



British Columbia
Centre of Excellence
for Women's Health

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A Full Measure

Towards a Comprehensive
Model for the Measurement
of Women's Health

By Colleen Reid

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Model for the Measurement
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Centre of Excellence
for Women's Health**

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Women's Health Reports

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When applied to women's health, standard measurements often result in oversights, errors, inconsistencies and simplifications.

Introduction

Currently, the determinants of health perspective conceptualizes women's health as a complex mix of social, political, economic and biological factors. Measurements of women's health have typically relied on a biomedical model, viewing health as independent from the social environment. This gap between health determinants conceptualizations and the measurements of health affects research, policy and practice in the early 21st century. When applied to women's health, standard measurements often result in oversights, errors, inconsistencies and simplifications. Critical social justice agendas, compatible with determinants discourse, are consequently unable to meet the increasing demand for accountability and evidence-based research, policy and practice. The purpose of this paper is to examine this gap between conceptualizations and measurements of women's health and suggest ways to advance measurements.

Four questions frame this discussion: (1) How have health researchers conceptualized women's health? (2) How have health researchers measured women's health? (3) How can the social determinants of health perspective, specifically focusing on gender, advance both conceptualizations and measurements? (4) What are the implications for research in women's health?

Analysis of Literature

Literature in the areas of health promotion, health determinants, epidemiology, women's health, gender studies, feminist theory, feminist research, community-based research and participatory action research were reviewed to inform this analysis. While the literatures reviewed were not exhaustive, they served to illuminate contemporary approaches to the measurement of women's health and approaches for broadening measurements so that the complexity of women's lives is better represented. Consequently, to serve this focus, some issues will not be addressed in detail. These include social support, social class and politics, body image and eating disorders, and physical activity, recreation and sport. This review also focuses exclusively on research conducted in the developed world.

A Gendered Analysis of Women's Health

A Full Measure adopts an explicitly gendered analysis to best explore the complexities and nuances of women's lives, which is needed to advance measurements and conceptualizations of women's health. A gender analysis examines the differences and disparities in the roles that women and men play, the power imbalances in their relations, their needs, constraints and opportunities, and the impact of these differences on their lives. A gender analysis examines how these differences determine differential exposure to risk, access to the benefits of technology, information, resources and health care, and the realization of rights (WHO, 1998). Women's everyday experiences must be understood within the context of the larger social organization and ideological structures generated from outside experience (Anderson, 1987).

For example, over the past 30 years Canadian women have been dramatically affected by social change. Political and social shifts in society can create policies and practices that change the context of women's lives. In British Columbia, for example, this has been the case for health reform, regionalization,

homecare and pharmacare. These (and other) policies reflect the political and social environment and can affect understandings and measurements of women's health.

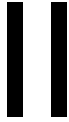
Over half of the population are women, and from birth women and men are socialized differently, experience different biological processes, and have different interactions with family, friends, parents and social institutions. In Canada today, more women than ever before are involved in the paid labour force (Pearce, 1993), more are single parents, more are elderly, and more are homeless. Women in Canada are diverse and live in diverse communities. Some are experiencing greater financial independence (Arber & Cooper, 1999) while many others are slipping below the poverty line.¹

To fully measure women's health these factors must be considered. Women's health involves the interplay of social, individual and biological factors and is experienced within physical, emotional, intellectual, social and spiritual dimensions. *A Full Measure* confirms the necessity of interweaving a variety of theoretical approaches in order to advance a comprehensive model for the measurement of health that reflects the complexity and fullness of women's lives.

Advancing Measurements of Women's Health

Measurement tools to reflect women's health have lagged behind conceptualizations. Crucial daily experiences of women's lives have not been considered. When standard measurements are applied to women, significant oversights, inconsistencies, errors and simplifications result. Oversights stem from the fact that, until recently, women have been excluded from clinical and biomedical health research. Inconsistencies in research results occur when inappropriate measurements are applied or compared. Stereotypical assumptions about women's and men's roles have led to oversimplifications of complex issues.

This paper explores conceptualizations and measurements of women's health in three areas: biological, socioeconomic and sociocultural. For each area, current understandings from the literature are summarized, current measurement strategies are outlined, and implications for advancing measurements in women's health research are suggested.



The Biological Dimensions of Women's Health

A biomedical approach seeks to explain gender differences in health in terms of genetic, hormonal, anatomic or physiologic differences between men and women (Kawachi et al., 1999). It focuses on organ systems, cells and genes. Indeed these characteristics can be very different for women and men.

A. Current Understandings of Women's Mortality and Morbidity

Women and men experience different patterns of illness, disease and mortality, and in many cases, women have bodily experiences that are different from men's, though the meanings women attach to them may vary dramatically (Doyal, 1995b). Women suffer more than men from chronic conditions, particularly migraines, allergies, arthritis and rheumatism. Women have also reported higher levels of depression, low self-image and higher rates of psychiatric hospitalization than have men (Health Canada, 1999).

Cardiovascular disease (heart disease and stroke) is the major cause of death and one of the major causes of disability among women. Currently, prevention, diagnosis and treatment of cardiovascular disease inadequately reflects an understanding that the symptoms, the course of the illness, the effect of medications, and the suitability of certain surgical procedures are different for women and men. As well, historically, in the area of heart research on new medications, women have rarely been included as subjects (Health Canada, 1999). When it comes to cancer deaths, women in the prime of their lives (aged 20-44) are dying in greater numbers than men. These deaths are primarily due to breast cancer, the causes of which are still largely unknown (Health Canada, 1999).

In cases such as heart disease, breast cancer and other illnesses and diseases that are unique or prevalent among women, a biomedical approach that measures morbidity and mortality rates and that does not take gender into consideration, can only illuminate the biological and physiological pathways of disease.

In the 1990s, women entered the paid labour force in increasing numbers. This has established a new and highly visible picture of women’s health, capacity and illness, a picture that has yet to be reflected adequately in measurements of women’s health.

B. Measuring Women’s Mortality and Morbidity

Since health research uses rates of death and disease (mortality and morbidity) as the primary means to measure health, it is illuminating to look at the widely accepted ideas about women’s health that such research has generated. Although there is no one accepted explanation, for decades these rates have been said to indicate that women live longer, men die prematurely, and women experience more morbidity than do men. If one equates longevity with health, then women appear to be healthier than men.

Standard explanations for why women report more ill health have included biological/genetic risks, risks acquired through social roles and behaviours (the burdens of domestic and female role responsibilities, such as childrearing and housework), illness behaviour (women appear or act more sick), health reporting behaviour (women are seen to be more verbal or “complaining”), and differential health care access, treatment and use (Macintyre et al., 1999). Some studies found little support for the finding that women are more ready to report on lower thresholds of illness than are men.²

As gender roles change, the orthodoxy that women “live longer but

sicker” is being contested. In the 1990s, women entered the paid labour force in increasing numbers and fewer women remained working at home full-time for more than a few years when their children were young (Arber & Cooper, 1999). This has established a new and highly visible picture of women’s health, capacity and illness, a picture that has yet to be reflected adequately in measurements of women’s health.

Another problem with morbidity data, according to Redman et al. (1988), is that they do not indicate highly significant events in women’s lives, such as rape, or problems such as arthritis and other chronic health conditions, challenges with childcare, and financial scarcity. Women’s experiences of violence and experiences of economic insecurity need to be investigated as major sources of mental and physical ill-health (Ruzek & Hill, 1986). It is essential to continue to explore, with epidemiological and social frameworks, new definitions of significant health problems, especially problems related to chronic illness and mental health.

“Add-women-and-stir” is a term coined by Lahelma et al. (1999) to refer to the practice of adding women as a secondary research focus to a study primarily concerned with men’s health. For example, the Black Report in the United Kingdom (1982,

cited in Lahelman et al., 1999) reported almost exclusively on studies of male mortality. When it presented observations on women, these were considered “additional” results to the studies rather than primary results. Because women were considered under the same terms of reference as were men, the data on women were fewer and less accurate.

Research in the health inequalities field is often gender-blind and makes statements about mortality and morbidity and about causality without examining whether these apply differentially to men and women (Macintyre & Hunt, 1997). For example, many studies have not separated male and female data. Others do not adequately consider or measure women’s domestic and caring roles or work experiences in paid labour. This practice is particularly inadequate because the fields of psychology, sociology and anthropology are suggesting that women and men have different life experiences and psychological experiences and have different resources for dealing with threats to their health (Macintyre & Hunt, 1997).

More recently, studies on women have sought to clarify female mortality and morbidity by examining problems such as reproductive

health that exclusively or disproportionately concern women. Assessing the influence of gender, or women’s and men’s social positions, has been touted as “standard good research practice” throughout the 1990s, but in fact, systematic analysis of the differences between sexes is rarely done (Lahelma et al., 1999).

C. Implications for Research

Despite sex differences in the prevalence and incidence of some illnesses and diseases, patterns of disease, which at times can become quite complex, illustrate that more than biological health is at issue. Explanations of women’s health that ignore gender and the social patterning of disease, and that focus only on biological factors, are inadequate (Krieger & Fee, 1994).

Human lived experience is simultaneously natural and cultural. Sex and gender go hand in hand: there is no biology without society and vice versa (Health Canada, 1997). Any measurement and analysis of women’s health must reflect consideration and understanding of the gendered nature of both women’s and men’s lives. Ruzek and Hill (1986) claim that the underlying gender system, which is socially and politically constructed, affects women’s biological and psychological life experience in fundamental ways. Krieger and Zierler (1995)

A challenge in understanding the nature and extent of women's similarities is in avoiding the extremes of reducing women's experiences as caused by biology (biological reductionism) and conceiving women's experiences as the result of social forces (social constructionism).

contend that, at the same time and with rare exception, a biological construct of sex and a social construct of gender are inextricably woven, and that both are lived simultaneously. Lowe (1983, cited in Love et al., 1997) states that with the possible exception of very specific reproductive behaviours, the relative influence of biological versus social factors on a particular trait or behaviour is not possible to determine. However, biological differences have been used to justify social difference, and have been exaggerated by social prescriptions and behavioural codes that serve to enhance the distinctions (Krieger & Fee, 1994).

For example, women's ability to become pregnant has been used to restrict women's employment in certain occupations that are male-dominant and relatively well-paid.

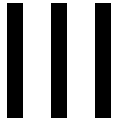
Social experiences of gender are expressed biologically in ways that may or may not be associated with biological sex. For example girls' and women's body building and exercise patterns are affected by underfunded and inaccessible athletic programs for girls (Krieger & Zierler, 1995; Krieger, 1996). As well, the "tyranny of slenderness" (Chernin, 1981) has disproportionately affected the lives of girls and women and contributed to an

increase in the rates of body image dissatisfaction and eating disorders. Beauty, health and fitness magazines send the inescapable message that personal initiative and commitment are all that are needed to make major changes in one's body and its appearance. Slenderness is not seen as the arbitrary genetic trait it is, but as a defining feature of beauty (Hesse-Biber, 1996). Extreme body dissatisfaction can lead to disordered eating: 10 per cent of teenage girls have clinical eating disorders (Boston Women's Health Collective, 1998).

It is important to remember that the underlying socioeconomic, political and sociocultural dynamics of what actually produces health for different groups of women are not integral to biomedical models (Ruzek & Olesen, 1997). A biomedical model is inadequate for identifying some of the key health issues for women since women's health is interwoven with their gendered experiences, diversity and multiple roles (Orme & Naidoo, 1995).

A challenge in understanding the nature and extent of women's similarities is in avoiding the extremes of reducing women's experiences to biology (biological reductionism) or conceiving women's experiences as the result of social forces (social constructionism) (Love et al., 1997). An integration of research paradigms

is indicated. Although the feminist health movement of the 1970s rejected the biomedical model because it focussed too exclusively on women's reproductive health and reinforced constraining images of women as childbearers and homemakers (Walters et al., 1995), today many feminist researchers acknowledge that gender analyses require a synthesis of approaches, including the biomedical.



The Socioeconomic Dimensions of Women's Health

Social and economic advantage increases the chances of benefiting from good housing and proper nutrition, and offers opportunities to reduce stress, which affects morbidity, mortality and quality of life. Social and economic advantage also increases access to better and lengthier education and more sound child development opportunities (Health Canada, 1997).

Health has long served as a barometer of the economic and social conditions under which people live. This is clearest where conditions are worst: poor housing, lack of adequate heating or other facilities, a polluted environment, accidental risks and hazardous or punishing work. These elements can all be readily seen as likely to affect health (Blaxter, 1990, cited in Walters et al., 1995).

A. Current Understandings of Women's Socioeconomic Status

Current measurements of women's socioeconomic status and health that rely on occupational measures derived primarily from a male-centred experience and understanding are inadequate. As the research below suggests, a gendered understanding of socioeconomic status and health yields a fuller, more complex perspective of women's health.

1. Poverty

Poor people, who are disproportionately women, children and people of colour, have more illnesses and die in greater numbers and earlier than people with more income and education (Salk et al., 1992, cited in Sargent & Brettell, 1996). Assuming that inequality is illness-producing, the socioeconomic position of women poses some hazards to health (Ballantyne, 1999).

According to the National Council of Welfare's report "Women and Poverty Revisited" (1990), women are extremely and increasingly vulnerable to poverty for reasons that are often beyond their control. The main causes of the feminization of poverty are labour market inequities,

Those who are poor, particularly women, experience more frequent, threatening and uncontrollable life events than the general population.

marriage breakdown and motherhood (National Council of Welfare, 1990). Living in poverty imposes a considerable amount of stress on individuals and on families. Those who are poor, particularly women, experience more frequent, threatening and uncontrollable life events than the general population. Inadequate housing, dangerous neighborhoods, burdensome responsibilities and financial uncertainties are inevitable, and potent stressors are commonplace (Belle, 1990).

Lone parent families headed by women have the highest incidence of poverty for all family types, a situation that has improved very little over the past decade (Health Canada, 1997). Living in poverty is associated with financial, parenting and childcare problems, making the daily realities of low-income single mothers difficult and exhausting (Belle, 1990; Reid, 1997). Many low-income women report feeling socially isolated and unconnected to community life (Lord & Hutchinson, 1993; Reid, 1997).

2. Women's paid work

Nowhere in the world have women entered the labour force on equal terms with men (Doyal, 1995a). Women are distributed within the labour market in a distorted "gender market" (Ballantyne, 1999), or crowded into "female employment

ghettos" (Doyal, 1995a). Hedman and Herner (1988, cited in Love et al., 1997) characterize the occupational pattern of women in Sweden as the "reproductive sector" in which women have remained even after entering the labour market, in contrast to the "productive sector" of industry in which men are prominent.

However, women who are employed report better health than those who are homemakers (Walters et al., 1995). This "healthy worker effect" occurs irrespective of housing tenure, marital and parental status. Employment can be viewed as a social resource, providing the opportunity for individuals to be attached to others socially. Women's increased labour force participation is generally viewed as indicative of increasing economic security and social well-being (Ballantyne, 1999). However, this emphasis on increased labour force participation belies the extent to which women are unemployed, face a high risk of unemployment, and bear a double burden of paid and unpaid work when they are employed (Ballantyne, 1999).

For the employed, the conditions and nature of work can affect workers' health. The work and home variables that can affect women's health include physical job demands, psychological job demands, work control, social support at work,

job hazards and number of hours worked (Walters et al., 1995). Women who are not in paid employment and have no dependent children report poor health. Women with young children report good health irrespective of their employment status (Arber, 1991).

There is a collective perception that women's attachments to the labour market are marginal, or at least less imperative than men's, a view that limits women's employment opportunities. Women's work in the labour market is frequently assessed with explicit or implicit referral to their work in the private sphere, suggesting the "taken-for-granted" nature of women's responsibilities with regard to marriage and the family.

3. Women's part-time work

Many more women than men are employed part-time in Canada. Twenty-nine per cent of women work part-time, compared with nine per cent of men (Kaufert, 1996). Part-time work is located in the most volatile segments of the market where workers are most vulnerable (Ballantyne, 1999). The nature of the double work burden varies among women and will have different implications for their physical and mental health (Walters et al., 1995).

4. Women's unpaid work

Around the world, the most fundamental feature of women's lives is their responsibility for home, family and household labour. Caring for and caring about others is a central feature of these activities wherever in the world they are carried out (Doyal, 1995a). In Western industrialized countries, the majority of women with children work outside of the home, though they still have primary responsibility for housework and childcare. In Canada, two-thirds of household work (domestic chores, childcare, shopping) is carried out by women (Health Canada, 1997). This responsibility often leads to an excessive workload, especially during the childbearing years. A growing number of women have the added responsibility of caring for aging parents (Ministry of Women's Equality, 1997). Doyal (1995a) notes that this responsibility often occurs after menopause. Domestic work is characterized by its open-endedness and sheer volume, in that there may be no obvious end to the working day, making it difficult for women to separate work from rest or "leisure" (Doyal, 1995a).

Recent research suggests that childrearing and society's definition of childrearing as a female activity place women and men in different

positions with respect to the flow of information and other resources in social networks. Women's social worlds are restricted during years of intensive childrearing, both in terms of the number of people with whom they interact, and in terms of the time spent interacting with those people (Ballantyne, 1999). There is a need to map the major areas of women's lives and then to analyze the impact of these various labours on women's health (Doyal, 1995b).

What are the patterns of resource allocation within the home and how does this affect women's health? Women are often engaged in a complex process of cooperation and conflict with male partners and other family members over resources, rights and responsibilities (Sen, 1990, cited in Doyal, 1995a). Doyal (1995a) characterized this process of negotiation as "patriarchal bargaining" with an outcome often detrimental to women's well-being, and an imbalance between responsibilities that women are given and the resources allocated to meet their needs. Women are challenging the rules of the "patriarchal game" in an attempt to increase their influence over the domestic decisions that can have a profound effect on their health.

5. Social class, occupation and "unhealthy lifestyles"

A striking aspect of smoking behaviour in women is its relationship to social class and occupational factors (Greaves, 1996). Women of lower socioeconomic status are more likely to smoke and less likely to quit, and Aboriginal women are more likely to smoke than non-Aboriginal women (Greaves, 1996). Smoking is concentrated among those who are most disadvantaged, which may be a way of dealing with the stress they encounter in their day-to-day lives. For women, cigarettes represent one of the few purchases directed solely toward their own pleasure, and one of the few luxuries in their lives (Greaves, 1996).

The social patterning of drinking, smoking and poor nutrition illuminates the role of the structural constraints that women face. In general women know that tobacco, alcohol and a poor diet are hazards to their health. Yet, these practices reflect ways of coping with deprivation, uncertainty, heavy workloads and a lack of support (Walters et al., 1995). Women's behaviour is set in context and can be understood as a response to the challenges of their lives (Walters et al., 1995). Focusing on individual behaviour not only "blames the

Violence against women is a public health issue on a global scale and has been a defining issue in the feminist movement and feminist health movement for the past thirty years. Yet the health care sector has not viewed violence as an important health issue.

victim” but diverts attention from more fundamental social inequities that cause poor health status (Ruzek, 1997; Crawford, 1984; Labonte, 1994).³

6. Violence against women

The World Bank has estimated that in industrialized countries, sexual assault and domestic violence take away almost one in five healthy years of the lives of women between the ages of 15-44 (United Nations, 1995). Violence is a part of the social condition of many women’s lives: millions of girls and women are sexually abused every year. Violence against women is a public health issue on a global scale and has been a defining issue in the feminist movement and feminist health movement for the past thirty years. Yet the health care sector has not viewed violence as an important health issue (Kinnon & Hanvey, 1996). To date no comprehensive study has been done to measure the impact of violence on women’s health.

Yet the myth of male protection persists, including the idea that the home is a haven from the threats of the outside world (Doyal, 1995a). Several studies in the United States have indicated that at least 20 per cent of women have been physically abused by a man with whom they have an intimate relationship (Doyal,

1995a). Ninety per cent of attacks of physical violence inflicted on partners in intimate relationships are perpetrated by men on women.

Fear of violence and the experience of violence limit the choices and expectations of many women in their homes, workplaces and communities. In their lifetime, approximately one in two British Columbian women experiences sexual assault, one in three spousal assault, and one in five experiences other types of physical assault. Nearly two-thirds of the women who experience violence are assaulted by men who are known to them (Ministry of Women’s Equality, 1997).

B. Measuring Women’s Socioeconomic Status

One of the most pervasive and enduring observations in public health is the “gradient of health.” This gradient can be pictured as a line on a graph that remains consistent across sex, age groups, cultural groups, countries, diseases and everything else that has been measured about health to date. The gradient of health shows that people who have the lowest income, education or occupation (socioeconomic status), experience the highest rates of mortality and morbidity. If people move up the socioeconomic gradient, their health improves relative to the gradient of health.

Regardless of your sex, if you are poor you are more likely to have poor health. However, gender and sex are important considerations because when men and women are considered together, differential patterns appear. Conventional measures of socioeconomic status (occupation, education, income, neighborhood deprivation and household access to assets) have, in some cases, shown less consistent gradients in women. One example of this is in cause-specific mortality or morbidity, as in coronary heart disease, which exhibits a steeper gradient for women than for men. Another example is that women display socioeconomic gradients in body mass index (obesity) in the expected direction, while men generally do not (Macintyre & Hunt, 1997).

Another area of health research maintains that there are universal differences between women's and men's health that cross social class, occupation and lifestyle delininations. This research supports the notion that examinations of gender and socioeconomic status will show that women have more in common with each other than with men even if the women are in different social positions. Both this approach and the health gradient approach testify to the need to review and revise research models for studying the

social patterning of health.

Occupational classifications

A significant barrier to understanding the link between women's socioeconomic status and health is the way in which occupation is measured. Because women are less likely to have paid work and tend to occupy different jobs than men, standard occupational classification systems that were developed to reflect men's work are inappropriate measurements for understanding the relationship between women's work and health (Matthews et al., 1999).

i) Gender segregation in work

When women are employed they are concentrated within a very limited number of occupations that tend to have relatively low wages and status. Given this entrenched gender segregation, measures based on occupations are inevitably problematic. When comparing occupational income inequalities in men and women, for example, it becomes clear that women in "male" occupations will generally remain in the least senior positions and earn less money, while men in "female" jobs are over-represented in more senior positions. The Canadian labour force has been characterized as neo-patriarchal because only seven per cent of men report to a woman, while women are almost equally

Few studies have attempted to treat work and home conditions symmetrically, although those that do have found that work conditions may be just as or more important for women's health than for men's.

likely to report to a man (Clement & Myles, 1994, cited in Kaufert, 1996). This means that women are over-represented in low-paying, low-status and low-security jobs and have a different experience and relationship to the paid labour force. The "Registrar General's Classification" in the United Kingdom was constructed based primarily on male occupational and work experience. It remains an example of one such problematical measure that is still widely used (Matthews et al., 1999).

ii) Biases in assumptions about the impact of work

There has been some suggestion in health research that work-related factors make a greater contribution to men's health status and that family situation and family composition factors may be more important for women's health (Matthews et al., 1999). This assumption constitutes a critical problem in the measurement of health because it prevents us from fully understanding gender differences in the socioeconomic gradient of health. Women's paid work has been treated as an additional rather than a primary role: this belies an unstated, stereotyped assumption of a traditional unpaid role for women as homemakers. Few studies have attempted to treat work and home conditions symmetrically, although those that

do have found that work conditions may be just as or more important for women's health than for men's (Macintyre & Hunt, 1997).

Women and men occupy particular sections of the labour market, though this has not been well measured or reflected in measures of work and occupation. This means that gender differences that have been found in the relationship between health and socioeconomic status may in fact indicate problems in the measurement of social status and paid work. Given that women tend to occupy particular sections of the labour market, the magnitude of socioeconomic inequalities between women and men might reflect gender differences in the measurement of social status, rather than true differences in the relationship between health and socioeconomic status for men and women.

A telling contradiction in health research is that men who are unemployed (unpaid) are seen as experiencing a disadvantage. With few exceptions, studies of men's health have paid less attention to their marital and parental roles (Arber, 1991). Arber and other feminist researchers have stressed the importance of examining both women's and men's occupational position within society and the family. Socioeconomic indices, such as

Some researchers contend that paid work improves women's health, while others believe that combining paid and unpaid work results in undue burdens of responsibility and "role accumulation" and can negatively impact women's health.

education, should be considered as another means to measure socio-economic inequalities between women and men. Measuring education can "round out" or provide a more complete representation. This has been applied in studies on men's health where there is greater inequality between men (Matthews et al., 1999). Using similar socioeconomic indicators for comparisons of men and women rather than examining different sorts of indicators for each sex (Macintyre & Hunt, 1997) could produce more accurate understandings.

iii) Primary and additional roles

The demands of housework and childcare are additional stresses for women who are also paid workers. For this reason women's employment should be examined as both a primary and an additional role. As a primary role, paid labour influences a woman's command over financial resources and may influence her and her family's lifestyle and life chances (Arber, 1991). Women's parental and marital roles within a particular setting are also significant, but little research has been done to examine the link between health and these roles (Arber, 1991). Similarly, there have been few studies examining whether and how poor health might affect women's re-entry into paid employment after childbearing,

or the likelihood of women leaving employment because of ill-health (Arber, 1991).

Can a single measure such as occupation adequately reflect the lives of women who are living in different family forms? (Arber, 1991) The experience of lone female parents, for example, is not captured in traditional measures of socioeconomic status. These women are often reliant on government subsidies as their primary income and are also expected to pursue employment training in order to secure work once their children are in school (aged seven in Canada). Current occupation and income measures do not reflect these categories and activities as work.

iv) Unemployment

Some research has shown that unemployment causes poor mental and physical health. Other research on men supports the notion that it is those who are already less healthy who are selected into unemployment. Research on women's health and paid employment complicates this debate. This research has focused on whether or not paid employment improves or inhibits women's health. Contradictory findings have resulted: some researchers contend that paid work improves women's health, while others believe that combining

paid and unpaid work results in undue burdens of responsibility and “role accumulation” and can negatively impact women’s health (Arber, 1991).

C. Implications for Research

The development of appropriate tools to measure women’s health has lagged behind conceptualizations about social and structural influences. Traditional measures of women’s and men’s socioeconomic status, paid and unpaid work, and childrearing must be reviewed and revised to accurately reflect the complexity and diversity of women’s and men’s lives. The impact of violence on women’s health must be investigated as a major source of mental and physical ill-health.

The Black Report in the United Kingdom (1982, cited in Lahelma et al., 1999) reported almost exclusively on studies of male mortality and, when women were added, observations on women were presented as additional results. This contrasts with current research that examines the intricacies of women’s socioeconomic status, including poverty incidence and rates, paid, part-time and unpaid work, and resource allocation and power dynamics within the household.

If men’s and women’s social positions, such as their employment status, family roles and social relations, approach each other in the future, it is plausible that convergent trends of gender differences in ill-health can be expected (Lahelma et al., 1999). A recent study of a national British bank, where there was little gender stratification between employees, suggests this convergence. Umberson et al. (1996, cited in Lahelma et al., 1999) state that among men and women working full-time for the bank, there were small gender differences in reports of symptoms of psychosocial malaise, but no differences in physical symptoms, and none according to a standard measure of mental health. Umberson et al. conclude that “similar social conditions elicit similar psychological reactions from individuals.”

As women’s and men’s relations to the formal labour market and to the domestic sphere change, it is particularly timely to examine the meanings and measurements of work and class for both sexes in order to elucidate similarities and differences that may provide clues to the causes and origins of various social inequalities in health (Macintyre & Hunt, 1997).

IV

Strategies to measure women's diversity have lagged behind understandings of diversity in the literature. Indeed, in most measures of women's diversity, only race/ethnicity and age are considered.

The Sociocultural Dimensions of Women's Health

The term diversity refers to race/ethnicity, immigrant status, sexual orientation, age/lifespan, geographic location and ability/disability. Strategies to measure women's diversity have lagged behind understandings of diversity in the literature. Indeed, in most measures of women's diversity, only race/ethnicity and age are considered.

A. Current Understandings of Women's Diversity

There are discrepancies between how women's diversity is measured and how it is currently conceptualized. It is not possible within the scope of this analysis to adequately reflect the daily struggles and realities of the diverse communities of women; the assumption that these categorizations are meaningful to all women is also problematic. Although there are many instances when women's diversities intersect, they have been inadequately researched and documented in the literature. For example, the forces of sexism and ageism intersect and severely impinge on the lives of old women. Older women who also face discrimination based on race, sexual orientation or physical ability have an even more difficult time (Boston Women's Health Collective, 1998).⁴

Mainstream classifications of diversity have served bureaucratic and database purposes and have been neatly packaged and represented as coherent and uniform categorizations. However, it is often difficult for mainstream categorizations to capture the complexity and subtleties of women's diversity.

B. Measuring Women's Diversity

1. Race/ethnicity

The word "ethnicity" is often used as a catchall for all non-Caucasian people. The characteristics generalized from the word are unclear and subject to many interpretations. It makes no sense to aggregate in a single category such as "Asian" the distinctive histories, geographic origins, and cultures of Cambodian, Chinese, Filipino, Japanese, Ko-

Health status that is measured only by race and ethnicity may mask the effects of socioeconomic status, diet, education, housing and other factors.

rean, Laotian, Thai, and East-Indian Canadians (Jones et al., 1996).

People who recognize multiple ancestries may not identify with a single culture or geography. An individual's identity may shift in response to the way the question is asked, or with the purpose of the survey (Jones et al., 1996). Within ethnic groups, there are large variations in experience, choices, and behaviours. For example, the "Hispanic" classification groups people who originate from Spain, Portugal, the Caribbean, Puerto Rico, Mexico and Central and South America, yet their culture, diet, social and behavioural norms, and even their language and appearance may differ markedly (Jones et al., 1996).

Differences in health status, outcomes or other indicators that appear to correspond to race and ethnicity should prompt investigators to look more closely. Health status that is measured only by race and ethnicity may mask the effects of socioeconomic status, diet, education, housing and other factors (Jones et al., 1996). As well, without data on more specific ethnic subgroups, public health efforts in a community may miss populations at particular risk and target others with inappropriate messages (Jones et al., 1995).

Krieger and Zierler (1996) illuminate these difficulties in a study of hypertension in a diverse group of women from the same ethnic/racial category (i.e., South-Asian). They found that the relationship between their illness and socioeconomic status depended on their particular ethnic/racial heritage. They also concluded that race/ethnic differences could not be reduced to a question of social class. There is, therefore, a complex relationship between social class and race that cannot be reduced to one or the other.

Accurate identification of health status differences among women within a specific racial/ethnic group is particularly important. If we know the experience of women who share aspects of ethnicity/race, but differ by other sociocultural and socioeconomic factors, more accurate strategies for addressing health issues may be developed (Ruzek & Olesen, 1997).

2. Age/lifespan

Matthews et al. (1999) report that it is at midlife that gender differences in socioeconomic status are most evident. Few studies have found significant differences in socioeconomic inequality in early adulthood.

When measuring the health status of older women and older men, a paradox in health reporting is re-

vealed. At a specific level of disability, women are less likely to assess their health as being poor than are men of the same age. Arber and Cooper (1999) suggest that gender differences in morbidity are smaller than previously assumed. The conventional wisdom of “women are sicker” must be regarded with more caution as a new paradox emerges: after controlling for age, class and income, older women are more likely to report good health than older men (Arber & Cooper, 1999). In cases where women and men similarly rate their health, older women have in fact a much higher level of functional impairment (Arber & Cooper, 1999).

Much research on gender and health focuses on very broad age groups. Given the well-known gender differences in mortality and the concentration of poverty among older women, it becomes increasingly important to include detailed age controls (Arber & Cooper, 1999). Older women are neglected in research on gender and health, and there has been a lack of research on how class (socioeconomic disadvantage) intersects with gender and age in later life (Arber & Gin, 1991, 1995, cited in Arber & Cooper, 1999). Half of older women are widowed, whereas this is the case for under one-fifth of older men (Arber & Cooper, 1999).

These omissions are ironic because health needs and the use of health services are greatest among older age groups, and because women outnumber men in later life (Arber & Cooper, 1999). In Canada there are approximately twice as many women than men aged 65 and over, and the numerical gender disparity increases with advancing age: there are three times more women than men over age 85. When studying older people it is essential to study gender as a basis of differentiation (Arber & Cooper, 1999).

C. Implications for Research

In the literature, recommendations are made for ways to expand our understandings of the complexity of women’s diversity. Researchers suggest that we reflect upon and integrate five key strategies into the conceptualization, representation and measurement of women’s diversity. They should be accomplished in conjunction with one another, and not in isolation from one another.

1. The use of language

Attention to which terms are used matters, because they expose and challenge us to articulate frameworks and assumptions that inform our work (Krieger, 1996). In many cases the language we have adopted to describe diversity has been poorly defined and haphazardly used.

Individual women have complex social and psychological identifications and commitments, each of which adds layers of complexity to defining their experiences.

Does our language refer to biology, to culture or to something else? Are the concepts we use identical, overlapping or distinct? There is the tendency to assume that “race” and “ethnicity” represent different groups of people, as opposed to arbitrary distinctions along a continuum. It is common to use race, ethnicity and gender in different contexts to explain different health outcomes when other factors may be more important (Jones et al., 1996).

“Culture” is difficult to measure and has been captured by different surrogate measures such as ethnic group and language. “Culture” has been used as a euphemism for “minority,” “diversity,” and “vulnerable population,” which are names for groups outside of the mainstream of society. “Culture” has multiple meanings and seems to have been used in reference to shared identity based on such elements as common language, shared values and attitudes, commonalities of diet or ideology. Yet these characteristics exist for everyone, immigrant or non-immigrant (Health Canada, 1997).

2. The multi-dimensional nature of women’s diversity

Women’s communities are as diverse as the women within them, and women can be a part of many communities. Individual women have complex social and psychological

identifications and commitments, each of which adds layers of complexity to defining their experiences. Our analysis needs to locate women in the intersections of diversity and social life (Whiteford, 1996). Our understandings of women need to include those who have “multiple identities” that put them outside the mainstream (Ruzek & Olesen, 1997).

3. The “contextuality” of women’s experiences

Experiences of discrimination, racism, prejudice and disadvantage occur in a particular social, economic, political and cultural context. The documentation and representation of a woman’s experience must be framed within its larger context.

The “contextuality” of the situation explores the time and space settings and sequences of human activity (Poland, 1998). A particular group of women who share a common set of experiences in a given time, space and location may identify with specific issues or concerns. bell hooks (1990) suggests that context should prompt questions such as “Who am I now? Where am I coming from? What are the multiple voices within?”

A group of lesbians, to use one example, may frame their analysis through a “sexual orientation” lens, while identifying similarities and differences in interests, assump-

tions, needs and experiences. Focusing attention on the interplay of systemic, social and individual factors that contribute to the experience of homophobia, broadens the analysis and shifts characterizations of this group that may reinforce negative stereotypes.

4. The “relativity” of women’s diversity

Recognizing and including difference in and of itself is not enough (Brown, 1997). A woman’s disadvantage may, directly or indirectly, be the result of another woman’s advantage. It is essential to recognize the experience of women in relation to one another. For example, middle class women live the lives they do precisely because working-class women live the lives they do.

“White middle-class women have been able to move into the labour force in increasing numbers not just differently from other women, but precisely because of the different experiences of other women” (Brown, 1997, p. 275). If we fail to acknowledge relativity, the experiences of white middle-class women will be normalized and that of all others made deviant, or different from, the norm (Brown, 1997)⁵. The same analysis and insight may be applied to better understand the range of health issues of girls and women of an entire range of ages.

Advantage and disadvantage are defined through domination and possession of selective and arbitrary characteristics, such as skin colour, ability, sexual orientation and location (Krieger, 1996; Jones et al., 1996). It is essential to question who are the “advantaged” implied by the “disadvantaged.”⁶

5. Women’s empowerment and alliances

“To be empowered is to increase your capacity to define, analyze and act on your own problems. The object of empowerment is not simply to convey new bits of information or to induce specific behaviours. It is to support people making their own analyses so that they can decide what is good for them” (Kent, 1998, p. 193, cited in Poland, 1998).

All areas of scholarship must evolve to reflect the complex and diverse realities of women’s lives. There remains much work to be done in order to appreciate the differences between women’s experiences of work, motherhood, race/ethnicity, class and gender, and at the same time, continue to challenge the white, middle-class, ageist and male biases that have informed the analyses so far. In the current climate of “contested language,” where awareness of power is acute and identity is understood as political and problematic, we must understand how

If we fail to acknowledge relativity, the experiences of white middle-class women will be normalized and that of all others made deviant, or different from, the norm.

women are similar and different. We must grapple with the substantial theoretical challenge of how to honour and appreciate diversity, while also recognizing how difference is constructed (Annandale & Clark, in press, cited in Hunt & Annandale, 1999). Women have diverse experiences and understandings, yet there are also connections between women. Use of the concept of an alliance, rather than a unity, can foster empowered action among diverse groups of women while enabling individuals to express difference. Forming alliances with women of diverse backgrounds, rather than assuming women's "unity" or sameness, may allow women to act together to improve health status (Ristock & Pennell, 1996).

V

Summary

Biomedical, socioeconomic and sociocultural measures of women's health do not adequately represent current conceptualizations of women's lives. Gender continues to structure opportunities and life chance, principally regarding paid employment and the bearing, rearing and day-to-day care of children. Women's and men's different roles and responsibilities, and the associated resources, might themselves be directly or indirectly health-promoting or health-damaging. There is a need for more systematic evaluation of existing evidence about gender, health and women's health, taking more explicit account of broad social, economic, political and cultural factors. There is a corresponding need to cite evidence with more specific reference to health concern, age and diversity (Hunt & Annandale, 1999).

We need to examine conventional wisdoms. Patterns of ill health are far from being deterministic in character. While we continue to find a female excess for some health indicators, we also find a gender equality and even a male excess for other indicators of ill health (Lahelma et al., 1999).

It is important to continue to collaboratively develop the language to name and the methods to measure how inequality and social justice affect health (Krieger, 1996). Given the somewhat inconclusive results from studies that have tried to measure health reporting, and given the disjunctures between measurement approaches and the determinants of health perspective, it is important to continue to find opportunities for conducting well-designed and broadly conceptualized studies.

VI

Conclusion

The relationship between gender and health is dynamic and complex. Biomedical, hierarchical and linear listings of factors and determinants and cause-and-effect theorizations cannot provide accurate knowledge about women's health needs. To simply reject previous understandings, however, and claim a separate framework as "new and improved" will not work either: we need to integrate and synthesize approaches.

This review and analysis proposes new strategies for measuring and conceptualizing women's health. Women's health research may be revitalized by incorporating the following principles:

- to closely reflect, in theoretical and practical terms, the multi-dimensional nature of women's health;
- to examine the interplay between biomedical, socioeconomic and sociocultural factors;
- to discover new and more accurate understandings;
- to develop and use research practices that integrate qualitative and quantitative approaches and revise traditional measures of morbidity, diversity and socioeconomic status.

These recommendations could have significant impact on health care research, policy and action.

No theoretical framework can claim to capture the total complexity and mystery of human life. As health researchers we can broaden the base of our inquiry, explore neglected structures, interactions and inequalities, and develop better measurement tools to advance health care policy that is more inclusive, accurate and humane. The fullness of women's lives – the fullness of life – requires it.

Endnotes

¹ One of the major divisions in society is between males and females, and all cultures characterize men and women as different types of beings, suitable for different kinds of tasks and entitled to differing levels of economic, cultural and political resources (Doyal, 1995b). Throughout life, the human experiences of birth, death, illness and disability are embedded in social contexts (Lorber, 1997). In any gender-dichotomized society, the fact that we are born biologically female or male means that our environments will be different, we will live different lives (Lorber, 1997), and we will have different experiences with health. The development of a gendered analysis is helpful in raising important issues in terms of conceptualization, measurement, practice, and policy.

Typically “maleness” and being male is more highly valued than “femaleness” or being female. Access to political and economic resources is differentiated by gender in most societies, and power is usually allocated along gender lines and in favour of men (Kaufert, 1996). Fundamental gender inequalities include the division of labour and the segregation of labour markets, the associated inequalities in wages, discrimination in hiring and promotion, and the distinction between paid and unpaid work. Power structures are also in place that systemically disadvantage women, including the machinery of authority, control and coercion, government and business hierarchies, the regulation and surveillance of sexuality and reproduction, and the dynamics of authority within domestic relationships (Connell, 1987, cited in Kawachi et al., 1999).

² Of all the conditions reported in this study, it was men who reported a slightly higher incidence of illness than women: 54 per cent compared to 48 per cent (Macintyre et al., 1999). Whereas in the 1970s, Macintyre suggests, women in the United States may have shown a greater propensity to report illness than men, but this gender difference is no longer apparent. It may also be that strong empirical evidence never existed and that these truisms reflected beliefs about women that were based on professional and lay stereotypes. “Overgeneralization has become the norm,” another Macintyre study stated, “with inconsistencies and complexities in patterns of gender differences in health being

overlooked. In the face of an apparently clear pattern, there has been a tendency to downplay (or maybe not even report) data that conflict with rather than conform to the general pattern” (Macintyre et al., 1996, p.621). This finding directly contradicts the conventional thinking that women are more likely to report ill health and have higher rates of morbidity.

³On the other hand, critics who disdain personal responsibility and deny individual agency may leave women at the mercy of distant forces and as passive recipients of life circumstance and health policy. While identifying the structural factors that lead to health-damaging behaviour may be accurate, it offers little direction to women who want better health and whose day-to-day lives are already crammed with at least a “double shift” (Ruzek, 1997, p.141).

⁴During the early years of the women’s health movement, health concerns were considered so fundamental to women as to cut across race and class lines. Criticisms were subsequently leveled against white, middle-class feminists for generalizing the needs of dominant groups of women to all women. As a result, race and class have been incorporated into feminist analyses as the second and third

“axes” of domination. Extensive theorization about the “additive,” “multiplicative” or “interwoven” nature of gender, race and class has resulted.

During the 1990s, theorists such as Martin (1994, p.643) suggested that “any naming or categorizing tends to call attention to similarities and to neglect differences, [yet] any human or social phenomena can be understood in countless different ways.” The categories we select to be definitive of our differences may be less significant than others (Martin, 1994). Does body size or involvement in an abusive relationship, for example, constitute diversity and a pattern of disadvantage, too?

⁵Brown (1997) draws an analogy to jazz, where multiple rhythms are played simultaneously and in dialogue with each other, and suggests that learning to think non-linearly and asymmetrically is essential in understanding women’s lives.

⁶We need to recognize and explore the connection between global industrial exploitation, rising unemployment and underemployment in the inner city, in largely minority communities, and the growth in opportunities for the middle-class (Brown, 1997).

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