Impact of poverty on women's health

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SUMMARY

Women's health is determined not only by biology but also by social context. While the health of both men and women is adversely affected by poverty, a higher proportion of women suffer from its effects because of increasing "feminization of poverty." The extent of this phenomenon, its multiple roots, and the role physicians could play in addressing it are discussed.

RÉSUMÉ

La biologie n'est pas le seul déterminant de la santé de la femme; le contexte social joue également un rôle important. Bien que la pauvreté puisse affecter négativement autant la santé des hommes que celle des femmes, une plus forte proportion des femmes sont victimes de ses effets à cause de l'augmentation de la « féminisation de la pauvreté ». L'article discute de l'extension de ce phénomène, de ses multiples racines et du rôle des médecins dans ce domaine.

Can Fam Physician 1994;40:949-958.

Two out of three women around the world presently suffer from the most debilitating disease known to humanity. [Its symptoms] include anemia, malnutrition, severe fatigue,... increased susceptibility to infection,... and premature death. [Furthermore,] the disease is often communicated from mother to child with markedly higher transmission rates among females than males.... The disease is poverty.[1]

THE CONSTITUTION OF THE WORLD Health Organization (WHO) asserts that: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economic or social conditions." However, a recent publication[2] of WHO states that many women throughout the world are being denied this basic human right. The WHO has also emphasized that, while some women's health problems are determined by human biology, many others arise from or are aggravated by socioeconomic factors.

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The WHO report states that, although girls are born with a biological advantage over boys, this advantage is often cancelled out by the *social* disadvantages girls suffer. These social disadvantages are often related to *gender** differences that discriminate against and disadvantage women and that permeate all aspects of women's roles in all societies.[3]

More specifically, women lag behind men on virtually every indicator of social and economic status, and they constitute a larger proportion of the poor in all societies, including our own. Throughout the world, gender bias in the allocation of resources generally begins at birth, for poverty and cultural beliefs about women's worth conspire to deprive females from infancy of the very resources they need to be productive members of society.[1] Thus, while poverty is a primary determinant of poor health for both men and women, it has a particular impact on women's health.

Feminization of poverty

In Canada in every age group, women's poverty rates are higher than

** Gender is used throughout this article to refer to the culturally determined thoughts, attitudes, and belief systems about women and men and the cultural notion of what it is to be a women or a man, ie, what it is to be feminine or masculine.*

men's. In 1987, although women constituted 51% of the population, they constituted 56% of all low income earners. Sixty-seven percent of all minimum wage earners are women. Women make up 72% of part-time workers – a group whose average hourly wage is $6.85 with no benefits.[4]

The problem of poverty for single parent families and for unattached women is particularly striking. In its 1990 report,[5] the National Council of Welfare reported that, based on current trends in marriage, divorce, and life expectancy, 84% of women can now expect to spend a significant period of their adult lives supporting themselves and often their children.

In 1986, single parent families constituted 13% of all Canadian families, and in 82% of these families the single parent was female.[4] These female single parent families are most likely to be poor. Indeed, 62% of single parent families headed by women live below the poverty line.[6] For families of single mothers aged 16 to 24, the number of families living in poverty jumps to eight in 10. Furthermore, female-headed single parent families are far more likely to live below the poverty line than male-headed single parent families, with the average annual family income for the former less than half of that for the latter.[4] Among those older than 65, 47% of unattached women are poor compared with 33% of unattached men.[6]

In a recent article, Harman[7] calls "feminization of poverty" an old problem with a new name, pointing out that women's poverty is taking a new shape. While women have always been poor through their dependent roles as wives, mothers, and daughters, their poverty has been concealed as only a potential plight. But as more and more women live without men, either by choice or necessity, women's poverty becomes more visible. This is true whether they be previously married, single parents, elderly unattached women, or never married.

This increase in poverty among women living alone reflects the increasing dependence of families on

Poverty is not random: *Poverty affects women disproportionately, especially those who are aboriginal, visible minorities, immigrants, and disabled.*

the wages of both partners in order to maintain an adequate family income. Indeed, women in traditional husband-and-wife families have made increasing contributions to their family incomes, and it is this increasing participation of married women in the work force whose pay, while still only two thirds of that of men on average, helps reduce the poverty rate of two-parent families.

The many routes to poverty for women reflect the social, political, and cultural context in which they live. The primary factor is due to sexual division of labour, which defines men as breadwinners and women as unpaid caregivers. This division of labour creates a sharp distinction. Work in the labour market is paid; work in the home is not. Thus, as a result of women's child rearing and other domestic responsibilities, a vicious circle develops, which explains the financial entrapment of women at home or in low paying, low status jobs.

Because of this unequal division of labour, women tend to have less educational and vocational opportunity and development, which, in turn, leads to overcrowding in female job ghettos where earnings on average are persistently lower than in male-dominated job sectors. As well, even in positions of equal value, women are frequently paid less than men. As a result, women who work full-time earn only 66%[4] of what full-time male workers earn. Even in high-status jobs, women on average earn 61% of what men do.[8] Furthermore, family caregivers must often leave the work force, rearrange their schedules, or take unpaid time off to fulfil caregiver obligations. These caregivers are more likely to be women than men.

This clustering of women workers in lower income jobs, coupled with discontinuity of work because of family commitments, are extremely important factors in contributing to the poverty of women. Such factors also contribute to the poverty of older women for they create significant disadvantages in pension accumulation. The potential for adequate pension accumulation is also often adversely affected because, in addition to those who were not part of the work force, many women have been employed in situations in which pension benefits were not provided.

A recent report from Hamilton-Wentworth[9] found multiple reasons for increasing poverty in the community, including lack of affordable housing, lack of support services for victims of family violence, lack of community supports for the disabled, lack of job opportunities, lack of affordable day-care, lack of accessible and inexpensive transportation, and lack of appropriate education training and retraining. In many of these areas, women are at an even greater disadvantage than men.

Significant linkages between being female and other factors also increase the rate of poverty: being disabled; having a minimal education; and being a member of a visible minority, immigrant group, or a member of our aboriginal peoples.† These linkages have led to the use of the label "doubly disadvantaged." For example, 38% of aboriginal women 15 years of age and older have less than a grade 9 education, double the rate of nonaboriginal women, and their rate of unemployment is 28%, double that of nonaboriginal women.

Furthermore, for those who do work, the incomes are just under three quarters of that for nonaboriginal women.[4] Similarly, disabled women older than 15 are two to three times less likely than nondisabled women to have less than a grade 9 education, and their labour force participation is half that of nondisabled persons.[4] Thus, while 16% of adults and 18% of children in Canada are poor,[6] poverty is not random but is disproportionately seen among women, particularly those who are aboriginal, in visible minorities, immigrants, and disabled.[6]

†*Aboriginal is used throughout this article to refer to Native and indigenous inhabitants of Canada and their descendents.*

Overall impact of poverty on health

The overall impact of poverty on health has been extensively documented. People in lower socioeconomic groups experience poorer health and die sooner than those in higher income groups. The percentage of those who are screened regularly or who practise healthy lifestyles is lower in the lower socioeconomic classes. Most importantly, children of those who are themselves poor experience poorer health and greater mortality and morbidity.

Several studies have documented the relationship between economic status and mortality. The British Whitehall Study[10] clearly documented a steep inverse relationship between employment grade and mortality among 17 530 civil servants in which, compared with the highest grade (administrators), men in the lowest grade had three times the mortality rate from coronary heart disease than from a range of other causes and from all causes combined.

A recent report from the United States[11] demonstrated that poor and poorly educated people still die at higher rates than those with higher incomes or better education and that this disparity had actually increased between 1960 and 1986. The Hamilton-Wentworth Study[9] also found that low income males die younger and have fewer disability-free years. Hirdes and Forbes[12] reported a significant relationship between income and mortality in their cohort of Ontario males, with an adjusted relative risk of .41 for the highest 20% compared with the lowest 20% income group. Overall, in Canada in 1986, the difference in life expectancy at birth between the highest and lowest income strata was reported to be 2.8 years for women and 6.3 years for men.[13]

With respect to self-rated health status and exposure to risk factors, the Ontario Health Survey of 1990,[14] Canada's Health Promotion Survey Special Study on the Socially and Economically Disadvantaged published in 1988,[15] the Hamilton-Wentworth Study,[9] and Canada's 1990 Health Promotion Survey[16] all found a correlation between perceived health status and household income. As well, those in lower income brackets reported a lower rating of self-help, lower satisfaction with health status, a lower level of happiness, a lower level of satisfaction with social life, and a lower measure of personal well-being.

In addition, those in lower income brackets reported more limitation of activity due to pain; lower levels of social support; and a greater number of days away from work due to sickness, injury, or disability. A greater proportion of those in the lower income brackets were also reported to be living in dysfunctional families.

Risk factors, such as smoking, obesity, lack of exercise, increased blood pressure, and failure to use seat belts are all more common among those of lower socioeconomic status. These individuals are also more likely to work in an environment where smoking is unrestricted, to have a spouse who smokes, and to live in a home without fire extinguishers or smoke detectors.

Economically disadvantaged people become ill because of poor nutrition, poor living conditions, and high stress levels. As a result of these conditions, illness might occur with greater frequency causing, among other consequences, many of these persons to miss work or lose jobs and become even poorer.[17]

Poverty and health

Because the level of poverty is greater among women than among men, adverse effects of poverty on health can be expected to have an even greater impact on women. A number of reports[1,2,17-19] have emphasized the importance of reducing poverty in order to improve women's health.

Reports looking specifically at women's health[20] found that poor and very poor women were much less likely to say that their health was excellent or very good for their age and much more

likely to report it as fair or poor than were their higher income counterparts. Greater limitations in long-term activities were reported by those in lower income groups.

Unemployment, too, is reported as affecting health directly through its relationship to anxiety, depression, and loss of self-esteem or indirectly through its influence on other health resources, such as income or housing. Not surprisingly, it was reported that, when women currently employed outside the home and those looking for work were surveyed with respect to self-rated health, 71% of employed women compared with only 58% of unemployed women said that their health was very good to excellent. This is particularly important because overall unemployment rates have tended to be higher for women than for men.[4]

Low socioeconomic status is associated with an increased incidence of mortality from cancer of the cervix.[21] Although the incidence of breast cancer is greater among women of higher socioeconomic status, there appears to be a lower survival rate in the poor, possibly related to the later time of diagnosis. This late diagnosis might in turn be related to limited access to screening or difference in quality and availability of care.

While wife abuse is certainly not limited to those who are poor, the poverty of women trapped in such situations makes it even more difficult for them to leave an abusive situation.

Finally, it might be more difficult for poor women to access health care when they need it (even with universal health care coverage), if they lack adequate funds for transportation or for child care or are in low-level jobs in which they cannot demand time off to visit the doctor.

Impact of poverty on preventive care

Health promotion, screening, and disease prevention also correlate with socioeconomic status. Canada's Health Promotion Survey of 1988[15] reported that there is a clear trend for women who have attained higher education and who earn higher incomes to be more likely than other Canadian women to have had a Pap smear within the year preceding the survey. Women who have never had a Pap smear are most likely to have low incomes and lower educational status.

Similarly, with respect to breast self-examination, women who most support the belief that they should examine their breasts regularly have higher incomes, higher levels of education, and tend to be English speaking. Similar findings with respect to Pap smears and breast examinations have been reported in other studies.[14,22] Those of lower socioeconomic status are also less likely to have had mammography screening within the last 2 years.[13,23]

A recent article[24] reports that the rate of death from cervical cancer was significantly higher among aboriginal women in British Columbia than among nonaboriginal women, largely because the provincial screening program did not reach as many aboriginal women as it did nonaboriginal women.

A study in the *American Journal of Public Health*[25] in 1989 reported that, during 1984 and 1985 in Connecticut, women of lower socioeconomic status with breast cancer were less likely than wealthier women to be diagnosed with early stage disease, even though in the same years, the overall incidence of breast cancer was greater among women of higher socioeconomic status. The rate of preventable deaths among women of lower socioeconomic status was 2.5 times as great as that for those of higher socioeconomic status. The conclusion was that early detection programs for breast cancer need to give special attention to lower socioeconomic women.

Many studies have found the incidence of smoking higher among those of lower socioeconomic status.[13,14,17-19] It has also been reported that unemployed women are more likely to smoke than employed women.

Tobacco use among aboriginal women and girls is very high, and even among those younger than 10 years, about 10% of aboriginal children use tobacco. This use has been attributed to the double pressure of being female and aboriginal, combined with traditional tobacco use by aboriginal people – a combination of factors that calls for Native-defined and Native-controlled interventions in smoking among Native peoples.[26]

Impact of poverty on children

The links between poverty and ill health have their greatest impact on children. Family physicians interested in overall family health must recognize that one of the most devastating effects of poverty on women is the intergenerational one. In our country, the rate of child poverty is increasing, and currently 18% of Canadian children live in poverty.[6] Children raised by single females are most at risk because this situation is practically synonymous with poverty.

To be born poor is to face a greater likelihood of ill health in infancy, childhood, and adult life; a lesser likelihood of completing high school; lesser still of attending university; and a greater likelihood of being judged a delinquent in adolescence. Those who are born poor are disadvantaged at birth and find life an uphill struggle ever after. To be born poor is unfair to children, yet poor children are the sons and daughters of poor adults, particularly poor women. Thus, child poverty cannot be viewed in isolation.

Child mortality is two times greater at the lowest income level than at the highest. As well, the lower the income level, the greater the incidence of having low birth rate babies. In a study of low birth rate babies in Metropolitan Toronto, it was observed that, in the poorest, most disadvantaged group, the risk of having a baby of low birth rate was 2.5 times that for the middle-class, more affluent groups (personal communication with Neil Johnston from the McMaster Health Intelligence Group). Children born to mothers in lower socioeconomic groups are less likely to be breastfed than the infants of mothers in higher socioeconomic classes.

A recent article[27] addressing decline in breastfeeding in the United States between 1984 and 1989 found that lower income was a factor in the decrease of initiating breastfeeding and in maintaining breastfeeding at 6 months. Several Canadian studies have reported similar findings. Breastfeeding was positively associated with increasing maternal education and socioeconomic status in one study,[28] and another reported that, at birth, twice as many mothers from the upper- or middle-classes breastfed their infants compared with those in the lower classes.[29] Because of the nutritional and immunologic benefits attributed to breastfeeding, this is another potentially significant factor linking maternal poverty to child ill health.

As these children grow older, they have a greater likelihood of dying in infancy and having their health adversely affected by lack of medication, lack of good food and vitamins, and by housing that is close to traffic and pollution. For these children, the largest number of deaths and those most strongly linked to income are motor vehicle accidents, respiratory diseases, and drowning.[9]

Failure to ensure adequate child support, to enforce child support payments, and the lack of proper support services to help the mothers of these children become independent all contribute to child poverty. Furthermore, the lack of adequate subsidized child care programs in our country makes it more difficult for women to work outside the home and condemns more women and their families to poverty. Finally, the increased stress of living in poverty will affect adversely both the health of the mother and of the child.

Role of physicians

With such discouraging statistics and the realization that so many of the

determinants of women's health lie beyond the scope of the traditional health care system, many family physicians feel helpless to address this problem. After all, the legacy left by past abuse, cultural discrimination, and intergenerational poverty often seems unfixable, particularly to the individual family physician.

But failing to address the effect of poverty on women's health, both in our day-to-day encounters with patients and in our role as members of society, is to abdicate our roles as family physicians who are committed to caring for and maintaining family health and well-being. For it is family medicine more than any other specialty that incorporates in its theory and practice a recognition of the broader determinants of health and illness.

Understanding the impact of poverty on women and the way in which this limits their options for coping is critical. Most of us come from a different culture and do not understand that the very poor are often overwhelmed by the emotional, social, and financial stresses in their lives and that they simply cannot comply with our evaluation or treatment.[30] It is important to be aware of the limitations that the poor face with respect to their ability to purchase nutritious food, the options available to them for dealing with stress, and the limited access to health care facilities even with universal health insurance. The latter might result from problems with office hours that fail to recognize the reality of women's lives or the need for transportation that might be unaffordable.

As well, women usually cope with poverty by putting their own needs last after those of their families. Physicians must be sensitive to the issues of low self-esteem, especially for women where self-esteem is so often linked to wearing the right clothes, using the right makeup, and participating in a lifestyle that is beyond the reach of those who live in poverty. Women who are poor do not see themselves portrayed in a positive way in the media, nor do they encounter many positive and empowering[‡] role models.

All of this requires physicians to be aware and to gear their management to the reality of patients' lives rather than label such patients as "noncompliant." In a recent article[31] the authors challenge the label attached to "hard-to-reach audience" segments – a label based on socioeconomic status, ethnicity, or level of literacy. Attention is drawn to the fact that the literature recognizes that persons in low economic strata might have fewer financial and psychological resources to respond to health problems and might suffer from increased exposure to environmental hazards. Despite this, such persons are often labeled as unwilling to delay gratification, obstinate, recalcitrant, chronically uninformed, and malfunctional.

These explanations create a sense of low socioeconomic status populations as "hard to reach." This results in depicting those below the poverty line as both financially and psychologically impoverished, focused on short-term rewards, and therefore uninterested in pursuing preventive behaviour. They are also labeled as less responsive to suggested health behaviour change because they are said to care less about themselves. All of these statements tend to reflect the frustrations of health professionals trying to reach people unlike themselves and of their failure to change high-risk behaviour.

The authors[31] challenge these assumptions and suggest that we develop alternative concepts that blame society rather than individuals, emphasize differences rather than deficits, and develop communication strategies that involve the poor themselves in developing approaches to their health.

Similar conclusions are drawn by the Report on Cancer and the Disadvantaged,[21] which, while recognizing that risk factors, such as cigarette smoking and sexual practices are

[‡] *Empowering is used to mean actions that give patients the power to make changes themselves.*

factors contributing to the difference in cancer rates among socioeconomic groups, points out that it is difficult to change lifestyle in the face of structural impediments to well-being. Poverty might be a barrier to a balanced diet, and adjustments in diet might be impossible without the knowledge and income to make changes. In addition, cancer education materials and outreach programs are often not culturally sensitive and relevant to persons with limited resources. Furthermore, the report points out that participation in cancer control programs might be adversely affected by illiteracy and homelessness.

Canada's Health Promotion Survey of 1990[16] reminds us that it is "no longer enough to admonish individuals to eat better or to increase their participation in physical activity when they do not have support from family and friends or the money they need to join a program or buy nutritious foods."[16]

The Educating Future Physicians for Ontario (EFPO) project has published a monograph addressing women's expectations of physicians.[32] Respondents urged physicians to approach women's medical problems more in the context of their social, economic, and cultural realities and urged that physicians increase their knowledge of the effects of illness in the growing numbers of poor and underprivileged people in Ontario.

It was suggested that the educational process include information on how poverty affects health and the behaviours that impact on health. Because of the socioeconomic status of physicians, the EFPO study found that physicians were seen as distant from poverty-related issues that affect some of their patients and likely to find it difficult to empathize. Without knowledge of a woman's financial resources, physicians might give insensitive and often meaningless advice to their patients. In addition, some respondents believed that physicians did not understand that poverty precluded some women from accessing medical help that was not covered by medical insurance plans.

Finally, the EFPO report stresses the importance of physicians realizing that, even if they personally cannot effect change in areas where there are gaps in services to women, they have a responsibility to advocate for changes to the system that would benefit their women patients. This includes participating in social agencies, in district health councils, in regional planning councils, and in antipoverty organizations.

To all of these organizations, physicians can bring an understanding of the significantly negative effect of poverty on health and participate in developing policies that recognize and respond to that effect. Physicians can and must participate in developing economic, social, and ecologic priorities for their community. Physicians are fortunate to be members of a highly respected profession. They are seen as authorities, and they have the resources to participate in the changes that are required in our society. To do less than that is to fail to fulfil our mandate as caregivers to the families in our practice, particularly for those who are economically disadvantaged.

Above all, physicians must learn to respect the skills and the dignity of those women who cope daily with poverty in the face of difficulties that many of us would find overwhelming. Physicians must confront the assumptions that many of us make: "that women who are illiterate, of low socioeconomic status, and with little or no economic or political power are reluctant or unable to analyze their problems and speak about their health and health needs." In the book, *The Health of Women: A Global Perspective*,[1] this assumption is challenged with the statement that "poor, illiterate women do speak eagerly and eloquently about their bodies and health needs – if they are given the chance and their views are respected."

Thus, in community organizations or in their own offices, physicians must

play an active role in ensuring that women, and particularly poor women, are actively involved in their care and in the development of policies that directly or indirectly affect their health.

Conclusion

We must recognize that women and children, and therefore all of our society, cannot be optimally healthy if they struggle daily with poverty. Because women's health status reflects the cultural, political, and socioeconomic context in which they live, we must take a leadership position in advocating for change in all those factors leading to women's poverty and in encouraging women to challenge and change discriminatory practices and gender bias. ■

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