

Women and Healthy Living in Canada

Fact Sheet Number 9 Fall 2012

SODIUM CONSUMPTION

Most women in Canada consume eight times the dietary requirements for sodium. Much of the salt in their diet comes from processed and pre-packaged foods, making it a challenge to reduce the salt content in their diets.

Sodium chloride (NaCl) is predominantly consumed as table salt that is present in processed food or added during food preparation [1]. Only a small portion of sodium is consumed from adding salt to foods during mealtimes. Many people who report eating foods already high in sodium report adding extra salt to their food [2]. Although a small amount of sodium is required for cellular metabolism, many Canadians exceed recommended daily sodium intake levels.

Specifically, most women and girls are consuming 75% more than the recommended upper sodium intake levels [2].

Sex-and gender-based analysis

Sex- and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

1. **Sex** refers to the biological characteristics that distinguish male from female bodies. Sex differences include different chromosomal patterns, reproductive organs, hormones and proportions of fat to muscle.

2. **Gender** refers to socially constructed roles, relationships, attitudes, behaviours, relative power, etc., that shape and describe what it means to be male or to be female in a society.

3. **Diversity** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.

4. **Equity** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [3].

cardiovascular diseases [5-8]; osteoporosis [9-11]; kidney stones and kidney disease [7, 11]; stomach cancer [11], and severe asthma [5,12]. Additionally, Canadians do not get enough potassium (found in fruits, vegetables, dairy products), which works in tandem with sodium to regulate metabolism and fluids [13] and may be implicated in hypertension.

Gender issues

According to data from the 2009-2010 Canadian Community Health Survey (CCHS), 60% of women reported that knowledge of salt content influences their food choices [14]. Women's food choices may subsequently affect the food their families consume given that women are often responsible for planning, purchasing, and preparing food for their families [15]. Using less healthy pre-packaged foods for meal preparation may be a convenient, less expensive option for many women.



Sex issues

The diets of Canadian women mirror those of many other high-income countries: a calorie-rich diet that is deficient in essential nutrients [4]. Excessive salt is associated with hypertension and

Diversity issues

The amount of sodium contained in women's diet increases with age, particularly during the teen years and at age 40 and older [14]. In a detailed analysis of data from the 2004 CCHS, adults (between the ages of 50 and 69)

RETHINKING WOMEN AND HEALTHY LIVING IN CANADA

Rethinking Women and Healthy Living in Canada: Challenging the Discourse, Evidence and Practice examines the sex, gender, diversity and equity dimensions of healthy living among women in Canada by conducting sex- and gender-based analyses of the healthy living discourse, key healthy living topics and selected healthy living strategies.

Fact sheets on women and healthy living have been prepared on physical activity, sedentary behaviour, self-injury, food insecurity, sodium, tobacco, alcohol, sexual behaviour and condom use.

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diagnosed with hypertension had higher salt intake compared to matched age controls without hypertension [16].

For Inuit women, traditional diets (when available and feasible) provide women with more protein and protein-related micronutrients and a lower intake of saturated fats, carbohydrates, and sodium [17].

Equity issues

“Food deserts” (city areas with few or no grocery stores) may be problematic for women with low income who lack regular access to stores where fresh groceries are readily available [18]. Fast food restaurants and/or small expensive local grocers may be the only local option for these women, resulting in them frequenting convenient and less expensive places to shop, with fewer healthy food choices available. Urban women, who have access to large grocery shops with fresh produce, may have more healthy food choices when it comes to reduced salt content .

Critique

Adequately measuring sodium consumption is difficult given that many pre-packaged foods contain varying levels of sodium. The 2004 CCHS, which focused on nutrition, asked individuals about their efforts to reduce salt intake, but did not measure whether or not people add salt to their food while cooking or at the table. Nationally representative research is required to further examine Canadians’ sodium consumption behaviours.

There are many reasons why it is not possible for individual women to consistently make healthy food choices. Additional research on these food choices could be used to create female-specific messaging and healthy eating education programs regarding sodium consumption.



FOR MORE INFORMATION

BC Centre of Excellence for Women’s Health:
www.bccewh.bc.ca

Atlantic Centre of Excellence for Women’s Health:
www.acewh.dal.ca

Prairie Women’s Health Centre of Excellence:
www.pwhce.ca

The Source:
www.womenshealthdata.ca

La Source:
www.lasourcesantedesfemmes.ca

SGBA e-learning resource:
www.sgba-resource.ca

References

- [1] Mattes RD & Donnelly D. (1991). Relative contributions of dietary sodium source. *Journal of the American College of Nutrition*, 10(4): 383-393.
- [2] Garriguet D. (2007). Statistics Canada. Sodium consumption at all ages. *Health Reports*, 82-003-XW3, Volume 18 (2).
- [3] Atlantic Centre of Excellence for Women’s Health, British Columbia Centre of Excellence for Women’s Health & Prairie Women’s Health Centre of Excellence. SGBA e-Learning Resource: Rising to the Challenge. <http://sgba-resource.ca/en/>
- [4] Paarlberg R. (2011). Governing the dietary transition: Linking agriculture, nutrition, and health. *International Food Policy Research Institute*, 8, 1-13.
- [5] Doyle ME & Glass KA. (2010). Sodium reduction and its effect on food safety, food quality, and human health. *Comprehensive Reviews in Food Science and Food Safety*, 9, 44-56.
- [6] Vasan RS. et al. (2002). Residual lifetime risk for developing hypertension in middle-aged women and men: The Framingham heart study. *Journal of the American Medical Association*, 287, 1003-1010.
- [7] Health Canada. (2010). Sodium reduction strategy for Canada: Recommendations of the sodium working group. Cat.: H164-121/2010E.
- [8] Public Health Agency of Canada. (2009). Tracking heart disease and stroke in Canada. Cat: HP32-3/2009E.
- [9] Hansen MA, Overgaard K, Riis BJ & Christiansen C. (1991). Role of peak bone mass and bone loss in postmenopausal osteoporosis: 12 year study. *BMJ*, 303, 961-964.
- [10] Heaney RP. (2006). Role of dietary sodium in osteoporosis. *Journal of the American College of Nutrition*, 25, 271S-276S.
- [11] World Action on Salt and Health. (2011). The international low salt cookbook: Heart healthy recipes from around the world. London, England: Consensus Action on Salt and Health.
- [12] He FJ & MacGregor GA. (2009). A comprehensive review on salt and health and current experience of world-wide salt reduction programmes. *Journal of Human Hypertension*, 23, 363-384.
- [13] Tanase C, Koski K, Laffey P, Cooper M & Cockell K. (2011). Canadians continue to consume too much sodium and not enough potassium. *Canadian Journal of Public Health*, 102, 164-168.
- [14] Statistics Canada. 2009/2010. Canadian Community Health Survey (CCHS) (master file) Statistics Canada (producer). Using remote access program of Health Division, Statistics Canada (distributor).
- [15] DeVault ML. (1991). Feeding the family: The social organization of caring as gendered work. Chicago: University of Chicago Press.
- [16] Shi Y, de Groh M, Morrison H, Robinson C & Vardy L. (2011). Dietary sodium intake among Canadian adults with and without hypertension. *Chronic Diseases in Canada*, 31, 79-87.
- [17] Egeland GM, Johnson-Down L, Cao ZR, Sheikh N & Weiler H. (2011). Food insecurity and nutrition transition combine to affect nutrient intakes in Canadian Arctic communities. *Journal of Nutrition*, 141,1746-1753.
- [18] Hanson Y & Stout R. (2012). Cartographies of salt: Sodium, healthy eating and the built environment. Prairie Women's Health Centre of Excellence.