BEYOND THE LIFE STYLE APPROACH:

The role of femininity codes in aspiring for healthy living.

A comparison of Moroccan migrant and Dutch women in the Netherlands.

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ABSTRACT

Public health interventions are mainly based on a physically oriented lifestyle approach: no smoking, moderate drinking, safe sex, healthy food, exercise and relaxation. But as the diversity of the population increases—socially, culturally and morally—this approach needs to be reconsidered.
Our participatory action research project "Aspiring to Healthy Living" aims at health promotion development from a multidimensional perspective. To this end, we collected ideas about "healthy living" for elderly men and women with low socio-economic status and a different ethnicity. In this paper we focus on the commonalities and differences between women.

Five Moroccan migrant women and five Dutch women - whose ages ranged from 48-62 and 56-67 years respectively - were interviewed with the assistance of peers and intermediaries. The interviews were qualitatively analyzed. Our questions were: a) Are dominant lifestyle themes included their ideas about "healthy living"? b) Do codes of femininity play a role in their ideas about healthy living? c) If mentioned, how are they referred to? d) What could this imply for public health interventions?

Societal and health services' dominant "lifestyle narratives" are frequently mentioned by Dutch informants but rarely by Moroccan informants. All respondents link healthy living to their responsibilities as mothers and housewives. Moroccan women centre mainly on men and (grand)children. Dutch women also mention their responsibilities as daughters to their parents, and to non-family members. If femininity codes are challenged, the respondents often take a historic perspective, referring to changes in women's socio-cultural position as well as roles and identities over the course of their life. Doing so, the disparate (migration and emancipation) histories of Moroccan and Dutch women become visible. Guilt, however, is a recurrent theme in the interviews with both groups.

The conclusion is that a mono-dimensional lifestyle approach does not connect well to Moroccan or Dutch women. The healthy living approach offers a better frame of reference to understand which dimensions of women's lives need attention and how. We discuss the implications of the commonalities and differences between the Dutch and Moroccan migrant women for health promotion interventions.

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Beyond the life style approach:
The role of femininity codes in aspiring for healthy living.

Public health approaches

The research I'm presenting today is an exploration of women's ideas about healthy living, with special attention to the role of femininity codes. First, I will briefly describe how the healthy living approach differs from the more traditional public health approach. Then, I will point to the diversity perspective, as it is built in into our "Aspiring to Healthy Living" project, and briefly explain the research design we followed—participative action. Subsequently, I will present our results, conclusions, and suggestions for intervention.

Traditionally, public health has focused on illness prevention, but in the 1970s interest in health education increased, and unhealthy life styles like smoking, alcohol consumption, fatty food, lack of exercise and unsafe sex became targets for intervention. This approach was characterized by a physical orientation, though mixed with psychological insights, and by a universalistic portrayal of mankind. In other words, special attention was not paid to women except for their reproductive function.

In contrast, the "healthy living" approach assumes that health and healthy lifestyles are multidimensional phenomena, not only physical and psychological, but also social, cultural, economic and existential layers must be taken into account. As such, this approach is better attuned to a society that is becoming increasingly diverse—like the Dutch.

A diversity perspective in action

In our project we have explicitly adopted a power-conscious diversity perspective in three respects. First, we focused on four important social categories of inequity: age, class, sex, and ethnic background. Second, we focused on disadvantaged groups, specifically seniors (originally defined as people between the ages of 55-75) with a low socio-economic status (SES)—a homogeneous group. But we also considered heterogeneity – in gender and ethnicity - and deliberately varied our original sample by including men and women who were Moroccan-born and native-born Dutch citizens. In this paper, however, we will focus on the women sample.

Third, we aimed for redistribution of power and control, by adopting a Participative Action Research strategy. This method avoids hierarchical relationships; includes intermediaries and peers; requires cyclic processes of research, learning and change; encourages mutual openness and dialogue, and strives for empowerment.

With the help of intermediaries and peers with a similar gender, ethnicity, age and SES, we interviewed 16 women in their homes, during the spring of 2003. The interviews were tape-recorded, and—if necessary—translated by the interviewers on a second tape-recorder. As some of the transcripts covered only a few pages and the answers were rather superficial, while in other interviews the interviewer did the talking instead of the interviewee, we limited our final sample for quality reasons to five Dutch and five Moroccan migrant women[3], all of whom were living in Rotterdam—one of four large cities in the Netherlands. See table 1.

[3] The Moroccan migrant women are generation immigrants.

Table 1: Women Respondents' characteristics for the "Aspiring to Healthy Living" Analysis (2003)

	DUTCH					**MOROCCAN**				
	Anna	**Carola**	**Lia**	**Lilian**	**Magda**	**Aisja**	**Azra**	**Dunya**	**Jamila**	**Rhiwi**
Age	75	56	56	64	61	62	49	49	62	48
Marital Status	wid [1)]	mrd [2)]	wid	mrd	mrd	mrd	div [3)]	mrd	wid	wid
Child at home	no	no	no	no	no	yes	yes	yes	yes	yes
Parents alive		yes	yes		yes					
Outdoor Activities	yes	yes; empl [4)]	yes	yes	yes	yes	yes; empl	yes; empl	no	no
Religion				Roman Catholic	Protestant	Muslim	Muslim	Muslim	Muslim	Muslim
Health Complaints	Knee damage	Hyper-tension	Muscular pain	Thyroid gland; depression; headaches	Eczema	Brain haemorrhage	None	Back pain; Sickness leave	Hypertension	None

[1)] Widowed, [2)] Married, [3)] Divorced, [4)] Paid Employment

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Actually, the participants varied more in age than intended because older Moroccan women were difficult to contact, and because Mediterranean migrants were said to enter the senior stage almost ten years earlier than the Dutch, in terms of validity, life history and self-experience (Schellingerhout, 2004, p.5). The education and income for all respondents was working class level. Five women were married, four widowed, and one divorced. So, half had a male partner at home; and half were "single". All participants had children, and several had grandchildren. Please, note that all the Moroccan mothers had children living at home. This maybe a cultural difference, but it certainly nuanced our idea of living in a senior stage of life.

Three of the Dutch women were looking after living parents (or parents-in-law). With the exception of Jamila and Rhiwi, all women had activities outside their home. For Carola, Azra and Dunya this also involved some (part-time) paid work. The Moroccan women were all Islamic while three Dutch women reported "no religion", one "protestant", and one "Roman Catholic". Apart from Rhiwi, all participants reported health complaints, varying from knee damage for Anna (the oldest one) to back pain causing sick leave for Dunya.

The interviews were semi-structured, with a set of guiding questions organized into six general topic areas: the meaning, ideal, and importance of healthy living, changes in life and the

possibilities to realize these changes now and in the future, and the factors contributing to change. Thus, femininity or femininity codes were not a focus at the start of the study.
After transcription[4], a content analysis was performed using Atlas-ti software. In the analysis we focused on four questions:
a) Are dominant lifestyle themes part of their ideas about "healthy living"?
b) Do codes of femininity play a role in their ideas about healthy living?
c) If mentioned, how are they referred to?
d) What are the consequences for public-health interventions?

Findings

I present our findings in four sections—healthy life styles themes, multidimensionality, femininity codes and ensuing problems, and insights obtained—while pointing at some remarkable differences and commonalities among the Dutch and Moroccan migrant women.

Life style themes

First, I describe the frequencies of selected themes mentioned by the respondents. See table 2.

Table 2: Frequencies of Healthy living themes mentioned by Dutch and Moroccan women participants.

	DUTCH WOMEN	**MOROCCAN MIGRANT WOMEN**
Number of words	78.000	35.000
Life style themes		
Food	37	2
Exercising	23	2
Relaxation	25	4
Safe sex	1	0
Environment		
Family	45	55
Social Relations	40	9
Other circumstances	24	12
Religion	2	6
Money	7	11
Feminity codes		
Consideration of others	24	6
Educating, tending, homemaking	25	14

[4] For transcription a relatively simple system was used that made note of unclear passages, interruptions and pauses (Billig, 1997; Sherrard, 1997). Subsequently, the interviews were analysed by using a computerised coding system (Atlas-Ti) that supports the development of interview transcripts to thematically structured and ordered text segments and facilitates the identification of (dis)similarities and regularities. The preliminary results were discussed by the two authors.

To put the frequencies into perspective we counted the number of words for each interview. As the Dutch women employed twice as many words (perhaps due to the way we performed the translations), one could argue that the word count for the Moroccan migrant women should be doubled to achieve a realistic comparison. Nevertheless, it is quite clear that the life-style themes were mostly mentioned by the Dutch women.

Sexuality was noted only by the eldest woman of the Dutch subgroup, who reported that she warns her granddaughter about sexual imprudence.

Family was an important topic for both groups. But social relationships were reported more often in the Dutch rather than the Moroccan interviews (even if the Moroccan word counts are doubled). Presumably, senior Moroccan migrant women require significantly more effort to participate in Dutch society or a Dutch Moroccan community. Other circumstances referred to by both groups were built environment, air pollution, accessibility of (health) services, discrimination, stereotyping, and "the war on terror" that had just begun.

Religion was mentioned eight times overall and more frequently by the Moroccan migrants than the Dutch respondents. Money was highlighted as something you need to have at your disposal if you want to keep your diet, do fitness, or fun shopping. Given the low SES of our respondents, these frequencies were definitely below our expectation.

As already stated, traditional life style topics were predominantly mentioned by Dutch women. This is not surprising in light of the extensive prevention campaigns in the Dutch society that are generally broadcast or written in Dutch. The Dutch women talked about several ways to achieve relaxation, and their struggle to maintain a healthy diet, for example. Lia explains her difficulties with exercising as follows: *"It is risky to go for a walk on your own"*. We could interpret this as public space being not freely available for women.
Most of the Dutch women expressed a rather critical attitude, and even resistance, towards the healthy life style advice. Listen to how Magda stands up for herself:

> *"I always respond to those saying 'You still smoke? Didn't you stop yet?': 'Yes, I've tried but I can't. But I don't drink or sleep around. May I smoke then?' For me, it is acceptable, I think. But I try to minimize when my grandchildren are around".*

And Lia refers to a kind of dictatorship in which everyone is prescribed a daily portion of vegetables, exercising and vitamin pills.

Multidimensionality

In general, table 2 shows that healthy living is associated with more than only a physical dimension. Even the mind-body dichotomy—so dominant in current health care—is transcended. In fact, four of the five Dutch women put emphasis on the mind-body *interaction.* Three respondents used the Dutch phrase "feeling comfortable in your own skin" as a necessary condition for feeling physically healthy. Another belief the Dutch women shared was that physical exhaustion can bring mental relaxation, and feelings of a very healthy living. And they say that physical ailments don't necessarily impede healthy living.

Interestingly, whereas the Dutch interviews offered a sort of summary of separate life-style aspects (physical, mental, social), Moroccan women presented a more holistic story. An example is Azra, the only divorced respondent.

Azra:

> *"My example for healthy living, in fact, is being free from work when I awake in the morning, take my time to dress myself, shower the kids. Then I think 'today is a day off'. So, I'm nicely cooking couscous, we leave, and when we come home, we eat together in our style: a teller full of couscous. Sometimes, I invite a friend or my sister. Then, with a full house, I think 'Oh, this is healthy living. Today I cared for myself".*

Femininity codes

We started our analysis with twelve femininity codes and concluded that only two had relevance in the respondents' stories about healthy living, namely: "Having consideration for other people" and "Being responsible for education, caring and home-making". Later on, we clustered these and labeled them "Caring for other people".

For all women, "caring for others" appeared to be a main norm; however, the answers on "Who the others are?" vary considerably. Whereas the Moroccan respondents emphasized their care for men and children, the Dutch respondents did not even mention care of their husbands (even though three Dutch women were married). The Dutch women referred mainly to their parents, and to lonely and handicapped people, as needing their attention, support, and care. Listen to Dunya, Azra (both Moroccan) and Magda (Dutch).

Dunya:

> *"Last time, my son had a good report. Done everything well. I can't describe my feelings that day. I feel really healthy, elated—no pain".*

Azra:

> *"Formerly, I see healthy living different, I see that I'm going to marry; that I get children; that I'm going to do everything together with my husband: upbringing children and so on but now [being divorced] it is completely different, and I therefore see my life not as a healthy life".*

Magda (about volunteer work):

> "It's an effort, but it's a mental relaxation –just because it's wonderful to do things for other people that react—so to say—immediately that they like it, that they feel fine".

Perhaps the difference in their subject of care must be understood as a consequence of the circumstances Moroccan migrant women and Dutch women live in: children at home or not, parents alive or not (or parents living in the country of origin), and the freedom to define your own time or not. Perhaps it is also a consequence of culture and self-definition. For Moroccan migrant women, "self" seems to coincide more or less with husband and children. So, spousal and motherly caring is simultaneously a form of self-care. Dutch women, on the contrary, repeatedly emphasized their need (perhaps also duty?) to have a life of their own, independent from their husband and children. This brings us to the health problems connected with the central femininity code.

It appeared that the "caring for others" attitude may entail specific health problems. First, it may threaten a woman's self-care. According to Magda and Carola, they have to protect their self-care: against their children, and against vulnerable people in general. For that, they had to learn to say "no". But that was in the past. For Dunya and Rhiwi, however, the conflict between self-care and care for others is still part of their daily life. Aisja tells about the self-care she had

aimed for in a future after her children left home. She had expected to enjoy life by traveling and so on, but her dream is now frustrated by her serious illness.

Second, Azra highlights the devastating effect of lack of recognition for caring labor. She points out that Moroccan husbands don't empathize with their wives' endeavors and well-being, and forget to value their wives.

Third, feelings of guilt turn out to be a problem, mentioned mainly by the Dutch women. Magda explains that guilt pops up if she does not contribute like she could. *"That's how I was educated"*, she explains. Carola struggles with guilt if she does not visit the lonely people she knows. And Lia disapproves of herself for following her own pleasure and perhaps sitting quietly somewhere; she thinks it would be better to do some volunteer work. Among the Morocan women, only Jamila expresses feelings of guilt, linked to her children in Morocco, because she cannot be with them.

Insights obtained

Now, I will summarize some of the points of attention we learnt during our analysis.
To begin with, life stages for older women must be distinguished by specifying

- if there are still children at home;
- if a husband (employed or retired) is around;
- if parents are still alive—and perhaps in need of help;
- employment (perhaps informal), and volunteer work;
- a woman's need to care for herself.

Additionally, the explanatory models about healthy living are filled with other narratives. The ideas of the Dutch women are partly interwoven with a lifestyle narrative, and partly with a narrative of women's emancipation, of "standing up for yourself", "saying no", "dealing with guilt" etc. Magda even explicitly mentioned the emancipation movement as a great support.
The ideas of Moroccan migrant women do not connect so much with a life style narrative, but are impregnated with a migration narrative - actually in two ways. On the one hand, the living conditions of migrants are said to undermine their healthy living: *"far from their extended family"*; *"discriminated against"*; *"always having to prove yourself"*. On the other hand, the clash of cultures causes a *"lost way of life"*, as Azra calls it. In some cases, it is precisely the Western ideas about women's emancipation that may cause conflicts and alienation, as there is no group you belong to anymore, or can connect to.

Moreover, the self-definition of women determines the chances and problems connected to the femininity code of "caring for other people". It would be unjustified to articulate the difference in terms of autonomy versus a community orientation, with Dutch women on the one side of the spectrum and the Moroccan migrant women on the other. In our opinion, we can characterize the differences more accurately along two other lines: on the one hand, being and becoming "self-in-relation", and on the other, identifying with traditional female roles, such as spouse and mother.

Finally, without having the time now to demonstrate the data we draw upon, we want to share our impression with you about the differences in attitude. It seemed that the Dutch respondents displayed an attitude that healthy living is possible and "do-able" more often than Moroccan migrant women, while the Moroccan respondents doubted those possibilities, as well as their own efficacy to accomplish a healthy living.

Implications for intervention

Now, I will share with you some of the implications for intervention, as we see them. First, one should account for the cultural embeddedness of the four attention points. Otherwise, the meaning and consequences of women's health problems and behaviors can easily be misunderstood.

Second, we recommend reflection on the "caring for others" code. For Dutch women, health education may stimulate them to explore the false dichotomy between "caring for others" and "self-care", with the help of the Self-in-Relation concept (Jordan, 1991) developed at the Stone Center at Wellesley College. It may help them to speak about the dilemmas linked to their senior age, and to find ways to deal with these without being prone to a guilt mechanism. For Moroccan migrant women, health education may raise their consciousness about "caring for others" as a femininity code they can revalue and perhaps adapt in the light of their ageing, their migrant position and the consequential social and material circumstances they have to address.

Third, a multidimensional health approach seems to be appropriate for all women, senior or not, as this can diminish the very general complaint that health care providers don't take them seriously. Women without much education especially will feel empowered if they are helped to express their ideas of a good and healthy life, thus becoming capable to discuss these matters with family members, as well as health professionals. (To this end we have developed some very effective materials such as vignettes, games, pictures, and health portraits). On the other hand, to avoid an attitude of powerlessness, health education should help to sort out which of the existential, physical, mental, social, cultural, and economic factors can be enhanced; in other words, what agency each woman can employ in her own situation.

Fourth, these reflective, consciousness-raising and empowering interventions can best be organized in groups of senior women only, preferably in the same social economic situation (although it is almost impossible to recruit for SES directly). Such a class- and gender-homogeneous setting will enhance sharing, recognition, mutual identification and may facilitate new socialization processes. To guarantee learning processes in the desired direction and to prevent powerless complaining sessions, a same-sex facilitator should be available. She must keep conversations on track and provide training opportunities for new behavior.

Fifth, considering the habit of preventive care to organize ethnically homogeneous groups for Moroccan migrant women and gender-mixed groups for autochthonous people (women and men), we see also promising possibilities for ethnically heterogeneous groups of senior women. However, such groups should only be organized with women who have sufficient proficiency in the Dutch language, and who are already trained in a (self-)reflexive attitude. This may require a somewhat higher education level than most of our respondents had.

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