Introduction

Developing alternatives to current government policies on health and illness is an important part of the struggle to improve women's health. To do so requires challenging traditional biomedical models that stress a combination of health determinants rooted in nature and individual responsibility, and deny the important connections between health and social factors. Biomedical models view women's health as being determined primarily by their sex, by their individual genetic make-up, or by harmful external pathogens such as germs. The Canadian health care system is based on this model, which is why it relies so heavily on prescribing drugs and other medical interventions, often at the acute stages of illness, to counteract the ill effects of germs and genes. The need for social change to promote better health among women is largely overlooked (Doyal, 1995).

Biomedical models also recognize the effects of certain narrowly defined lifestyle factors but often fail to situate such factors in a social context. For example, smoking has generally been interpreted as an individual behavioural choice, reflecting strictly personal preferences. However, studies have shown that rates of smoking and other health-related behaviours are linked with people's socioeconomic circumstances. Over-emphasizing individual responsibility for poor health outcomes amounts to blaming the victims, and also serves to downplay the social determinants of health and undermines the potential to improve women's health. By ignoring the socioeconomic environment in which behavioural choices are made and in which germs and genes can have their unhealthy effects, biomedical models are restricted in what they can tell us about why some groups of people are more likely to be healthy that others (Doyal, 1995; Chernomas, 1999).

In opposition to mainstream biomedical models, many progressive health analysts have focused their attention on the social conditions underlying population health patterns. Perspectives on health focussing on social determinants have helped to clarify the critical relationships that exist between health and such factors as income levels, stages of economic development, degrees of inequality and environmental conditions (Chernomas, 1999; Doyal, 1981; Navarro, 1976). Gender, along with other key social health determinants such as class and race, is an important determinant of health. Gender differences in opportunities and expectations about social roles generate marked inequalities between women and men in terms of access to health promoters (such as income, wealth, social support and leisure time) and health risks (such as stress, excessive work and dangerous occupational environments) (Bird and Reiker, 1999; Armstrong, 1995; Doyal, 1995). Not surprisingly, differential access to health re-

sources translates into significant gendered variation in health status.

It is our aim in this paper to consider some of the social, historical and cultural contexts that have shaped women's health experiences and made them different from those of men. We do so by exploring five main themes that are prominent in the social sciences and feminist literature on women and health: (1) the health inequalities between women and men, and among women; (2) the social/historical development of these differences; (3) the health implications of women's paid and unpaid work; (4) the biomedical model and the medicalization of women's health; and (5) women's resistance and advocacy. The study focuses on the experiences of Canadian women but also draws on literature from other industrialized countries, most notably Britain and the United States.

It is our main contention that women's health is conditioned by the social, cultural, economic and political environment in which they live, work, make choices and take action, and that the significance of gender must be fully accounted for in a social determinants perspective on health. The social nature of women's health problems suggests that much can be done to improve women's well-being through public policy and other social change.

Part I – The State of Women's Health

Differences in Health between Women and Men: The Morbidity-Mortality Paradox

Literature on the differences between women's and men's health status often refers to what has become known as the morbidity-mortality paradox. On the one hand, women have lower rates of mortality than men in every age group. Technically speaking, this means that fewer women die per 1,000 of population every year on account of women living longer on average. On the other hand, women have higher rates of morbidity than men. Women experience more sickness, more disability, and more psychological distress. In general then, the picture that emerges is one in which women live longer than men, but, suffer more illness and disability.

A common interpretation of the morbidity-mortality paradox rests on differences in patterns of disease among women and men. While men experience sickness less frequently than women, they also experience more life-threatening health problems earlier in life. Health statistics show that men have higher incidence of life-threatening chronic diseases, such as coronary heart disease, some cancers and kidney disease. Women tend to experience many such life-threatening chronic diseases later in life. Compared to men, women have higher rates of non-life threatening physical health problems, including many chronic disorders (such as arthritis, gall bladder conditions, anemia, and thyroid conditions), and acute conditions (such as respiratory infections and gastroenteritus). These differences in disease patterns are often cited as underpinning men's lower morbidity and women's lower mortality (Statistics Canada, 2001; Bird and Reiker, 1999).[1]

The life expectancy of both sexes grew dramatically over the course of the twentieth century, and women maintained their longevity advantage throughout. A woman born in Canada in 1901 could expect to live an average of three years longer than a man, the difference between 50.1 years and 47.1 years. By 1997, female and male life expectancy had risen to 81.4 years and 75.8 years respectively, a difference of 5.6 years. The gender gap in life expectancy grew to a peak of 7.1 years in Canada in 1981 (Statistics Canada, 2001).

Among the important early socioeconomic transformations that helped to extend the lives of women and men were improved diets, sanitation, early public welfare initiatives and labour legislation. By helping to strengthen people's immune systems, such enhanced living standards went a long way towards curbing mortality from the prevalent infectious and communicable diseases that dominated nineteenth century mortality statistics (Chernomas, 1999).

Women's life expectancy also received a boost from lower birth and maternal mortality rates. The overall number of

deaths among women of child-bearing age began to fall as women had fewer children (Loudon, 1993). In Canada, like other Western nations, the birth rate fell by over thirty percent in the last fifty years of the 19th century, and remained roughly stable until further reductions in the 1920s and 1930s (Finkel and Conrad, 1998). After some growth during the relatively prosperous years of the 1940s and 1950s, the fertility rate began to fall again after 1960. According to Statistics Canada data, 1,000 women in 1926 would have given birth to an average of 3,357 children over the course of their lifetime; by 1974, the same number of women would have given birth to only 1,875 children (Fraser, 1983).

However, women did not always enjoy the full health benefits of reduced birth rates, because astonishingly high numbers of women continued to die as a result of pregnancy and childbirth. Unlike other significant causes of death, maternal mortality rates did not start to fall in Canada until the late 1930s (Fraser, 1983). From its Great Depression high of 5.6 deaths per every 1,000 live births in 1936, the maternal mortality rate dropped to 1.1 deaths in 1950. By 1974, this rate had fallen further still, to 0.1 deaths per 1,000 live births (Fraser, 1983). Today, women in Canada are sixty times less likely to die giving birth than in 1930. Much of the reduction in risk occurred over the post-World War II period. In the United States, maternal mortality dropped by 90 percent between 1950 and 1989 (Bird and Reiker, 1999).

Compared to that of women, the rate of improvement in men's life expectancy over the last century, while positive, has been inhibited by high rates of premature death and injury on the job. Traditionally, gender pressures have also led men to exhibit higher rates of various negative-health related behaviours, which have been tied-in with a risk-taking lifestyle (Doyal, 1995). According to a recent Statistics Canada report, compared to women, men are more likely to smoke[2], are less likely to consider health implications when making food choices, are almost twice as likely to consume alcohol on a weekly basis and are much more likely to binge drink (Statistics Canada, 2001).

In recent years, however, the longevity gap between women and men has been narrowing in Canada and many other industrialized countries, as gains in male life expectancy have outpaced those of female life expectancy (Trovato and Lalu, 1999). The life expectancy of women and men in Canada grew less during the 1990s than during previous decades, and less for women than for men. From 1990 to 1997, the death rate[3] dropped by half as much for women (4%) as it did for men (8%) (this contrasts with a drop of 52% for women during the longer period from 1950 to 1997 and only 39% for men) (Statistics Canada, 2001). To date, the predominant explanation of this internationally observed departure from earlier trends has rested on the convergence of health risks assumed by women and men, including specific occupational hazards and health-threatening behaviours (Waldron, 1993).

A recent Statistics Canada report suggests that of any cause of death, changes in rates of smoking-related respiratory cancers[4] have likely had the greatest effect on recent trends observed in gender differences in mortality. For men, the rate of res-

piratory cancers leveled off in the mid-1980s, after a steady climb from 1950, and actually fell throughout the 1990s. For women, by contrast, the rate of these cancers began to rise in the mid-1960s and continued to grow through the 1990s. These gendered patterns reflect the earlier popularity of smoking among men as well as earlier drops in male smoking prevalence. Thus, while male death rates from respiratory cancers are still much higher than female rates, the gap is closing as male rates fall while female rates rise (Statistics Canada, 2001).

Unlike the convergence presently observed in male-female life expectancy, the gender gap in morbidity does not appear to be narrowing. In trying to explain women's greater relative morbidity, some have argued that this morbidity excess is a product of reporting bias, reflecting a higher female propensity to report health problems. Today, it is still widely believed that women are socialized to take better care of themselves and hence to seek health care more readily, while men are assumed to be reluctant to report illness and seek care.[5]

In spite of the prevalence of such notions, studies find no conclusive evidence to support the idea of a greater relative predisposition among women to report health problems (Bird and Reiker, 1999; Macintyre et al, 1999; Popay, 1992). In fact, some studies suggest that women underplay their health problems and show reluctance in reporting illness. In a study of British households, for instance, Jennie Popay found that women were unlikely to identify severe tiredness as an illness, no matter how extremely or chronically they experienced it, or to take on a sick role in response (Popay, 1992). Another study, carried out by Sally Macintyre of the Medical Research Council, Social and Public Health Sciences Unit, in Glasgow, found that compared to the ratings given by clinical observers, men tended to over-rate the severity of their common colds symptoms, while women tended to under-rate them (as cited in McKie, 2000).

Although research does not support the idea that women's excess morbidity is an artifact of a reporting bias, the entrenchment of this idea in medical and other health circles puts women's health at serious risk. It does so firstly by discouraging concrete action to address women's high morbidity rates (Broom, 1991). It does so also by implying that women's health complaints are less substantive than those of men, since women are assumed to be exaggerating their health problems. It is easy to see how this sort of thinking could have detrimental effects on the quality of health care that women receive. In fact, a recent study conducted by researchers at the New England Research Institute in Boston suggests that the diagnoses and care prescribed to women may be very different than those prescribed to men reporting the same symptoms.

The Boston study had male and female actors play the part of patients suffering from chest pains and shortness of breath. Close to 200 doctors then examined the actor patients and described what they would do for patients in like conditions. What the Boston researchers found was that the doctors were much less likely to make cardiac diagnoses for women, to treat women medically or to make lifestyle modification recommendations for

women. At the same time, female patients were more likely to be diagnosed as suffering from emotional problems and to be prescribed psychiatric treatment (as cited in McKie, 2000). These results suggest that proper health care may be withheld from women in need, including for serious conditions such as heart disease.

A growing body of evidence confirms that women's greater relative morbidity is a social product. For instance, studies have found that once gender differences in social roles are controlled for, gender differences in morbidity shrink and often cease to be statistically significant (Bird and Fremont, 1991; Verbrugge, 1989). In fact, after controlling for gender differences in time spent in social roles (most notably men's greater time spent in paid work with higher wages and women's greater time spent on housework), Bird and Fremont found that being female is actually associated with better self-rated health than being male.[6] This suggests that if women and men had social roles that were more similar, women's health would improve comparatively (Bird and Fremont, 1991).

Health Inequalities Among Women

The stark differences in health status that exist between women and men are in many ways akin to the significant variation in health status observed among women of different socioeconomic groups. While women share a number of important characteristics that affect their health in similar ways, such as subordinate gender positions and many common bodily experiences, they also have very divergent health experiences based on class, race and other social divisions. On an aggregate basis, women's health is adversely affected by their disadvantaged position with respect to poverty, the labour market, treatment in terms of social security, political power, wage levels and so forth, but some women are more disadvantaged than others. Professional women belonging to the predominantly white middle class of prosperous Canadian society, for example, enjoy living, working and other health advantages which are unavailable to women who are poor, unemployed, working in the secondary labour market or suffering from racism and other forms of discrimination (Kaufert, 1996). Women in Canada and in many other industrialized countries also enjoy the benefit of a national universal public health care system. In the United States, by contrast, a mostly private for-profit health care system severely limits the access of millions of women to even the most basic health services.

The magnitude of health inequalities among women is revealed in just a few examples. For instance, although female life expectancy is around 75 to 80 years in most industrialized countries, this average disguises large variations among women of different socioeconomic groups. According to Britain's 1978 Registrar General's Decennial Supplement, for example, the death rate for women aged 15 to 64 within the highest social class (professional/managerial) was 2.2 per 1,000. For women within the lowest socioeconomic class (unskilled), the death rate was 5.3 per 1,000.[7] Indeed, the social class variation in mortality was so great as to cross gender lines. In spite of women's general advantage with respect to longevity, women in unskilled and partly skilled occupations were found to

have higher mortality rates than men in the top professional/managerial class. The women of Britain's lower socioeconomic classes have also been observed to have higher incidence of morbidity, greater likelihood of premature death and higher maternal mortality rates than women in higher classes (as cited in Doyal, 1995; 1985).

In Canada, Aboriginal women have significantly shorter life expectancies than non-Aboriginal women. The life expectancy of Canadian women as a whole in 1991 was 80.9 years but significantly lower for Aboriginal women. The life expectancies of Non-registered North American Indian women, Métis women, Registered North American Indian women and Inuit women were 77.9 years, 76.9 years, 74 years and 68.8 years respectively (estimates of M. J. Norris et al., as cited in Janzen, 1998, p. 14). Aboriginal women in Canada are more likely to die as the result of violence and have higher rates of suicide than non-Aboriginal women (Donner, 2000). Rates of smoking and disability are also higher among Aboriginal women (Janzen, 1998).

The need for social change to overcome these health inequalities has been clearly articulated by Aboriginal women themselves. In interviews conducted as part of Lissa Donner's study of *Economic Inequality and Women's Health in Manitoba* (2000), Aboriginal women identified their health conditions as being deeply rooted in persistent poverty, manifested in inadequate diets, housing and education. It is striking that Aboriginal women are at greater risk of low-income and poverty than either Aboriginal men or non-Aboriginal people of either sex. Measures to reduce poverty are therefore crucial to create the living and working conditions that are essential to improving the health of Aboriginal women (Donner, 2000).

Health-related behaviours also bear close relation to socioeconomic conditions (as they do to gender). For example, Canada's National Population Health Survey found members of the lowest income households to be nearly twice as likely to be current smokers (30%) as members of the highest income households (as cited in Statistics Canada, 2001). According to a 2001 report of the U.S. Surgeon General, smoking is three times as prevalent among women with only 9-11 years of education (32.9%) than it is among those with 16 or more years of education (11.2%) (Surgeon General, 2001). An understanding that health-related behaviours reflect social conditions means that we cannot look at risk factors such as smoking, poor diet and alcohol consumption as representing strictly individual preferences.

Differences among women are also evident in their use of health care services. In Canada and other wealthy countries, women have higher rates of health care utilization than men. This greater relative use of health care services reflects factors that include sex specific conditions (such as pregnancy and childbirth), and women's tendency to live longer than men (Mustard et al., 1998). Among women, those in lower socioeconomic classes have generally higher rates of health care utilization, reflecting their greater needs stemming from higher morbidity and mortality. Some evidence suggests, however, that when patterns of health care utilization are corrected

for need, women in lower socioeconomic classes make less use of health care services than women in higher classes (Doyal, 1985).

In contrast with patterns of overall health care use, studies find an inverse relationship between women's use of some valuable preventative services and their socioeconomic class. For example, recent data from the province of Manitoba shows that women in the lowest income groups are least likely to make use of screening procedures, including Pap smears for cervical cancer and mammography for breast cancer (Donner, 2000). This information is very alarming given the class distributions of disease and illness.

Access to health care within Canada's health care system varies considerably. In the 1980s, Manitoba Planned Parenthood, as part of their Immigrant/Refugee Health Program, discovered many barriers to good reproductive health care experienced by immigrant and refugee women (Stevens, 1993). These findings are consistent with numerous studies documenting the potential barriers to access encountered by immigrants and refugees, including language, lack of culturally appropriate care, and other practical concerns such as restricted hours of service where newcomers work shiftwork, or fear for their job security if they take time off work to seek medical care (Masi, 1993; Stephenson, 1995).

Many women living in Northern and rural areas also experience difficulty in accessing appropriate health care services, sometimes needing to travel long distances in order to make it to suitable health care facilities. Along with their identification of poverty as a major health risk, the Aboriginal women in Donner's Manitoba study highlighted inadequate access to health care as a major contributing factor to poor Aboriginal health (Donner, 2000). Women may be blocked from accessing proper health care services by barriers such as lack of affordable child care, insufficient resources for drug and other direct costs, unfamiliarity with health care resources and inaccessible transportation. Women can also face discrimination from health care professionals on the basis of gender, race, class etc., which can interfere with their ability to access quality care.

A recognition of the health inequalities that exists among women highlights the need to treat women as a diverse group. Women's differential access to health promoting resources and exposure to health risks must be front and centre in analyses of women's health (Morgan, 1998).[9]

Part II – Exploring the Social Roots of Women's Health

Having outlined some of the many and diverse health inequalities that affect women, it is important to recognize that women's health has a history. An awareness of how the historical evolution of women's social roles has shaped their health experiences has been central to feminism's analysis of women's health inequality for nearly thirty years. Research done in this vein allows us to challenge the apparently natural – indeed, seemingly inevitable – health consequences of a gendered social reality.

The Burdens of Home and Family

For example, we know that even as women make hard-won gains in gender equality in the workplace, they continue to be responsible for the majority of household chores. The origins of women's double burden - the dual pressures of work for wages and household responsibilities – can be found in early capitalism. The Industrial Revolution fundamentally altered what had previously been a largely agrarian-centred way of life, driving the masses of people away from family-oriented production into wage labour in factories. Family survival came to require that its members sell their labour for wages, in order to purchase what had previously been produced within the family unit or local community. This change had particular implications for women. In pre-capitalist communities, women's skills within the family economy made visible contributions to its wellbeing. Early pioneering women, for example, raised and butchered livestock, made dairy products, grew and preserved fruit and vegetables, and often carded and spun wool and sewed clothing. When needed, they would chop wood, or plow the fields. Within the household, they might also make goods to trade or sell, sometimes alongside their male family members and sometimes separate from them. Although patriarchal relations permeated the household, women nonetheless had a clear role in its economic survival and prosperity.

The economic growth and technological changes that drove the Industrial Revolution could have meant greater autonomy for women, by freeing them from household work, for example, or providing economic independence through wage work. As we will see however, women did not enter the wage labour market as equals of men; they were excluded from the most lucrative jobs, and were poorly paid even relative to the most exploited male workers. (see Part III) At the same time, household work, while still time-consuming and difficult for women, lost its status and much of its economic visibility. Although change took longer and was less complete in some communities than in others, the market began to gain supremacy in the provision of domestic goods, which were more often produced by wage labour, outside of the family setting. The pre-capitalist household order was replaced by an

ever-expanding capitalist mode of production that turned textiles, clothes, food, and health care – goods traditionally made by women within the family economy – into commodities bought and sold on the market. Women of the working class often performed aspects of their traditional labour – for wages - in the new industrial world. But in the transition they lost control of the productive process, many of their distinctive skills, and their unique and visible role in the family economy (Ehrenreich and English, 1978).

The public world of the factory was identified as the site of wealth production, where "real work" was performed and, of course where the horrors and notorious exploitation of the Industrial Revolution took place. The home, on the other hand, was increasingly represented as non-productive. A new middle class ideology emphasized the role of the home as a haven against the negative side of capitalist development. For men, "Private life now [took] on a sentimental appeal in proportion to the coldness and impersonality of the 'outside' world. They look[ed] to the home to fulfill both the bodily needs denied at the workplace, and the human solidarity forbidden in the Market (Ehrenreich and English, 1978, p. 11)." Women were to be responsible for maintaining this warm retreat.

Women's subordination and their role as 'angel of the home' have been beneficial for capitalism beyond allowing some men to enjoy a humane and nurtured home life. Women's work in the middle class home was at the heart of growing domestic consumption, so important for continued capitalist development. Wealthier women were far from idle or frail, as they were often depicted. Their responsibilities included the smooth running of increasingly elaborate homes, the education of the young, participation in a culture of bourgeois consumption, assisting in the family's business enterprises, and facilitating the husband's networking and social relationships. These tasks often meant both physical and mental labour, particularly in households on the margins of the middle class, in which money to hire domestic servants was limited (Davidoff and Hall, 1997).

Women, of course, bore children and nurtured the family; working class women reproduced the capitalist work force. The pressure to create a domestic haven for the male breadwinner was a much more serious challenge in working class and poor homes, and this fell upon women. "Keeping up appearances" and maintaining respectability were a constant struggle for working class families. Maintaining the household on inadequate incomes, cooking, cleaning, and caring for the sick were female responsibilities, and were often extremely demanding, physically as well as mentally. At the turn of the century, most working class households in Canada had no running water or sewage connection. Water had to be carried long distances and up stairs. There were no toilets, no electricity, modern stoves or refrigerators. Cleaning, cooking, and shopping for food were heavy tasks, and often took a physical toll on the female members of the family who did most of this household work. Despite the technological progress of industry, labour-saving devices for the home were slow to appear, expensive, and im-

practical for many households. It was the 1950s before a majority of Canadian homes had hot running water to support automatic washing machines; such amenities came even later to isolated prairie and Northern families, and not at all to many homes on Aboriginal reserves (Parr, 1999).

Among poor and working-class families, women's household labour was often the only thing keeping the family from destitution, particularly when male wages were absent or unstable. When times were tough, market consumption dropped, and women fell back on pre-capitalist means of producing subsistence. During the Great Depression, for instance, women found endless ways to economize, produce food, trade and barter, and earn small amounts of cash. They returned to growing vegetables in small gardens wherever possible, something that was quite common in the 19th century, when women might also raise chickens and pigs. They mended, sewed, canned food, picked berries, and stretched the family's resources as far as they could go. They might take in boarders, in order to help pay the rent or mortgage (Comaccio, 1999; Baillargeon, 1999). These kinds of strategies were used when needed by working families, but they took their toll. Sickness, exhaustion, and injury were routine in the lives of working class women (Ehrenreich and English, 1978).

Although the once idealized nuclear family composed of male breadwinner and female nurturer can hardly be said to represent most families today, women are still closely associated with home and family. Women continue to be assigned primary responsibility for domestic work, and for stretching family resources to their limit. And while twentieth century developments, such as running water, gas and electricity and introduction of new domestic appliances, have removed much of the drudgery involved with domestic work where they are available, the performance of this work remains a time-consuming activity for women. Cooking, cleaning, laundry, shopping, gardening as well as raising children and caring for other dependents are among the many jobs for which women take a major responsibility. Some women also perform income-generating work inside their homes (Doyal, 1995).

Household Work and the Health of Women

Modern health research tells us that the expectation that household work will be performed by women has particular health implications. Traditionally, research into the health consequences of household work has focused on the adverse consequences for women's mental health, largely ignoring the possibly of damaging physical effects. Numerous studies have shown that full-time housewives are particularly prone to depression, especially when at home with young children. The strain that may be placed on women's mental health in conjunction with household work is not simply the product of the nature of this work; it is also fundamentally connected to the low social status which it is generally assigned, as well as the isolating and other conditions under which it is performed (Doyal, 1998).

Women often express dissatisfaction with their household work. They complain of the monotony and loneliness involved

with the performance of household jobs and the shortage of opportunities to learn new skills and to put them to use. The knowledge and skills that come with domestic work are rarely recognized as such, since they are not the products of formal education and training. Working at home can also cause women to experience tight confinement to their workplace, generating feelings of isolation. New mothers frequently report the sensation of being trapped at home. While household work may provide women with a sense of accomplishment, they often have little discretion over the tasks they must perform as part of their duties (Rosenberg, 1990).

Women's characterizations of housework are particularly significant, from a health perspective, in light of the growing number of studies of wage workers which associate job characteristics such as monotonous, boring and repetitive, with poor physical health.[10] Far from wearing only on women's mental health, therefore, these studies suggest that domestic work may raise women's susceptibility to a whole host of physical health problems as well.

Household work can pose a variety of specific occupational hazards. For, example, Harriet Rosenberg has detailed how household work can involve the use of numerous home-cleaning products which contain an array of potentially harmful chemicals, toxic substances and pollutants. Women make regular use of products such as drain cleaner, toilet bowl cleaner, scouring powder, oven cleaner, chlorine bleach, window and glass cleaner, disinfectants, all-purpose cleaner, dishwashing detergent, floor and furniture polish, room deodorants and laundry detergent. Home-cleaning products can immediately cause harmful effects such as skin burns, rashes, eye irritation, allergic reactions, nausea, and if ingested by children, these products may be lethal. More research is still needed on the relationship between home-cleaning products and serious chronic diseases, such as cancer (Rosenberg, 1990).[11]

Women are also at risk of having accidents while they work at home. Approximately half of all home accidents are the result of falling (primarily from level ground, rather than from heights) (Rosenberg, 1990) and about forty per cent of injuries to women happen at home (Statistics Canada, 2001). Numerous standard household appliances are capable of injuring users; for example, gas stoves that emit carbon monoxide and nitrogen dioxide, refrigerators that feature extremely hot coils and drop pans in which bacteria can grow, fluorescent light bulbs that emit ultraviolet radiation and microwaves that may leak radiation through faulty seals. Women's home and garden work may also bring them into contact with a variety of dangerous insulating materials, insecticides, pesticides and fungicides, which pose health threats, not only to exposed factory and farm workers, but to exposed household workers as well. Chemicals found in these products have been associated with such serious conditions as cancer, brain damage, liver damage and with birth defects (Rosenberg, 1990).

When women perform paid work such as industrial sewing in their homes, their work equipment may pose additional hazards such as the production of heavy dusts (Armstrong, 1995). Women's homes often do not offer comfortable working condi-

tions or sufficient ventilation. Sewing and other routine work performed in the home commonly involves the performance of highly repetitive tasks at very fast speeds, performed in stationary and uncomfortable positions. In addition, low piecework pay may encourage women to increase their pace of work and to extend their working day (Messing, 1991).

It is clearly in the interest of capitalist producers of household products to maintain the social division between the home and the formal workplace, in order to escape the pressure of organized occupational health and safety movements. Forging links between domestic workers and unions and other formal worker organizations would certainly be a useful step in creating the processes required to gain access to information about, and protection from, household dangers and hazards (Rosenberg, 1990). And while women may be most at risk of injuries such as falls, cuts, burns and exposure to indoor air pollution, it is important to recognize that unsafe domestic working conditions affect the whole family through food safety, home hygiene and risk of accidents (Doyal, 1998).

Reproductive Work: Mothering and Women's Other Caring Duties

There are significant health risks associated with women's role as mothers. As noted earlier, high maternal mortality rates remained a remarkably persistent health issue for several decades after death rates from infectious diseases and infant mortality had declined. Even in the late 1920s, pregnancy and childbirth claimed the lives of about 1500 Canadian women every year, a number not significantly different from the mid-19th century (Comacchio, 1999). There were three conditions responsible for most maternal deaths: puerperal sepsis, toxemia, and hemorrhage. Puerperal sepsis, which included streptococcal infection (puerperal fever) and septic abortions, was the most common cause of death (Loudon, 1993). In Canada and the United States, death as a result of abortion was probably increasing in the 1920s and 1930s. The toll that abortion death was taking on Canadian women was known to observers at the time. For example:

> In a 1934 study of 334 maternal deaths in one year in Ontario an important finding was unearthed. Researchers found that fifty-nine, or 17 percent, of all maternal deaths were due to abortion. These abortion deaths were "artificially" inflating the number of deaths attributed to normal pregnancies (McClaren & McClaren, 1990, p. 127).

The McLarens have argued that a high number of women sought to terminate their pregnancies in the 1930s and 1940s relative to other periods, for reasons that remain obscured. Poverty, and the lack of reliable birth control, may have played significant roles. The historical data on death caused by complications from abortion are fragmentary and difficult to analyze. However, it is commonly accepted that maternal death rates were greatly increased because of unsafe abortions; a fact that historical amnesia should not be allowed to obscure.

Certainly the lack of high-quality prenatal and obstetric care available to women was also a significant contributing factor

to maternal mortality in this period (Loudon, 1993). By the early 1940s, a majority of Canadian women gave birth in hospitals, although there were regions where women were too isolated to go to hospitals, and others could not afford to. Ironically, the latter women were probably safer. Jo Oppenheimer's research on Ontario has revealed that in the 1930s, maternal mortality among hospital births was 5.3 per 1,000, but 2.3 per 1,000 among women who gave birth at home (Oppenheimer, 1990). There was a high risk of fatal infections associated with hospital births, and this did not change until the post-World War II availability of sulpha drugs and antibiotics.

Socioeconomic conditions were also important factors in maternal mortality. Generally poorer health, inadequate nourishment and poor living conditions put working class mothers and babies at risk. "The average working-class mother of the 1890s, married in her teens or early twenties, had ten pregnancies and spent fifteen years in a state of pregnancy or nursing," according to historian Jane Lewis (Lewis, 1990). Frequent pregnancies, combined with heavy household labour and inadequate financial resources, put a heavy strain on women's health. Conditions for childbirth were particularly dire for the poor of isolated areas, or for extremely marginalized communities, such as black women in the southern US (Loudon, 1993).

Beginning in the late 1930s, maternal mortality rates in most industrialized countries began a steady and rapid decline. Women benefited from generally better health, higher standards of living, and a higher standard of obstetric care. Many improvements came as a result of active lobbying by women. In the campaigns of the Women's Cooperative Guild in Britain, for example, working class women argued for public policy changes such as family allowances, which were to improve the material conditions of women's lives, in addition to campaigning for qualified midwives, free medical care, and hospital beds (Lewis, 1990).

In Canada, the risk of dying in pregnancy and birth fell from 1 in 150 in the 1930s to 1 in 3000 by the 1960s (McLaren & McLaren, 1997). Today, the lifetime risk of maternal mortality in Canada is only 1 in 7,700. This compares with the less impressive figure of 1 in 3,500 in the United States, the only industrialized country without a developed national health care system (Save the Children, 2000). Inequality in maternal mortality is, however, evident among women of different social groups. In Britain, for example, wives of unskilled workers are twice as likely to die of childbirth-related causes than women married to professionals (Doyal, 1995). In the United States, the maternal mortality rate among black women is more than three times as high as it is among white women (Save the Children, 2000). Deaths related to childbearing are thus a good indication of how women's health status differs most clearly from men's, but also of how women's health experiences are related to social inequality (Doyal, 1995).

The health risks of motherhood do not end with childbirth. When women have children, their workloads increase dramatically. Clothing, washing, feeding, nurturing and socializing children are some of the many jobs involved with women's

mothering work. Although the work of caring for children can be very rewarding, it can also be highly physically and emotionally demanding. Childcare almost certainly involves interrupted sleep, heavy lifting and the provision of intense emotional support (Rosenberg, 1990). Women's mothering work is made easier and more enjoyable when they have support in their childcare duties from partners, other family members, friends or childcare workers, allowing them to take periodic breaks from their work. When support from family and state-supported child care is lacking, women will find child-care more draining and may experience chronic fatigue, increasing their susceptibility to other health problems (Armstrong, 1995).

Immigrant women may lack these valuable support networks, particularly in their initial period of migration. Interviews with immigrant women who came to Winnipeg from the Caribbean in the late 1960s – 1980s show that isolation can be a difficult aspect of adjustment to life in a new community. Claire, who had emigrated as a domestic worker, then worked as a secretary before she married a university professor, had a new baby when they moved from Toronto to Winnipeg. She was alone often, disliked the city, and experienced anxiety about her baby's health. "[The baby] was not three months yet, and I looked at him one day and I thought he was going to die!" she recalls. Through her small network of friends from the Caribbean, she was able to find a doctor who reassured her that her baby was perfectly healthy. Her own health remained "up and down" (Jones, 2000).

Women also contribute to the social reproduction of their partners, or what Harriet Rosenberg terms "wifework", which may involve heavy emotional, sexual and physical support. These efforts play a key role in supporting family members in their work and other pursuits. It is notable that a study of British civil servants (known as the Whitehall II study) found that marriage was positively associated with the occupational mobility prospects of men, but not women. This may denote that men receive positive support from marriage that impacts favourably on their work. For women, marriage and children may generate a strenuous double burden of domestic and paid work responsibilities (Kaufert, 1996).

Rather than representing social support, women's family members can, in some cases, pose a serious threat to women's health. Domestic violence against women remains all too common, though its frequency, its legal status and degree of acceptance by society, vary (Doyal, 1995). Different studies of wife abuse indicate that anywhere between ten and twenty-five per cent of women in Canada are abused annually. Statistics Canada estimates that half of all Canadian women have experienced some kind of physical or sexual abuse at least once in their adult lives (as cited in Armstrong, 1995).

Women's care-giving work extends to adult dependents, the sick, the disabled and the elderly as well. Women are commonly expected to care for sick and aging relatives, in part because their forfeiting paid work often involves a smaller loss of income than it does for men (Doyal, 1995). Indeed, studies suggest that while women

and men are equally likely to provide financial resources for the care of elderly parents, women are more likely than men to additionally contribute their own time and energy to this care. (Of course, given women's lower average level of compensation, financial contributions are likely to be more burdensome for women than they are for men) (Bird and Reiker, 1999).

While many women choose to engage in this sort of caring work, more and more women have been pressured into taking on this work as a result of government "community care policies" which have transferred responsibility for health care and other social services onto civil society, and onto women in particular. Policies to release patients from hospitals earlier have added to women's caring burden. Numerous studies reveal longing among women for more help in their caring capacity. Moreover, many women are faced with caring duties for which they have no training and which require skilled attention (Armstrong, 1995). The loss of autonomy which can stem from the process of first caring for children, then taking care of aging relatives and finally looking after one's maturing partner can be very stressing to women's health (Doyal, 1995).

Part III – Women's Health and Waged Work

From the time of the first mill and factory women were drawn into waged work. In 1871, women and children made up 42 percent of the industrial work force in Montreal and 34 percent in Toronto (Phillips and Phillips, 1983). When men's wages were insufficient to support the family – which was often the case, particularly among unskilled workers - children's and women's wages were necessary to the survival of the family (Bradbury, 1993). Often, women widowed late or early in life had to seek employment. And unmarried women usually had to support themselves to some extent, even if living with family. But women worked for wages under conditions that were in many cases different from those of men. They did different work, and almost always worked for less money than men.[12]

Employment opportunities for women did improve from the early 20th century onward, but female job ghettoes continued to be the norm. Probably the largest female job ghetto before the First World War was domestic service. Between 1851 and 1891, the number of domestic servants in Britain nearly doubled, peaking at 1.4 million, and not falling below one million until the late 1930s. Most of these were women. Historian Leonore Davidoff has concluded that a great many working class women must have worked in domestic service at some point in their lives, often during adolescence. Domestic service accounted for 34 percent of all female employment in Britain in 1891 (Davidoff, 1995). Domestic work was also a major source of employment for women in Canada, particularly for young immigrant women (Smith, 1985). In 1891, domestics made up 41 percent of the female work force in Canada (Phillips and Phillips, 1983).

Working conditions for domestic servants varied by employer, but in all cases pay was room and board with a small cash wage. Deference to the master was expected. Servants had little privacy, and residential domestics were to be at hand twenty-four hours a day. Domestic workers were expected to deal with all of the dirt and filth of everyday life in the 19th century. They cared for ill children and the elderly, with no recognition that these were important healing tasks. Women performing housework were assigned to the lowest rungs of the social ladder, and were in fact considered unclean and undeserving of respect. Employing servants symbolized status for upwardly mobile families, and served to draw a clear class line between themselves and the working class.

Given these conditions, women escaped domestic employment whenever possible. The proportion of domestics in the female workforce fell to 18 percent by 1921, as more job opportunities became available (Phillips and Phillips, 1983). The garment industry employed many young Canadian women in the mid-19th century onward, but most lucrative tasks in the manufacturing of clothing were reserved

for men. For example, cutting the garments, which was viewed as a skilled job for which women had no training or ability, was a male job only. Women often did finishing work, sewing on trim, buttons, or hemming garments. This work was invariably poorly paid (Frager, 1992). Other gender-specific jobs for women, like shop girls and telephone operators, were likewise unfairly paid relative to male wages. In 1910, the average wage for women in manufacturing was $5.44 per week, while men earned on average $9.58 (Phillips and Phillips, 1983).

Much has been said about the failure of the union movement to organize women workers. In many cases, working class men (particularly those working in the skilled trades) had embraced the notion of the male breadwinner as head of his family. Many argued, along with their bosses, that women's place was in the home. Union leaders tended to view women as expendable workers who drove down male wages, and as uncommitted to class struggle. However, it could also be difficult to organize women workers. They were often isolated in small workplaces, or in the home earning money sewing at piece rates. Male members of their families may have opposed their union activism, and domestic responsibilities often made taking the time for union activities difficult. In such a social climate, even active socialist women tended to subscribe to prevailing gender norms and expressed their commitment to class struggle over goals of sexual equality (Kealey, 1984). While there were those whose socialism was also militantly feminist, these women were the exception. It took the large influx of women into the workplace after World War II, and the strength of 'second wave' feminism, to begin to alter the sexism of organized labour, and to more successfully argue women's right to equality inside and outside of the workplace.

This is not to say that women did not organize for social change. Women workers in Winnipeg early in the last century, with the support of the Women's Labour League and union ladies' auxiliaries, struggled for better pay. Attempts to increase wages were in this case supported by middle class reformist women, who sympathized particularly with the plight of young single women, but who also feared that working girls would turn to prostitution to supplement their earnings. Women were sometimes successful in their lobbying efforts, as was the case with Manitoba's Minimum Wage Act (1918). This and other protective legislation, which attempted to limit hours and increase pay for women, found its most effective public argument in the need to protect young women as future mothers and wives, not their right to a living wage (Kealey, 1998).

The structural inequality of women in the capitalist workplace was likely to enforce a dependence upon men, and reinforce the ideal nuclear family at the heart of capitalist relations. Young working women found it almost impossible to survive on their own. An investigator hired by the Manitoba government in 1918 to look into wages and living conditions among single female workers discovered dismal conditions. Working 52 hours a week, a young retail clerk made $5 to $7 dollars, out of which she had to pay $2 for a rented room. For food, she could afford

only bread, honey, tea, and some meat. The investigator concluded: "Just how long a girl can exist under these conditions I cannot say. I know I was hungry all the time, and after my third day's experience at keeping house on six dollars a week, I went to a restaurant for a decent meal, as hunger is a sharp thorn ... No one but those who actually experience this daily routine can realize what it means to eat bread and butter sandwiches for lunch ... " (Smith, 1985, p. 42). Without equal access to jobs, or to equal wages, women without male support were at heightened risk for health problems associated with poverty.[13]

Many aspects of women's waged work remained the same over the course of the 20th century. New job ghettoes such as clerical work, retail and banking, nursing, and teaching absorbed most of the female workforce, and manufacturing fell in importance as a source of employment for women. Wage inequality persisted, remarkably unchanged by shifts in the makeup of the economy, or by the temporary positive impact of the two World Wars. As Paul and Erin Phillips note, "the relative wage levels of women through the industrial revolution in Central Canada … remained consistently at between 55 and 60 percent of male wages, the same as in the 1980s, one hundred years later, throughout Canada (Phillips and Phillips, 1983, p. 22)."

What has changed markedly, though, is women's rate of participation in the labour force. Over the course of the past fifty years, women, especially married women with children, have entered the labour force in ever growing numbers. While many women have voluntarily taken up paid employment, others have been pushed into accepting paid work out of financial need. Despite their growing direct involvement in paid employment, women who work outside the home continue to shoulder primary responsibility for housework and childcare (although men have been increasing their share of unpaid labour in many parts of the world). In addition, research indicates that men often maintain determining control over how women's income is spent. Thus paid employment is not a guarantee that women and girls will not suffer discrimination in terms of the distribution of resources within the household (Doyal, 1995; Rosenberg, 1990).

Although it was made illegal to pay women less than men for the same work in Canada and other industrialized countries in the 1960s and 1970s, women continue to make considerably less than men because they are crowded into select occupations and because they hold the worst jobs within these occupations. Women also predominate in the informal sector where there are few restrictions on hours of work and few controls over working conditions. Women have lower employment rates, work more part-time jobs, make less money (at all educational levels, and particularly, at low ones) and have lower rates of unionization. It is clear that if health bears any relationship to income, then women are relatively disadvantaged compared to men. Very low income can be damaging to women's health by preventing access to basic necessities such as adequate nutrition and decent housing (Armstrong, 1995; Kaufert, 1996).

In addition to low pay, women's jobs tend to be characterized by low status and a lack of discretion, control and decision making power, as is typical of clerical, sales, service and routine factory work. Women are thus likely to be disadvantaged relative to men in terms of job satisfaction as well. Countless studies reveal that health suffers as a result of poor compensation, low status, few job ladders, high demands and low levels of control over one's work. Some evidence indicates that while women with heavy work responsibilities have high levels of stress, it is those women with the least power and discretion over their work who suffer the greatest adverse health effects from high stress (Doyal, 1995).

Is Waged Work Beneficial or Harmful to Women's Health?

For some time, it was feared that women's increasing performance of paid employment combined with unpaid domestic work would result in "role over-load", as well as exposure to new occupational hazards, causing greater morbidity and mortality among women. Most studies suggest, however, that while wage work can be severely damaging to women's health, those who engage in wage work are frequently in better health than women who do not. (This finding may, in part, reflect the exclusion of unhealthy women from paid work. A woman's poor health may prevent her from getting, retaining or performing paid work) (Janzen, 1998). The work of well-known women's health epidemiologist Sara Arber suggests that paid employment may be especially beneficial to the health of women who are unmarried and to those with jobs yielding high levels of satisfaction (Arber, 1997). Although many studies of the health effects of women's paid work have sought to develop general conclusions about whether employment is good or bad for women's health, answers depend heavily on the type of work and the circumstances under which work is performed.

Formal employment may benefit women's health in a number of different ways. The financial rewards of paid employment may translate into better health for women, especially in cases where women's income improves access to basic necessities. Paid employment may also provide women with formal benefits, such as dental and drug insurance plans and paid sick leave, as well as a sense of accomplishment, greater independence, self-esteem, status, social networks and companionship, all of which promote well-being (Doyal, 1995). On the other hand, Canada's National Health Survey found women to have higher rates of work stress than men, in terms of low co-worker support, high job strain, high job insecurity, low supervisor support and job dissatisfaction (the only type of work stress that men experience more than women is high physical demands). Work stress can have a very detrimental impact on physical and emotional well-being (as cited in Statistics Canada, 2001).

> For both sexes, personal and work stress are predictive of mental and physical health problems. Women, however, are much more likely than men to experience stress. This may reflect social expectations and the division of labour in the workplace

and at home. The fact that women are more likely than men to experience stress may account for their higher prevalence and incidence of health problems (Statistics Canada, 2001, 31)

Occupational Hazards of Women's Paid Work

Women drawn into wage labour have historically been, like men, exposed to occupational injury and disease. Unfortunately, like so many aspects of women's working lives in the past, we know little about the particular occupational health hazards they faced. There are some well known examples, however. Women employed in match and fireworks factories, who made up 40 percent of that workforce in America, suffered phosporous necrosis of the jaw - popularly known as "phossy jaw" - which resulted in their jaws deteriorating in an extremely painful way, sometimes resulting in starvation. Phosporous exposure could also lead to miscarriages and stillbirths. In France, young women workers unionized and fought to have phosphorous banned, succeeding in 1898. Health was also an issue in the famous match girls' strike in London in that period. In America, it was the middle class health reform movement that took the lead on the issue. The American Congress banned phosphorous in 1912 after an investigation into its ill affects by the Bureau of Labour.

During World War I, toxic jaundice was found among British female munitions workers, the result of TNT poisoning. This created a shortage of women willing to fill munitions shells. American industrial health crusader Alice Hamilton (formerly of Chicago's settlement project, Hull House) was frustrated in her efforts as a member of the War Labour Board to guarantee the health and safety of women munitions workers. She deplored "the abyss of insecurity on which our pleasant and comfortable material American civilization rests." Hamilton also exposed the risks to women working in the lead industries (Bale, 1990).

In the 1920s, the women workers who painted luminous dials on watches and clocks too developed necrosis of the jaw. The dials were applied with radium paint, which was inhaled and ingested when women sharpened the point of their paint brushes with their tongues. Public attention to the suffering of these women "alerted the world to the health risks of internal radiation (Bale, 1990, p. 412)." Anthony Bale has drawn links between women's activism on this issue, and the public campaigns since then against other toxic substances: the carcinogenic synthetic estrogen DES (diethylstilbestrol); toxic waste in Love Canal; the risks of dioxin; the Karen Silkwood case; and, the fight for compensation by abestos workers and their families. [14]

But the occupational hazards for work for women are not restricted to the effects of toxic substances. Some are less dramatic, if no less detrimental. Many of the jobs traditionally performed by women share a number of features in common that may affect their health. A large number involve fairly boring, repetitive work, in stationary and sometimes very constrained posi-

tions (be it sitting or standing) for long periods. Many involve performing tasks at high speeds under intense time pressure. These frequently involve rapid and repetitive hand movements, such as the work of data entry operators. Piece rate pay can make these jobs more dangerous by heightening time pressure. Many of women's main occupations involve an element of caring for the needs of others, a carry over from women's household work, as in health care, education and customer service. Jobs that involve caring for or serving the public are often characterized by low levels of control and discretion over work - features often linked with higher incidence of heart disease, particularly when combined with heavy workloads. The stress of these jobs is increased when workers have insufficient time to deal adequately with their patients/students/customers. Nurses have been arguing vocally that deep cuts to public spending have created precisely these conditions in health care, to the detriment of patients and workers alike (Messing, 1991).

Office work continues to be the largest occupational category for women. Roughly a third of all Canadian women with paid jobs perform some sort of clerical or related work. Clerical workers include secretaries, bank tellers, telephone operators, clerks, data entry operators etc. Clerical workers perform high-speed repetitive work, frequently described as boring, and under close direct supervision (machines or supervising personnel may monitor their speed and performance). This type of work is very prone to repetitive strain injuries, reflected in pain and stiffness in particular muscles (Armstrong, 1995). Office workers must often tolerate features of badly constructed work environments, such as unsuitable lighting, poor temperature and ventilation control, excessive noise and non-supportive seating. Clerical workers also come into contact with small doses of pollutants from glues, inks, and cleaning fluids which can produce skin and eye irritation, dizziness, headaches as well as allergic reactions. Exposure levels to these toxic substances has traditionally been considered safe but little research has studied the health effects of long-term exposure (Doyal, 1995). Clerical work may also involve lifting and carrying heavy loads of paper and files (Armstrong, 1995).

Many clerical workers must sit or stand in a stationary position for long periods of time, generating immobility problems such as leg pain, varicose veins, impeded blood circulation, swelling and birthing problems. More and more, clerical work involves spending large portions of the working day facing video display units (VDUs). This technological development has meant that clerical work is less frequently interrupted and workers have fewer opportunities to change their posture; no longer do they take short breaks from typing in order perform tasks such as adjusting margins, making corrections, looking up spellings or adding more paper (Armstrong, 1995). While significant attention has been paid to the health effects of radiation emitted by VDUs, less emphasis has been given to other common problems such as sore and tired eyes, muscle strain, reduced capacity to distinguish

colours, headaches and nausea (Armstrong, 1995; Messing, 1991). Computers and other electronic technologies are also a source of additional stress in that they represent a constant threat of job loss as workers are replaced with machines (Armstrong, 1995).

Nursing is another important occupational grouping for women. Nurses have much higher rates of accidents than other service workers do (Messing, 1991). Cuts and falls are common not only among nurses but among those working in hospital kitchens and laundry rooms as well. Nurses come in contact with various skin and eye irritants, infections, germs, chemicals, solvents and sources of radiation. Nurses also have high rates of backache, related, in part, to lifting patients and other heavy weights (Doyal, 1995). Moreover, as Canada and many other countries have participated in the trend towards reduced public spending on health care, the job demands of nurses and the rest of the health care hierarchy (in which women continue to be clustered in the lower ranks) have been growing. There is evidence that nursing has become increasingly stressful under conditions of health care restructuring (Jones, 1997). Nurses are organizing in many parts of the world to get the message out that they need better resources in order to properly care for patients. The stresses of nursing are reflected in high rates of turn over (Doyal, 1995).

Canadian women also perform repetitive assembly line work in many industries, including, most commonly, operating sewing machines. Short work cycles, repetitive tasks performed over and over, fast work speeds and cramped working positions characterize industrial sewing and other assembly line work. In addition, industrial workers may face extremely noisy work environments (generating stress and, potentially, hearing problems), inappropriate lighting (causing eye strain and other problems, especially among workers performing inspection or other close-up work) and exposure to various solvents (with possible adverse effects on the nervous system). When women perform sewing out of their homes on a piece-rate basis, these risks are compounded by isolation from co-workers and union representation. Low piece rate pay promotes long work hours and potentially dangerous works speeds in home settings, not designed for safe and comfortable work (Messing, 1991). Chemicals, dusts, fumes and gases are among the toxic substances which women come into contact with in industrial employment. Substances such as these may "cause direct poisoning (e.g. lead or mercury); an allergic response (e.g. industrial dermatitis); abortions or congenital abnormality (e.g. over-exposure to radiation); or specific diseases such as cancer..." (Doyal, 1981, p. 67).

When considering farming, little is known about the health risks facing women farm workers. As Karen Messing points out, women are often excluded from studies of farm workers because these studies focus on farm owners, which are generally men. This lack of knowledge is very serious given that farming stands out as one of Canada's most dangerous occupations, with the same number of fatal accidents as mining. Long hours, over-expo-

sure to heat and sun combined with physically strenuous work all wear on women's health. Farm work exposes women to a variety of chemicals, pesticides and fertilizers. Allergies, respiratory problems, back pain and hearing problems are common after years of farm work (Doyal, 1995; Messing, 1991).

As women continue to enter less traditional occupations in larger number, the need to fill the knowledge gap about the health risks associated with these occupations grows. This is especially necessary, given that traditional male-dominated jobs tend to have higher rates of disabling and fatal work injuries. Sometimes, the set-up or parameters of particular jobs, as well as the design of certain protective equipment, has been developed to fit the average (white) man, and will need to be adjusted for use by women. Unsuitable designs may interfere with women's ability to perform jobs, it may increase their risk of injury or accident and it may reduce the effectiveness of protective equipment (Messing, 1991).

Women's other occupational stresses may be exacerbated by sexual harassment by bosses, other co-workers or customers. In general, little research has been undertaken with respect to the specific health consequences of sexual harassment. This sort of abuse can take many different forms: the display of nude calendars, unwanted touching or even rape. The U.S. Working Women's Institute has collected information on the effects of sexual harassment of women seeking assistance with harassment cases. Women reported effects to the Institute which include reduced work performance, doubting their own capabilities, various feelings of distress, sleeplessness, nausea, headaches and alcohol use. Many reported exacerbated work hazards resulting either from lack of concentration or deliberately dangerous behaviour on the part of the their, usually male, aggressors (as cited in Doyal, 1995). Thus a whole range of mental and physical health problems may result from sexual harassment. Canadian and other women continue to struggle to get compensation for sufferings caused by sexual harassment (Messing, 1991).

Despite these and many other persistent health risks, the health hazards facing women continue to be treated less seriously than those affecting men. Indeed, historically, more attention has been paid to the potential health hazards to women's unborn children than to those threatening women themselves (Doyal, 1995). Moreover, where action has been taken in response to research which uncovers potential dangers to unborn children, it has at times been used to pass legislation barring women from such work, rather than to make changes to the workplace to eliminate the danger for all workers. Although the health hazards threatening foetuses are generally dangerous to all workers, and some research indicates that fathers may also transmit health threats to babies, it has often been only women who have lost their jobs. In 1977, the America Cynamid Corporation's Willow Island plant passed a regulation stating that all fertile women working in areas featuring possible lead exposure would have to be transferred or let go. The alternative jobs proposed for these women offered significantly reduced earning potential. The following year, five

female employees submitted to sterilization in order to keep their jobs. As one of these women explained, "[t]hey don't have to hold a hammer to your head – all they have to do is tell you that's the only way you can keep your job" (as cited in Doyal, 1995, p. 164).

The exclusion of female workers from employment, based on perceived vulnerability, has justified the continued exposure of other workers to all types of toxic and otherwise dangerous conditions by their employers. Excluding fertile women from exposure to health hazards has effectively been a substitute for setting and enforcing health standards to protect all workers (and their unborn children). By consequence, male workers remain exposed to dangerous and unhealthy workplaces and women lose their jobs all together. This has generated reluctance among some to press for occupational health and safety research (Doyal, 1995; Stellman, 1977).

Pat Armstrong has noted that women's labour force health hazards tend to be less visible than men's for at least two reasons. Firstly, the health hazards facing women are less likely to result in immediate death or obvious injury, than are those facing men. For example, men's injuries in the construction industry tend to be more visible than the headaches generated by women's computer work. This relatively low visibility is often associated with claims that women's health hazards are strictly psychosomatic. Secondly, men have received far greater attention in occupational health research than have women (Armstrong, 1995). Systematic research into the health effects of women's paid jobs did not get underway in most industrialized countries until the 1970s. Today, the jobs of men still receive a disproportionate amount of the attention of health research (Doyal, 1995). Bias against women in occupational health research and the neglect of occupational variables in women's health research has translated into a lack of information on women's occupational health and safety problems (Messing, 1991).

It is important to recognize the health risks that women face in their paid jobs not as chance hazards, but rather as the product of the performance of work within a system marked by clear gender division in the performance of work and driven by the expansion of profit, rather than the well-being of people. Given the costs involved with protecting workers from occupational accidents, diseases and other health problems, employers will often have a disincentive to investigate whether or not their workers face occupational health and safety risks. Work is thus generally assumed to pose no danger to health, unless or until, there is significant evidence to the contrary. Rather than admitting to offering unsafe work environments, employers often charge that worker apathy or carelessness is the cause of occupational injuries. Alternatively, health problems are presented as unintended but unavoidable byproducts of the use of modern technology. On the contrary, they are better understood as:

> the inevitable outcome of a situation where extremely powerful techniques for controlling the natural world have been developed within the context of a social and economic system which ensures

that these techniques are used primarily for private rather than public gain and that most individuals are unable to protect themselves from these widespread threats to their health (Doyal, 1981, p. 80).

Part IV – Medical Science, Ideology, and Women's Health

The Medicalization of Women's Health

Having established some of the ways in which women's health has evolved historically, along with differentials of class and race/ethnicity, we turn now to the question of how medicine has responded to the health needs of women. Medicine has always treated women differently from men. An analysis of the social causes of disease must note the close relationship between 19th century medical science, the subordination of women, and the development of industrial capitalism (Ehrenreich and English, 1978). Evolving away from pre-capitalist patriarchal relationships, where religious law decreed the inferiority of women, capitalism nonetheless needed a new rationale for women's subordinate place in social relations. It needed, in other words, a new ideology of gender. Science and medicine became central to this ideology.

The male body was seen by Victorian medical science as the norm, and the female body was understood as different and pathological. In keeping with the Victorian attachment to reason and science, medical views about women were supported by "scientific" rationale. After Darwin's *The Origin of Species*, biologists elaborated woman's place on the evolutionary scale, somewhere alongside the "grown-up Negro", the child, and "the senile White" (Ehrenreich and English, 1978, p. 117). Women were considered to be the weaker sex, and highly vulnerable to poor health. Male commentators in the mid-19th century believed that "female invalidism" was common among white middle class women. Women were also understood to have inferior intelligence; medical science attributed this to the fact that the energy utilized by men to develop their intellectual capacity was normally used by women to reproduce, as was natural. But medical ideology went one step further. Any attempt to change this natural order, as when women attempted to develop their intellect, would distort their reproductive organs and function, leading to a breakdown in women's health and well-being, it was argued (Mitchinson, 1991).

Medical scientists increasingly viewed the female reproductive organs as the center of a woman's existence; the uterus or the ovaries (depending on the theorist) shaped the characteristics of the female body and mind. Biological and medical arguments centred on "the tyranny of women's reproductive organs (Clark, 1990, p. 14)." Any symptom - backaches, irritability, indigestion, etc - could provoke "a medical assault on the sexual organs," resulting in a bizarre and often painful set of treatments (Ehrenreich and English, 1978, pp. 122-123).

This image of frail womanhood was, as Ehrenreich and English point out, subject to class bias. The health of working

class women was much less a topic of medical interest in the second half of the 19th century. Ironically (or perhaps conveniently) medical experts portrayed working class women as healthy and robust, in comparison with their frail and withering middle class sisters. Partly, this attitude was commercially motivated; poor women were hardly a lucrative medical market (although they were used as guinea pigs and teaching tools). But it also fit nicely into the medical critique of the women of their class. The hard lives of the workers were not a significant health issue, and may even have been a positive factor, in the view of the American popular health writer Dr. Lucien Warner: "It is not then hard work and privation which make the women of our country invalids, but circumstances and habits intimately connected with the so-called blessings of wealth and refinement (as cited in Ehrenreich and English, 1978, p. 114)."

Toward the end of the 19th century, scientific and medical experts entered wholeheartedly into the debate around the Woman Question, prescribing female behaviour on questions not just of health, but also topics such as education for women, marriage, sexuality, appropriate exercise, and the care and feeding of children. Their claims to expertise in these areas supported their own claims to professionalism, and often bolstered medical practices and incomes. The key to the professional preeminence of physicians was based upon claims to expert and specialized knowledge of women's bodies. The doctor knew more about a woman's body than she did herself, and "he knew her more intimately in some respects than even her husband" (Mitchinson, 1991, p. 360).

Women's reproduction became subject to increasing medical intervention. An important part of the medicalization process was the suppression of traditional women healers, and the erosion of the role of the midwife. Historical research in Canada confirms that the decline and eventual near-elimination of the midwife can be attributed to the emergence of a male-dominated medical profession, and the power of an ideology that "fostered male control over a uniquely female experience (Biggs, 1990, p. 20)." Male medical authority also eroded the role that mothers, "wise women" and other female elders played in passing down traditional knowledge regarding health and the treatment of disease in families.

Traditional caregivers, including midwives, had a smaller and smaller role as a result of encroaching medicalization, but eliminating mutual support networks and feminine healing practices was a long and uneven process. Working class and immigrant women used home remedies and patent medicines, and continued to have their babies delivered by community midwives even as the medical profession was rising to dominance. Isolated farm women had no choice but to find ways to heal themselves, their families and their neighbours, particularly before rural physicians and hospitals became more readily accessible (Langford, 2000). By the end of the nineteenth century, however, physicians were attending most births, though women generally continued to give birth at home. Wendy Mitchinson estimates that in 1899, eighty-four per cent of births in

Ontario were attended by a physician while only three per cent were attended by a midwife (Mitchinson, 1998a, 131). The evolution of medical technology and demands for more extensive pre- and postnatal care (associated with concern over still-high maternal mortality rates and post-World War I pro-natalism) helped to promote the hospitalization of birthing, removing birthing from the home environment and setting the stage for increasing medical interventions in birthing. By the 1940s, most births were taking place in hospitals (Mitchinson, 1998a). Since the 1960's, many within the women's health movement have opposed the excessive medicalization of the birthing process. Their efforts have been successful in providing for women more choices and greater control over birthing.

The women's health movement has also struggled for reproductive choice. Physicians have often publicly opposed women's right to birth control and abortion in the past. In the early 20th century, access to birth control was strongly resisted by conservative forces in Canadian society, including the elite of the medical profession, and feminists who argued women's moral authority as "mothers of the race" (Ursel, 1992; McLaren and McLaren, 1997). Women's historians now argue that, whatever the profession said publicly, some doctors did help women get abortions, or even performed them themselves (Mitchinson, 1998b). Too often, however, women were forced to seek treatment from illegal abortion providers, or attempt a self-induced abortion, often with tragic consequences. Even after abortion was decriminalized in 1969, access was often difficult for women. Women living in rural and Northern areas have always had difficulty accessing services in a timely and confidential way. Reproductive choice for women has been, and unfortunately continues to be, a pressing issue.

Gender Bias in Medical Practice and Research

The effects of the historical development of medicine continues to be visible in on-going gender bias in medical research and practice. Different women's health researchers give emphasis to different forms of medical research bias, though all point to a relative neglect of women's non-reproductive health issues. Some call attention to how the health problems faced primarily by women (particularly those unrelated to reproductive functions) have received less attention in medical research than those faced primarily by men. Others contend that focusing too heavily on conditions faced mainly by women may be problematic for women's health. They argue that women's health is at substantial risk as a result of the tendency to ignore women's chances of developing conditions common to both sexes. Although many diseases and other health conditions are common to both women and men (although frequency of incidence may vary by gender), investigations of such conditions have often focused on their experience by men alone (Bird and Reiker, 1999). This has been especially true in cases of life-threatening chronic diseases. It has not been sufficiently recognized that while men tend to experience earlier onsets of many chronic conditions, women also experience them later in life. It is notable that both heart disease and AIDS were for some

time treated as diseases for which women were at little risk (Bird and Reiker, 1999; Doyal, 1995; Krieger and Fee, 1994).

Women's health advocates also denounce the long established medical practice of excluding women participants from medical trials, or of including them only when the focus of study is women's reproductive systems or mental health (Janzen, 1998). Women have been grossly underrepresented as subjects in clinical and epidemiological studies. The many important studies of coronary heart disease that have considered male subjects either exclusively or primarily, are frequently cited as examples in this regard. Some researchers argue that a lingering tendency to treat white men's bodies as the norm, explains the exclusion of women and non-white racial groups in clinical trials. Contrary to this, others researchers insist that ideas about the differences between women and men and between racial groups were deeply engrained by the time that most researchers began the process of standardizing methods for clinical and epidemiological research. Krieger and Fee contend that health researchers have simply been uninterested in the health status of non-whites and in the non-reproductive health of women, and for this reason, have included only white men in their studies. In their view, the omission of women and non-white racial groups from health research must be read as "evidence of a logic of difference rather than as an assumption of similarity (Krieger and Fee, 1994, p. 16)."

Women's cyclical hormonal changes and the possibility that they may become pregnant are frequently cited as reasons to include only men in research studies. Clinical trials are said to be more robust when involving a homogeneous group of subjects. Although women's exclusion is defended by reference to important physiological differences between women and men, the results of such research have too frequently been applied to women with little questioning (Doyal, 1998). If women are excluded on the grounds that they are different, then it cannot be valid to generalize the results from studies of male subjects to women uncritically, or to assume that treatments developed on the basis of studies of men will be equally effective for women (Bird and Reiker, 1999). Because health research has tended to extrapolate and generalize the health and illness experiences of men, to women, possible differences between women and men in symptoms, in the experiences of illness, in prognosis and in treatment effectiveness, have frequently gone unacknowledged (Doyal, 1998). Hence Lesley Doyal argues that:

> while it is clear that biomedicine had produced knowledge which has been used to improve the health of individual women, in ignoring sex differences and differences in women's social circumstances, biomedicine has been limited in what it can tell us about what makes women sick (Doyal, 1995, p.18).

In their investigations of gender bias in medical practice, many feminists initially placed considerable emphasis on how the personal relations between women and their physicians (usually men) were affected by the power differential between them. The high social value

placed on medical knowledge was identified as making it difficult for women to express their own opinions about their health, particularly when these contradicted those of physicians (Doyal, 1998). Women have complained bitterly that they have been unable to convince physicians that their particular symptoms warrant attention (Broom, 1991). More recently, studies of gender bias in medical practice have focussed on documenting differences between the treatments offered to women and those offered to men, including in situations where it appears that both sexes have the same clinical condition.

Gender differences in drug prescriptions provide a good example of how doctors treat women differently than men, and speak to what appears to be a lingering perception that women are prone to mental illness. Numerous studies find that when women and men report the same symptoms, physicians are more likely to prescribe mood-altering drugs to women than to men. In agreement with many other studies, Jim Harding's well-known research on the province of Saskatchewan concluded that mood-modifiers were being over-prescribed to women. As Harding explains, even though the over-prescribing of drugs to women is frequently justified with bio-medical arguments, including women's reproductive functions and longer life expectancies, gender differences in the prescription of pain killers are not observed; it is with respect to phychoactives that the major gender difference in prescription patterns exist (Harding, 1986). Specifically, it was found that among those aged 20-29 receiving prescriptions, "eight times as many women as men receive anti-depressants, and four times as many women as men receive tranquilizers or sedatives and hypnotics (Harding, 1986, p. 61)."

Women's ability to determine medical priorities and resource allocations continues to be limited by their lack of power in health care institutions. Lesley Doyal argues that medical research suffers from bias because, although the majority of health care providers are women, the majority of practicing doctors, those with determining control, are men. Under-representation in positions of power has meant that women have little control over the allocation of research funding or over research practices (Doyal, 1995).

The Invisibility of Gender: Women and Population Health Models

Feminist critics of the ways in which mainstream medicine has addressed women have also become concerned about a new brand of health models, calling themselves population health models, which have received significant attention in debates over health determinants in recent years.[15] The population health model put forward by the Canadian Institute for Advanced Research (CIAR) in *Why Are Some People Healthy and Others Not?* (Evans et al., 1994) has become the established Canadian version, coming to play an important role in shaping current debates on health determinants and serving as an important reference for policy makers. The CIAR argues that people's health is principally determined by social and economic factors, and that medical care contributes only marginally to the health of populations (Evans et al., 1994).

In contrast with works such as McKeown's (1979) that stress the detrimental effects on people's health associated with impoverishment and material deprivation, the CIAR emphasizes that differences in health status persist among all socioeconomic groups, not only between the poor and the non-poor. *Why Are Some People Healthy and Other Not?* makes frequent reference to the Whitehall I study of British civil servants, classified according to formal job rank. Whitehall I found a clear social status gradient in mortality among its civil servant sample population, from the top of the hierarchy to the bottom. That is, not only were very high-ranking civil servants observed to have a much longer life expectancy than very low ranking civil servants, but, mortality was found to increase with every drop in formal rank. Since none of the sample participants (even those in the bottom grades) could be classified as poor by conventional standards, well-known CIAR researcher Robert Evans, concludes that "there is something that powerfully influences health that is correlated with hierarchy per se. It operates, not on some underprivileged minority … but on all of us (Evans et al. 1994, p. 6)." It is notable also, that although death from coronary heart disease was found to be positively correlated with levels of smoking, blood pressure and cholesterol, most of the gradient could not be attributed to differences in these risk factors; the socioeconomic gradient in CHD mortality persisted even after correcting for these factors. What's more, contrary to the common suggestion that behavioural risk factors reflect the free and independent choices of individuals, Whitehall I confirmed that these factors are distributed differently across the socioeconomic spectrum, suggesting that socially structured contexts constrain behavioural choices. On average, people in lower civil service grades were observed to have higher levels of smoking, blood pressure and cholesterol, which contributed to their greater risk of CHD. Thus, social inequality affects health independently, as well as through its influence on health related behaviour (Evans et al., 1994).[16]

Evans and his CIAR colleagues suggest the variable that is associated both with health and with hierarchy (and which expresses itself through many different diseases) is stress. They propose that occupational ranking is inversely related to one's stress level and that one's stress level is positively related to mortality. The CIAR researchers propose that high occupational ranking serves as a good proxy for a high level of compensation, substantial discretion and control over one's work as well as considerable job security and satisfaction, all of which bear on a worker's stress level (Evans et al., 1994).[17] The persistent reality that women are less likely than men to hold jobs with these health-promoting characteristics is not pointed out. Nor is the fact that none of the civil servant participants in the Whitehall I study were women (Kaufert, 1999).

Although applauding the influence of CIAR research in stimulating interest in social health determinants, feminist health researchers have strongly criticized the absence of any concept of gender being an important health determinant in the CIAR and other similar population health models. The findings of the second Whitehall

study (in which one third of the subjects were women) suggest that the inclusion of gender within a model of health determinants is, in fact, very important, especially since gender affects access to many of the health influences identified by the CIAR (Kaufert, 1999; 1996). The Whitehall II study found that women are concentrated in the worst jobs of the British civil service, those with the lowest levels of job satisfaction, of task variety and of personal discretion - the very same characteristics identified by the CIAR as stimulating stress and depressing health. Women are also disproportionately recruited into low civil service grades, they experience less occupational mobility than men and they receive a smaller return on education (in terms of their occupational ranking) than men (Roberts et al., 1993). These observations are consistent with the finding that Canadian women and men are disproportionately located in different occupational groupings, with women less likely to be in high status professional, managerial or supervisory positions and less likely to report incomes in the highest range (Denton and Walters, 1999). That the Whitehall II study found a social status gradient in health among its female and its male participants has little practical meaning, therefore, unless it is considered in the context of women's position in society's occupational and wider economic structure. Women's under-representation in higher occupational categories (those categories that offer high levels of work control, autonomy, variety, satisfaction and remuneration, qualities which the CIAR insists are good for people's health) must be recognized as an important determinant of women's health (Kaufert, 1999; 1996).

A feminist leading critic of population health models, Pat Kaufert, makes the important point that insofar as the CIAR social determinants' model becomes the basis for health policy in Canada, women's health stands to be affected by the invisibility of gender (Kaufert, 1999). The rapid rise to prominence of the CIAR thesis cannot be separated out from the political climate into which it was released, one in which its devaluation of health care was sure to give it instant appeal to governments committed to restraining health care budgets (a movement which took off at the Federal level in Canada the same year that *Why Are Some People Healthy and Others Not?* was published). Extensive cuts to health and other social services in recent years have had distinctly gendered effects. As a result of health care cuts, women lose more jobs, they are forced to take on more unpaid care work and, as the largest users of health care services, they are most disadvantaged in terms of access to care (Kaufert, 1996).

Furthermore, in concentrating on the health inequalities that exist among all socioeconomic classes (no matter how important this focus is), the CIAR has detracted attention from the effects of impoverishment and material deprivation on health status (Kaufert, 1996), at a time when women progressively make up the majority of those living in poverty in Canada. The poverty rate among Canadian women in 1996 was 18.8%,[18] compared to 14.1% among Canadian men (National Welfare Council estimates as cited in Donner, 2000, p. 8).[19] And 56 percent of women heading

single parent families now have incomes below the poverty line (Townson, 2000). The feminization of poverty in Canada points to a serious need to address how the growing economic marginality of women and their children affects health status.

Thus, while the CIAR's main points about the distribution of health across the socioeconomic spectrum, about the association of behavioural risk factors with socioeconomic position and about the limitations of a health promotion strategy focused strictly on access to health care services are well taken, it is clear that gender must be treated as an important explanatory variable with respect to population health.

Women's agency and activism – the past and future of women's health

Although much of what we have examined in this paper points to the barriers preventing women from enjoying wellness in their lives, women should not be viewed as passive victims of medical ideology and its gender-blindness, nor of the life circumstances that threaten their health. Women's awareness of shared health concerns and their active pursuit of social change has a long history. Many 19th century middle class women openly expressed their feelings of physical and intellectual restriction in contemporary society, and gave voice to the health effects of gender inequality. In her well-known autobiographical novel, *The Yellow Wallpaper*, Charlotte Perkins Gilman describes "a sort of gray fog [that] drifted across my mind, a cloud that grew and darkened."[20] Rather than following the standard medical prescription for cure – rest and limited activity – Gilman resisted her illness and the medical view of women's health through her writing. Jane Addams, who struggled against depression throughout her life, transgressed gender boundaries when she started the Chicago settlement project Hull House. Hull House provided material support, education, and nursing care to the poor and working class.

These and other middle class women made women's and children's health their central concern. Their efforts were behind much of early health and social welfare policy. But they are also a good example of the ways in which class and racial/ethnic bias can colour campaigns for improved public policy.

In carving out an active social and political space for themselves, reformist women sometimes embraced a class-laden set of ideas about health; one which viewed their working class and immigrant sisters as ignorant and in need of education. Increasing class and ethnic tensions in Europe and North America in the late 19th century gave greater weight to the efforts of public health and social reformers to improve the health of working class men, women, and particularly, children. Women laypersons and professionals played a significant role in many of the medical campaigns of the period – indeed, most analysts give women a central role in these movements. However, as the state took on greater responsibility in health and welfare programs, the leadership role of women in voluntary charitable organizations gave way to a more male-dominated, state-controlled effort (Comacchio, 1993).

Historian Cynthia Comacchio has argued that in the early 20th century child health and welfare became increasingly de-

fined "from the viewpoint of the material realities and ideological imperatives of industrial capitalism (Comacchio, 1993, p. 4)." During a period of very high infant and maternal mortality rates, reform was justifiably important to reproducing the working class, to ensuring future supplies of labour power, and to supporting the military and imperial strength of the nation. Working class movements were demanding state-provided social services, as well as labour law protection. However, the push for reform had to be carefully managed to exclude the possibility of radical social change. The social problem of child nurture and health, was appropriated and shaped as a campaign through which to support existing class and gender relations.

This appropriation included support for an allopathic healing model, which, although well aware of the links between living conditions and disease, preferred not to address them directly. Public health and medicine instead placed the blame for infant mortality upon the individual behaviour of ignorant mothers, arguing that even the poor could be healthy if they were educated and adopted the correct health and hygiene practices. While the discourse of reform may have promoted a sense of collective social responsibility for child and maternal health, the underlying logic emphasized external causes or personal responsibility and self-reliance. Therefore, government programs focused upon educating and reforming the working class mother, and urging her to seek out medical care. However, little was done to provide affordable public health care, let alone programs to improve standards of living.

The impact of these aggressive policies upon working class women is unclear. These women left few written accounts of their lives. But recent historical research argues that medicine was rarely able to completely dominate the healing process for women. Until publicly funded health care was available, working class women had limited access to physicians; they could not afford them. Oral histories of working class women in Quebec during the Depression indicate a skepticism about the medical profession. Although they sought out medical care during pregnancy and delivery, as they had been urged to do by medical authorities, they were not totally confident: "In those days, women would have fifteen or sixteen children because they would lose five, six, or even more. That's how the babies died - the doctors didn't know a thing (Baillargeon, 1999, p. 81)." Fear of medical practitioners was not uncommon, nor unfounded. Historians of women's health have found evidence that women often delayed seeking out medical attention for as long as possible, suffering considerable pain rather than go to a doctor. This refusal to seek treatment can be seen as resistance to medical power. Women may have also deplored their lack of control in the doctor-patient relationship. Informed consent for medical procedures, as we know it, is an outcome of consumer health movements, which have argued the patient's right to know and choose their own treatment. In the past, women lacked control over what surgical procedures were performed by the doctor. Even when the physician sought consent, it was often the husband's consent that was crucial, not the opinion of the woman (Mitchinson, 1998b).

Aside from everyday scepticism and resistance, working class women have advocated and struggled for health and social programs that served their needs, although these tend to be poorly documented. The Women's Labour League and the Women's Cooperative Guild in Britain ran a campaign early last century for maternity benefits and medical care, emphasizing that benefits should go to the mother, not the male head of household (Porter, 1999). Socialist women in Canada advocated for birth control in the same period, and the organizing efforts of women in social democratic parties such as the CCF/NDP were pivotal in the introduction of public medical care. As historian Linda Gordon has noted for the American case, poor women shaped the evolution of social welfare services by repeatedly demanding their right to material relief, even when their lives were considered immoral by the standards of social welfare professionals, male and female (Gordon, 1989).

The most highly organized and effective social movement to improve women's health, in explicit opposition to the power of the medical profession, did not arrive until the 1960s and 1970s, and was an offshoot of 'second wave' feminism. This women's health movement saw reproductive control as fundamental to the goal of women's equality, and initially focused upon issues of birth control, abortion and childbirth. However, the movement quickly branched out to other aspects of women's health, and became broadly concerned with women's bodies: in particular, giving women access to better information about their health, and promoting self-care. The publication in 1970 of *Our Bodies, Ourselves*, published by the Boston Women's Health Book Collective, was a milestone. Networks of feminist women's health centres followed (Geary, 1995).

Commentators generally agree that the women's health movement in this time period was dominated by well educated, white, middle class women, and that the movement tended to give their interests precedence (Geary, 1995; Armstrong, 1996). However, its critique of the health care system increasingly stressed the importance of social and economic structures as key factors in health, and its activism was aimed at bringing about social change in the realm of public policy, and more broadly. As Pat Armstrong has noted, "prevention was more about conditions and relations than about personal choices and practices (Armstrong, 1996, p. 131)."

Yet, it has become difficult for the women's health movement (and other health movements) to maintain the efficacy of its critique and the strength of its advocacy. Various authors have noted the co-optation by the state of the discourse of progressive analysis. It is now routine for health researchers and policy experts to make reference to social determinants, community-based care, and patient empowerment; all central arguments in the feminist agenda (Armstrong, 1996; Anderson, 1996). This discourse, however, has been used to mask the preservation of the status quo. Furthermore, federal and provincial public policy in the 1980s and 1990s undermined demands for social equality by severely reducing funding for feminist organizing and advocacy. The federal government is now more likely to provide funds for women's health research that it is to support advocacy on behalf on women's equality.

Conclusion

In this paper we have explored the social bases of women's health and illness. Social health-determinants do not affect women and men in an identical manner, and social inequality between women is reflected in health status differences among women. From an historical point of view, the inequalities of gender, class and race/ethnicity that now confront us as health activists are by no means inevitable or unavoidable; but they are the outcome of long-standing divisions in our society that should be addressed at their source. Models of health that focus primarily on germs, genetic make-up and women's sex characteristics are inadequate, and cannot result in substantial overall improvements in the health of women. Since women's subordinate social position clearly has strong health effects, social change directed at empowerment and equity must be a priority.

This does not mean, however, that governments share no responsibility for women's health. The erosion of social welfare that has characterized the last two decades has been particularly harmful for women. By putting public programs such as health care and social assistance at risk, and by failing to create a national child care program, budget-cutting governments have put up additional barriers to women's realization of good health. It is therefore in the interest of women's health and equality more generally, to continue resisting cuts to social services that can improve women's and men's health.

Moreover, governments at all levels should begin by issuing a genuine challenge to current thinking about health and disease. Despite the attention to 'health determinants' that has become *de rigueur* in health policy circles, the dominant model of health care in Canada in effect places the burden of responsibility upon individual women, increases reliance upon allopathic care, but leaves fundamentally unchanged the health issues facing women.

What kind of things can our governments do? A well-known comparative study of Finland and the U.K. advises that the availability of employment opportunities and adequate social supports can go a long way in safeguarding women's health. In considering the health of previously married women (who reported poorer health than married or single women), Sara Arber and Eero Lahelma found Finnish women to be in much better health than British women, particularly those not in paid employment. The authors attribute these differences to Finnish social policies and employment opportunities that promote women's economic autonomy, and the lack thereof in Britain. In Finland, women participate on a nearly universal basis in full-time paid employment, whereas in Britain women are more likely to perform part-time paid work or none at all. Finnish women also enjoy more adequate state provision of daycare services, parental leave and other social ben-

efits, as compared with women in Britain (Arber and Lahelma, 1993).

Better health for women relies upon social change; the Finland case illustrates that it is not beyond the power of public policy to play an important role in generating women's well-being and equality.

End Notes

1 See Macintyre et al. "Gender Differences in Health: Are They Really as Simple as They Seem," 1996, for a view of how gender differences in health vary by age and by condition.

2 It is notable that in contrast with historical trends, teen and young adult women are now just as likely to be smokers as their male counterparts (Statistics Canada, 2001).

3 This is the age-standardized death rate, which removes the effects of changes in population age structure.

4 Cancer of trachea, bronchus and lung (Statistics Canada, 2001).

5 At the extreme, this argument has been applied to men's excess mortality to suggest that men postpone seeking health care until their health problems are so far advanced that they cannot be treated satisfactorily.

6 Self-rated health has been found to be an excellent predictor of more objective health measures.

7 British official statistics generally assign single women to a particular socioeconomic class based on their own occupation but assign married women according to their husband's occupation. Lissa Donner has pointed out that choosing which variable to use in order to measure socioeconomic status for health research is more complicated for women than for men. Typically, personal occupation is chosen to represent men's socioeconomic status since it is expected to reflect both the nature of their employment and the material circumstances of their households. However, because women are paid less than men on average, work more part-time jobs and may experience periods of absence from the labour market in order to raise children, women's personal occupation may not accord with their material resources if they are married. For this reason, measures such as housing tenure, car ownership or husband's occupation are sometimes used to represent women's socioeconomic status. Another commonly used measure is education. Of course, there is no substitute for looking at women's personal occupation when examining women's particular occupational health and safety concerns (Donner, 2000).

8 We use the term Aboriginal to describe First Nations, Métis and Inuit people.

9 See B. L. Janzen, *Women, Gender and Health: A Review of the Recent Literature*, 1998, for an excellent account of the diversity in health status among women in industrialized countries, with a special focus on women in Canada.

10 See, for example, J. Garfield, *Alienated Labor, Stress, and Coronary Disease*, 1990.

11 See Rosenberg, *The Home is the Workplace: Hazards, Stress and Pollutants in the Household*, 1990, for a detailed list of common home cleaning products along with their specific health risks and a list of alternative cleaners such as baking soda and vinegar.

12 The history of the gendered nature of work in Canada has grown substantially in recent years. See for example Ruth Frager, *Sweatshop Strife: Class, Ethnicity and Gender in the Jewish Labour Movement of Toronto* (Toronto, 1992); Joy Parr, *The Gender of Breadwinners* (Toronto, 1990); Bryan Palmer, *Working Class Experience* (Toronto, 1991) ; Marjorie GriffenCohen, *Women's Work, Markets and Economic Development in 19th Century Ontario* (Toronto, 1988); Joan Sangster, *Earning Respect: The Lives of Working Women in Small-Town Ontario 1920-1960* (Toronto, 1995); Mercedes Steedman, *Angels of the Workplace: Women and the Construction of Gender Relations in the Canadian Clothing Industry, 1890-1940* (Toronto, 1997).

13 Comacchio, 1999, p. 29. At the turn of the 20th century, nearly one-quarter of women in Canada were widowed by the time they were in their fifties, compared with one in ten widowed men. Approximately one in six families in 1900 were headed by women alone.

14 On the plight of asbestos workers in Canada, see Doug Smith, *Consulted to Death* (Winnipeg: Arbeiter Ring Publishing, 2000).

15 See, for example, Evans et al., 1994 and Wilkinson, 1998.

16 Canadian data also suggest that while lifestyle factors (particularly smoking, alcohol consumption, physical activity and weight), explain part of the social gradient in women's health, they cannot explain all of it. Women's health remains positively associated with socioeconomic status after controlling for differences in lifestyle factors (Denton and Walters, 1999).

17 Based on a study of a broad range of industrial occupations, Karasek and colleagues found that workers who enjoyed considerable decision making power and control over their job tasks were at lower risk of coronary disease (as referenced in Garfield, 1980).

[18] Women's aggregate poverty rate disguises much higher incidence of poverty among particular groups of women, including among senior women (most strikingly among unattached senior women), women with disabilities, single mothers, women of colour and Aboriginal women (Donner, 2000).

[19] It is notable that women's poverty rates have continued to grow despite the entrance of increasing numbers of women into paid employment in recent decades (Donner, 2000).

[20] Quoted in Ehrenreich and English, 1978, p. 1.

Bibliography

Anderson, J. (1996) "Empowering Patients: Issues and Strategies." *Social Science of Medicine*. Vol 43, No. 5.

Arber, S. (1997) "Comparing Inequalities in Women's and Men's Health: Britain in the 1990s." *Social Science and Medicine.* Pergamon Press Ltd. Great Britain. Vol. 44, No. 6.

Arber, S. and E. Lahelma. (1993) "Women, Paid Employment and Ill-Health in Britain and Finland." *Acta Sociologica.* Scandinavian Sociological Association. Vol. 36.

Armstrong, P. (1996) "Unravelling the Safety Net: Transformations in Health Care and Their Impact on Women." *Women and Canadian Public Policy*. J. Brodie (ed.) Harcourt Brace. Toronto.

Armstrong, P. (1995) "Women and Health: Challenges and Changes." *Feminist Issues: Race, Class, and Sexuality.* N. Mandel (ed.). Prentice Hall Canada Inc.. Scarborough.

Biggs, C. (1990) "The Case of the Missing Midwives: A History of Midwifery in Ontario From 1795-1900." *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries*. Katherine Arnup, Andree Levesque and Ruth Roach Pierson. (eds.) Routledge. London.

Baillargeon, D. (1991) *Menageres au Temps de la Crise*. Editions du Remue-menage. Montreal.

Baillargeon, D. (1999) *Making Do: Women, Family and Home in Montreal During the Great Depression*. Wilfred Laurier University Press. Waterloo.

Bale, A. (1990) "Women's Toxic Experience*." Women, Health and Medicine in America: A Historical Handbook.* R. Apple. (ed.) Garland Publishing Inc. New York.

Bird, C.E. and A.M. Fremont (1991) "Gender, Time Use, and Health." *Journal of Health and Social Behaviour.* Vol. 32: 114-129.

Bird, C.E. and P.P. Reiker (1999) "Gender Matters: An Integrated Model for Understanding Men's and Women's Health." *Social Science and Medicine*. Elsevier Science Ltd. Great Britain.

Bradbury, Bettina. (1993) Working Families: Daily Survival In Industrializing Montreal. McClelland and Stewart. Toronto.

Broom, D.H. (1991) *Damned If We Do: Contradictions in Women's Health Care.* Allen and Unwin Pty Ltd.. Sydney.

Chernomas, Robert. (1999) *The Social and Economic Causes of Disease*. Canadian Centre for Policy Alternatives. Winnipeg.

Clarke, A. (1990) "Women's Health: Life-Cycle Issues*." Women, Health, and Medicine in America: A Historical Handbook*. R. Apple. (ed.) Garland Publishing Inc. New York.

Comacchio, C. (1993*) "Nations Are Built of Babies": Saving Ontario's Mothers and Children, 1900-1940*. McGill-Queen's University Press. Montreal.

Comacchio, C. (1999) *The Infinite Bonds of Family*: *Domesticity in Canada, 1850-1940*. University of Toronto Press. Toronto.

Davidoff, L. (1995) *Worlds Between: Historical Perspectives on Gender and Cla*ss. Routledge. New York.

Davidoff, L. and Hall, C. (1987) *Family Fortunes: Men and Women of the English Middle Class, 1780-1850*. Hutchinson. London.

Denton, M. and V. Walters. (1999) "Gender Differences in Structural and Behavioural Determinants of Health: An Analysis of the Social Production of Health." *Social Sciences and Medicine*. Vol. 48.

Donner, L. (2000) *Women, Poverty and Health in Manitoba: An Overview and Ideas for Action.* Prepared for Women's Health Clinic, Winnipeg.

Doyal, L. (1998) *Gender and Health: A Technical Paper.* Prepared for the World Health Organization. Geneva.

Doyal, L. (1995) *What Makes Women Sick: Gender and the Political Economy of Health.* Rutgers University Press. New Jersey.

Doyal, L. (1985) "Women and the National Health Service: The Carers and the Careless." *Women, Health and Healing: Toward a New Perspective*. E. Lewin and V. Olesen (eds.). Tavistock Publications. London.

Doyal, L. (with Pennell, I.) (1981) *The Political Economy of Health*. South End Press. Boston.

Ehrenreich, B., English, D. (1978) *For Her Own Good: 150 Years of the Experts' Advice to Women*. Doubleday. New York.

Eisentein, Z. (1979) "Developing a Theory of Capitalist Patriarchy and Socialist Feminism." *Capitalist Patriarchy and the Case for Socialist Feminism.* Z. Eisentein (ed.) Monthly Review Press. New York.

Evans, R.G., Barer, M.L., T.R. Marmor (Eds.) (1994) *Why Are Some People Health and Others Not: The Determinants of Health of Populations.* Aldine De Gruyter. New York.

Finkel, Alvin and Margaret Conrad. (1998) *History of the Canadian Peoples, Vol II 1867 to the Present*. Copp Clark. Toronto.

Fraser, RD. (1983) "Vital Statistics and Health." *Historical Statistics of Canada* (2nd edition). F.H. Leacy, ed. Statistics Canada. Ottawa.

Frazer, R. (1992). *Sweatshop Strife: Class, Ethnicity, and Gender in the Jewish Labour Movement of Toronto*. University of Toronto. Toronto.

Garfield, J. (1980) "Alienated Labor, Stress, and Coronary Disease." *International Journal of Health Services.* Baywood Publishing Company Inc.. Vol. 12, No. 2.

Geary, M.A.S. (1995) "An Analysis of the Women's Health Movement and Its Impact of the Delivery of Health Care Within the United States." *Nurse Practitioner*. Vol 20, No. 11. p. 24-35.

Gordon, L. (1989) *Heroes of Their Own Lives: The Politics and History of Family Violence, Boston 1880-1960*. Penguin Books. New York.

Harding, J. (1986) "Mood-Modifiers and Elderly Women in Canada: The Medicalization of Poverty." *Adverse Effects: Women and the Pharmaceutical Industry*. K. McDonnell (ed.) Women's Educational Press. Toronto.

Janzen, B.L. (1998) *Women, Gender and Health: A Review of the Recent Literature.* Prairie Women's Health Centre of Excellence. Saskatoon.

Jones, Esyllt. (1997) "Creating Healthy Work: Nurses and Occupational Stress." *Revolution: The Journal of Nurse Empowerment*. Fall.

Jones, Esyllt. (2000). Health and the Immigrant Experience: Caribbean Migrants in Winnipeg." Winnipeg Immigration History Research Group, unpublished paper.

Kaufert, P. (1999) "The Vanishing Woman: Gender and Population Health." *Sex, Gender and Health.* Cambridge Press. Cambridge.

Kaufert, P. (1996) *Gender as a Determinant of Health: A Canadian Perspective.* Written for the Canada -U.S.A. Women's Health Forum, August 8-10, 1996. Ottawa.

Kealey, L. (1984) "Canadian Socialism and the Woman Question, 1900-1914." *Labour/le Travail*. 13. p 77-100.

Krieger, N and E. Fee (1994) "Man-Made Medicine and Women's Health: The Biopolitics of Sex/Gender and Race/Ethnicity." *Women's Health, Politics and Power: Essays on Sex/Gender, Medicine, and Public Health*. N. Krieger, E. Fee and V. Navarro (eds.) Baywood Publishing Company Inc.. New York.

Lampford, N. (2000) "Childbirth on the Canadian Prairies, 1880-1930." Telling Tales: Essays on Western Women's History. C. Cavanaugh and R. Warne, eds. UBC Press, Vancouver.

Lewis, J. "'Motherhood Issues' in the late Nineteenth and Twentieth Centuries." (1990) *Delivering Motherhood*. K. Arnup, A. Lévesque, R. Pierson, eds. Routledge. New York.

Loudon, I. (1993) "Maternal Mortality: Definition and Secular Trends in England and Wales, 1850-1970." *The Cambridge World History of Human Disease*. K. Kiple (ed.) Cambridge University Press. New York.

Macintyre, S., Ford, G. and K. Hunt (1999) "Do women 'over-report' morbidity? Men's and Women's Responses to Structured Prompting on a Standard Question on Long Standing Illness." *Social Science and Medicine*. Pergamon Press Ltd.. Great Britain. Vol. 48, 89-98.

Masi, R. (1993) "Multicultural Health: Principles and Policies." Health and Cultures: Exploring the Relationships, Vol. 1. R. Masi, L. Mensah, K. McLeod, eds. Mosaic Press. New York.

Matthews, S., Manor, O. and C. Powers (1999) "Social Inequalities in Health: Are There Gender Differences?" *Social Science and Medicine*. Pergamon Press Ltd.. Great Britain. Vol. 48.

McLaren A and A.T. McLaren (1997). *The Bedroom and the State*. Oxford University Press. Toronto.

McLaren A and A.T. McLaren. "Discoveries and Dissimilations: The Impact of Abortion Deaths on Maternal Mortality in British Columbia." (1990) *Delivering Motherhood*. K. Arnup, A. Lévesque, R. Pierson, eds. Routledge. New York.

McKeown, T. (1979) *The Role of Medicine: Dream, Mirage or Nemesis?* 2nd edition. Basil Blackwell. Oxford.

McKie, R. (2000) "Moaning Men Push Women to the Back of the Health Queue." *U.K. Observer, May 7*.

Messing, K. (1991) *Occupational Safety and Health Concerns of Canadian Women*. Women's Bureau, Labour Canada. Ottawa.

Mitchinson, W. (1991) *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada.* University of Toronto Press. Toronto.

Mitchinson, W. (1993) "The Medical Treatment of Women." *Changing Patterns: Women in Canada.* Burt, S., Code, L. and L. Dorney (eds.). McClelland & Stewart Inc. Toronto.

Mitchinson, W. (1998a) "Agency, Diversity, and Constraints: Women and Their Physicians, Canada, 1850-1950." *The Politics of Women's Health: Exploring Agency and Autonomy.* The Feminist Health Care Ethics Research Network (ed.). Temple University Press. Philadelphia.

Mitchinson, W. (1998b) "Problematic Bodies and Agency: Women Patients in Canada, 1900-1950." *On the Case: Explorations in Social History*. F. Iacovetta and W. Mitchinson. (eds.) University of Toronto Press. Toronto.

Morgan, K. P. (1998) "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization." *The Politics of Women's Health: Exploring Agency and Autonomy.* The Feminist Health Care Ethics Research Network (ed.). Temple University Press. Philadelphia.

Mustard, C., Kaufert, P., Kozyrsky, J. and T. Mayer. (1998) "Sex Differences in the Use of Health Care Services." *The New England Journal of Medicine*. 338 : 1678 - 1683.

Navarro, Vicente.(1976) *Medicine Under Capitalism*. Prodist. New York.

Oakley, A.(1974) *The Sociology of Housework.* Pantheon Books. New York.

Oppenheimer, J. (1990) "Childbirth in Ontario: The Transition From Home to Hospital in the Early Twentieth Century." *Delivering Motherhood*. K. Arnup, A. Lévesque, R. Pierson, eds. Routledge. New York.

Parr, J. (1999) *Domestic Goods: The Material, the Moral, and the Economic in the Postwar Years*. University of Toronto. Toronto.

Phillips, P. and Phillips, E. (1983) *Women and Work*: *Inequality in the Canadian Labour Market*. James Lorimer and Co. Toronto.

Popay, J. (1992) " 'My health is all right, but I'm just tired all the time': Women's Experience of Ill Health." *Women's Health Matters.* H.Roberts (ed.). Routledge. London.

Porter, Roy. (1999) *The Greatest Benefit to Mankind*.

Roberts, R., Marmot, M., Brunner, E. and I. White (1993) "Gender Differences in Occupational Mobility and Structure of Employment in the British Civil Service." *Social Science and Medicine*. Pergamon Press Ltd.. Great Britain. Vol. 37, No. 12, 1415-1425.

Rosenberg, H. (1990) "The Home is the Workplace: Hazards, Stress and Pollutants in the Household." *Through the Kitchen Window: The Politics of Home and Family.* M. Luxton, H. Rosenberg and S. Arat Koç (eds.) The Network Basic Series, Garamond Press. Toronto.

Save the Children (2000) *State of the World's Mothers 2000*. Available at: www.savethechildren.org

Smith, D. (1985) *Let Us Rise: An Illustrated History of the Manitoba Labour Movement*. New Star Books. Vancouver.

Smith, D. (2000) *Consulted to Death: How Canada's Workplace Health and Safety System Fails Workers*. Arbeiter Ring Publishing. Winnipeg.

Statistics Canada (2001) *How Healthy Are Canadians? 2001 Annual Report*. Minister of Industry. Ottawa.

Stellman, J. M. (1977) *Women's Work, Women's Health: Myths and Realities.* Pantheon Books. New York.

Stephenson, PH. (1995). "Vietnamese Refugees in Victoria, BC: An Overview of Immigrant and Refugee Health Care in Medium-Sized Canadian Urban Centre." *Social Science and Medicine*. Vol. 40, No. 12

Stevens, S. (1993). "Newcomer Canadians and Mainstream Services." Health and Cultures: Exploring the Relationships. Vol II. R Masi, L. Mensah, K. McLeod, eds. Mosaic Press. New York.

Surgeon General (2001) *Women and Smoking: A Report of the Surgeon General – 2001*.

Taylor, Barbara. (1983) *Eve and the New Jerusalem: Socialism and Feminism in the 19th Century*. Pantheon. New York.

Townson, Monica. (2000) *A Report Card on Women and Poverty*. Canadian Centre for Policy Alternatives. Ottawa.

Ursel, J. (1992*) Private Lives, Public Policy: 100 Years of State Intervention in the Family*. Women's Press. Toronto.

Verbrugge, L (1989) "The Twain Meet: Empirical Explanations of Sex Differences in Health and Mortality." *Journal of Health and Social Behavior.* Vol. 30: 282-304.

Verbrugge, L. and M. Wingard (1987) "Sex Differentials in Health and Mortality." *Women and Health.* 12(2)

Waldron (1993) "Recent Trends in Sex Mortality Ratios for Adults in Developed Countries." *Social Science and Medicine*. Pergamon Press Ltd.. Great Britain. 36(4):451-462

Walter, V., Lenton, R. and M. Mckeary (1995) *Women's Health in the Context of Women's Lives.* Health Canada. Ottawa.

Wilkinson, R (1996) *Unhealthy Societies: The Afflictions of Inequality.* Routeledge. London.

World Health Organization (1992) *Women's Health: Across Age and Frontier.* Geneva.

Women's Health and Social Inequality

By Esyllt Jones and Anna Ste. Croix Rothney

ISBN: 0-88627-257-2 November 2001

CAW 567 OTTAWA

Acknowledgments

The authors would like to thank Lissa Donner and Sari Tudiver for their assistance with finding sources for this research as well as for their encouragement in pursuing the field of women's health. We would also like to thank Robert Chernomas, Ardeshir Sepehri, Todd Scarth, and three anonymous reviewers for their valuable comments on earlier drafts of this paper.

About the Authors

Esyllt Jones is a PhD candidate at the University of Manitoba; her dissertation focuses on the "Spanish" Influenza epidemic of 1918-1919. She was previously employed as researcher for the Manitoba Nurses' Union, and was Health Policy Coordinator for the Alternative Federal Budget project.

Anna Rothney holds a Master's degree in economics, with a focus on health economics. She has been actively involved with community economic development work and is currently employed by the Province of Manitoba.

Contents