This is not the first book on gender and health to be published; nor is it likely to be the last. Its focus is on those gender inequalities which evidence suggests are inequities—‘unjust’ consequences of gender differences. The two key terms here are ‘gender’ and ‘evidence’. The book’s emphasis on gender as a conceptual framework/explanatory variable both promises and delivers a welcome return to the primary differentiation introduced in the 1970s between sex as a biological, and gender as a cultural, category. Of course these two interact with, and mediate, one another in complex, often poorly understood ways, but material differences in power and resources between men and women must be taken into account in any attempt to explain the social patterning of health and illness.

‘Evidence’, the second key notion informing this book, can only itself be understood as a theme in the social construction of science. As we all now appreciate, science is as much driven by values and personal perspectives as any human activity. Thus, many of the datasets epidemiologists draw on in explaining the gender patterning of health and illness are themselves gendered. Research many only include men (on the grounds that women’s bodies are inconveniently cyclical), standardized instruments may have been developed with all-male samples and therefore be male-oriented, and, less visibly, the choice and definition of research topics may be gender-blind. Thus, for example, the field of occupational health largely omits household work, despite the known health hazards of such work. One solution discussed in this book is the ‘Total Workload Scale’ which measures stress in both paid and unpaid work. Applied to a sample of Swedish white collar workers, this yielded the perhaps not too surprising finding that the only gender-equal activity was gardening. I was intrigued to learn from another analysis of Swedish occupational health statistics that ‘exposure to human secretions’ is a feminine speciality even in the paid work sector.

Sweden is no paradise of gender equality, but certain aspects of gender inequity may be taken more seriously in Scandinavian countries. For example, complaints about the exploitation of women in medical encounters led to the formation some years ago of a National Committee on Gender Disparities in Patient Care. This book was prompted by a doctoral course on gender and health inequalities held at the Karolinska Institutet in Sweden in 2000. As a collection of chapters by 15 different authors, it is, like all such collections, uneven in quality (and the publisher’s copy-editing, particularly of references, is annoyingly even more so).

An interesting chapter by Anne Hammerstrom comments that increasing attention to gender as a research issue is not necessarily matched by a growing gender-sensitivity in public health research. How one deals with gender is as complicated a problem in research as it is in real life. There are useful summaries in this and other chapters of some of the main theoretical and methodological debates relating to the study of gender as applied to health and illness. It is abundantly clear that traditional public health epidemiology has been rather unthoughtful about gender, in much the same way as it has focused on the biological essentialism of ‘race’ rather than explored the study of ethnic and cultural diversity. This is a valuable source book for graduate and undergraduate students. It contains many thought-provoking illustrations of the ways in which the human and material resources we persistently attach to the classification of sex structure our life-chances and experiences in unequal and in equitable ways.

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In the words of the editors, ‘this is the first book that addresses terrorism from a public-health perspective that is both comprehensive and balanced’. The scope is wide, and spread over three sections: I. The public health response to September 11 and its aftermath; II. Terrorist weapons; and III. Challenges and