- Recognition of the costs and supports for participation for people with disabilities: many persons with disabilities have restrictions such that it takes more time to be able to participate; someone may be needed to read documents; meetings should be shorter; seating arrangements should be conducive to lip reading; there is a need for accompaniament services; flexibility is important;
- Provision of information and materials in alternate formats: large print is preferable for shorter pieces; tape is better for lengthy documents; use of plain language;
- Development of an approach: service delivery and planning which does not view the needs and rights of persons with disabilities as special and different from that of the rest of the population.

Elderly populations

The National Advisory Council on Aging has also proposed several recommendations with regard to overcoming barriers to access for elderly populations. The report argues that seniors are perceived as forming a homogeneous group in society, whether positively stereotyped (warmth, kindness, wisdom) or negatively stereotyped (passive, physically weak, sow in thinking rigid, incompetent, unproductive, costly to the State…).

Some of the Council recommendations include:

- Consultations with seniors to provide information and advice to government officials on aging and seniors;
- Enhancement of public awareness about aging and modify negative attitudes;
- Guidelines for print and non-print materials: take into account the normal sensory and perceptual changes associated with aging that may affect comprehension; project realistic illustrations of persons of all ages; portray seniors' lifestyles and the individual and cultural differences within the older population;
- Educating business, professionals, students and teachers at all levels (from primary school through to university) on normal aging and the diversity of seniors;
- Media coverage: needs to present the diverse and complex reality of aging, including references to ethnic minorities and Aboriginal seniors; present seniors' achievements and contributions to society instead of impending social and economic crisis from the seniors' boom;
- The role of business: Advertisements to depict seniors; business firms consult with seniors to develop marketing strategies that are free of age bias; retail outlets and commercial services to assure that personnel treat all clients with equal courtesy and respect;
- The role of the Arts: foundations and organizations concerned with seniors' well-being establish an award to recognize artistic productions that enhance the public's awareness and appreciation of seniors;
- The role of educators and community organizations: parents, educators and community groups support existing intergenerational activities between seniors and children (e.g., Grandpal Program, Prime Mentors, Generations in Various Exchanges, Senior Tutors Assisting Children) and organize such activities where they do not exist; educators of children participate in training seminars or workshops to increase their understanding of aging.

As noted in the introduction, in this section we have presented a limited number of

examples of studies and reports dealing with barriers to access in domains other than active living. The barriers identified, as well as the solutions proposed in these documents give an idea of the range of the issues and solutions proposed with regard to access in general.

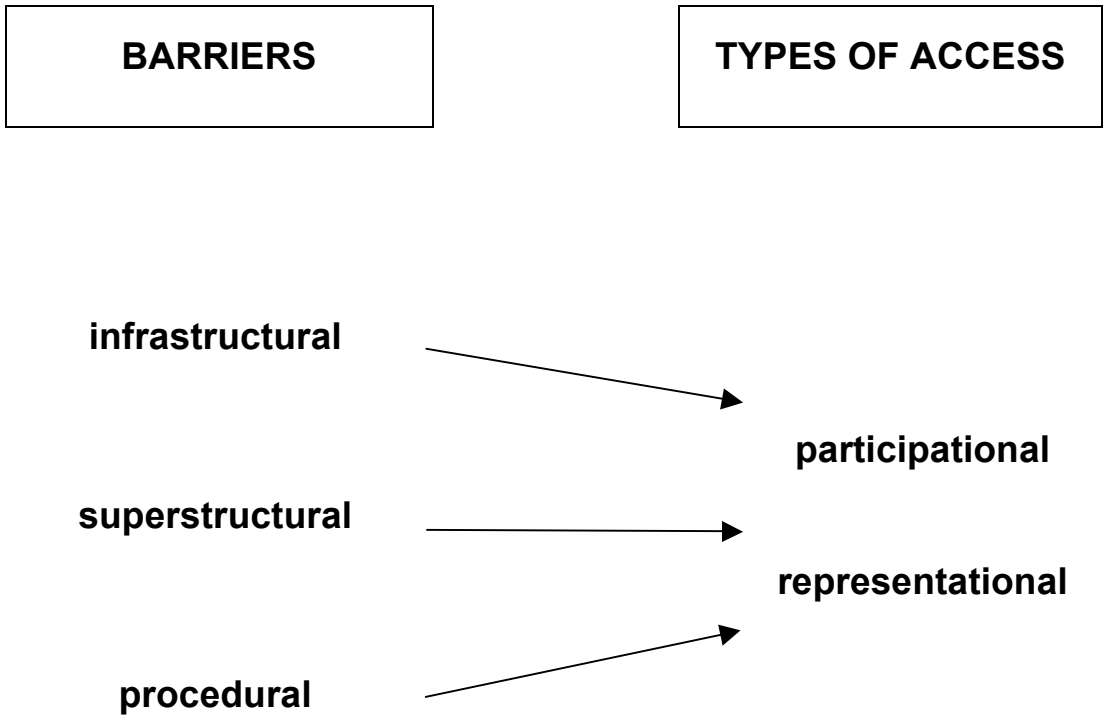
The Model

Drawing from an extensive review of the literature, from which the examples noted previously in the Chapter were chosen, a model for a systemic approach to equity and access in active living has been developed. A schematic representation of the main components of the model is shown in Figure 1.

The model is based on the premise that socioeconomic determinants (class, gender, heritage, age, abilities) create substantive inequity or substantive barriers. These barriers fall into three main categories: *infrastructural* barriers, or material means to access; *superstructural* barriers, or limits originating from the sphere of ideas and perceptions; *procedural* barriers, or limits emerging from the course of action. These categories are similar to, but slightly modified from those to be found in the literature. The *superstructural* category, for example, is a modified version of what is generally characterized as attitudinal barriers. Attitudes mostly refer to individual predispositions. Since this model is concerned with systemic barriers, we have chosen a category that reflects more collective ideas and representations. As for the two types of access, *participational* and *representational*, they are also modified categories from those found in the literature. We consider that *participational* access is maximized when targeted groups have information about existing services or opportunities; when they can cope with registration or other procedures (if any) to enter an activity or to receive a service; when they meet competent facilitators; and when they receive services from providers who are sensitive to diversity. We consider that *representational* access is maximized when targeted group members are present in the service organization's structure and decision making process.

Figure 1

A SYSTEM MODEL OF ACCESS AND EQUITY IN ACTIVE LIVING



A list of the different systemic barriers included in the model is provided in Appendix A. We now discuss these specific barriers bearing in mind two key points. First, most of these barriers are common to all minority groups. However, some barriers may be harder to overcome given the nature of the differences lived by these groups. Second, the nature of these differences may well have, as a consequence, some groups defined as minorities on several grounds. Barriers to access for the latter may be very difficult to overcome.

Infrastructural barriers to access

Infrastructural barriers are related to the material means of access. **Cost** can be a major barrier to access. Most goods and services are scarce and involve costs. In the current context of the demise of the welfare state, where user fees are increasingly imposed on public services, cost may become a bigger barrier. Moreover, minority groups tend to be economically deprived in comparison to mainstream society. **Transportation** is a major issue, not only for people with a physical disability, but also for many minority groups, especially living in non-urban areas, that do not have access to public transportation. **Time** is a scarce resource. People working long hours, or women combining work outside the home with domestic labour. The timing and scheduling of activities or services are part of this time issue. **Location** of facilities may also be a significant barrier. Minority groups may live in neighbourhoods that are often deprived of open public spaces or services such as parks ad community centres. Distance from location combines with transportation as a barrier. **Facilities** may obviously constitute a barrier for people with a physical disability if they are not adapted, but specialized facilities limit the range of activities that can be organized. The range of service, such as day care, included in facilities is an important issue. **Security** can also be a major *infrastructural* barrier to access. Facilities, and the neighbourhoods in which they exist, must be safe.

Superstructural barriers to access

Overall policies may represent significant barriers to access. Policies are often designed to fit the needs of the mainstream population. Their quality and success is often measured by criteria such as efficiency and rationality that may not be compatible with diversity and inclusiveness. The **nature of activities** or services may constitute barriers since they are often not appropriate for the wants and needs of minority groups. Inadequate **knowledge** about existing programmes or facilities also constitutes a significant barrier. **Facilitators** or leaders who are not trained, do not have any cultural sensitivity to diversity, or who hold stereotyped views of minority groups' abilities are a major barrier to access. **Cultural exposure** through formal education, or through family and/or community, to existing opportunities can be a major barrier to participation. Indeed, learned ideas about the appropriateness of activities shape the range of

activities in which one might choose to become active. **Prejudice** or ideas attributing certain characteristics to minority groups is another form of cultural barrier. Prejudice is a major factor in creating a non-inclusive climate in services. Finally, **language** when non-inclusive for cultural diversity, or unavailable in different forms and format, also constitutes a cultural barrier to access.

Procedural components to accessibility

Procedural barriers emerge from the service delivery process. Lack of **social support** can be a barrier to certain minorities who need help or support to be released from certain responsibilities (e.g., child care). **Citizens' rights** to access to services or opportunities may not be recognized, therefore organizations or facilities do not feel the obligation of diversity. Citizens' rights are at the core of the definition of the nature of services, opportunities or activities offered. They set the functioning norms of an organization or facility. **Organizational structure** becomes an important barrier when minority groups are not present in the structure of the organization, at the central decision making level as well as at every level where decisions are made. Finally, top down, hierarchical **management styles** constitute a barrier for service users since their needs do not constitute a constant input into the service, organization or facility daily functioning, and since these styles focus on efficiency and rationality instead of flexibility and openness.

Conclusion

In this Chapter we have developed a systemic model of access and equity that may apply to minority groups in active living. The model has been developed from a review of literature on access and equity that deals with issues other than active living. The next Chapter presents a review of access and equity issues and proposals applied to active living. This sets the stage for a test of the systemic model developed here.

Notes

1. 15(1). Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability.

15(2). Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability (Department of Justice, *Equality for All*, pamphlet).

2. 28. Notwithstanding anything in this *Charter*, the rights and freedoms referred to in it are guaranteed equally to male and female persons.

3.*Sex* refers to biological/anatomical differences distinguishing men from women. *Gender* refers to culturally determined differences between males and females. Although differences in primary sexual characteristics between men and women are evident, secondary characteristics such as hormone levels, weight, strength are not (CAHPERD and Réseau national d'action education femmes, 1995, p. 6).

4. Catalina Ferrer et Simone LeBlanc Rainville, "´A propos d'éducation," *Recherches feminists*, 1 (1), 1988, pp. 79-92.

3. FACTORS CONTRIBUTING TO INEQUALITY IN ACTIVE LIVING

Introduction

In recent years, a variety of studies have been conducted to identify those who have been labelled as “sedentary” or “inactive” Canadians (now unfortunately coming to be known as “inactives”). These include the Canada Fitness Survey (1983), the Campbell’s Survey (Stephens & Craig, 1990), the Health Promotion Sur3636vey (1993), the Ontario Health Survey (Allison, 1995), and the Profile of Physically Active Canadians (Fitness Programme, 1995a). These surveys have used several different measures of activity, and several different thresholds for determining inactivity, although the more recent surveys have used a similar measure of <700 kilocalories / week, or <1.5 kilocalories per kilogram of body weight per day (kkd) of energy expenditure. The major limitation of such surveys is that they are derived from self report measures of leisure time and physical activity. Self report measures are notoriously unreliable, although the surveys have used large enough samples to establish a certain amount of reliability. However, the restriction to leisure time physical activity excludes a great deal of the physical activity that many people in, and contradicts the emphasis on active living (which includes such things as housework, child care, home maintenance, and paid work).

Despite these limitations, the results of the surveys are remarkably similar. An analysis of the Ontario Health Survey shows that: “The odds of being inactive are greater among the following groups: older age groups; females; lower income; those currently working or engaged in housekeeping, or other activities; those who have few friends participating in physical activity; smokers; drinkers; those in higher body mass index categories; those believing they will develop health problems in later life; and those believing they are in poor health” (Allison, 1995, p. 2). The following analysis focuses primarily on the socio-demographic variables.

Craig, et al., extrapolated from the Campbell’s Survey to provide the following demographic description of “inactive” Ontarians: “Ontarians who are inactive in their

leisure time are more likely to be females. They are more likely to be older as well. The inactive population is more concentrated among lower education and income levels. Inactive people are more likely to live in communities with fewer than 75,000 residents. They are more likely to be found among the sales and clerical workforce and among homemakers. A sizable number are also blue collar workers" (1995, p. 97). The national surveys show results similar to those for Ontario.

Demographic Characteristics of the 'Inactive' Population

Following an in-depth review of a number of recent physical activity surveys we focus on the five demographic characteristics employed in this paper. The details are as follows:

Age

Children and Youth

- Inactive children and youth are more likely to be girls than boys. Youth working in sales or clerical jobs are much more likely to be inactive than those who are students. Inactive children and youth are more likely to reside in communities with fewer than 1,000 residents (Craig, et al., 1995, p. 106).
- Males show a large decrease in physical activity between the ages 15 and 16, while females show a large decrease between ages 14 and 15 (Allison, 1995, p. 13).
- The extent of child poverty has been documented, making it clear that barriers exist for many children. The increasing use of user fees for activities such as skating, swimming and school skiing expeditions raises new barriers, financial and psychological (Fitness Program, 1995b, p. 11).

Older Adults

- Inactivity increases with age (Fitness Program, 1995a).
- Participation in physical activity declines with increasing age (Allison, 1995, p. 12).
- More women aged 55 and older are inactive compared with men of the same

age. Inactivity is higher among older adults with lower education and income levels. Those who are inactive are more likely to reside in communities with fewer than 75,000 residents (Craig, et al., 1995, p. 115).

- After adolescence, active participation in sport and physical activity is inversely proportional to age (Hall, et al., 1991, p. 156, writing with reference to the Canada Fitness Survey). McPherson (1984) notes that this decline with age is more pronounced for those with less education, lower income, living in rural areas or small towns, and women (especially if married and have pre-school children).

Gender (women)

- The proportion of women who are inactive increases across age groups. "Inactive" women are more likely to be retired; to work in sales, clerical or blue collar jobs; or to be homemakers. They are also likely to have lower education levels and family incomes under $14,000 a year or between $25,000 and $34,000. Inactive women are likely to be found in communities with fewer than 1,000 residents (Craig, et al., 1995, p. 123).
- Inactivity is higher for women than men (Fitness Program, 1995a, p. 2).
- Participation in physical activity is lower among females compared to males (Allison, 1995, p. 12).
- Males and females are now equally active in low intensity exercise activities, and in some activities like walking, social dancing, and home exercise women are considerably more active. More males, on the other hand, opt for golf, jogging, and gardening. The major sex differences occur in sport activities which, except for bowling and volleyball, are socially and competitively oriented, the majority of the small percentage who do participate are male. Males and females now spend equal amounts of time on physical recreation, but males more often engage in physical activities that are more intense in terms of energy expenditure (Hall, et al., 1991, p. 156, writing with reference to the Campbell's Survey).

Heritage[1]

Immigrant

- The 1991 General Social Survey covered 82% born in Canada and 18% born outside Canada (10% Europe, 4% Asia, 2% Central and South America, 1% Africa/Oceania, 1% other North America). Those most likely to be inactive are from Asia and Africa. Least likely to be inactive were other North Americans (despite their generally older age structure) and Central/South Americans. Europeans and Canadians were in the middle (Fitness Program, 1995a, p. 5).

Anglophone/Francophone

- English only – 65% of the sample; French only – 24%; other languages only – 6%; English and French – 1%; English and other – 2%. Those speaking another language at home were substantially more likely to be inactive than those speaking English, French, or both (Fitness Program, 1995, p. 5).
- Using 1976 and 1988 data, there were no significant differences between Anglophones and Francophones in their general sport participation, but both male and female Anglophones were more involved in competitive sport than Francophones (White & Curtis, 1990; Curtis & White, 1992).

Aboriginals

- Data appear to suggest a high percentage of “inactives” in leisure time physical activity.

Social Class [**social class** may be measured using a combination of income, education and occupation]

Income

- Among those with low family incomes, the inactives are more likely to be females, to have lower education levels, to work in blue collar jobs or to be unemployed or on strike, and to live in communities having less than 75,000 residents. Inactive individuals are more likely to have family incomes of less than $14,000 (Craig, et al., 1995, p. 130).

- For income adequacy (a combination of household income and household size) there is a general decrease in inactivity from 36% in the lowest income adequacy group to 20% in the highest income adequacy group (Fitness Program, 1995a, p. 3).
- There are higher levels of physical activity among those with higher income levels (Stephens & Craig, 1990; Health and Welfare Canada, 1993).
- The analysis shows higher levels of involvement in physical activity by those with higher family incomes (NB, total family income, not personal income) (Allison, 1995, p. 17).

Education

- Almost half (48%) of those with elementary schooling are inactive compared with 21-27% of the other three categories (secondary (27%), post-secondary (21%), university (22%) (Fitness Program, 1995a, p. 2).
- There is a positive relationship between level of education and physical activity participation (Stephens & Craig, 1990; Health and Welfare Canada, 1993).
- The highest proportion of Actives are found among those with the highest levels of education…. The highest proportion of "Inactives" (86.6%) appears in the group with the lowest education (Allison, 1995, pp. 15-16).

Income and Education

- Low income and education groups still display higher levels of physical inactivity than their higher income or education counterparts. It is unclear whether income or education is the more powerful predictor (Fitness Program, 1995b, p. 17).

Occupation

- Students are by far the most active, with only 13% in the inactive category. The most inactive are retired persons and those keeping house (35%). In the middle are those working and looking for work (Fitness Program, 1995b, p. 17).
- Findings have shown higher levels of participation among white collar as opposed to blue collar workers. When occupational prestige is used as a

measure, those in occupations with the highest level of prestige (e.g., professionals and higher level managers) were more likely to report higher levels of participation than those with lower occupational prestige levels (Fitness and Lifestyle in Canada, 1983; Stephens & Craig, 1990; Health and Welfare Canada, 1993).

- Findings from the analysis do not present a strong case for a linear relationship between occupational prestige and physical activity participation. [However] those in the self-employed professional and employed professional groups were more likely to report active participation in physical activity than those in other (lower) prestige categories (Allison, 1995, p. 16).

Education and Occupation

- Whether or not someone is in the paid labour force is a strong predictor of active involvement in sport and physical activity. On the whole, those not in the labour force (e.g., homemakers, retirees, unemployed, disabled) are inactive in sports, athough some may be quite active in exercise activities like walking, swimming, and gardening.
- The type of occupation is also a good predictor of involvement. Salaried professionals and managers with good educations and high incomes are far more likely to be involved in individual sports that cost money, such as downhill skiing, indoor tennis, squash, windsurfing, golf, sailing, and equestrian sports. Male blue collar and white collar workers, who generally have less education and lower incomes, tend to seek out more social situations for their sporting activity, notably bowling, baseball or softball, hockey, and fishing. Working class women, on the other hand, display little or no interest in sport, or even in physical activity, most likely because of such insurmountable barriers as inadequate child care and a lack of money (Hall, et al., 1991, citing Stephens & Craig, 1990; Boulanger, 1988).

Different Ability

- Persons with disabilities have lower rates of participation in physical activity,

although not as dramatically as might be thought…. Segments within this group can be defined by the same characteristics that apply to other groups such as occupation, income, education, place of residence, etc…. The young, severely disabled, and older degeneratively disabled are especially at risk (Fitness Program, 1995b, p. 15).

- Less than 15% of Canadians with a disability use community facilities because of a lack of inclusionary programming, inaccessible facilities or transportation, lack of companionship, and negative attitudes toward persons with disabilities in physical activity settings (*Active Living*, 1(4), p. 4).

Problems with the process of segmentation (categorizing a population by, in this case, socio-demographic characteristics) are beginning to become apparent in this examination of the demographic characteristics of the "inactive" population. These are discussed in detail in the following section.

Barriers to Access to Physical Activity

A number of studies have focused on the actual barriers to access to physical activity. These are frequently described in the following terms: physical barriers; social barriers; psychological barriers; environmental and structural barriers; and systemic causes. An in-depth review of these studies revealed significant overlap in the various types of barriers to access for the five population segments. The following analysis has been re-structured from the original (physical, social, psychological, etc.) terms in order to conform with the model (infrastructural, superstructural, and procedural barriers) outlined in Chapter 2.

Also, because of the significant overlapping, the results of this review are presented in a series of three Charts (included in Appendix B), one for each element of the model. Each Chart includes a General category of barriers to access, and the five population segment categories (Age, Heritage, Gender, Different Ability, and Social Class). The quotes in each cell are coded (by number) to the reference list in Appendix B.

Infrastructure

Chart 1 provides a clear indication of the *Infrastructural* barriers to access to physical activity in terms of: cost, location and transportation, time, facilities, and security.

- **Cost** refers to the expense of involvement in an activity; while this has always represented a barrier to participation in many activities to all people (including children) who may be classified as low income, the growing tendency to introduce user fees for public **facilities** (facilities which many people feel they have already paid for through their taxes) will no doubt result in decreased access to opportunities to be involved in certain activities
- **Location** of facilities and **transportation** to facilities frequently combine in limiting access to involvement in certain physical activities; **transportation** may be related to **cost**, but also to its availability (including specialized **transportation** for the disabled) and to **security**; **location** may also be related to **security**
- **Time** for involvement in physical activities may be limited for those who are obliged to work several jobs or overtime, or those who are engaged in child care and domestic labour (possibly in addition to paid labour); **time** may also be connected to the scheduling of activities and opening times of **facilities** (both of which may restrict or facilitate access), and it may be related to **location** and **transportation** in terms of time required to travel to **facilities**
- **Communications** primarily refer to the actual dissemination of information about the availability of physical activity opportunities – a significant number of "inactive" people indicate that they were not aware of the existence of various opportunities for participation; communications also refer to the actual messages being transmitted – whether they involve fear and threat, whether they are promoting unrealistic expectations about body size and shape, or whether they promote healthy and pleasurable involvement based in good research about the effects of active living
- **Facilities** refers to both the adequacy of **facilities** (climate controlled, secure, clean, etc.), and to the availability of **facilities** and the imaginative and efficient

use of, for example, schools

- **Security** is frequently a concern of women, older adults, some disabled groups, and of parents about their children; easy access to safe and pleasant **facilities** may encourage increased participation

Superstructure

Chart 2 provides a clear indication of the *Superstructural* barriers to access to involvement in physical activity in terms of: policies; nature of the activities; knowledge; facilitators/leaders; cultural exposure; prejudice, and language.

- **Policies** and policy makers must have a strong sense of equity, must be aware of the structural and systemic barriers to access to physical activity, should be aware of the potential benefits (not overstated) of involvement in physical activity, and sensitive to the needs of the individuals the **policies** are designed to serve
- **Nature of the activities** – activities need to be appropriate and attractive to the population being served, but must not be based on outdated stereotypes (e.g., sedentary activities for seniors); there is a need for innovation in the types of physical activity available and promoted – many prefer not to be involved in the facility centred formal classes or machine / equipment-based exercises
- **Knowledge**, or more accurately, lack of **knowledge** represents a barrier to involvement in physical activity in three ways: lack of research on the benefits of exercise and the way in which exercise may be a specific benefit to particular communities; lack of **knowledge** on the part of 'experts' with regard to prescribing and promoting exercise; and lack of **knowledge** about the benefits of physical activity in the general public
- **Facilitators / leaders** relates to both the **knowledge** and **policy making** categories in terms of the need for sensitive and informed leadership, and in the need for community-based leadership rather than outside 'experts'
- **Cultural exposure** also relates to the need for sensitivity and **knowledge** with regard to cultural difference; this relates particularly to the assumption that "white, male, middle class, young, and able-bodied" represents some type of

norm with regard to participation in physical activity

- **Prejudice** represents an overt barrier to the provision of opportunities to participate in physical activity, and is frequently grounded in stereotypes regarding the propensities and abilities of various populations
- **Language**, while not specifically mentioned in any of the studies reviewed, represents a significant barrier to involvement (in a country with a large immigrant population, a large Aboriginal population, and two official languages) in terms of the provision of programmes and **communications** about opportunities.

Procedure

Chart 3 provides a clear analysis of Procedural barriers to access to involvement in physical activity in terms of: social support, organizational structure, citizens' rights, and management style.

- **Social support** is one of the key factors involved in access to physical activity; as Allison notes: "One of the strongest predictors of activity status is the degree of friends' participation in physical activity. Those with no friends participating are more likely to be inactives than those with more friends participating. The relationship holds when taking into account age and gender differences in activity" (1995, p. 2); **social support** includes support from family, friends, role models, professionals and 'experts', and members of one's own community
- **Organizational structure** refers to the need for collaboration between all of the possible agencies and parties involved in the provision of access to physical activity – political and **policy** making bodies, health care professionals, educators, community leaders, participants, etc.
- **Citizens' rights** were not mentioned specifically in the studies reviewed, and are not usually thought of in the context of access to physical activity; however, various international charters specifically mention the 'right' to participate (e.g., "Every individual shall have the right to participate in sport," Article I, European Sport for All Charter, Council of Europe, 1975; "The practice of physical education and sport is a fundamental right for all," Article I, International Charter

of Physical Education and Sport, UNESCO, 1978); development of the notion of the 'right' to participate in sport and physical activity in Canada could facilitate the increased involvement of Canadians in healthy activity

- **Management style** was not mentioned specifically in the studies reviewed; however, it is clearly related to **organizational structure**, and to the *superstructural* elements of **policies** and **facilitators**.

Types of Access

In overcoming these barriers, the types of access achieved must be taken into account. The model presented in Chapter 2 notes participational and representational forms of access, which represent stages in the democratization of access to active living opportunities. The identified barriers are overcome, in part, when targeted populations achieve participational access. But, as Donnelly has noted with regard to sport: "Can a sport be said to be democratized if a large proportion of the participants have little or no say in the rule changes or administration of the sport, no say in who can play, the conditions of play, or the meanings that are attributed to a particular activity" (1993, p. 416). More successful programmes of active living are likely to aspire to a more completely democratized representational access in which targeted populations are represented in the organizational structures and ecision making processes.

The Problem of Segmentation

The data regarding the demographic characteristics of the "inactive" population presented in the first part of this Chapter clearly indicate the enormous data loss resulting from segmentation. Segmentation was intended to identify specific 'at-risk' target groups for allocation of resources. But when such segmentation is restricted to specific socio-demographic categories it creates an artificial notion of target groups. From the distinct categories employed in this paper, it appears that the "inactive" population is made up of: adolescents and older people; women; certain immigrant groups and Aboriginals; those of lower social class (as determined by income, education, and occupation, separately or in some combination); and the disabled.

While it is possible to target any single one of these groups, few individuals fit into just one of these groups. If we take the three categories that have produced the most social research, “Each of us has a gender, a social class background and a racial / ethnic affiliation; we live our lives in some combination of these three (and other characteristics); and we relate to each other on the basis of ours and theirs” (Donnelly, 1993, p. 417).

If the data presented here are combined into a specific target group, the most resources should probably go to Aboriginal females with a disability, adolescent or old, and of lower social class. But even this represents some data loss because the socio-demographic characteristic that appears to be the most significant, and which appears as a qualification for all the other categories, is social class. [Also, as noted in the Charts regarding barriers to access to physical activity, social class barriers are embedded in all categories of this analysis.] While those with lower class are more likely to be defined as “inactives,” it is also apparent that:

- Children and youth of lower social class backgrounds are less likely to be involved in physical activity than other children
- Older adults of lower social class backgrounds are even less likely to be involved in physical activity than other older adults
- Women of lower social class backgrounds are even less likely to be involved in physical activity than other women
- Immigrants and Aboriginals of lower social class backgrounds are less likely to be involved in physical activity than those of other social class backgrounds
- Persons with different abilities and lower social class backgrounds are less likely to be involved in physical activity than those with other social class backgrounds

Thus, while social class is in itself a risk factor, it is also a basic condition that exacerbates other risk factors.

This does not mean that women, the disabled, certain immigrant groups, and older

adults of middle and upper class backgrounds should not be considered at risk. The data indicate that there are clear barriers to involvement for such populations. However, it appears that a combination of poverty / low income, low level of education, and low job status or unemployment represents the major risk factor, and if that is combined with at least one of the other socio-demographic risk factors, it represents a key target population:

> Whether it is measured by income, educational levels or occupation, low socioeconomic status (SES) has long been associated with lower levels of participation in activity and an increased likelihood of illness, disability and early death. Low-SES families are more likely to have low birth weight babies who are at high risk for the development of physical, social, emotional and behavioural problems while growing up. [More than] one million Canadian children, or about one in six, live in low income families. About 50% of these families are headed by female single parents (*Active Living*, 1(4), p. 6).

Problems of Defining Inactivity

While self-report measures of physical activity have a number of problems, those problems are exacerbated when attempting to determine levels of leisure activity. The concern is two-fold: (1) how is leisure activity determined?; (2) how do we account for an individual's total energy expenditure?

(1) Leisure is one of the more difficult concepts to define. It tends to be quite personal – one person's leisure is another person's work. If we go for a **work-out**, is that leisure?, work?, a health maintenance or slimming activity?, exercise undertaken on orders from our physician? Home maintenance, gardening (including grass cutting), spending time with our children, auto cleaning and repairs, walking the dog, putting in a backyard rink – all of these and many other activities may be defined a either leisure or a chore, even by the same person depending on the circumstances. Surveys of leisure physical activity tend to include physical educators' notions of such activity, and include sports and various forms of active recreation, but they rarely incorporate the whole realm of **active living**.

(2) Housework, child care, manual labour, work that involves being on your feet, and the

various leisure / chore activities outlined above account for the majority of energy expenditure for the majority of Canadians; and yet, this source of energy expenditure remains unrecorded in most surveys. It is apparent that the standards are often determined by, and for, white collar desk workers – i.e., those in sedentary occupations whose main source of energy expenditure may be in leisure physical activity. Only Craig, Russell and Cameron (1995), citing data from Stephens and Craig (1990), have addressed this issue in a tangential manner: “Are people inactive during leisure because they have more active jobs? Not necessarily. Inactive and active individuals have similar work-related energy expenditure patterns” (p. 97). However, this does not take into account the total circumstances of individuals’ lives (e.g., the number of small children at home; employment of a maid service, etc.) that would account for total energy expenditure.

The key questions then become:

- **In which populations do we find both low levels of leisure physical activity and various health problems?**
- **Will an increase in leisure physical activity reduce the health problems?**

In addition, increased energy expenditure may be only one aspect of the solution; increased quality of life, and increased social activity must also be taken into account, as must alternative forms of activity that are less amenable to measurement in terms of energy expenditure.

Notes

1. These data do not take account of racism, except perhaps in the case of Aboriginals. Systemic racism against both immigrant and non-immigrant persons of colour in Canada is well established. A recent British report notes that, “Access to ‘Sport for All’ is not a reality for many black and ethnic minority people” (Sports Council, 1994, p. 15); and goes on to make a point that we develop subsequently, viz.: “It has long been recognized that socio-economic status has had an effect on black and ethnic minority involvement in sport” (Sports Council, 1994, p. 15). There is no reason to expect that the situation in Canada will be very different from that in Britain.

4. RECOMMENDATIONS AND CONCLUSIONS

The purpose of this chapter is to present a series of recommendations to address the problem of systemic barriers to access to active living. These are listed under the three types of barriers identified in the systemic model of access outlined in Chapter 2: *infrastructural*, *superstructural*, and *procedural*. This format has the advantage of easily identifying concrete actions that must be taken in order to overcome systemic barriers to access to active living. However, such a format may give the impression that each of these proposed actions are of equal importance.

Hence, before outlining the recommendations, we would like to underline the following points:

- Among all of the major population segments considered in our examination of systemic barriers to access, social class appears to be the major variable to consider – both as a distinct segment, and in relation to all of the other population segments. The model presented in Chapter 2 identifies social
- Class as the primary socio-economic determinant that creates substantive inequalities. This point is consistent with population health research (e.g., Evans, 1994). Therefore, the increasing inequity in the distribution of wealth among Canadians – particularly during the last decade – may constitute the single most important barrier to access to active living, and may undermine most of the proposed initiatives to overcome other barriers.
- We would like to emphasize the need for research taking into account the total physical activity of Canadians, rather than just leisure physical activity. A person reporting no leisure physical activity should not simply be identified as “inactive.” A combination of wage, domestic and reproductive labour on the part of that person could easily represent a greater *kkd* expenditure than that of an office worker who visits the gym five times per week. Leisure time spent as a ‘couch potato’ may represent a rational solution to physical and mental stress to such individuals.

- However, a high level of energy expenditure in wage, domestic and reproductive labour is not necessarily health promoting. Emphasis must be placed on the significance of social relations as a part of leisure physical activity. Researchers (e.g., McTeer & Curtis, 1990) have emphasized the importance of social relations in achieving a level of psychological well-being deriving from physical activity, and the proximate social network of each individual may be vital to attaining and motivating access. People living in isolation cannot easily have access to opportunities for active living. Also, social networks that develop as a result of participational access to active living may have transformative and empowering effects beyond health and quality of life issues. As Donnelly (1993) has noted: "We have long held, although with little evidence, that sport participation has the capacity to transform the character of individuals. It is possible that the struggle to achieve a fully democratized sport and leisure might result in the capacity to transform communities. People could learn initiative, community endeavour, collective rather than individual values, self determination, and so on, that could permit them to begin to take charge of their own lives and communities" (p. 428).
- It is also necessary to underline again the importance of the empowerment of individuals coming from various disadvantaged populations. Potential participants in active living initiatives must be empowered to determine their own form of activity, as well as to have some control over the provision of services. This may be achieved only through the development of community action at the local level.

These remarks lead us to point out that, in order to achieve access to active living, many initiatives have to be undertaken whose impact is broader than active living *per se*. Ball has recently pointed out that health care is only part of the answer to improving the health and well-being of Canadians. "There is strong and growing evidence that much more could be achieved if greater effort was put into improving other factors that have an important impact on population health, such as living and working conditions. In short, the health of Canadians would improve significantly if more attention was paid to underlying factors affecting health and well-being, rather than just treating disease" (1995, p. 5).

Of course, active living and leisure physical activity are among these underlying factors, but initiatives that attempt to increase access to active living without taking into account the overall living and working conditions of the target populations are unlikely to be successful in terms of improving health. The need for such broadly based initiatives is being recognized in a number of areas. For example, with reference to youth-at-risk, John Hagan notes that, “Social problems – poverty, racism and deprived neighbourhoods – are interrelated. Social agencies must concentrate not on individual problems and programs but rather on combining their efforts and their expertise. Comprehensive integrated approaches are needed to reduce the exposure of children and adolescents to high-risk settings” (Cusack, 1995, p. 17).

We cannot over-emphasize the point that the following recommendations will have a much larger positive impact if implemented in conjunction with a broad population health approach which acts on major health determinants.

Overcoming Infrastructural Barriers

- Affordable, if not free-of-charge services: the most at-risk groups identified in this report generally represent the lowest income Canadians
- Transportation: services and events must be within reach of the targeted populations
- Timing and scheduling: events, activities and services must take into account the time constraints and availability of the targeted populations, on a daily, weekly, monthly, and yearly basis
- Location: services should be within reasonable distances of targeted populations and their communities
- Facilities: should be welcoming with regard to their physical aspects (ramps, spacious hallways and washrooms, accessible switches, counters, automatic doors, etc.), and with regard to the atmosphere (music, decoration, hosting that is sensitive to particular situations and needs)
- Integrated facilities: ‘one-stop-shopping’ where various services are to be found

(e.g., library, cultural centre, leisure centre, commercial centre, child care facilities, counselling centre, etc.)

- Communications: Language, style and format of communications has to be appropriate in service delivery and publicity
- Security: facilities and services must be safe, particularly for women, children, the elderly, and the disabled (e.g., lighting, accompaniment services)

Overcoming Superstructural Barriers

- Policies: regarding equity and harassment have to be designed, implemented, and respected
- Nature of activities: must be designed appropriately to involve, accommodate and invite targeted populations, and must respect cultural mores
- Positive action strategies: outreach programmes to inform and invite targeted populations to participate
- Facilitators (professional or volunteer): must have appropriate social awareness, cultural sensitivity and technical training; must play a key role in advocating the development of policies and programmes that reduce barriers to access
- Cultural exposure: outreach programmes to inform targeted populations about possible activities, their cultural appropriateness, and benefits
- Prejudice: must be eradicated by disseminating information to majority and minority groups about access to activities and facilities that are inclusive
- Language: must be inclusive
- Maximizing equal opportunities through dialogue: individual members, and their groups and communities must voice their concerns, be heard, and act in concert to overcome barriers together (individuals and groups should not be set against each other)

Overcoming Procedural Barriers

- Hierarchical structures must give way to widespread consultation, equal representation, positive and community based action, empowering people to make their own choices and keep control on service delivery

- Social support: should be provided or facilitated for isolated groups or individuals needing help to be able to participate
- Members of targeted populations must co-ordinate efforts to participate and lead various organizations (e.g., 'buddy' strategies, approaches to mentoring, etc.)
- Federally, provincially and municipally administered resources must be accessible to the targeted populations
- Targeted populations must be made aware of their rights, and of resources that may be made available to them

Conclusion

This foundation paper represents a preliminary attempt to conceptualize a comprehensive understanding of systemic barriers to access to active living; and an attempt to identify actions that should be implemented in order to remove those barriers. We have achieved this through the development of a systemic model of access and equity in active living. In Chapter 1, the importance of access to active living is underlined, given the benefits of active living for population health. This is followed by a note of caution regarding overstated claims for the benefits of physical activity. Chapter 2 presents a model for a systemic approach to equity and access to active living. The model recognizes three types of barriers – infrastructural, superstructural, and procedural; and two types of access – participational and representational. Chapter 3 of the report presents an overview of studies dealing with barriers to access to physical activity. Finally, Chapter 4 provides a list of recommendations to overcome the barriers to equity and access to active living. The following concluding remarks identify the major points of this report:

- The systemic barriers identified in this paper are deeply rooted in socio-economic determinants – the most pervasive of which is social class. Any action to be taken to remove barriers at the systemic level must take account of the substantive inequities that exist.
- Action to overcome systemic barriers to active living will be more effective if taken in conjunction with a larger population health approach dealing with the

major determinants of health.

- Although all groups with low levels of physical activity do not experience the same barriers to active living, most barriers are common to all groups. This justifies a systemic model of equity and access, as well as a comprehensive course of action to address the barriers that apply to all groups.
- Major caveats have been identified with regard to research on active living and purported levels of inactivity. Such research has been focused on activity levels assessed only in terms of energy expenditure. As a consequence, only a limited range of human activity is taken into account. There is a need for alternative methods of assessing activity levels which would take into account the impact of activity other than that based in energy expenditure (e.g., flexibility levels, relaxation, and so on), and which remove the idea of exercise and physical activity from what is, to many people, and intimidating room full of machinery.

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APPENDIX A: LIST OF SYSTEMIC BARRIERS

Socioeconomic determinants (class, gender, heritage, age, abilities) create substantive inequity

INFRASRUCTURAL	SUPERSTRUCTURAL	PROCEDURAL
Cost	Policies	Social support
Transportation	Nature of activities	Citizens' rights
Time	Knowledge	Organizational structure
Location	Facilitators (leaders)	Management style
Facilities	Cultural exposure	
Security	Prejudice	
	Language	

APPENDIX B: CHARTS OUTLINING BARRIERS TO ACCESS TO ACTIVE LIVING

INFRASTUCTURAL (chart 1 of 2 – focused on general, age and heritage)

General	Age		Heritage
	Youth*	**Aged**	
Cost: • cost is a growing concern as user fees increase for private and public programmes and facilities – this concern is emphasized when considering the population income distribution polarization trend. (2: p. 9- 11) (14: p. 25)	**Cost**: • difficult for some children (or their families) to afford programmes (18: p. 19) (12: p.12)	**Cost**: • seniors commonly have lower incomes; structured programmes can be beyond their budget (13: p.16)	**Cost**: • financial barriers resulting from chronic unemployment for Aboriginal people (8: p. 166) • increasing participation fees combined with low incomes a problem for Aboriginal people (8: p. 141- 142).
Transportation and Location: • perceived access to facilities is an important factor influencing exercise participation (this is especially important for aged, youth and different ability persons) (3: p.s223) (12: p.18) (10: p. 4) (9 : p. 50-51)	**Time:** • lack of time (2: p. 9-11)	**Security**: • many seniors, due to decreased mobility, have fear of accidents (especially falling), also fear of crime (13: p. 15) (16: p. 20)	**Communication**: • government fails to reach minorities with information – often questions asked or information sought inappropriate because government not aware of racial diversity (7: p. 27) • many minorities do not read or write English or French very well – programme promotions may not be understood (9: p. 5)

Time: • lack of time due to school, work or family ranks highest with most groups as a barrier to increased activity up to retirement age – with heightened time pressures, this barrier can only increase (1: p. 9- 11) (2) (3).	**Transportation and Location**: • lack of available and accessible activity programmes for youth who are disabled, females, low income or live in less developed regions of Canada (12: p. 10, 12, 13)	**Transportation and Location**: • many seniors do not have access to automobile – transit services often cater only to commuters, parking is expensive – facilities not always accessible (urban sprawl) (13: p. 18).	**Location and Transportation**: • many Aboriginal people live in remote communities and have limited access to recreational opportunities because of high cost of transportation (8: p. 156).
	Communication: • need more media coverage and social marketing of active living for youth (12: p. 12) • need more marketing of existing youth programmes and how to get involved (12: p. 13).		**Facilities**: • in some Aboriginal communities, harsh winters, need proper facilities for these times (8: p. 156) • generally lack facilities, equipment (8: p. 144) • need to make better use of existing school facilities (9: p.3).

*see *social class* category for references to “at risk” youth

INFRASTRUCTURAL (chart 2 of 2 – focused on gender/sexual orientation, different ability and social class)

Gender/ Sexual Orientation	Different Ability	*Social Class
Security: • fear of crime (13: p.15)	**Location**: • inaccessible facilities discourage disabled from using community facilities (10: p.4)	**Cost**: • cost of registration, equipment, travel (youth at risk especially) (9: p. 50) (2: p. 12 -13)
Cost: • high incidence of low income for single females and elderly females, restricts participation – trying to survive, little leisure time (19: p.40) • lower incomes of women does not allow them to participate in structured activities, buy "necessary" attire (13: p.13)	**Transportation**: • inadequate transportation discourages disabled from using community facilities (10: p.4)	**Transportation**: • (specific reference to youth at risk) transportation expensive, badly scheduled (9: p.50-51)
Time: • little free time for women who have child-care and home responsibilities, or for women with career and home responsibilities (13: p.13) (18: p.16) (19: p.26)	**Communication**: • need for better promotion of available programmes and services, and promotion of active living concept (15: p.9) • need for improved communication of research findings (15: p.20)	
Transportation and Location: • often necessary to have automobile to access facilities, high proportion of women do not have vehicle (13: p.18, 23)		
Communications: • physical activity for women often promoted based on negative issues (e.g., weight control) (19: p. 27)		

* *Social class* based barriers are embedded in all categories of this analysis. Although *social class* is separated as a category here, the breadth of information pertaining to this variable is found in all the other categories.

SUPERSTRUCTURAL (chart 1 of 2 – focused on general, age and heritage)

General	Age		Heritage
	Youth	Aged	
Knowledge: • there is a lack of specific knowledge about health benefits of activity –- this may reflect lack of advice from health professional (2: p.7-8) (4: p.13-14) • primary care physicians do not typically offer patients an exercise prescription –- such information not taught to physicians in residency – - also lack of time and reimbursement for these services for physicians (3: p. s228-229) (4: p. 12). • lack of research on chronic care, hypokinetic disease processes and community prevention (4: p.12) • overall lack of research on effective implementation of active living principles for noted groups (12: p.10) (4: p.9) (8: p. 171-172) (19: p.26) (15: p.11)	**Knowledge**: • lack of awareness among children and those who influence them about importance of being physically active (12: p.10) • lack of knowledge about how to go from being aware of activity benefits to being active (12: p.10) • need more school health education experiences (12: p. 13) • need research agenda directed to active living and children (12: p. 25)	**Knowledge**: • elderly need to be better informed about benefits of physical activity (need more awareness and promotion) (13: p. 18) (4: p. 13-14) (17: p.48) • more research needed on programme implementation and evaluation (4: p.9)	**Knowledge**: • there is a lack of understanding of Aboriginal culture –- as a result, programmes offered not of interest to Aboriginals (8: p.153) • Aboriginal people have limited understanding of the services that are/can be provided (also relevant to communication barriers) (8: p. 146) • Aboriginal people to be educated in the broader definition of recreation in order to find appealing activities (8: p.175) • need more research (specific to Aboriginal community) in several areas including programme options, physical education programmes in schools, instructional techniques, effective service providers, cultural appropriateness of programmes, potential funding sources for recreation projects (these areas also relevant to policy, nature of activities) (8: p. 171-172)
Nature of Activities: • services do not take into account the diversity of all members of community. (7: p. 27-28) (14: p.25) (12: p.11) (13: p.14, 20) (8: 171-172) (19: p.31) (9: p.5, 50) (10: p.4) (15: p1) • need for home based programmes for people who prefer not to attend formal classes (3: p. s229) • need for work site programmes which are convenient and offer a variety of physical activities (3: p.s229)	**Nature of Activities**: • lack of quality PE programmes (12: p.11) • need more " fun", convenient, well organized (but not too structured) programmes (12: p. 13)	**Nature of Activities**: • organizations catering to seniors often opt for sedentary activities (13: p.14) • exercise opportunities need to be structured for people with similar abilities / segregated into ability groups (13: p. 20)	**Cultural**: • lack experiences, attitudes, awareness, values and clothing to feel comfortable in public recreation (9: p.3) • many Aboriginals do not feel comfortable walking into predominantly on-Aboriginal recreation centres (8: p.153)
Policies: • policy development necessary to increase opportunity for recognized groups (6: p. 5) • policy makers are seen to be insensitive to community group distinctive experiences, situations, cultural mores; on a local level, decision making bodies sometimes have a entrenched conception of community interest. (7: p. 24) (1: p.7)	**Facilitators**: • lack of administrative and leadership support. (12: p.11) • need for more skilful leaders and caregivers who interact with children and youth. (12: p.12) • need for more leadership development regarding youth programming (12: p.24)	**Prejudice**: • stereotypical attitudes towards seniors (in organizations catering to seniors and in society) discourage participation (13: p.14) (16: p.20) (18: p.14)	**Prejudice**: • discrimination against Aboriginal athletes, Aboriginal community (8: p.149) (9: p.3)
Facilitators(leaders): • require better leadership that is aware of the need of noted groups (12: p.12) (17: p.33) (8: p.139) (9: p.3) (19: p.26) (20: p.5) (15: p.10)	**Policy**: • need stated government priority on active living for youth (12: p.12)	**Facilitators(leaders)**: • health clubs cater to performance, inferior coaches for seniors(13: p.17) • lack of qualified personnel / younger instructors may be insensitive to needs (17: p.33, p.48) • need for peer instructors(17: p.54)	**Facilitators**: • racial minorities excluded from network of social providers –- this is self-perpetuating, leads insiders to think that minorities are not interested (7) • need more qualified, full-time Aboriginal recreational directors in Aboriginal communities (8: p. 139) (9: p.3)

	Facilities: • need more physical space reserved for outdoor activities (12: p. 12)	**Policy**: • further research into programme implementation and evaluation required (4: p.9)	**Policy**: • need more programmes for Aboriginal youth, women and seniors (8: p. 175)

SUPERSTRUCTURAL (chart 2 of 2 – focused on gender/sexual orientation, different ability and social class)

Gender/Sexual Orientation	Different Ability	Social Class
Knowledge: • lack of awareness of benefits of physical activities due to sex stereotyping (physical activity is undervalued) (19: p.25). * need more research aimed at determining cultural, ethnic and religious beliefs that may inhibit participation of females (19: p. 26) • need more research determining barriers to females involvement (19: p.26)	**Knowledge**: • misconceptions and lack of knowledge about the availability of beneficial types of activities, due in part to popular stereotypes (2: p.12) (15: p.9) • lack of awareness among Canadians with disability about the importance of an active lifestyle (15: p.9) • lack of research about how to adapt programmes and services to ensure accessibility for all participants (15: p.9)	**Knowledge**: • those with lower education have less knowledge of the benefits of physical activity (2: p. 12-13) • (for youth at risk) not aware of recreational services or activities (9: p.51)
Prejudice: • due to sex stereotyping, women not encouraged to participate in physical activity to same extent as males –- problem exists in family, support services, school, media, employers (19: p. 25) (13: p.13) (9: p.5)	**Prejudice**: • stereotypes and traditional understandings of fitness lead to fear of injury and perceived lack of skill as perceived barriers to activity (15: p.9) • negative attitudes towards persons with a disability has discouraged use of community facilities (10: p. 4)	**Cultura**l: • (for youth at risk) lack experiences, attitudes, awareness, values and clothing to feel comfortable in public recreation centres (9: p. 50)
Cultural: • older women grew up when women had more family responsibility (those who "played" were considered tomboys), thus many have little understanding of and experience with activity (17: p.40) • exercising "old", "overweight" bodies associated with embarrassment for many *older women* (17: p. 40) • lack of skills because of limited skill development for women during school years – difficult to break "inertia" if not active previously (19: p.29) (18: p. 16) (13: p.18) • women may have activity restricted by religious and cultural beliefs (13: p.13)	**Facilitators(leaders):** • social and attitudinal barriers prevent communities, schools and workplaces from employing self-empowerment model that would put leadership and decision making in hands of persons with a disability (10: p.4) • lack of quality leadership development opportunities which address needs of people with a disability. (15: p. 10)	**Nature of Activities**: • (for youth at risk) programmes not of interest, considered "adult focused", " boring" (9: p.50)
Facilitators(leaders): • lack of non-stereotypical leadership, females underrepresented in administration, programme provision of PE activities (19: p.26) (20: p.5)	**Nature of Activities**: • lack of inclusive programming discourages use of community facilities (10: p. 4) (15: p. 1)	**Policies**: • (for youth at risk) internal policies and structures inhibit service (no smoking areas, lack of staff, limited hours, dress codes) (9: p.51) • (for youth at risk) decision makers lack knowledge of benefits of physical activity when formulating policy (9: 52-53).
Nature of Activities: • females have inadequate variety of activities offered to them (19: p.31) (9: p.5) (9: p. 50).		**Prejudice**: • (for youth at risk) some view youth at risk with "disdain", do not want to use tax money to help (9: 51-52)

Policy: • policies needed that ensure equality of funding, equal representation in leadership, quality leadership, training programmes for female leaders, and research to determine barriers to female involvement (19: p.26 -27)		

PROCEDURAL (chart 1 of 2 – focused on general, age and heritage)

General	Age		Heritage
	Youth	**Aged**	
Organizational structure: • not enough collaboration among health care professionals or decision making agencies. (4: p.12) (15: p.10) (9: p.52) (19: p.27) (12: p.11) (8: p.175) • procedures governing decision making intimidate and alienate community groups who lack education or resources (7: p.23) (1: p.5) • need for internal organizational effectiveness (consensus, motivation, empowerment) – this is related to leadership category of superstructure section (1: p.5) (9: p.52) (8: p.157, 175)	**Organizational structure**: • lack of coordination among agencies (12: p.11) ● need PE to be internal part of education curriculum (12: p.12)	**Organizational structure**: • not enough collaboration among health care professionals (4: p.12) • eligibility requirements and screening procedures (e.g., signed doctor consent) deterrent (17: p.48)	**Organizational structure**: • need to empower Aboriginal people – in the past, services have been delivered for them, they have not learned to service their own people (8: p.157, 175) • (Aboriginal people) require recreation committees (8: p.144) • (Aboriginal people) need more volunteers to help with programmes (8: p.144) • need to build a working relationship with Ministry and Aboriginal community for sake of improving access to programmes and services (8: p. 175) (9: p.3) • (for youth at risk in the Aboriginal community) health and community services for Aboriginal families need to address issues more holistically (9: p.3)
		Social support: • insufficient social support – lack of role models and lack of support from physicians (13: p.24) (4: p.14) (17: p.46) • lack of funds and recognition for efforts; more funding needed for chronic care vs. acute care (17: p.33)	**Social support**: • lack of funding from provincial sources (8: p.146) • absence of Aboriginal role models (those that do exist are not promoted) (8: p.167) • general absence of role models (10: p.4) • need more parental involvement for Aboriginal youth (8: p.156)

PROCEDURAL (chart 2 of 2 – focused on gender/sexual orientation, different ability and social class)

Gender/Sexual Orientation	Different Ability	Social Class
Organizational: • lack of cooperation/coordination among sectors providing physical activity experiences for young females (19: p.27) • lack of flexible programming and lack of flexible day care facilities, inhibiting mothers of young children (19: p.27) • networking among women's groups is needed (9: p.31)	**Organizational**: • lack of coordinated effort exists among organizations that develop programmes and services for people with a disability (15: p.10) • few opportunities available for Canadians with a disability to assume responsibility for their active lifestyles (15: p.10)	**Organizational**: • (reference to youth at risk) formal and inflexible structure of current services not conducive to involvement; no participant input/empowerment (9: p.50, 62) • (reference to youth at risk) middle class bias in decision making and delivery of physical activity (9: p.51) • (reference to youth at risk) lack of communication among organizations responsible to groups (lack of awareness, communication – some professional territorialism) (9: p.50) • (for youth at risk) emphasis on elite sport and not community development (9: p.52)
Social support: • lack of role models and encouragement (19: p.25) (13: p.24) • unsure if doctor's approve of physical activity (13: p.24) • women do not receive fair share of resources in terms of programmes, and variety of programmes and facilities (19: p.27, 31)	**Social support**: • frequently, service and programme providers are not able or not willing to accommodate requests for access by people with a disability (15: p.10)	**Social support**: • (for youth at risk) no support from family, no role models (9: p.50) • (for youth at risk) lack of financial resources (9: p.52-53) • (for youth at risk) programme cut-backs reduce opportunity (9: p.62)

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**** Reference to these source articles also includes reference to articles cited by these sources.***

APPENDIX C: NOTE TO TRANSLATORS

Traduction française de certaines citations

Á elle seule l'école ne saurait faire le changement social qui permettrait une veritable égalité des sexes. Elle peut cependant prendre le leadership dans ce domaine en créant un environement qui incite les enfants á effectuer le changement de valeurs et de perception necessaire. Elle peut également constituer un des noyaux autour duquel la communauté organisera les différentes actions culturelles et socio-politiques qui jetteront les bases d'une nouvelle société (Ferrer and LeBlanc-Rainville, 1988, pp. 79-82).