Engendering Health Disparities

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ABSTRACT

How is gender implicated in our exploration of health disparities in Canada? Set against the backdrop of federal government policy, this review paper examines the ways in which gender intersects with other health determinants to produce disparate health outcomes. An overview of salient issues including the impact of gender roles, environmental exposures, gender violence, workplace hazards, economic disparities, the costs of poverty, social marginalization and racism, aging, health conditions, interactions with health services, and health behaviours are considered. This review suggests health is detrimentally affected by gender roles and statuses as they intersect with economic disparities, cultural, sexual, physical and historical marginalization as well as the strains of domestic and paid labour. These conditions result in an unfair health burden borne in particular by women whose access to health determinants is – in various degrees – limited. While progress has certainly been made on some fronts, the persistence of health disparities among diverse populations of women and men suggests a postponement of the vision of a just society with health for all that was articulated in the Federal Plan on Gender Equality. Commitment, creativity and collaboration from stakeholders ranging from various levels of government, communities, academics, non-governmental agencies and health professionals will be required to reduce and eliminate health disparities between and among all members of our society.

MeSH terms: Gender; gender bias; inequalities; research; health behaviours; health services

La traduction du résumé se trouve à la fin de l'article.

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Health disparity can be defined as a "marked difference or inequality between two or more population groups defined on the basis of race or ethnicity, gender, educational level or other criteria" (p. 274).[1] Engendered by the inequitable access to health determinants such as income, social support, good quality housing and clean environments, and the stresses imposed by structural forces, multiple roles and discrimination, health disparities reflect a gradient in socioeconomic status and power.[2,3] When health disparities are examined in terms of gender, Matthews, Manor and Power observe that the relationship between health outcomes and social hierarchy appears to be more linear in predicting men's health while the association to women's health appears to be more complex.[4] The relationship between gender inequities and health is seldom static and intersects with factors such as ethnicity, sexuality, age and disability in dynamic and complex ways.[5]

While gender refers to the cultural constructions and layering applied to sex categories, the existence and persistence of gendered social hierarchy in our society means that women are most often associated with health disparities. This recognition is reflected in policies, programs and research that often focus on women. Importantly, some men are vulnerable to marginalization and impoverishment and must therefore be considered in the context of reducing health disparities; however, we must also attend carefully to the possibility that the term "gender" can inadvertently mask discrepancies *between* women and men.

Policy context

Are gendered disparities in health a problem in Canada? Canada has been viewed as a world leader in forwarding gender equality and encouraging other nations of the world to adopt similar goals, yet the response by the United Nations Committee on the Elimination of Discrimination of Women to a recent government report on the status of gender equality was not wholly laudatory.[6] Some committee members opined that a country with Canada's wealth and reputation should have made greater progress in terms of its commitment to reducing inequality between women and men. Their comments focussed on a number of key issues

including: the high percentage of women who live in poverty and report poor health status, the persistence of violence against Canadian women and the apparent decline in funding for shelters, the vulnerability of Aboriginal women to domestic violence and incarceration, the diminished status of immigrant and refugee women and the promulgation of neo-liberal policies as well as changes to federal-provincial transfer payments that have reduced spending on social and health services. The committee, however, praised Canadian efforts to improve parental leave and child tax benefits, to introduce measures to reduce the trafficking in women, and to further develop gender-based analysis and indicators to monitor governmental progress on gender equality.

A variety of international commitments inform the Canadian government's approach to improving women's access to determinants of health. The United Nations' *Declaration on the Elimination of All Forms of Discrimination Against Women*[7] proclaimed that discrimination against women – defined broadly as denying or limiting women's equal rights with men – is unjust. The *Declaration* forwarded an agenda in support of public education and the abolition of practices that reinforced the notion of male superiority. Importantly, it also stated that women had the right to equal pay for work of equal value and to appropriate retirement, sickness and old age security benefits. In 1981, the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW)[8] moved these issues further by drawing attention to topics of poverty and racism in a variety of forms. The CEDAW identified discrimination against women as any means by which women are prohibited from obtaining, exercising and enjoying rights equal to those of men. Signatories to the Convention are obliged to abolish laws, regulations, customs and practices that likewise discriminate against women. Additionally, the CEDAW urges respect for maternity and details the right of women to health and safety in the workplace. Notably, Article 11, no. 2(c) urges governments to "encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, particularly through the establishment and development of a network of child-care facilities." The CEDAW further states that women have a right to participate in sports and cultural life and draws attention to the particular needs of rural women with respect to access to health care including family planning, employment, good quality housing and sanitation.

Canada is signatory to the *Declaration on the Elimination of Violence Against Women*[9] that identifies unequal relationships between women and men as the source of violence against women. Defined "as any act of gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women including threats of such acts, coercion or arbitrary deprivation of liberty," governments are asked to consistently work to prevent, investigate and punish acts of violence against women. Additionally, the *Declaration* notes that particular groups of women, including indigenous women, immigrants and refugees, women with disabilities and the elderly, are particularly vulnerable to violence. Signatories are urged to develop appropriate and sufficient support services for women surviving violence. In 2000, Canada joined other countries in supporting the *United Nations' Millennium Declaration*[10] thereby committing itself to the support of human dignity and equality and to eliminating the scourges of poverty and racism that interfere with the ability of individuals and communities to live their lives with self-respect and in good health.

Canada has responded to its international commitments by supporting the implementation of various initiatives under the auspices of the *Federal Plan for Gender Equality*.[11,12] The *Federal Plan* was designed to engage all levels of government as well as non-governmental agencies in the development of policies and programs that would enhance gender equality in Canada. The document acknowledges the disparate and multiple realities of women and the need for government policies to engage in gender-based analysis as a matter of routine to ascertain the potential impact of policy on women and men in all of their diversity. The authors emphasize that gender-based analysis demands attention to social context, therefore, policy-makers must account for the fact that women perform a disproportionate amount of care work and domestic labour, and are pooled in low-wage positions. In Canada, the *Federal Plan for Gender Equality* identifies various sites of action including promoting affordable housing, reducing violence against women, enhancing women's economic participation, developing child care programs with other levels of government and addressing health inequities by learning more about sex differences in disease presentation and treatment and identifying the health needs of marginalized women.[12]

The Women's Health Bureau provides much of the leadership in efforts to examine government policy and health disparities using a gender lens. Established within Health Canada in 1993, the Women's Health Bureau's mandate is to ensure that the Canadian health care system responds to the needs of women.[12] The *Women's Health Strategy*[13] was designed to improve our state of knowledge about women's health and to support the development of health services and preventive health measures that will meet the needs of women. The Women's Health Bureau also oversees the administration of the Centres of Excellence for Women's Health who conduct research and work with the Canadian Women's Health Network to disseminate information and advocate for gender equity and improvements in women's health. In addition, the Women's Health Bureau produces a variety of tools to enable policy-makers and programme planners to engage in gender-based analysis of their own work. In a recent publication, *Exploring Concepts of Gender and Health*,[14] the need for mainstreaming gender-based analysis is demonstrated through a discussion of concepts and examples. Finally, in response to feedback from researchers, organizations and the public, the federal government established the Institute of Gender and Health in 2000 as one of the Canadian Institutes of Health Research.[15]

Overall, the Canadian government has demonstrated a commitment to gender equality and improving the health of women through its varied international and national agreements and programmes; however, the need for a symposium on health disparities in 2003 suggests that these issues persist. This synthesis article will provide an overview of gender and health in Canada and describe the poten-

tial mechanisms through which women and men may be vulnerable to poor health outcomes. It will conclude by offering recommendations for future action and research.

Engendering health disparities

A Canadian child born in 1997 can expect to live to just under 76 years if male or over 81 years if female;[16] however, in a trend referred to as the gender paradox, the girl child is more likely to experience those years as unhealthy ones. For instance, 11% of Canadian women versus 4% of men suffer from chronic conditions;[16] in particular, women are diagnosed more often than men with conditions such as multiple sclerosis, lupus, migraines, hypothyroidism and chronic pain.[17,18] The disparities in life expectancies between women and men in Canada can be attributed primarily to higher rates of accidents and injuries leading to excess mortality among men.[19] General statistics, however, belie the considerable diversity in circumstances of birth and life that confer both advantage and disadvantage to the health and well-being of individuals throughout their life course. The question must be asked: what makes people sick?

Certainly increased longevity results in greater risk of disability and chronic illness associated with aging;[20] however, the consequences of aging do not explain the existence and persistence of health disparities throughout the life cycle. While genetic heritage and negative health behaviours can contribute to susceptibility to certain ailments, a population health approach that considers the full range of health determinants suggests that social factors are more salient overall than health behaviours in determining health status.[21]

Gender itself is a determinant of health and is interlinked with biological and social determinants. If prominence is granted to social factors, then health must be considered within the context of gender roles, access to social and economic capital, the geopolitical environment, cultural values and the impact of racism, sexism and ageism.[22] Gender disparities in health are further configured by ethnicity and the potentially corresponding discrimination. As the rubrics "women" and "men" mask heterogeneous populations marked by disparate class statuses, ethnicities and sexualities, so too are the pathways through which women and men are constituted in various degrees as vulnerable to health risks. Certain common touchstones, however, manifest themselves on the journey. A review of the literature suggests that health inequities emerge from the dynamic intersections of the demands of multiple gender roles, environmental exposures, the threat and consequences of gender violence, workplace hazards, economic disparities, the costs of poverty, social marginalization and racism, aging, health conditions and interactions with health services and health behaviours. Psychosocial resources, whether positive, such as social networks and systems of support, or negative, such as stress and its physiological expressions, also mediate embodied expressions of inequality although the mechanisms through which these factors influence health status are poorly understood.[22,23] A consideration of these intersecting issues that contribute to the development and persistence of gendered disparities and health follows.

Gender Roles and Status

Gender is generally regarded as the culturally ascribed attributes and roles assigned to the biological categories of, at minimum, the dichotomous pairing of male and female. This definition, however, denies both the complexity of gender as an interactive and socially influenced performance and that sex categories themselves can be regarded as historically situated constructions whose boundaries are perhaps more blurry than is often recognized. Gender disparities in health, then, must be viewed in the context of the contingencies of these categories.

Male gender roles may, for example, produce deleterious health effects that contribute to excess male mortality. For instance, notions of masculinity that valorize risk-taking behaviour, aggression and stoicism are associated with increased injury and death.[24-27] Once they have survived childhood, where boys are more susceptible to disease than girls, adolescent males are generally healthier than their female counterparts – with the exception of injuries.[28,29] Adolescent injuries in turn are linked with behaviours such as binge drinking, smoking and having multiple sexual partners, which are associated with masculinity by young Canadian males.[30] Notably, not all men ascribe to this definition of masculinity as this construction differs along economic, educational, sexual and ethnic lines.[25]

Gender roles and relations produce different responses and exposures to stressors that in turn result in varied health outcomes.[31,32] Additionally, gender roles and statuses change throughout one's lifetime and may influence access to health resources. In some societies, women's status increases with the birth of male children and as women reach maturity, while in others status peaks in married adulthood and declines as women age.[33] Female gender roles generally require women to be responsible for a disproportionate amount of domestic labour, cultural transmission and socialization of children and kin work that includes attending to familial social relations. In many parts of the world, women are engaged in subsistence production and may be further engaged in the labour market. The multiplicity of roles enacted by women make them vulnerable to role conflict between family and work demands that can further lead to a variety of negative health outcomes.[34]

Gender differences in health are linked to disparate access to resources determined by cultural attitudes towards gender, class, social policy and labour market patterns[22,35] and are replicated in the household. Intra-household allocations of resources are usually invisible and not always equitable; therefore, even though household income and occupational status of the head of household – usually regarded as a male income earner – are used to determine socio-economic status, not all members may share in this rank position.[22] Income-earning individuals, usually male, may receive preferential access to health services where financial constraints are a factor and may be provided with more nutritious food than female members of the household. Cultural notions that women are meant to be smaller and that women's labour requires less energy expenditure provide the rationale for unequal distribution of food resources that in some instances can result in under-nutrition.[36]

Cross-culturally, women are presumed to be the most appropriate caregivers for children, the infirm and the elderly. While these responsibilities are presumed to be

"natural", they can also be overwhelming; for instance, an average American woman will have spent 18 years caring for an elderly spouse and 17 years caring for children.[37] The care work activities of women must also be situated within a broader context. Globalization has impelled the waves of health care restructuring that have resulted in a movement towards deinstitutionalization and abbreviated hospital stays. The resultant off-loading of responsibilities onto families that have neither extended networks nor an equitable division of labour results in "compulsory altruism" on the part of women.[38-40] Moreover, the types of tasks required by caregivers have changed; caregivers are now expected to handle complicated medicines, insert catheters and change dressings among other tasks.[38,41] Certain groups of family caregivers are most affected by these changes in policy and programs. Low-income women who are least likely to have supplementary insurance are now required to pay for medications that would have been distributed free of charge in hospital.[39,40] Rural communities are also hard hit as services once available are shifted to larger communities, requiring caregivers to travel long distances to obtain services or contend without additional assistance.[39]

Caregiving activities of immigrant women must also be contextualized by the migration experience, value systems and the roles prescribed for women and as well as the centrality of caring to women's lives.[42] Truncated familial support networks, limitations placed by provincial governments on access to auxiliary health services, culturally inappropriate services, and lack of information about what kinds of resources are available to help caregivers, all contribute to an intensification of caregiving responsibilities for many immigrant women. The centrality of care work to gender and ethnic identities means that women are generally unable and unwilling to relinquish these responsibilities, regardless of emotional, physical or financial cost.[43,44] Even affluent caregivers appear reluctant to relinquish these responsibilities although they may be amenable to purchase the services of others to assist with other domestic tasks.[44,45]

While caregiving may be a rewarding activity, even if obligatory, it may also have considerable health costs for the caregiver.[46] Indeed, North American studies suggest that demanding social ties are strong predictors of depression in women.[47] Backaches, insomnia, arthritis, depression and hearing problems are among the conditions associated with caregiving and are especially trying for women who caregive more frequently, in more complex situations, and for double the hours of male caregivers.[41,48-50] Moreover, women are more likely to forgo their own health to meet the needs of the care recipient first.[51] The role can be so burdensome that even its anticipation can contribute to health problems for those who have prior experience with the role.[52]

Environmental Exposures

Environmental influences – both biological and social – are greatly significant to early childhood development especially in the first five years of life when normal brain development occurs. Factors such as poverty, housing and caring relationships contribute to lifelong capacities (emotional, cognitive and behavioural development) and vulnerabilities; as a result, holistic early childhood interventions are vital to decreasing health disparities.[53-55] These issues are of vital importance in Canada where child poverty rates remain at approximately 20%.[56,57]

Toxic exposures are socially distributed[58] and assert influence from fetal development through older adulthood. Maternal nutrition, smoking, alcohol consumption and stress can have an impact on birthweight and contribute to problems with bone mineral density in adulthood.[59-61] Maternal stress, engendered by any number of conditions including material deprivation, may have a significant impact on the fetus and contribute to longer-term consequences. Children whose mothers sustained stress during their pregnancy are at higher risk for diagnosis with ADHD and psychiatric conditions. In addition, they may experience delayed early motor development and behavioural problems. Animal studies suggest that post-natal maternal attention can moderate the effects of stress.[62]

Women and girls are more likely to spend time at home where they may be exposed to a variety of environmental hazards. Household cleansers can contain toxic properties and home cooking may expose women to noxious substances accumulating from cooking fumes due to poor ventilation. Poor housing, related to socioeconomic status, can further contribute to respiratory problems as can exposure to second-hand tobacco smoke.[63-66] Additionally, low-income households are disproportionately located in the vicinity of industrial sites, whose pollutants residents are expected to eliminate from their homes through their own efforts.[67] Exposure to smoke can also facilitate the accumulation of trace metals, such as cadmium. Cadmium concentrations tend to be higher in women due to higher rates of absorption at low levels of iron. In addition, while males tend to have higher levels of lead in their bodies compared to women, the effects can be more deleterious to women due to the pace of its release from the bone marrow where it is stored.[68,69]

Outside the home, women are exposed to environmental hazards in female-dominated workplaces including electronics plants, fireworks and brick factories, agricultural and floral industries and laundry operations.[64] Moreover, women may also have differential access to public space depending upon ethnicity, sexual orientation and disability that may pose various threats to health and safety. For instance, a study of rickets among British South Asian women found that women lacked exposure to sunlight as they feared traversing public walkways after a series of racist attacks were reported in their neighbourhood.[70]

Gender-based Violence

Males are the most frequent perpetrators of violence against women, children and other men.[71-73] Violence can take the form of physical, sexual or psychological harm and while males are more likely to be subjected to physical violence, women and members of sexual minorities are more often subject to a range of violent acts, including sexual assault, and are more likely to be targeted because of their gender status at the hands of men.[72-74] While gender-based violence may take a variety of guises throughout the life cycle, it is often presented in gender-neutral terms such as child and elder abuse.[75] Only in preschool years are there no gender differences found among victims of sexual abuse by male family members.[76] It is important to note that violence against women is tolerated

and legitimized in many societies such that if similar acts were perpetrated against neighbours, strangers or employers, they would be regarded as punishable crimes.[75]

In the US, four million women are battered by their partners each year while one in five women will be abused by a partner or ex-partner at some point in their life. Domestic violence is a major cause of injury and accounts for 40% of female homicides in the US, resulting in an estimated four deaths daily.[77,78] US authorities also estimate that 38% of pregnant adolescents and 25% of pregnant women of all ages, are physically or sexually abused during pregnancy, generally by their partners.[75] In 1992, the American Medical Association estimated that 35% of emergency room visits were from women suffering from injuries relating to battery or rape.[79] In Canada, gender-based violence is estimated to cost health and justice services $1.6 billion annually.[80] Furthermore, 4.5 women and 1.1 men per million married couples per year are murdered by their spouses while 26.4 women and 11.5 men per million common-law couples and 38.7 women and 2.2 men for every million separated couples meet the same fate.[81,82]

Women in abusive relationships are often isolated socially and financially, making it increasingly difficult to remove themselves from a violent situation. Additionally, they may be conflicted by the desire to keep their family together.[83]

Unfortunately, separating from a violent partner does not ensure that the threat will cease. Forty percent of women and thirty-two percent of men who experienced spousal violence within the previous five years revealed that the violence commenced after separating from their partner.[81] Notably the type of violent activities reported by women and men differed. Fifty-seven percent of these women were beaten, sexually assaulted, threatened with a weapon or choked while fifty-eight percent of men were kicked, bitten or hit.[82]

Exposure to gender-based violence is not limited to any one socio-economic class or ethnicity; however, geographic variation in violence against women has been noted. Prince Edward Island currently leads the country in rates of male partner violence. In Quebec, the odds of encountering male partner violence decreases by 18% for each unit increase of education; while the impact is 6% for the rest of Canada. Partners with similar levels of education are most vulnerable to abuse in the rest of Canada, while in Quebec dissimilar education is associated with violence.[84]

As noted in the Canadian report to the CEDAW committee indigenous women in Canada are particularly vulnerable to violence.[11] Aboriginal women are three times as likely to report violence by a current or former spouse than Euro-Canadian women. Over 12% of Aboriginal compared to 3.5% of non-Aboriginal women reported experiences of violence in the past five years;[85] moreover, they generally report experiencing more life-threatening forms of violence than non-Aboriginal women.[82] Higher levels of education increase Aboriginal women's odds of violence by 22%. Living common law increases the likelihood of violence 13% among non-Aboriginal women and 217% for Aboriginal women.[85]

While under-reporting of gender-based violence is problematic overall, the issue is particularly troublesome in some sectors of society. Immigrant and refugee women who regard themselves as having precarious immigration status may fear deportation for themselves or their partners if they report violent episodes to the authorities.[86,87] Fear of reinforcing negative stereotypes about men from ethnic minority communities may also reduce rates of complaints from women in those communities.[78] Members of sexual minorities who may feel too stigmatized to report crimes are also particularly vulnerable to violence. Over 50% of transgendered persons have experienced some form of violence in their lifetime.[88] Lesbian survivors of violence may be hesitant to access support services as it may require them to disclose information about their own or their partner's sexuality in what they may perceive as a hostile or judgemental environment.[89] Violence is increasingly common in the lives of homeless women who may also hesitate to report abuse.[90] Lastly, women who have survived state-sanctioned violence as either subjects of or witnesses to torture may not readily disclose their experiences to health or social service personnel in Canada, even though these experiences are present in their lives today.[91,92]

As our knowledge of the experiences of the survivors of torture attest, the sequelae of violence are dramatic for both victims/survivors and witnesses of such acts. Depression, post-traumatic stress disorder, spinal injuries, low-self esteem, sexual dysfunction, substance abuse problems, HIV/AIDS, and other sexually transmitted diseases have been associated with a legacy of violence for survivors.[93-96] Children of batterers have lower self-esteem and suffer from anxiety and inattention; they also hold more stereotyped views of gender and tend to regard physical force as an appropriate outlet or tool of persuasion.[97] The consequences of child sexual abuse, experienced by an estimated 16% of men and 27% of women in the US, includes an increase in risky sexual behaviours, depression, suicide, sexual difficulties, alcoholism and drug abuse.[98-100] Self-medication is one way of coping with undesirable emotions that can emerge from abuse.[96] Generally, adolescent girls are believed to internalize their experiences while boys externalize their pain resulting in anti-social behaviour.[101,102] Abuse sustained in childhood may have long-term effects that are unrecognized in later years. One study examining the impact of childhood abuse found that 80% of survivors developed at least one psychiatric disorder by the age of 21.[103] Depression in older women is often undiagnosed and while it may be comorbid with other conditions, it may also be the legacy of childhood abuse and exposure to violence or the result of more current elder abuse.[104]

Detecting the health impact of violence, however, can be problematic. Women may present non-specific somatic complaints that compel health care personnel to label them as difficult patients.[95] Health professionals are also at times hesitant to involve themselves in domestic violence. For instance, some professionals are reluctant to engage in issues pertaining to gender violence in minority communities and may instead relegate these incidences to religious and cultural differences.[105] A recent survey of British health professionals revealed that only 54% of respondents knew that hitting one's partner was a crime and 44% felt uncomfortable asking patients about violence.[106]

While gender-based violence is not universal, it is widespread and more common where males have witnessed abuse or been abused as children, where masculinity is

linked to notions of male honour and toughness and where violence is tolerated.[75,94] Male identity crises wherein male abusers perceive threats to their masculinity precipitated by loss of economic power and status are seen as potential instigators of male violence.[94] Alcohol and other substances have been regarded as incendiary factors; however, it is not clear whether substance abuse problems are the result or the cause of these behaviours.[75,106] Generally, higher education is regarded as protective for women, but this is not always the case as the statistics for Canadian Aboriginal women attest. However, as isolation and lack of social support allows violence to be perpetuated, more opportunities for women to become financially and emotionally independent will be vital to halting these crimes.[75,94]

The Hazards of Work

Occupational injuries, job insecurity and unemployment may be distributed differentially across class, ethnic and gender categories.[107] Specifically, conditions of employment (including control in the workplace, exposure to sexual harassment, and job insecurity), exposure to occupational hazards, and the intersections of paid and unpaid labour, are all implicated in producing gendered health disparities.

Epidemiological studies of the British civil service, the Whitehall Studies, have drawn attention to the relationship between health status and social gradients and the salience of lack of control in the workplace as a workplace hazard.[108] Control in the workplace is socially distributed and women are generally afforded less of it. Even women in female-segregated occupations tend to have lower levels of control than men in the same positions.[109] Jobs with low control and high demand are associated with poor self-rated health.[110] Women working in low control environments have a 40% increased risk of developing depression compared to women who have high decision latitude in the workplace; these effects are intensified if women experience low control at home as well.[111] Low-control work environments can have an impact on cardiovascular disease. High diastolic blood pressure has been found among laundry and dry cleaning operators, food service workers, private childcare workers and telephone operators, while risk of coronary heart disease is heightened among clerical and sales staff.[112] Stymied self-efficacy and eroded self-esteem exacerbated by the gap between high work demands and little perceived gain can induce autonomic and neuroendocrine stress responses that may underpin the health problems associated with low control work environments.[113]

Brooker and Eakin[108] suggest that power – organizational, social and material – is a more salient concept to consider in relation to health and stress. They maintain that lack of power is a stressor and that coping resources are differentially distributed. Discrimination, restricted mobility and restricted access to power networks are particularly pervasive issues for women.

Sexual harassment, the impact of the double shift and environmental hazards in work disproportionately affect women.[114] Women in the workforce, particularly those who are employed part-time or as home-workers, are more likely to report negative work characteristics than male counterparts.[115] In addition, job insecurity appears to have the greatest effect on high strain jobs[110] and more women report high job strain that is associated with poor self-rated health status.[116] Men, however, are not immune from the effects of job insecurity; the Whitehall II study demonstrates that men anticipating privatization in their workplace were more likely to report poor health status than those who anticipated a secure position in the public service.[117] Changes in the labour market suggest that dissatisfactory work conditions, and their attendant health effects, may become more commonplace among certain sectors of society. Nearly one-third of the Canadian workforce is self-employed, employed part-time or engaged in multiple part-time jobs wages.[118] Conditions of these forms of employment, most commonly associated with young workers, women and recent immigrants, are characterized by a paucity of employee benefits, high levels of job insecurity and low wages. Lax occupational health standards, lack of control in the workplace and irregular work schedules, coupled with uncertainty about current and future employment, tasks, earnings and workload contribute to poor self-rated health status and increased stress among this sector of the workforce.[118]

In addition to employment conditions that may have more impact on women workers and certain male employees – predominantly immigrants and youth – occupational exposures also contribute to health problems. While men encounter considerable hazards in industrial and agricultural labour, most occupational health regulations are predicated on male labour and male bodies.[119] Women's health at work is jeopardized by inappropriate workplace configurations and tools designed for men, job segregation, resulting in increased task fragmentation and monotony, the stress of discrimination and sexual harassment and the paucity of employee benefits as women are disproportionately relegated to low-wage, low-control and part-time labour.[112,120] Importantly, the rate of workplace accidents is higher among temporary employees, the majority of whom are female.[121] While employers may disregard the effects of workplace hazards on women's health, in some instances these concerns can affect the opportunities women have to obtain employment. Women have often been constrained from entering certain positions due to the potential endangerment of a fetus by workplace materials; men, whose reproductive health may be similarly jeopardized by these conditions, generally do not face the same prohibitions.[122,123]

Women can, however, face considerable health costs for their labour. Women tend to lift materials for longer periods and are subject to a faster pace of repetitive labour than men, resulting in disparate but nonetheless significant pattern of injuries.[124] Ergonomic exposures, repetitive work and high psychological demands contribute to job strain that results in poor self-rated health.[117] Depression is commonly associated with computer processing and women employed in the poultry and garment industries experience musculoskeletal problems and stress-related disorders attributable to their working conditions.[114] Long hours standing and cold exposure can contribute to peri-menstrual symptoms in poultry slaughterhouse workers and hairdressers.[112] Additionally, standing for long periods can also lead to the development of varicose veins.[125] Three times more women than men report sick building syndrome related to working in an open plan office or reception area, exposure to tobacco smoke, and handling paper; low control and more negative per-

ception of psychosocial and physical environments contributed to symptoms.[126] Exposure to pesticides is also problematic for those who work and live in agricultural areas, although the issue may be underestimated among women in part due to measurement standards.[127,128] Professional women such as accountants also report higher levels of anxiety than their male colleagues.[129] Much of women's work is characterized by monotony and repetition that can contribute to mental and physical health problems.[112,130]

Other female-dominated occupations appear to be injurious to women's health. For instance women employed in home care agencies report a host of complaints including stress, respiratory illnesses, arthritis, back problems, hypertension, migraines and work-related injuries.[131] In hospitals, the stress wrought by the instabilities of health care restructuring, particularly coupled with heavy domestic responsibilities, has contributed to health problems among nursing staff.[132] Another study found that practical nurses were particularly vulnerable to assault by patients.[133] In the US and Hong Kong, foreign domestic workers contend with stress stemming from immigration issues, long hours of labour and isolation in addition to exposure to toxic cleaners and physical strain.[134,135] Call centre employees, predominantly women, suffer from a variety of complaints including headaches, neck and eye strain and insomnia attributable to the stress of work surveillance, job insecurity and shift work.[136]

The health effects of working conditions are compounded by domestic responsibilities that further enhance gender disparities in health. The interaction between work and home environment on socio-economic inequalities and health differ for women and men. For example, family structure had a more significant impact on inequality for women but not men.[4] While women find employment generally beneficial in terms of improving social position, social support and control in the family, the pressures of the second shift can be disadvantageous.[111] In one study, female clerical workers with major domestic responsibilities and a punitive psychosocial environment showed highest risk of stress. Repressed hostility, low job mobility, a non-supportive employer, children and a blue-collar husband, were all associated with higher incidences of coronary heart disease.[109] In the Framingham Heart Study, incidence of coronary heart disease was twice as high among employed women with three or more children than those without. Other studies suggest that while men's stress levels may decline at night, women's do not due to familial and household responsibilities. Distress appears to intensify when domestic labour is unequally shared. The interactions, therefore, between work, household and child care responsibilities can have deleterious effects on women's mental and physical health.[137,138] The double shift of domestic and labour market responsibilities also means that women have little time to engage in physical activity, relaxation or self-care.[131] In fact, although marriage can be a source of social and economic support for women, it may also contribute to enhanced levels of stress due to increased responsibilities and lack of control at work as well as at home.[139] Conversely, job strain can be moderated by the effect of satisfying spousal partnerships and mothering roles.[140] Others have observed that social support and appropriate levels of self-esteem operate to reduce work-related stress more effectively for women than for men.[141]

Economic Disparities and the Costs of Poverty

Economic inequities, evidenced by income, employment and the demands of domestic labour, appear to underpin gendered health disparities most broadly. Economic status has significant impact on health and well-being and as gender figures prominently in income generation, health effects are decidedly gendered. Moreover, gender roles intersecting with household configuration, social mobility, immigration status, and disability further influence economic status contributing to poor health status.

Income disparities between women and men in Canada have been well documented. Statistics Canada[16] reported that as of 1997 average annual income for women was 67% of that of men. Individual women may earn as much or more than individual men; however, the composite wage gap is due to a disproportionate number of women who are either low-waged or unwaged.[16,142] The Survey of Labour and Income Dynamics (SLID), a longitudinal study that collected data from 1993-94 revealed that 1.4 million women over 16 (13.4% of all women) were persistently poor. Nearly 25% of women were poor for one year. Among seniors, 29% of women versus 12.9% of men were poor for at least one year. Women's chances of persistent poverty change over the life course: they are greater in youth and reduce in middle age and increase as labour market participation declines and family composition changes.[143] Certain groups of women are particularly vulnerable to poverty. By 1996, female-led single parent households were twice as likely to be poor as those led by single males.[144] Statistics may mask a more complex picture, as men and women of colour are further disadvantaged not only with regards to the population as a whole, but in comparison to Euro-Canadian women.[142]

Income disparities between women and men in Canadian society mean that women's access to education, housing, child care and nutrition are potentially compromised.[114] On a population level, increasingly unequal distribution of income is associated with increased mortality – especially for working-age populations.[145] Economic disparities between women and men are also reflective of their relative differences in power in a variety of spheres. Moreover, the disparities may be detrimental to men's health as well. In their examination of the relation between women's status and health in the US, Kawachi, Kennedy and Gupta found that in regions with a smaller wage gap between women and men and higher political participation, mortality rates were lowest for women and men as were deaths from specific causes such as stroke, ischaemic heart disease, cervical cancer, homicide, and infant mortality.[146]

Socio-economic class and gender differences account for disparities in self-rated health status, chronic disease and disability among older populations.[147,148] Gender differences in health vary according to stage in the life cycle and evidence suggests that socio-economic facts acting over the lifetime can have cumulative effects.[149] Caution, however, must be applied when considering factors such as socio-economic status. As mentioned earlier, determining

the social class of women is complicated by the assignation of class status based on the occupation of the male head of household and the presumption that household resources are equitably shared.[22,150] Moreover, calculating women's social class based on the traditional elements of education, income and occupational prestige is also problematic as women's education does not always translate into well-paying jobs nor is women's work necessarily commensurate with occupational prestige.[151]

Women's self-rated health status also appears to be more sensitive to the effects of low-wage employment, declining more than men's health and improving less than men's health status when work and economic circumstances are on the upswing.[117] Men and women appear to experience differential health effects of poverty. In Britain, standard mortality rates for people of colour are higher than those for the general population and the disparities are even more apparent when female mortality is considered.[152] Furthermore, while material disadvantage contributes to higher rates of mortality overall, there appear to be gender distinctions in the pathways leading to this outcome. European and US studies suggest that men respond differently to poverty than women by embracing poor coping strategies such as alcohol consumption and smoking, contributing to substance-related conditions that lead to their demise, while women succumb more often to diseases such as diabetes and heart disease exacerbated or precipitated by psychosocial stressors and poor diet related to their impoverishment.[153,154]

Domestic roles also contribute to economic disparities between women and men. Women who are absent from the labour market during childbearing and childrearing are often penalized financially over the course of their lifetime as income levels and accrual of pension benefits are affected.[155] Furthermore, familial and economic roles that contribute to gender inequality result in differential mortality rates both in childhood and adulthood.[156] In addition to discrimination, women's poverty is linked to low-wage, part-time employment, the demands of caregiving, and the impact of divorce or separation.[57,157] The unequal distribution of household resources can further impoverish women.[158]

Change in household configuration – whether due to an increase in family size or loss of household income earners through death or desertion – is a major factor driving women into poverty.[143] Once in poverty, women's economic mobility is limited. The so-called feminization of poverty must be contextualized by contemporary global economic trends that have resulted in the loss of full-time industrial jobs and the expansion of part-time, non-unionized positions, designed to meet the flexible demands of the market, that have increasingly become the domain of women's labour.[159] Engagement in part-time labour is also regarded as desirable for women who must balance caregiving responsibilities, especially in the absence of universal daycare programs or adequate home care services.[160]

The dynamics of social mobility may further render health impacts. Adult members of the working class who had non-working class childhoods are more likely to have higher levels of low-density lipoproteins and glucose levels, placing them at higher risk for heart disease and diabetes, and are inclined to report fair or poor health than those who were not downwardly mobile.[161] Women who lead single-parent households and immigrant and refugee women and men are most vulnerable to the effects of downward mobility, which are associated with changes in household configuration and migration.

Most foreign-born workers experience a decline in socio-economic status after migrating to Canada.[162] Lack of Canadian experience and employers' unwillingness to accept foreign credentials and education on par with Canadian ones produce formidable barriers to fair labour market participation by migrants – even for those who were selected to enter Canada based on employment criteria.[163,164] Women in particular tend to relinquish their efforts to obtain positions commensurate with their skills or education and will take on low-wage employment in order to contribute to household income.[163] In addition, while most migrants recover their former socio-economic status in the following generation, this trend does not hold true for visible minority migrants, suggesting that racism plays a significant role in economic mobility in Canadian society.[162]

Similarly, persons with disabilities face considerable barriers in obtaining remunerative work and are also disproportionately poor, with women facing higher rates of poverty than men.[57,165] Fifty-two percent of working-age persons with disabilities are unemployed.[163] Over 33% of women with disabilities live below the poverty line compared with 28.2% of men.[57] A survey conducted by the Canadian organization, DaWN (Disabled Women's Network) found that 60% of women with disabilities have relied on social assistance at some point. Moreover, women with disabilities often incur greater costs for aids and services than male counterparts.[166] When married women become disabled, divorce is almost inevitable: 99% of them will face the end of their relationship compared to 50% of men.[167]

The social and health implications of poverty include ongoing stress that increases health problems and low participation in sports and education that is especially troubling for children.[168] Living in poverty is associated with higher rates of chronic disease, distress and low self-esteem. Children raised in poverty are more likely to have learning disabilities, language delay and to exhibit anti-social behaviour.[57] Almost half of low-income single mothers show signs of clinical depression. Maternal depression can likewise result in poor parenting of offspring.[169] Intersecting issues of racism and poverty may enhance the risk of contracting HIV/AIDS. For instance, despair may contribute to drug use that could lead to infection or incarceration in prisons where disease rates are high. A study in Los Angeles found that African American women who relied on a male partner for financial assistance for housing were less likely to insist on condom use. Threats of violence are also an issue.[170]

Marginalization and Health

Marginalization refers primarily to the lack of equitable access to social, political and economic benefits and exclusion from full participation in these realms due to one's membership in an identifiable group. Marginalization, economic disadvantage and gender are closely related, and social exclusion engendered through low income, culture, gender, ability or geography can have deleterious health effects.[40,171] In Canada, members of visible minority communities, immigrants and refugees, Aboriginal peoples, the homeless, sexual

minorities and persons with disabilities are among the marginalized.

The term "visible minority" – regarded as a creation of the Canadian government – tends to collapse a heterogeneous group of persons into a singular category, thereby masking class and ethnic disparities.[172] While the term is problematic, there is some evidence that both foreign- and Canadian-born persons of colour are responded to by Euro-Canadian society in a similar fashion. In turn, these responses have real repercussions in terms of opportunities and experiences that are further reflected in the colour gradient of our socio-economic hierarchy. Regarded as evidence of structural inequalities, racism can in fact be viewed as a chronic stressor that can illuminate disparate health conditions reported by members of marginalized communities.[173,174] Discrimination is enacted through a variety of means ranging from structural inequities promulgated by state and non-state institutions to the personal racist behaviours of individuals who as employers, landlords, classmates, colleagues, neighbours or strangers may have disparate impacts on the lives of their targets. The impact of discrimination is often rendered in the form of social and economic marginalization evidenced by limited labour market participation and highly charged familial roles that may have health consequences for women in particular.[175] Living in an environment that is characterized by economic and social deprivation, exposure to environmental hazards, socially inflicted trauma or the marketing of drugs, alcohol, junk food and inadequate health care are also ways in which discrimination is experienced by members of ethnic minority groups. These circumstances may constitute conditions for chronic stress that can, directly or indirectly, have a deleterious impact on health and may, therefore, provide the potential link between social context and individual health outcomes.[176] Overall, social inequities are embodied in such a way that social arrangements of power – that are structured by gender, class and ethnicity – influence ecological context and individual life course status.[176]

The impact of racism on health is also influenced by gender. Reports of racist encounters have been linked with hypertension, depression, distress, self-reports of poor health status, increased rates of smoking, increased sick time and low birthweight.[174] Respondents who experienced verbal abuse were 50% more likely to describe their health as poor or fair; those who were personally attacked or had their property vandalized were 100% more likely to do so. Among the informant sample, women were more apt to internalize their response contributing to health effects and 60% were more likely to report poor health than men.[174] Conversely, those who were able to confront the situation were found to have lower blood pressure than those who attempted to ignore it.[174]

Discrepant expectations, racism and downward mobility may contribute to chronic stress that may become more evident to new Canadians as they settle in this country. Resettlement is associated with a variety of stress-related health effects including diabetes, hypertension and negative health behaviours in concert with experiences of trauma.[149,177,178] In addition, precarious immigration status produced while awaiting refugee claims, under conditions of trafficking or through participating in programs such as the Live-In Caregiver Program, is more common to women; therefore, women are more vulnerable to the health effects of stress related to immigration concerns.[179,180] Among non-European immigrants those who are more likely to report poor health did so after a decade of life in Canada. Single migrants and those who felt unloved were also more likely to report fair or poor health.[21] Moreover, women may be more vulnerable to mental health problems due to previous trauma, the impact of discrimination, social isolation, and economic and social marginalization.[181] A British study revealed that the type of trauma Somali refugee women experienced in their homeland in conjunction with their current social, economic and familial context led to different health outcomes such that women who were identified as housewives were more likely to express suicidal ideation.[182] In a study of migrants who came to Canada under the auspices of the Live-In Caregiver Program, women who had fulfilled their contracts and were living in Canada as permanent residents were more likely to rate their health as poor than those who had arrived in Canada within the previous two years and were still employed under the program.[180]

The legacies of colonization and conditions of neo-colonialism have contributed to severe health and social conditions that contribute to high rates of violence and substance abuse in Aboriginal communities.[183,184] Even though they are more likely to use alcohol than women, Aboriginal men also forgo alcohol at higher rates, report better health status and engage in more positive health behaviours such as physical activity than women.[184,185] Aboriginal women face high suicide rates, cardiovascular disease, diabetes and gastrointestinal problems. Diabetes, for instance, occurs two to three times more often among Aboriginal women as among other Canadians and is diagnosed at twice the rate of Aboriginal men. Furthermore, Aboriginal women residing in urban areas may be relegated to living in substandard housing and may be isolated from their customary sources of social support.[114,183]

The lack of affordable housing has contributed to the proliferation of homelessness in Canada. The estimated number of homeless individuals in Canada ranges from 35 to 40 thousand to several hundred thousand.[55,186] Depression and high levels of stress are common to the experiences of homeless mothers who often lack access to services such as child care.[90,187] Many homeless women have also sustained abuse and suffer from higher rates of mental illness than men.[90] Homeless men, however, appear to engage in binge drinking more often than women.[188]

In the US, 1.3 million youth have run away from home or are homeless. In this constitutency, girls are more likely to rate their health as fair compared to boys.[189] Homeless youth are often at risk for contracting sexually transmitted diseases including HIV/AIDS. While they may be cognizant of the risk, safe sex behaviours require a sense of self-efficacy, future orientation, support and power to be able to control sexual encounters.[190] Lesbian, gay, bisexual and transgendered youth comprise anywhere from 6% to 35% of the homeless population. Many are more vulnerable to health problems due to a history of abuse and addiction. Violence poses a significant threat and some may be compelled to trade risky sexual behaviours for food and shelter. Fourteen percent of respondents in one study left home due to a conflict over sexual orientation: this group was

more likely to be physically and sexually abused since becoming homeless.[191]

Members of sexual minorities do not need to be homeless to experience marginalization. Gay, lesbian, bisexual and transgendered students experience more harassment in school; a Massachusetts study found that they were four times more likely to have attempted suicide and five times more likely to admit they missed school because of feeling unsafe. Authorities tend to view harassment as normal adolescent behaviour and underestimate its impact on mental health.[192]

Women tend to have higher rates of disability than men.[193] School-aged boys, however, are diagnosed with learning disabilities more often than girls – possibly because they garner greater attention.[194] Moreover, men with disabilities are often granted more household assistance and training than their female counterparts.[195] Disability rates are higher for those who are poorly educated, live alone, live in poverty, and/or are suffering from depression and anxiety. In the US, these characteristics tend to describe a disproportionate number of women and African Americans.[196] In some communities, women with disabilities are discouraged from finding a partner even though marriage and childbearing are highly valued.[197]

Aging

Aging is one of the major demographic features of Canadian society, although some cultural communities do not share in this trend. Both economic status, which is closely linked with gender, and gender roles, which influence use of health services, influence the health trajectory of individuals as they age.

As of 1996, women accounted for 70% of Canadians over 80 years of age and 58% of those over 65.[198] The National Advisory Council on Aging[199] reports that a greater proportion of older women are diagnosed with dementia. Moreover, senior women are less likely to be able to perform daily tasks and more likely to experience restricted mobility than men.[147] Nearly half of all women over 75 years of age reside by themselves and may therefore require more formal support to attend to daily activities.[200,201] Men, too are likely to experience increased morbidity with age. As men are more likely to eschew preventive health measures and avoid medical encounters, they are more likely to present with more advanced health conditions when they seek medical treatment.[202] Lunenfeld asserts that five out of six men in their 60s contends with a chronic degenerative disease.[202]

Aging also intersects with poverty for many women. Over 20% of senior women have not engaged in the paid labour market, resulting in little or no pension benefits, even though they may have been engaged in household labour and caregiving activities for much of their lives.[199,203] Importantly, the relationship between poor health status and socio-economic status often emerges with age such that health problems associated with maturation are reported at an earlier age by those who are less affluent. Nearly 25% of senior women, compared to 12% of men, live below the poverty line. Single and widowed mature women have even higher rates of poverty: just under 50%.[204] This contrasts with the situation south of the border where 80% of widows are plunged into poverty after the death of their partners.[203] Women of colour are more vulnerable to poverty and many women who have witnessed the disadvantages of gender, ethnicity and age are more anxious about growing old than Euro-Canadian women.[205-207] Gay, lesbian, bisexual and transgendered seniors may confront additional problems as they mature; single lesbian seniors may report poorer health than those who are living with a partner.[208]

Health Conditions and Interaction with Health Services

Health services utilization is influenced by gender as it interacts with socio-economic and immigration status and gender roles. Moreover, diagnosis and treatment options are potentially shaped by the patient's gender, as are decisions to access health services and social support, these all contribute to disparate health outcomes.

Health care reform has been implemented without consideration of its potentially gendered impact,[209] yet restructuring has had a tremendous impact, particularly on women as caregivers, patients and health care staff. Immigrant and visible minority women comprise a disproportionate number of health care workers who have been employed in positions such as: food and laundry services that have been contracted out to non-union employees;[210] and the most recently hired nursing staff who were laid off during the height of restructuring.[211] In hospitals, nurses are required to economize their interactions with patients in ways that can potentially further disadvantage minority women, as has been observed in labour and delivery units.[212] Furthermore, early discharge policies that involve releasing women from hospital 24 to 36 hours following delivery have resulted in increased re-admission rates for disadvantaged newborns.[213] Time stress and restructuring of health services mean that nurses and other health professionals are unable to invest in building ongoing trusting relationships with migrant women.[179,212,214]

Health services utilization has been problematic at times for some culturally, physically and sexually marginalized women. Once diagnosed, women with disabilities are often regarded as problem patients and may be patronized if they desire to become pregnant.[215] Lesbian and bisexual women may avoid health care providers due to previous experience with homophobia or fear of disclosure, especially in rural regions. In a Canadian survey, 38% of the respondents admitted to avoiding seeking help due to sexual orientation. Lesbian and bisexual women may also avoid health screening and diagnostic and preventive services.[216]

Access to health services is also problematic for many migrant women and women of colour who generally occupy the lowest echelons of the Canadian workforce. Low-wage jobs are less likely to provide supplementary employee benefits and may also lack the flexibility that would allow employees to take time off for health appointments. Lack of interpreter services may make the hospital an unwelcoming environment for non-English or French speakers. In addition, the focus on individualism and self-care in our health care system makes it difficult for economically and culturally marginalized women who may not be able to afford, or are unwilling to expend, household resources on individual self-care.[155,212,217,218] Reductions in settlement services and community health programs, new co-pay arrangements for prescription medications and longer waiting periods to be eligible for provincial health

care insurance plans have been burdensome for many new Canadians.[219] In certain regions of the country, newcomers have a difficult time finding physicians who can take on new patients. Language barriers, lack of information about services and the impression that physicians are not listening to them may also affect the use of medical services.[220] Isolation from Euro-Canadian society due to differing values can affect health not only due to inappropriate health services, but also stigmatization.[118] Stereotyping, lack of respect and inappropriate care have been cited as barriers for Aboriginal women seeking health services[183,212,221] as well as for migrant women.[164,210,220] In the U.K., women of colour are offered more hysterectomies and more Depo-Provera than other British women, sending the message that this group of women should be encouraged to control their reproduction.[222]

Overall, gender has not figured prominently in health-care policy and planning. In their review of provincial regional health plans, Horne, Donner and Thurston[223] found that policy-makers and planners lacked appropriate sex-disaggregated data on the health of women and men, relegated women's health to reproductive issues and breast or cervical cancer, refrained from consulting women's organizations and feared backlash if they moved forward with any women's health initiative. Despite this apparent lack of attention to gender, women tend to use the health care system with greater frequency than men. Ninety-five percent of women compared to ninety percent of men consulted a health professional between 1996 and 1997. Moreover, women were more likely to be hospitalized than men primarily due to pregnancy and childbirth and conditions related to aging.[16] Notably, low-income individuals avail themselves less often of preventive health programs.[224]

Males tend to access health services for specific problems rather than preventive services. Help-seeking behaviour is viewed by some men as incompatible with masculinity.[25,225,226] The pattern of eschewing health services appears in late adolescence. Young adolescent boys use health service at the same rate as girls; however, as they become older, they begin to avoid health professionals.[227] This avoidance behaviour, coupled with value placed on stoicism, may result in delays in diagnosis and treatment that may account for higher mortality rates for conditions such as cancer.[228]

If reproductive health services are excluded from consideration, health-care expenditures for women and men appear fairly similar;[20] however, women may not receive an equitable share of certain treatments and technologies. For instance, women are less likely to undergo kidney transplants, cardiac catheterization and revascularization when presenting with coronary heart disease than men. Men are more apt to be candidates for hip-replacement surgeries, renal and heart transplants and to be offered AZT for treatment of HIV/AIDS.[229]

Some conditions, such as multiple sclerosis and fibromyalgia, can be difficult to diagnose. This can contribute to health professionals' perceptions that women are neurotic clients.[215] Women with disabilities are more likely to have their conditions attributed to psychiatric causes than men and physicians are more inclined to provide a diagnosis of depression to female patients.[20,230,231] Depression has also been cited as a reason why women report more symptoms and functional decline than men.[232-234] Differential patterns of symptoms and disparate responses to pain may be grounded in physiology as the result of hormonal influences on opiate receptors.[235] Moreover, women may be more perceptive about somatic stimuli due to an internal focus, the sensations produced by the menstrual cycle, and gender socialization that shape response to such bodily sensations.[236] While women complain of pain more often than men, men receive stronger and more frequent prescriptions of analgesics.[235]

The proliferation of mental health diagnoses for women has been contentious. Some authors assert that notions of normalcy are configured by hetero-normative standards that reinforce narrow gender stereotypes and unjustly pathologize women.[237-239] For instance, Stein and Nair[240] note that routine aspects of female physiology such as the luteal phase of the menstrual cycle, pregnancy, and lactation are being placed under medical surveillance, constructing an image of the female body as one that requires medical intervention.

Both under-diagnosis and over-medicalization are problematic; however, these issues cannot allow us to lose sight of the fact that some women truly suffer from mental health problems, most notably depression; women in North America report significantly higher rates of depression than men,[169,241] although suicide rates are higher among men.[242] Weidner[243] suggests that men are less able to cope with the effects of depression due to more limited social integration and social support than can be generally mobilized by women. Furthermore, men who subscribe to more traditional gender roles are more likely to experience anxiety, depression, distress and problems with intimacy.[244]

Depression is disproportionately found among low-income populations such that nearly half of single mothers in the US can be defined as clinically depressed.[169] Stress pertaining to finances, personal safety and household inequality can predict depression.[137,245] In Canada, single mothers who are unemployed report twice the rates of distress compared to all other groups.[246] Patel[247] observes that depression has become a world-wide issue for women as globalization contributes to gender inequities, declining living standards and reduced government spending on health and social services as well as the disruption of social support networks engendered by movements of urban and out-migration for economic survival. Poor mental health among women can also be the result of physical and sexual abuse and state violence.[248,249] Females are generally socialized to internalize distress and indeed adolescent girls report more depression, eating disorders and suicide attempts than their male counterparts.[191,250,251] The internalization of distress is also problematic for lesbian and bisexual women who report higher levels of depression than heterosexual women.[252,253]

The attribution of complaints to psychological origins and misunderstandings about sex differences in presentation of symptoms may result in misdiagnosis of conditions, most notably heart disease. Studies have found that some physicians have failed to appropriately diagnose the condition, postponing access to appropriate care and have prescribed contraindicated activities in the interim.[254,255] This delay can be even more problematic as women suffer twice the number of silent heart attacks as men and thus may have already

sustained damage prior to presenting in a physician's office.[255] US statistics demonstrate that women under 50 years of age perish from heart attacks at twice the rate as men and are five times more likely to die in hospital.[256] Once diagnosed, women are less likely to be offered invasive treatments; those who have been are more inclined to suffer from surgical complications.[257-260] Some pharmaceutical therapies are also less effective or even contraindicated for women; for instance, according to one randomized controlled trial, digoxin increases mortality for women.[261] Women's propensity to succumb to heart disease is related to social location. Heart disease is greater amongst those who suffer from depression and anxiety, people who work in low-control environments and those who care for large families – all factors that indicate women.[138,262,263]

Social environment plays a role in the development of osteoporosis throughout the lifecycle. Stress, maternal and childhood nutrition, constrained use of public space (which limits physical activity and exposure to sunlight), and eating disorders such as anorexia nervosa all contribute to loss of bone mineral density.[59,264-266]

While marginalized women throughout the world are increasingly vulnerable to HIV/AIDS due to low sexual autonomy,[267] lack of power is also linked to the pattern of HIV/AIDS in Canada. Socially, culturally and geographically marginalized individuals such as rural residents, Aboriginal Canadians and intravenous drug users are less likely to seek medical attention for the condition; as women appear to decline faster than men, this delay may be particularly detrimental. HIV-positive women face particular challenges in prioritizing their needs as women are often inclined to meet their family's needs before their own.[268,269]

Health Behaviours

Gender differences in drug and alcohol use have been noted; men are more likely to use them to socialize, cope with distress and reaffirm their masculinity while women may use them to relieve stress.[244,270-272] Moreover, women with addiction issues are judged more harshly by others than men and tend to be of lower socio-economic status.[273] There is, however, a paucity of data on women's use of substances in Canada.[274] The impact of alcohol abuse appears to be more deleterious for women as they sustain brain and liver injury more quickly and die at rates 50-100% higher than males.[275-277] Female alcoholics are also more likely to experience physical and emotional abuse than males.[278] A history of family violence, childhood abuse and negative life events are associated with substance use by young women.[279] Birth mothers of fetal alcohol syndrome (FAS) children have often contended with mental health problems, violence and abuse, and controlling relationships. FAS is an outcome often associated with First Nations women who are already familiar with the impact of systemic racism, therefore, imposing further surveillance and labels can only contribute to further marginalization.[274]

While alcohol consumption is more prevalent among Canadians in higher status occupations, smoking rates are higher in low-income populations.[55,280] Smoking is also more prevalent among adolescent women who may use tobacco as a means of weight loss, as a coping mechanism or as a projection of their identity.[281-283] According to 2001 statistics, 25% of men and 21% of women smoke. Among low-income Canadians, 40% of men and 36% of women are smokers. Rates are highest among Francophone and Aboriginal women.[282,284] In British Columbia, 17% of adolescent females and 13% of adolescent males smoke. Girls who feel more adversarial about school are likely to be smokers while boys who share these sentiments are generally non-smokers. Smoking, therefore, may be a way for disenfranchised young women to assert themselves.[285] Smoking may also be regarded both as a coping mechanism used by women managing the stress of poverty and motherhood and as a method of claiming some time and space for themselves.[286] Female smokers tend to have poorer nutrition than non-smokers and can suffer miscarriage, infertility, increased menstrual symptoms, reduced bone density as well as increased risk of lung cancer, COPD, heart disease, stroke and myocardial infarction.[287-291] When coupled with oral contraceptives, risk of coronary heart disease increases status dramatically as well.[287] Smoking during pregnancy can produce conditions such as gestational diabetes and can increase risk of miscarriage and low birthweight infants.[61,288] While these issues must be addressed, much of the literature on pregnant women and mothers tend to blame them for harming the health of their children.[292]

Health-promoting practices differ across geographical, cultural, educational and economic divides.[293] Men engage in leisure activities more often and for longer periods of time than women.[294,295] Rates of physical activity decline with income, although the trend is more obvious for women than men.[296] While physical activity is a decidedly healthy option, women may find it increasingly difficult to pursue these activities. The demands of the double shift mean that women have more fragmented time, resulting in less potential time to engage in exercise. Moreover, women are often too fatigued to engage in physical activities. In addition, activities may be too costly and difficult to partake in if child care is not readily available. Some activities may be regarded as culturally inappropriate and facilities may feel unwelcoming to members of minority groups if participants are relatively homogeneous.[297-302]

FUTURE DIRECTIONS

This review suggests health is detrimentally affected by gender roles and statuses as they intersect with economic disparities, cultural, sexual, physical and historical marginalization as well as the strains of domestic and paid labour. These conditions result in an unfair health burden borne by women in particular whose access to health determinants is, to various degrees, limited. The federal government, however, has documented its commitment to gender equality in the *Federal Plan on Gender Equality*[12] and its support of international conventions on the elimination of discrimination and violence against women. Many of the issues identified in those agreements, such as racism and violence against women and members of other marginalized communities, are deeply entrenched in Canadian society and will require concerted and committed efforts to dislodge them from the social landscape; however, without ongoing work, the wounds they produce will continue to fester. Progress on other issues such as affordable housing, child-care pro-

grams, equal pay for work of equal value, assistance for rural women, and a commitment to gender-based analysis throughout all levels of government, however, appear to have slowed or stalled over the past number of years. Indeed, government representatives responding to the criticisms of CEDAW committee members to its 2002 report[11] concede that the country has struggled with its priorities in the period since 1995 as it moved on efforts to address deficit and debt issues.[6]

While progress has certainly been made on some fronts, the persistence of health disparities among diverse populations of women and men suggests a postponement of the vision of a just society with health for all that was articulated in the *Federal Plan on Gender Equality*. The evidence presented in this paper demonstrates that there is a considerable amount of work to do to bring this vision to fruition; however, a blueprint for action detailed in a host of documents produced by the federal government and its agencies provide a solid basis from which we can take action.

If Canada is to meet its international commitments and adhere to policy as outlined by Health Canada, then it must move forward with strategies that will address major issues regarding women's poverty, discrimination against women, migrants and people of colour, violence, and inappropriate and inadequate health services. Furthermore, more attention must be paid to the health consequences of male gender roles among men who are members of both dominant and marginalized communities.

Interdisciplinary initiatives that facilitate holistic and situated approaches to gender and health research will not only be useful to this field, but can enrich the disciplines involved in the projects. Innovative programs have been developed in Canada and beyond that have worked to reduce health disparities by building on the strengths of local communities, using peer mentorships and community health development. For instance, the work of a cultural brokers cooperative where bi-cultural women have been trained in health promotion and community health development has not only helped employ immigrant and refugee women, but has benefited client families and contributed to the development of greater gender and culture sensitivity in the mainstream health institutions with whom they work.[303] In other instances, the use of photo-novellas, storytelling and focus groups have been used to convey the voices of women and minority community members to policy-makers and program planners; these processes can also engender further collective action.[304-307] For example, Kieffer et al.[306] describe how ongoing community-university alliances that foster participatory research have not only helped to illuminate explanatory models of disease for health professionals, but have contributed to community action to enhance availability of nutritious foods and demands for safer streets in disadvantaged neighbourhoods. Resources such as the Commonwealth Secretariat's 2001 publication, *Models of Good Practice Relevant to Women and Health: Women's Health Initiatives* contains numerous examples of innovative participatory programs that attend to issues of gender and health.[308] Overall, these models may all contribute to a re-shaping of community-based as well as institutional health services. More participatory research is required that can build on the strengths of women, men and their communities to help develop empowering, appropriate and long-term solutions.[309] Enhancing health by strengthening resistance resources such as social support and social capital are also offering potential avenues of insight and intervention.[310,311]

On a more general level, mainstreaming gender analysis is essential to health-care planning and setting the agenda for health research. Developing what Miers terms gender-sensitive care, wherein health services are designed to account for the gendered lives of groups and individuals[312] – both clients and staff – is also vital. Health Canada's 2003 publication *Exploring Concepts of Gender and Health* is an important resource available to policy-makers and program planners that can help them work through the gendered implications of programs and policies.[313]

Finally, the root of an individual's experience of health disparities lies predominantly in economic inequalities and unequal gender roles; therefore, efforts to close the gap in health must address these issues. Raising the rates for provincial minimum wages and social assistance levels might bring about improvements in health that exceed those of a singular intervention. Studying the impact of these issues and experimenting with other schemes such as a guaranteed annual income might provide some valuable information about the importance of economic security to health. In addition, the health of foreign-born Canadians might be improved if the means of adjudicating foreign credentials and enhancing opportunities for educational or occupational upgrading were given greater priority. A national child-care program might have considerable impact on alleviating the caregiving burden on women and would enable women to participate more actively in the public arena. National investment in an affordable housing program including cooperative housing could reduce homelessness, build safer neighbourhoods and enhance social capital.

CONCLUSION

The considerable affluence of Canadian society may mask the disparities that exist between women and men and within these categories. Individuals occupy various locations on our social landscape that can change throughout the life cycle; each position offers a range of potential opportunities and experiences, oppressions and insights. The pathways by which persons can be constituted as vulnerable – or conversely, placed on the road to good health – depends in part on where one is located in this social tableau. Health disparities may begin prior to birth as maternal health will have an impact on the life chances of children. Notions about what is appropriate behaviour for boy or girl children will have an impact on physical activity, the development of social skills and sense of self. At the level of the household, exposures to hazards, violence or other adverse conditions, allocation of health resources, nutrition, education, and gender socialization will further influence health and well-being. Neighbourhood and community can offer opportunities to form trusting relationships with others, provide a sense of identity and security or conversely, be a source of anxiety, the setting for discrimination and/or the site of environmental hazards and poor housing stock. Ethnicity, sexual orientation, mental health, physical ability, age, and socio-economic status also shape identities, opportunities and atti-

tudes that dominant Euro-Canadian society has towards individuals and groups of individuals. Access to health and social service facilities and housing, the status, conditions and strains of paid employment, the configuration of domestic life and its interaction with labour market involvement can all enhance social capital or contribute to stress. Importantly individual pathways are largely shaped and constrained by cultural values and gender roles and ideologies as well as structural phenomena including the "isms" of racism, sexism, ableism, agism and homophobia, globalization and neo-liberalism that underpin the policies and practices that have wrought a restructuring of workplace and home life with little concern over their impact on women and men. Examining these pathways through a gender lens suggests that – in general – women are decidedly more vulnerable to worsening health status due to their association with lower socio-economic status, domestic and familial responsibilities and gender ideologies. Notably, some men, particularly those who are members of marginalized groups, are similarly affected. The result is that, to differing degrees, all Canadians need more equitable access to determinants of health – or to phrase it more precisely, power – in order to reduce health disparities. Commitment, creativity and collaboration from stakeholders ranging from various levels of government, communities, academics, non-governmental agencies and health professionals will be required to reduce and eliminate health disparities between and among all members of our society.

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RÉSUMÉ

Quelle est l'importance du genre dans l'analyse des disparités sur le plan de la santé au Canada? Dans le contexte de la politique du gouvernement fédéral, l'auteur de ce document de synthèse analyse la façon dont le genre interagit avec les autres déterminants de la santé pour créer des disparités. Il examine les problèmes prépondérants dont l'impact des rôles assignés à chacun des sexes, l'exposition à l'environnement, la violence liée au sexe, les risques sanitaires en milieu de travail, les disparités économiques, les coûts associés à la pauvreté, la marginalisation et le racisme dans la société, le vieillissement, l'état de santé, l'interaction avec les services de santé et les comportements en matière de santé. Ce document montre que l'interaction entre, d'une part, les rôles et le statut selon le sexe et, d'autre part, les disparités économiques, la marginalisation culturelle, sexuelle, physique et historique et les tensions du travail impose un fardeau inéquitable sur le plan de la santé et fait en sorte que l'accès aux déterminants de la santé – en particulier celui des femmes – est limité à divers degrés. Cette situation se traduit par un fardeau injuste sur le plan de la santé, porté en particulier par les femmes dont l'accès aux déterminants de la santé est, à divers degrés, limité. Des progrès ont sans nul doute été réalisés sur certains fronts, mais la persistance des disparités en matière de santé entre divers groupes de femmes et d'hommes indique que la vision d'une société juste et de la santé pour tous énoncée dans le Plan fédéral pour l'égalité entre les sexes ne peut s'incarner aujourd'hui. Les intervenants, qu'il s'agisse des divers paliers de gouvernement, des communautés, des universitaires, des organismes non gouvernementaux et des professionnels de la santé, devront faire preuve de détermination, de créativité et de collaboration pour réduire et éliminer les disparités en matière de santé entre tous les membres de notre société.