

GENDER EQUITY AND SOCIOECONOMIC INEQUALITY: A FRAMEWORK FOR THE PATTERNING OF WOMEN'S HEALTH*

Nancy E. MOSS

Center for AIDS Prevention Studies, University of California, San Francisco, U.S.A.

Abstract

This paper explores the interrelationship of gender equity and socioeconomic inequality and how they affect women's health at the macro- (country) and micro- (household and individual) levels. An integrated framework draws theoretical perspectives from both approaches and from public health. Determinants of women's health in the geopolitical environment include country-specific history and geography, policies and services, legal rights, organizations and institutions, and structures that shape gender and economic inequality. Culture, norms and sanctions at the country and community level, and sociodemographic characteristics at the individual level, influence women's productive and reproductive roles in the household and workplace. Social capital, roles, psychosocial stresses and resources, health services, and behaviors mediate social, economic and cultural effects on health outcomes. Inequality between and within households contributes to the patterning of women's health. Within the framework, relationships may vary depending upon women's lifestage and cohort experience. Examples of other relevant theoretical frameworks are discussed. The conclusion suggests

* This paper has already been published in *Social Science and Medicine*, special issue, vol. 54, no. 5, March 2002, p. 649-661.

strategies to improve data, influence policy, and extend research to better understand the effect of gender and socioeconomic inequality on women's health.

Keywords: *Gender equity, Socioeconomic inequality, Women's health, International development, Policy.*

Résumé

L'auteur examine les interrelations entre l'égalité des sexes et les inégalités socio-économiques, ainsi que la manière dont elles affectent la santé des femmes, aux niveaux macro (pays) et micro (ménage, individu). Au moyen d'un cadre intégré d'analyse, elle tire des perspectives théoriques de ces deux approches et du champ de la santé publique. Dans la sphère géopolitique, les déterminants de la santé des femmes sont l'histoire et la géographie particulières du pays, ses politiques, ses services, son droit, ses organisations, ses institutions et les structures qui engendrent les inégalités sexuelles et économiques. Les normes et sanctions culturelles, au niveau des pays et des communautés, et les caractéristiques socio-démographiques, au niveau individuel, influencent les rôles productif et reproductif des femmes dans le ménage et sur le lieu de travail. Les influences sociales, économiques et culturelles sur la santé passent par le capital social, les rôles, les ressources et contraintes psychosociales, les services de santé et les comportements. Les inégalités entre ménages et au sein du ménage jouent un rôle dans la détermination de la santé féminine. Dans le cadre d'analyse retenu, les relations peuvent varier en fonction du vécu des générations et du cycle de vie des femmes. L'auteur examine quelques exemples de cadres théoriques alternatifs. En conclusion, elle suggère différentes stratégies d'amélioration des données, d'infléchissement des politiques et d'élargissement de la recherche, afin que l'on comprenne mieux l'impact des inégalités sexuelles et socio-économiques sur la santé des femmes.

Mots-clés : *Égalité des sexes, Inégalités socioéconomiques, Santé des femmes, Développement international, Politique.*

1. Introduction

Gender equity and socioeconomic inequality represent two different paradigms for understanding women's health and well-being. They often draw their sources from different disciplines: gender equity from the law, political sciences, development economics and the humanities; and socio-

economic inequality from economics, sociology, epidemiology and public health.

This paper develops a unified model that brings gender equity and socioeconomic inequality together in a common framework. A comprehensive framework should improve our understanding of the social and economic patterning of women's health outcomes and offer new directions for research, interventions, and policy. A criterion for a unified approach is that it should be relevant to women across cultures and nations, while allowing for country-to-country and culturally-specific fine-tuning. The advantage is that researchers can learn something from the gender equity approaches developed particularly for women in less industrialized southern countries, while northern researchers can contribute insights from research on socioeconomic inequalities in health among higher income nations.

2. Socioeconomic inequality

Despite unprecedented prosperity in the US, the tentative extension of democratization to many countries worldwide, and rapid economic development of some countries, the gaps in income between the poorest and the richest individuals and countries continue to widen (Smeeding and Gottschalk, 1995). In 1960, 20% of the world's people had 30 times the income of the poorest 20%. In 1997, the figure was 74 times as much (UNDP, 1999). Countries such as Russia, China, Indonesia, and Thailand that had achieved more equitable income distribution prior to the early 1980s have seen a marked growth in income inequality along with their emerging market economies (UNDP, 1999). The UK, US, and Sweden also experienced rapid growth in income inequality in the 1980s and 1990s. Among industrialized nations, Sweden moved from having one of the most equal income distributions to being one of the most unequal. During the 1980s and early 1990s there continued to be large earnings inequalities between men and women in the Western industrialized nations (Gottschalk and Smeeding, 1997).

The growth of income inequality has been accompanied, in European countries and the US, by an increase in the number of families living in poverty, which grew during the 1980s by 60% in the UK, and by nearly 40% in the Netherlands. In Australia, the UK, the US, and Canada, more than half of single-parent households with children have incomes

below the poverty level; in the vast majority of cases, these single parents are women (UNDP, 1999).

Worldwide, the number of people living on less than \$1 a day is increasing and was projected to reach 1.5 billion by the end of 1999 as a result of the economic crisis in Asia and its aftermath. It is now acknowledged that the international lenders' structural adjustment policies of the 1980s contributed to worsening hardship and inequality among debtor nations (Lewis, 1999; Science and Technology, 1995; Dahlgren, 1990). Because structural adjustment usually imposed user fees on health services, schools, and transportation, among other services, the burden often fell disproportionately on women. As the World Bank's policies have been forced to change, gender equity has become a cornerstone of the Bank's recent anti-poverty strategy (World Bank, 2000).

Impoverishment in southern nations and unequal development in industrialized countries contrasts, according to the UNDP (1999, p. 37), with "the staggering concentration of wealth among the ultra-rich" and with an increasing fascination with celebrity culture, money and greed among the high income nations (Rich, 1999; Frank, 1999). It is against this background that we turn to a discussion of gender equity and its intersection with socioeconomic inequality as they affect women's health.

3. Gender equity

In contrast to the dismal picture of international trends in income inequality in the 1990s, the adoption of a gender perspective in health and development research and programs and new legal frameworks for protecting women's rights were major advances of the past decade. The Platform for Action of the Fourth World Conference on Women in Beijing (1995) emphasized a wholistic and life-cycle approach to women's health. In addition to tackling the problems caused by harmful social and economic policies, the Platform targets the discrimination and gender inequalities that underlie women's health. The foundations for the Beijing Platform were laid at the International Conference on Population and Development that took place in Cairo in September, 1994, addressing women's right to control all aspects of their health and affirming the equality of the relationship between women and men in sexual relations and reproduction (UNFPA, 1999). The Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) provides a

legal framework for the promotion of gender equity in health and reproduction, as well as in social and economic life (Sullivan, 1995). As of 1999, virtually all nations had ratified CEDAW, the major exceptions being Afghanistan and the United States (UNDP, 1999).

Gender equity and economic structures are closely linked. Gender equity has been promoted by the international development organizations (e.g., the World Bank) because it is positively associated with lower fertility and better health for women and children as well as with economic development (Barrett, 1995; Razavi, 1997; World Bank, 1998). A literature with theoretical origins in neo-classical economics has focused especially on male-female equity in intrahousehold decision-making and allocation of resources, and on the economic and social benefits of education for girls and women as a form of human capital investment (World Bank, 1994).

In this approach, intra-household processes involving the exchange of resources among men and women are assumed to affect nutrition, reproductive decision-making and health (Dollar and Gatti, 1999). It singles out the balance of power, fairness and justice of gender relationships, as an analytic criterion on a par with social and economic equity. But gender equity and socioeconomic equality are not synonymous. UN data suggest that gender equity is somewhat independent of economic inequality, at least at the country level (UNDP, 1999).¹

4. Socioeconomic inequalities and health

One reason for the recent interest in socioeconomic determinants of women's health is the recognition that the two decades between 1973

1. The United Nations uses two indices to capture gender related development and gender empowerment, the Gender Development Index (GDI) and the Gender Empowerment Measure (GEM) (UNDP, 1999, p. 160-162). The GDI measures results for 143 countries in three key indicators of human development: life expectancy, educational attainment, and income, and adjusts those results for gender inequality. For every country, the GDI is lower than the UN's Human Development Index [HDI], showing that gender inequality is universal. But in some cases, the GDI ranks higher than the HDI, suggesting that gender equality does not depend upon a country's income level or stage of development. There are developing countries that do better than richer industrialized nations in promoting women's participation in political and professional activities, as measured by the GEM (UNDP, 1999, p. 133). There are also differences among regions within countries.

and 1993 were a period of striking growth in income and wealth inequality in the U.S. and other developed nations (Karoly, 1996; Wolff, 1995), paralleled by increasing socioeconomic disparities in health. The increases in income inequality are attributable to a number of causes, including increases in differential wage rates for more and less skilled workers, devolution of publicly funded social services or "structural adjustment," tax policies favoring the rich, and the decline of labor unions. The increased proportion of female-headed households and the concentration of females' earnings gains in higher-income households also contributed to overall inequality (Karoly and Burtless, 1995). A number of recent studies in the US and in Europe have shown that growing income and wealth inequality is associated with widening differentials in mortality (although estimates of the impact on women have varied) (Wilkinson, 1996). A widely-cited study found that from 1960 to 1986 the death rates in the US for blacks and whites and for men and women showed an overall decline, but the difference in mortality rates between those in higher and lower income and education categories actually increased. By 1986 there was actually a greater disparity between mortality rates of women in the higher and lower educational categories than there had been in 1960 (Pappas *et al.*, 1993).

At the aggregate level, there is a relationship between how income is distributed in the population (percent of income going to a particular segment of the population) and life expectancy, such that countries or regions where a larger share of income goes to the less well-off have higher life expectancy than countries or regions where income distribution is skewed to the better-off. Countries with a more equitable income distribution (such as Japan) enjoy higher life expectancy. The fact that it may be relative rather than absolute aspects of income that affect people suggests a strong psychosocial component (Wilkinson, 1992; Haan *et al.*, 1989). In other words, it may not be occupation and its rewards, per se, that determine health, but job characteristics (e.g., job strain- low control, high demands), limited psychological and social resources, perceived hostility and discrimination, lifestyle "incongruity", and related frustration. The literature is well-summarized in Krieger *et al.* (1993) and Wilkinson (1996). In formerly Communist states such as Russia, Czechoslovakia, and Hungary, social disintegration and dramatic income polarity have led to decreased life expectancy, more so for men than for women (UNDP, 1999, p. 79, 85).

Significantly, the association of societal and state level income inequality with mortality appears to be independent of the proportion of the population engaged in risk behaviors such as smoking, and of access to health services. In other words, something in the nature of inequality itself appears responsible for socioeconomic differences in mortality patterns (Wilkinson, 1996; Kennedy *et al.*, 1996; Kaplan *et al.*, 1996). Despite the burgeoning literature examining how gender roles interact with socioeconomic position, the extent to which societal patterns of gender equity condition the impact of economic inequality on women's (or men's) health is unknown.

5. Social capital as a bridge among inequity, inequality, and health

Recognizing how inequality and disparities among gender and income (as well as ethnic) groups create a burden of psychosocial, functional, and health risks, brings us to the threads of human life that create and support well-being. These threads, woven into a cloth that we call social capital, include kin and community ties and social networks (Wilkinson, 1996; Coleman, 1988). As defined by Coleman (1988), social capital is a resource inherent in the relationship among people or among organizations. Mark Granovetter, an American sociologist, wrote:

“...the analysis of processes in interpersonal networks provides the most fruitful micro-macro bridge. In one way or another, it is through these networks that small-scale interaction becomes translated into large-scale patterns, and that these, in turn, feed back into small groups.” (Granovetter, 1973, p. 1360).

It is through interpersonal and inter-group behaviors, and the extent to which they augment or diminish personal resources and well-being, that macro-level events may have their effects at the individual level (Kawachi, 1999; Kawachi *et al.*, 1999). Social capital refers to the resources people experience in their everyday interactions, and thus helps to connect the quality and experience of everyday life with the more abstract experience of aggregate events. Women's interpretation, judgment and experience of events differ from men's (Gilligan, 1982); their experience of the “micro-macro bridge” may differ also.

6. A comprehensive model of socioeconomic inequalities and gender equity

Epidemiologists and demographers have only recently begun to consider the processes within households and in women's daily lives that may actually shape their health, or the health of men. Conversely, development economists, researchers and advocates concerned with gender equity are often focused on intra-household processes or women's status in the community, but may pay less attention to socioeconomic inequality as one of the driving engines that ends in women's disadvantage (Schultz, 1997). The World Bank's prioritization of global poverty reduction has been motivated partly by the drastic effects of the structural adjustment policies of the 1980s (World Bank, 2000). While attention to household and community may provide effective guidance for planning programs and services for women, it is by stepping back to the geopolitical context that we can most effectively create and target policies that diminish gender inequality and promote health (Östlin *et al.*, 2001). Ideologies of power, economic reward and exchange, and gender roles and relations are expressed through macro- and micro-level institutions and behaviors. Recent research has demonstrated how variations in economic and social policy contribute to household decisions, role patterns, and health (Khat *et al.*, 2000; Lahelma *et al.*, this volume).

Explicating how socioeconomic and gender inequality affect women's health demands a comprehensive model that encompasses the multiple ways in which women's health is shaped. Figure 1 presents a framework for this integrated, comprehensive approach. It takes into account the historical, geographical, legal, and political frameworks that provide the overarching context in which men and women live. It includes the cultural and normative dimension that has a profound effect on individual behaviors, and demographic characteristics such as race, place of birth, education, marital status and age. At a level more proximate to health, the focus is the household, the locale for the exchange of the resources that are basic to life, sex, food, warmth, and emotional sustenance. Women's roles in reproduction and production are simultaneously determined by what occurs within the household and community, and also help to shape them. Related, but not identical, are the psychosocial aspects of life: stress, coping strategies, including spirituality, and, more biologically rooted, mood, and other psychological characteristics. Women's roles in family and social networks determine the extent to

Figure 1
A comprehensive framework of factors influencing women's health

Geopolitical environment	Culture, norms, sanctions	Women's roles in reproduction and production	Health-related mediators	Health outcomes
<p>Geography</p> <p>Policy and Services Transportation Welfare Employment Health care Child care</p> <p>Legal rights Women's Health Human Employment</p> <p>Organizations Banks Credit coops Political parties Advocacy Unions</p> <p>Economic: Policy Extent of inequality</p>	<p>Discrimination: Ethnic Gender Age</p> <p>Sociodemographic characteristics: Age Gender Ethnicity Birthplace Education Marital status Language</p>	<p>Household: Structure Division of labor Ownership/property Support/caretaking Equality of access to household resources, e.g.: Wages Other income Land Other assets Community roles Labor market role</p> <p>Workplace: Sector: Formal Home/market-based Hierarchies, control, Authority, discretion Sex segregation/discrimination</p>	<p>Social capital/Social networks/Support: Friendship Family Work mates Other ties</p> <p>Psychosocial: Stress Mood Coping Spirituality</p> <p>Health services Availability/use</p> <p>Behaviors Sexual Substance use Physical activity Diet Contraception Breastfeeding Smoking, drinking</p> <p>Violence</p>	<p>Chronic disease Infectious disease Disability Functioning Mortality Mental health/illness</p>

which they have access to “social capital.” Life stage and cohort experience, while difficult to show on this two dimensional framework, provide the dynamics shaping women’s health. Finally, and most proximate to health outcomes are the biological endowments of individual women. While part of this biological endowment is genetically determined, a large part is not, and is shaped through a process of foetal experience and exposures in infancy and early childhood, as well as in adult and later years. A woman’s biological characteristics and inheritance, together with institutional, social, and psychological processes, affect her subsequent health and well-being. Like others (Link and Phelan, 1995; Williams, 1997; Wil-

liams and Collins, 1995), I argue that there are fundamental causes of health differences among women, and that they are rooted in the economic, political, historical, and social arrangements that structure how women live.

7. Geopolitical environment

The geopolitical environment includes the economic, political and social structures, as well as characteristics of the actual physical environment in which people live. It is here that ideologies find their expression in institutional structures including laws and policies. Welfare, health, child care, and labor policies and laws have a particular impact on women (Östlin *et al.*, 2001). Environmental quality and regulation are also important, because they determine the degree of cleanliness or pollution to which people are exposed, and the protections to which they are entitled. The legal framework may include laws that protect women's rights in different spheres and that do or do not give women equal protection under the law. The ratification of CEDAW provides a fundamental marker for the support of women's legal rights among nations. However, legislation concerning rights may offer necessary but not sufficient institutional protection for women and may even be inimical to it by encouraging complacency or siphoning programmatic resources into legal, but less interventionist directions (Sharma, 1995; Plata and Calderon, 1995; Scheper-Hughes, 1996). Women's reproductive and health rights are a special kind of rights that have immediate and direct impact upon health. In the geopolitical environment are formal organizations that provide vehicles for women's empowerment or women's oppression. These might include labor and trades unions, or women's welfare unions, microcredit organizations and grameen banks, or other vehicles for collectivized resources, but they might also include organizations opposed to women's reproductive and household rights.

The geopolitical environment includes the degree of economic equality or inequality measured at an aggregate level, such as a city, state, province or nation. Included are social and economic policies such as retrenchment and structural adjustment. These affect health services, transportation, and other publicly funded services through the imposition of user fees, in ways that may pose differential burdens for women, depending upon their resources. Finally, in this area, we should include such

expressions of ideology as sexism, racism and ageism, all of which both contribute to laws and policies and result from them (Krieger *et al.*, 1993).

8. Culture, religion, norms, and sanctions

Culture, religion, norms and sanctions are closely related to but not identical with the legal and institutional structures that regulate peoples' lives. Hammel (1990) proposed a "theory of culture for demography" that moves far beyond the "culture as identifier" approach used by most epidemiologists and demographers. His key idea is that:

"Explanations of individual-level demographic (or any other) social behavior must be situated at a microlevel that not only reflects immediately relevant economic and ecological considerations and overarching social institutions, but also includes especially the identity of significant co-actors in a social network." (p. 45)

He continues:

"Culture is an evaluative conversation constructed by actors out of the raw materials afforded by tradition and ongoing experience. It is continually modified by them in processes of social interaction, and their behavior is guided by anticipation of such cultural evaluation." (p. 45)

Culture provides the explanations and guidelines for individual behavior (including reproductive and health-related behaviors) but it is collectively and socially constituted within a framework of economic and social institutions. A thoughtful consideration of culture moves us beyond the language of the dominant institutions into the understandings that women themselves have about their health-related behaviors, and into a more rounded consideration of the ways in which equity and power are expressed in every day life (Bledsoe *et al.*, 1994; Watkins *et al.*, 1992). The interplay of culture, institutional hegemony, and deprivation often forces women to make choices that appear self-defeating (Scheper-Hughes, 1992). Cultural preferences, including religious norms, help to explain variations in gender inequality (Dollar and Gatti, 1999).

9. Women's roles in reproduction and production

Women's roles in reproduction and production are framed at the household level. It is in the household that intimate relations are struc-

tured and issues of the allocation of resources between sexual partners and between generations are organized and expressed. Important issues to consider are: women's role in the formal labor market or the informal sector such as market and home-based work, and how work roles are integrated with household labor (Nathanson, 1980; Arber, 1991); the division of labor within the household; and other family and household members for whom the woman may be responsible (Matthews and Power, this volume). Closely related, but conceptually distinct, is the intra-household allocation of material, informational and psychosocial resources, in other words, the pattern of exchange in the household. Here, too, relationships of power, control, authority and equity may be played out with varying consequences for women's health (Nanda, 2000). Another dimension, for many women, of their responsibilities, is care, nurturance, and support of household members (in many cases, this caring and nurturing is extended beyond the physical confines of the household, within the kin or social network, and should be taken into account). Support and caretaking are a double-edged sword. The provision of support and care may be emotionally satisfying and may also provide some future social credit or capital for the woman's own needs that she can draw upon from children, siblings, or friends. At the same time, supporting and caretaking can be tremendously draining. Many women experience the "double" or even the "triple" day (Hochschild, 1997b).

Simply providing more schooling for women is not sufficient to reduce the gender inequality in control of resources within the household. Schultz (1997) estimated income inequality in the world from 1960 to 1994 at three levels of aggregation: countries, households within countries, and between women and men within households. He found that despite women's gains in education there is persistent unequal control of resources in the household.

Also, within the household, women are producers of human capital. In rearing their young they produce human capital through the promotion of their own and their children's health, nutrition, child care, and the teaching of language and other skills that have labor market value, and gender preferences are expressed through these activities, also (Sen, 1984; Thomas, 1990). They also contribute to human capital by the feeding and caretaking of partners and other working members of the household. Depending on other resources and constraints on women, these activities may have positive or negative effects on health.

The way in which women share in community activities is often interwoven with their household tasks (Barrett, 1995). In western industrialized countries this may include volunteer activities in children's schools, involvement in local political campaigns, or involvement in children's recreational sports. In non-industrialized nations it may include household maintenance chores performed in public or communal settings such as washing clothes, drawing water, or shopping for food, as well as the participation in local market organizations. Increasingly, women are playing roles in non-governmental organizations in their communities and integrating these roles with household labour. Women's credit co-operatives alter the relationship between market and reproductive roles and diminish the impact of socioeconomic inequality on the organization of women's lives (Brill and Kobre, 1999). These bridging roles are crucial to the formation of social capital (Kawachi, 1999; Kawachi *et al.*, 1999). The household is the most intimate setting for the playing out of dramas of power, authority and control, all of which may affect women in a number of ways. Male partners, and sometimes in-laws, may control women's access to children, food, money, health services, and even life itself. The expression of violence, a product of cultural, socioeconomic and power relations, towards women is a direct and indirect risk to women's health. Violence towards women is associated with higher rates of sexually transmitted disease, including HIV/AIDS, and adverse birth outcomes (Jaspard and Saurel-Cubizolles, this volume; Gielen *et al.*, 1994). Violence towards women takes a large toll on women's psychological health, as well as on the health and well being of children in the household. There is evidence, too, that intra-household and community violence against women is an expression of socioeconomic inequality at the interpersonal level (Ocampo *et al.*, 1995).

The workplace, too, provides a setting for dramas of control, authority, and relative power, much of which is gender-based (Wolf and Fligstein, 1979; McGuire and Reskin, 1993). The decline of the power of labour and trades unions, combined with the increase in contract and temporary labour, have diminished the status and rights of individual workers, many of whom are now isolated in space (as home workers) or in time, as employment tenure shortens. In California, until the 1960s, thousands of Mexican-origin women found employment in fruit and vegetable canneries. Despite the often poor working conditions, cannery culture promoted close ties among women workers that often spilled into the organization and maintenance of the household, and the work had

seasonal predictability that allowed women to integrate home chores with wage labour (Zavella, 1987; Ruiz, 1987). More recently, immigrant women have found employment as domestic servants, janitors, or low-wage workers in electronics and garment industries, work that is often isolating and demeaning, and offers no opportunity for advancement (Segura, 1989). Globalization and the proliferation of free trade zones have led to the proliferation of workplaces where “discretion” and “job control” are non-existent. Women’s occupational as well as household roles, separately and together, relate to their physical and mental health and to their mortality risks (Smith and Waitzman, 1994).

10. Health-related mediators

The way in which resources such as money, food, and emotional warmth are exchanged in the household influences psychosocial health, nutritional well-being, access to health services, and the expression of violence. Resource exchange mediates the effects of geopolitical, cultural, and household patterns of equity and inequality on health status and outcomes. Health-related mediators of inequality and equity include health behaviours; access to and use of health services; stressors; and psychosocial resources and strategies including social ties, coping and spirituality.

Health behaviours include eating patterns, use of tobacco, alcohol and other mood-altering substances, and exercise and physical activity, by others in the household as well as by women themselves. Other behaviours that affect women’s health include contraception, breast-feeding and the use of different forms of prescription and over-the-counter medications, and the growing use of therapies such as homeopathy and meditation in Western industrialized nations. Although these are often viewed and “treated” as individually determined, they are almost always the result of a complex pattern of causes including marketing, pricing, and social and cultural meaning (Graham, 1994). One of the most fascinating phenomena in epidemiology is how behaviors become more or less accepted by women. For example, smoking rates among women vary with social class in ways that are culturally and nationally quite specific. As better educated women (and men) in the US have rejected smoking as unhealthy (e.g., National Center for Health Statistics, 1998), cigarette companies have aggressively turned their marketing efforts towards adolescents, especially females, and to populations in newly emergent market

nations such as China, which had, until recently, quite low rates of cigarette smoking.

Access to health services is differentially available to women depending upon their geographic location, insurance status or ability to pay, their ease in handling the bureaucratic and authoritarian structure of health care delivery, the presence of traditional or non-bureaucratic providers of care, and the extent to which families support women's access to and use of services (Weisman, 1998). Once within the health care system, women may experience differential diagnosis or treatment depending upon their status, social power, and socioeconomic standing, as well as upon racial, ethnic, linguistic or cultural background (Clancy, 2000).

Stress, and stressful life events, are related to a number of disorders, both psychological and physical, among women (Hogue, 2000; Williams and Umberson, 2000). Effective coping strategies such as support from social networks, and spirituality, can reduce stress, promote physical and mental well-being, and improve health. A woman's role in formal and informal labor markets, her position in a kin network and household, and her marital and parental status, shape the number and extent of her social ties. The "family" may come to be workmates with whom a woman spends much of her day (Hochschild, 1997a). The effect of social ties and support networks on women's health depends on a variety of demographic and environmental factors such as age, occupational position and role including discretion and control on the job, whether she lives in an urban or rural setting, and genetic resilience.

One coping strategy, spirituality, is helpful to women in two ways. By promoting internal resources (coping) women are able to come to terms with personal and social hardship, and obtain a feeling of well-being and calm. Spirituality as expressed through church, mosque, or synagogue attendance or participation in prayer or meditation groups, provides a form of social capital, extending an individual's caring networks, that may be protective and assist in difficult times (Jarvis and Northcott, 1987; Levin and Vanderpool, 1989; Miller, 1995).²

In virtually all societies, powerful market forces, often globalized, shape women's behaviours and expectations through the manipulation of cultural symbols and their commodification. Market forces reinforce existing socioeconomic patterns of women's psychosocial response by play-

2. This is quite different from organized religions as legal or political state-sanctioned authorities, which have often been associated with the oppression of women.

ing on the importance of children and partners. Qualitative research conducted by Hilary Graham in the UK suggests that women's choice among commodified coping mechanisms (e.g., smoking and certain foods) is socioeconomically determined (Graham, 1994). Class-based strategies sell products that demonstrate rank (designer handbags); reduce stress (food, tobacco); or assist in coping (cosmetics, "labour-saving" devices.)

Mood, personality disorders, depression and anxiety are mediators of other health outcomes and mental health endpoints in themselves; their incidence varies by age, class and ethnicity. Depression and other adverse psychological states place women at risk of violence, including sexual assault, and, via the immune system, may lead to increased incidence of chronic and infectious disease (McDonough *et al.*, this volume). We are only beginning to understand how the natural hormonal fluctuation over the life course affects women's mood, health and well being, independently, and jointly with other mediators, such as diet and physical activity (Seeman, 2000). Complicating the picture is evidence that perceptions of hormonal variations, such as the symptoms of menopause, may be culturally determined (Sowers, 2000, Chapt. 92).

11. Health outcomes

Many health outcomes, including disability, perceived health status, and the presence or absence of disease and mortality risk, are shaped by a complex process of environmental, social, behavioral, psychosocial, and genetic events. Socioeconomic factors, including education, poverty, income, income inequality, and occupation, are some of the strongest and most consistent predictors of health and mortality. Gender (in)equity, combined with socioeconomic inequality, together form a powerful explanatory framework for variations in women's health. We have seen how the geopolitical environment, with its legal, political, and economic institutions, in turn contributes to patterns of inequality in the household, where the more proximal actions that affect health often take place. Psychosocial resources, whether positive, such as social networks and systems of support, or negative, such as stress and its physiological expression, also mediate expressions of inequality. Recent research is examining the extent to which repeated hardship, or "allostatic load," car-

ried by some individuals may depress the immune system and contribute to disease (e.g., Seeman *et al.*, 1997).

12. A life course perspective

Health is the result of a complex interplay of biological, including genetic, demographic, socioeconomic, psychosocial and behavioral factors. Much of the research on women's health is based upon a snapshot of a small part of this complexity. A dynamic perspective that takes account of intergenerational, foetal, childhood, and adolescent precursors to adult health, as well as of cohort experiences, will deepen our understanding of the social and economic patterning of women's health. This is often constrained by the absence of longitudinal data sets that include socioeconomic and health variables, with some exceptions (e.g., Power *et al.*, 1998; Matthews and Power, this volume). In the US, the Health and Retirement Survey and the AHEAD Survey are filling in our picture of socioeconomic-health relationship for older men and women of different ethnic groups. In the UK, the British birth cohort studies (e.g., Wadsworth and Kuh, 1997; Matthews and Power, this volume) allow researchers to test causal hypotheses about health trajectories of men and women over time.

13. Examples of integrated social and economic frameworks of women's health

Several researchers in the English-speaking world have attempted to develop theoretical approaches to women's health that integrate inequality in social and economic position with women's roles in production and reproduction. I present examples from the US-UK literature, but their theoretical implications are applicable cross-culturally and cross-nationally.

The "weathering" hypothesis, or analytic framework, proposes that women age in different ways depending upon how varying life circumstances undermine or promote health, and that women's health and mortality experience reflects a cumulation or cascade of advantages and disadvantages (Geronimus, 1992). The strength of this approach is that it unites lifespan and environmental factors and is applicable to many aspects of women's health. The theory helps to explain ethnic as well as socioeconomic differences in the development of chronic conditions

since women of different ethnic backgrounds “weather” or age at different rates, and it encompasses age-based trajectories of behaviors such as smoking, as well as environmental exposures and access to health services. The weathering framework also helps to explain the intergenerational transmission of the link between SES and health, by connecting physical manifestations of accelerated aging such as hypertension to infant’s and children’s health (Geronimus *et al.*, 1991; Geronimus and Hillemeier, 1992). The weathering hypothesis emphasizes how the chronic burdens of everyday deprivation and environmental exposures affect health and how age-related patterns of childbearing and caretaking are responses to perceived vulnerability.

The analytic framework that integrates women’s roles in the household (and the consumption patterns that follow from these roles) with structural measures such as occupational class and other socioeconomic indicators, inherently captures aspects of equity and equality (Arber, 1991; Khat *et al.*, 2000; Walters *et al.*, this volume). This approach is particularly useful for capturing socioeconomic factors in women’s lives, since paid employment is both a potential stressor (when added to child care and marital roles) and also an indicator of potential material and social resources. It takes account of the differing day-to-day realities of men’s and women’s lives within a socioeconomic framework. Consumption measures, such as housing tenure and car ownership, have been shown to be equally or more revealing of a woman’s class position than occupation, perhaps because they are resources that make a difference in women’s everyday lives. The interaction effects of work and home roles differ depending on gender and household configuration and several studies have found that lone mothers are particularly disadvantaged with regard to physical and mental health (Arber and Cooper, 2000; Lahelma *et al.*, this volume). The socioeconomic factors as well as the family and occupational roles that influence health in women may be different from the factors that influence health in men. Women are more likely to experience role strain and overload that occur when familial responsibilities are combined with occupation-related stress. These are compounded (or alleviated) by material circumstances. For men, occupational class and employment status explain more of the variation in health than do familial roles and responsibilities (Arber, 1991). In southern countries, similarly complex relationships occur among gender, family, and labor market role variables, although effects may be in different directions. For example, working does not always enhance women’s control over resources. The

roles played by consumption variables, culture and level of development differ. In one Indian study, possession of a pressure cooker freed women's time, but the presence of a sewing machine increased servitude within the household (Nanda, 2000).

In the UK, Hilary Graham uses a combination of qualitative and quantitative methods and data drawn from a variety of sources to examine how women, especially women with children, make different kinds of decisions about health-related behaviors (Graham, 1984; Graham, 1994). She looks at how the interplay of economic circumstances and household structure influence individual family members. Both social class and gender structure the organization of family life and it is in family life (for the most part) where health is produced. Graham writes:

"Assumptions about the needs and obligations of men and women play a primary role in shaping the distribution of resources *within* families... However, their effects are not restricted to the domestic domain. In the labour market, too, there are sex differences in employment and earnings. With the increasing numbers of female-headed families, these differences have become an important factors in fueling inequalities *between* families.

"The patterns of resource allocation within and between families are seen to reflect a structure of sexual divisions as deep-rooted and pervasive as the class divisions traditionally associated with Western societies. This structure is linked to family health in obvious and important ways...

"...[T]he theme of justice, power, and fairness, in how social environments and life chances are structured and how roles are allocated within social institutions, including the workplace, the household, and the family, lies just below the surface... [S]ocioeconomic circumstances, in combination with culturally appropriated women's roles, produce differing patterns of health, disability, and mortality." (Graham, 1984, p. 58-59)

Graham's work explores how the arrangement of space, the preparation and distribution of food, and the provision of heating relates to gender relations within the household, given the impact of socioeconomic relations or social class on household resources. Because of the symbolic significance of food, when resources are short women often accommodate first to children's and men's needs, putting their own nutrition last, a pattern that is found in a number of cultures.

HIV/AIDS provides, perhaps, the most vivid example of how women's lack of power within and outside of the household, and the forces of social and economic inequality and marginalization, lead to disease, social disintegration, and death. The burden is especially great on the most vulnerable women in the most vulnerable economies (often, but

not exclusively, southern). It is in HIV/AIDS that the geopolitical and historical vividly transect socioeconomic and gender relations. A paper by Bassett and Mhloyi (1991) provides a dramatic illustration of how these processes occur in Zimbabwe. The paper's underlying theoretical premise, that a historical, geographically-specific legacy of economic and gender relations poses epidemiologic vulnerability for women, is universally true. Other examples include: son preference (for example, in India and China) resulting in female infanticide (Östlin *et al.*, 2001), and female genital mutilation.

14. Operationalizing a multi-level framework

Introducing historical, policy- and institutional-level constructs into empirical studies of health mediators and outcomes is not an easy task, theoretically or statistically (Diez-Roux, 1998; Von Korff *et al.*, 1992). Much, if not most, of the research in women's health has been focused on the right-hand end of the framework shown in Figure 1, with demographic characteristics used as "control" variables. On the other hand, there is a very long tradition in public health and in the social sciences that recognizes the importance of the environment to individual behavior and health, as well as the difficulty in estimating it (Mason *et al.*, 1983; Wong and Mason, 1991). Our task as researchers on women's health is to move towards the left-hand side of Figure 1, carefully defining what we mean by "environment," making certain that it is appropriately measured, and choosing the correct statistical techniques for our models (Wiggins *et al.*, this volume). In Figure 1, geopolitical environment, culture and norms refer to aspects of the environment that cannot be measured by aggregating individual-level data. Aggregate data *are* important in characterizing group-level phenomena such as the portion of women in a community engaged in employment out of the household, or the role of social networks and social capital (e.g., Kawachi *et al.*, 1999). While many environmental characteristics are measurable, others are not and may be unobserved or unmeasured (e.g., norms or perceived social and economic opportunities) but are an important part of causal thinking (Brewster, 1994). But we also need to include the more "macro" or geopolitical factors in our models. Particular care is needed when taking a cross-national or comparative approach because some constructs, such as "ethnicity", "household" or even marriage, are not really comparable

across societies (Wong and Mason, 1991). An example of a cross-national multi-level analysis of an issue integral to women's health is provided by Mason and Smith (2000). They use data from communities in Pakistan, India, Malaysia, Thailand and the Philippines that have different gender traditions to explore how gender context in different types of communities in each country influences the joint goals of husbands and wives in desire for children, and their use of contraceptives.

15. What can be done to improve understanding of the social and economic patterning of women's health?

Elite research institutions and international governmental and non-governmental organizations have rushed during the past 15 years to make gender a focus of research, policy and program activity. Gender equity is viewed as a cornerstone of economic development. Policy initiatives have made primary school for girls nearly universal during the past decade, an investment that results in lower fertility, lower infant mortality, and better nutrition and health practices in the household. Reproductive health services for women have proliferated, and there is increased interest in the health and well being of the growing elderly segment of the population which is predominantly women. I propose a variety of ways that we can continue to make progress in research and policymaking as they promote gender and socioeconomic equity and women's health.

(a) *Put pressure on the leading research and development organizations to develop integrated approaches to women's health*, using frameworks, like the one developed for this paper, that consider jointly gender equity and socioeconomic inequality, and that situate health in specific historical, political, legal and social contexts. Research and programs that do this are in the minority. More typically, researchers use sex and socioeconomic status as control variables, and clinicians persist in developing programs or treatment regimens that focus on one limited aspect of women's health or behaviors. Disciplinary boundaries reinforce the difficulties of integrating social, economic, and epidemiological approaches to women's health. Strategies such as conferences and research initiatives that challenge the boundaries will provide a substantial contribution to our understanding of the patterning of women's health.

(b) *Domestic and international funders should continue to support research initiatives* that encourage detailed and sophisticated tests of a variety of hy-

potheses about the social and economic patterning of women's health. The framework presented in this paper can guide studies that examine how gender equity and socioeconomic inequality jointly shape women's and men's health across the lifecourse. It demands a multilevel perspective, taking account of contextual and individual level variables. Comparative research will lead to a better understanding of how policies and culture shape socioeconomic and household structures and roles. Attention to the methodological issues posed by a multilevel approach to women's health, and the sharing of problems, techniques, and solutions across disciplinary and national boundaries, will deepen our understanding and improve policy and programmatic strategies.

(c) *Use ethnographic techniques to provide new insights.* Survey research and vital and disease registries are necessary but not sufficient. The insights that generate theory and advance testable, quantifiable hypotheses often come from detailed qualitative field work (e.g., Graham, 1984). The recent integration of ethnographic methods by demography and epidemiology has produced exciting insights, often about marginalized populations. Applying some of this research creativity to women in the mainstream may open new lines of inquiry.

(d) *Create and maintain appropriate data systems for monitoring and reporting on socioeconomic inequalities and gender equity,* both in themselves and as they affect women's health. Even in the affluent developed countries, such systems are far from perfect and they are often weak in poorer nations (Braveman, 1996). Vital and disease registries and periodic surveys such as the Demographic and Health Surveys (DHS) can inform communities and policy makers about problems and prospects in improving women's health. Through the MEASURE project, the DHS now includes questions on gender relations and empowerment and questionnaires are administered to men as well as to women.³ In order for the data to be meaningful, appropriate socioeconomic and equity measures must be included and it is critical that survey questions are formulated to take account of women's own perspectives and interpretations. Health and economic data should be longitudinal and integrated, and data sets should contain contextual legal, political, and health services variables at country, regional, and local levels. Supporting the data gathering, analytic and reporting capacity of nations is an important goal. United Nations statistics

3. Information about the Demographic and Health Surveys, including the MEASURE project, is available at <http://www.measuredhs.com>.

provide an example of how gender equity and economic equality can be monitored simultaneously at the country level, resulting in useful equity and empowerment indices that facilitate international comparisons (UNDP, 1999).

16. Why propose a unified framework of women's health?

Research is costly, but so is the failure to understand. It would be nearly impossible to test the entire model proposed in this paper. Yet, advances in our understanding of women's health have come through multi-disciplinary work that expands paradigms: an example is the burgeoning literature describing the physical and mental health effects of gender, labor market, and household roles. These studies take a large step forward in integrating gender equity (fairness in resource distribution) with socioeconomic position and rewards. Contextualizing studies in historical and geopolitical frameworks is a next big step, along with deepened exploration of how patterns may vary across different points in the lifecourse and for different birth cohorts. An advantage of this combined framework is its applicability to health outcomes across nations and cultures. It allows us to understand what in the patterning of women's health is universal and what is unique, and to develop humane and effective policies that promote equity, equality, and well-being.

Acknowledgements

The leadership of Sara Arber, Myriam Khlal, and CICRED in organizing the seminar on "Social and economic patterning of health among women" (Tunis, January 2000) is gratefully acknowledged, as are the insights, warmth and stimulation of colleagues who attended the meeting.

References

ARBER, S. (1991), "Class, paid employment and family roles: Making sense of structural disadvantage, gender and health status", *Social Science and Medicine*, vol. 32, p. 425-436.

- ARBER, S., and COOPER, H. (2000), "Gender and inequalities in health across the life course", in: E. Annandale and K. Hunt, eds., *Gender Inequalities in Health*, Buckingham, Open University Press, p. 123-149.
- BARRETT, H. (1995), "Women in Africa: The neglected dimension in development", *Geography*, vol. 80, p. 215-224.
- BASSETT, M. T., and MHLOYI, M. (1991), "Women and AIDS in Zimbabwe: The making of an epidemic", *International Journal of Health Services*, vol. 21, p. 143-156.
- BLEDSCOE, C. H., HILL, A. G., LANGEROCK, P., and D'ALESSANDRO, U. (1994), "Constructing natural fertility: The use of Western contraceptive technologies in rural Gambia", *Population and Development Review*, vol. 20, p. 81-113.
- BRAVEMAN, P. (1996), *Equity in Health and Health Care: A WHO SIDA Initiative*, World Health Organization, Geneva.
- BREWSTER, K. L. (1994), "Neighborhood context and the transition to sexual activity among young Black women", *Demography*, vol. 21, p. 603-614.
- BRILL, B., and KOBRE, K. (1999), "The power of small change", *San Francisco Examiner*, May 2-6. [Http://www.examiner.com/microloans](http://www.examiner.com/microloans).
- CLANCY, C. M. (2000), "Gender issues in women's health care", in: M. B. Goldman and M. C. Hatch, eds., *Women and Health*, San Diego, Academic Press, p. 50-54.
- COLEMAN, J. S. (1988), "Social capital in the creation of human capital", *American Journal of Sociology*, vol. 94, supplement, p. S95-S120.
- DAHLGREN, G. (1990), "Strategies for health financing in Kenya - The difficult birth of a new policy", *Scandinavian Journal of Social Medicine*, supplement 46, p. 67-81.
- DIEZ-ROUX, A. V. (1998), "Bringing context back into epidemiology: Variables and fallacies in multilevel analysis", *American Journal of Public Health*, vol. 88, p. 216-222.
- DOLLAR, D., and GATTI, R. (1999), "Gender inequality, income and growth: Are good times good for women?", World Bank, Development Economics Research Group, Poverty Reduction and Management Network, Working paper series, no. 1.
- FRANK, R. H. (1999), *Luxury Fever: Why Money Fails to Satisfy in an Era of Excess*, New York, The Free Press.
- GERONIMUS, A. T. (1992), "The weathering hypothesis and the health of African-American women and infants: Evidence and speculations", *Ethnicity and Disease*, vol. 2, p. 207-221.
- GERONIMUS, A. T., and HILLEMEIER, M. M. (1992), "Patterns of blood lead level in US Black and White women of childbearing age", *Ethnicity and Disease*, vol. 2, p. 222-231.
- GERONIMUS, A. T., ANDERSON, H. F., and BOUND, J. (1991), "Differences in hypertension prevalence among US Black and White women of childbearing age", *Public Health Reports*, vol. 106, p. 393-399.
- GIELEN, A., OCAMPO, P., FADEN, R., KASS, N., and XUE, N. (1994), "Determinants of interpersonal violence during the childbearing year", *Social Science and Medicine*, vol. 39, p. 781-787.
- GILLIGAN, C. (1982), *In a Different Voice: Psychological Theory and Women's Development*, Cambridge, MA, Harvard University Press.
- GOTTSCHALK, P., and SMEEDING, T. (1997), "Cross-national comparisons of earnings and income inequality", *Journal of Economic Literature*, vol. 35, no. 2, p. 633-687.
- GRAHAM, H. (1984), *Women, Health and the Family*, Brighton, Harvester Press/Wheatsheaf Books.
- GRAHAM, H. (1994), "Gender and class as dimensions of smoking behavior in Britain: Insights from a survey of mothers", *Social Science and Medicine*, vol. 38, p. 691-698.

- GRANOVETTER, M. S. (1973), "The strength of weak ties", *American Journal of Sociology*, vol. 78, p. 1360-1380.
- HAAN, M. N., KAPLAN, G. A., and SYME, S. L. (1989), "Socioeconomic status and health: Old observations and new thoughts", in: J. P. Bunker, D. Gomby, and B. H. Kehrer, eds., *Pathways to Health: The Role of Social Factors*, The Henry J. Kaiser Family Foundation, Menlo Park, CA, p. 76-135.
- HAMMEL, E. A. (1990), "A theory of culture for demography", *Population and Development Review*, vol. 16, p. 455-485.
- HOCHSCHILD ARLIE, R. (1997a), *The Time Bind: When Work Becomes Home and Home Becomes Work*, New York, Henry Holt and Co.
- HOCHSCHILD ARLIE, R. (1997b), *The Second Shift*, New York, Avon Books.
- HOGUE, C. J. R. (2000), "Gender, race and class: From epidemiologic association to etiologic hypotheses", in: M. B. Goldman and M. C. Hatch, eds., *Women and Health*, San Diego, Academic Press, p. 15-23.
- JARVIS, G. K., and NORTHCOTT, H. C. (1987), "Religion and differences in morbidity and mortality", *Social Science and Medicine*, vol. 25, p. 813-824.
- KAPLAN, G. A., PAMUK, E. R., LYNCH, J. W., COHEN, R. D., and BALFOUR, J. L. (1996), "Inequality in income and mortality in the United States: Analysis of mortality and potential pathways", *British Medical Journal*, vol. 312, p. 999-1005.
- KAROLY, L. A. (1996), "Anatomy of the US income distribution", *Oxford Review of Economic Policy*, vol. 12, p. 77-96.
- KAROLY, L. A., and BURTLESS, G. (1995), "Demographic change, rising earnings inequality, and the distribution of personal well-being, 1959-1989", *Demography*, vol. 32, p. 379-405.
- KAWACHI, I. (1999), "Social capital and community effects on population and individual health", *Annals of the New York Academy of Sciences*, no. 896, p. 120-130.
- KAWACHI, I., KENNEDY, B. P., and GLASS, R. (1999), "Social capital and self-rated health: A contextual analysis", *American Journal of Public Health*, vol. 89, p. 1187-1193.
- KENNEDY, B. P., KAWACHI, I., and PROTHROW-STITH, D. (1996), "Income distribution and mortality: Test of the Robin Hood Index in the United States", *British Medical Journal*, vol. 312, p. 1004-1007.
- KHLAT, M., SERMET, C., and LE PAPE, A. (2000), "Women's health in relation with their family and work roles: France in the early 1990s", *Social Science and Medicine*, vol. 50, p. 1807-1825.
- KRIEGER, N., ROWLEY, D. L., HERMAN, A. A., AVERY, B., and PHILLIPS, M. T. (1993), "Racism, sexism and social class: Implications for studies of health, disease, and well-being", *American Journal of Preventive Medicine*, vol. 9, p. 82-122.
- LEVIN, J. S., and VANDERPOOL, H. Y. (1989), "Is religion therapeutically significant in hypertension?", *Social Science and Medicine*, vol. 29, p. 69-78.
- LEWIS, P. (1999), "World Bank says poverty is increasing", *New York Times*, June 3, p. C1.
- LINK, B. G., and PHELAN, J. (1995), "Social conditions as fundamental causes of disease", *Journal of Health and Social Behavior*, extra issue, p. 80-94.
- MASON, K. O., and SMITH, H. L. (2000), "Husbands' versus wives' fertility goals and use of contraception: The influence of gender context in five Asian countries", *Demography*, vol. 37, p. 299-311.
- MASON, W. M., WONG, G. Y., and ENTWISLE, B. (1983), "Contextual analysis through the multilevel linear model", in: S. Leinhardt, ed., *Sociological Methodology 1983-1984*, San Francisco, Jossey-Bass, p. 72-103.

- MCGUIRE, G. M., and RESKIN, B. F. (1993), "Authority hierarchies at work: The impacts of race and sex", *Gender and Society*, vol. 7, p. 487-506.
- MILLER, M. A. (1995), "Culture, spirituality and women's health" [Review], *Journal of Obstetric, Gynecologic and Neonatal Nursing* vol. 24, p. 257-263.
- NANDA, A. K. (2000), "Socio-economic determinants of health among women: Some evidence from a poor society", Paper presented at the CICRED seminar on "Social and Economic Patterning of Health Among Women," January, Tunis.
- NATHANSON, C. (1980), "Social roles and health status among women: The significance of employment", *Social Science and Medicine*, vol. 14A, p. 463-471.
- NATIONAL CENTER FOR HEALTH STATISTICS (1998), *Health United States with Socioeconomic Status and Health Chartbook*, Hyattsville, Maryland.
- OCAMPO, P., GIELEN, A. C., and FADEN, R., (1995), "Violence by male partner against women during the childbearing year: A contextual analysis", *American Journal of Public Health*, vol. 85, p. 1092-1097.
- ÖSTLIN, P., SEN, G., and GEORGE, A. (2001), "Gender, health and equity", in: T. Evans, M. Whitehead, F. Diderichsen, and A. Bhuiya, eds., *Challenging Inequities in Health: From Ethics to Action*, Oxford, Oxford University Press, Ch. 13.
- PAPPAS, G., QUEEN, S., HADDEN, W., and FISHER, G. (1993), "The increasing disparity between socioeconomic groups in the United States, 1960 and 1986", *New England Journal of Medicine*, vol. 329, p. 103-109.
- PLATA, M. I., and CALDERON, M. C. (1995), "Legal services: Putting rights into action - Profamilia - Colombia", *The American University Law Review*, vol. 44, p. 1105-1111.
- POWER, C., MATTHEWS, S., and MANOR, O. (1998), "Inequalities in self-rated health: Explanations from different stages of life", *Lancet*, vol. 351, p. 1009-1014.
- RAZAVI, S. (1997), "Fitting gender into development institutions", *World Development*, vol. 25, p. 1111-1125.
- RICH, F. (1999), "Who doesn't want to be a millionaire?", *New York Times*, op-ed, November 20, p. A27.
- RUIZ, V. L. (1987), *Cannery Women, Cannery Lives. Mexican Women, Unionization and the California Food Processing Industry, 1930-1950*, Albuquerque, University of New Mexico Press.
- SCHEPER-HUGHES, N. (1992), *Death without Weeping: The Violence of Everyday Life in Brazil*, Berkeley, University of California Press.
- SCHEPER-HUGHES, N. (1996), "Small wars, invisible genocides", *Social Science and Medicine*, vol. 43, p. 889-899.
- SCHULTZ, T. P. (1997), "Inequality in the distribution of personal income in the world: How it is changing and why", Paper presented at the annual meeting of the Population Association of America, March 27-29, Washington, DC.
- SCIENCE AND TECHNOLOGY (1995), "Good intentions, road to hell? The World Bank's ideas for better health care in poor countries have not always worked out in practice", *The Economist*, October 7, p. 121-122.
- SEEMAN, M. V. (2000), "Mental illness in women", in: M. B. Goldman, and M. C. Hatch, eds., *Women and Health*, San Diego, Academic Press, p. 989-996.
- SEEMAN, T., SINGER, B., ROWE, J., HORWITZ, R., and MCEWEN, B. (1997), "Price of adaptation-allostatic load and its health consequences", *Archives of Internal Medicine*, vol. 157, p. 2259-2268.
- SEGURA, D. (1989), "Chicana and Mexican immigrant women at work: The impact of class, race, and gender on occupational mobility", *Gender and Society*, vol. 3, p. 37-52.

- SEN, A. (1984), "Family and food: Sex bias in poverty", in: A. Sen, ed., *Resources, Values and Development*, Cambridge, MA, Harvard University Press, Ch. 15.
- SHARMA, M. (1995), "What role can rights play in the work of international agencies?", *The American University Law Review*, vol. 44, p. 1097-1103.
- SMEEDING, T. M., and GOTTSCHALK, P. (1995), "The international evidence on income distribution in modern economies: Where do we stand?", Invited paper for: "Income distribution: Theory and evidence" session, International Economic Association World Congress, Tunis, December 1995. *Luxembourg Income Study Working Paper #137*, Maxwell School of Public Affairs, Syracuse University, Syracuse, NY.
- SMITH, K. R., and WAITZMAN, N. J. (1994), "Women, work, and whether occupation matters: Differences in mortality by occupation in the US, 1971-1987", Paper presented at the annual meeting of the Population Association of America, Miami, FL.
- SOWERS, M. F. (2000), "Menopause: Its epidemiology", in: M. B. Goldman and M. C. Hatch, eds., *Women and Health*, San Diego, Academic Press, p. 1155-1168.
- SULLIVAN, D. (1995), "Introduction. Conference on international protection of reproductive rights", *The American University Law Review*, vol. 44, p. 969-973.
- THOMAS, D. (1990), "Intra-household resource allocation: An inferential approach", *Journal of Human Resources*, vol. 25, p. 635-664.
- UNDP (United Nations Development Programme) (1999), *Human Development Report 1999*, New York, United Nations.
- UNFPA (United Nations Population Fund) (1999), *Women and Health: Mainstreaming the Gender Perspective into the Health Sector*, Report of the expert group meeting, 28 September-2 October, 1998, Tunis, United Nations, New York.
- VON KORFF, M., KOEPEL, T., CURRY, S., and DIEHR, P. (1992), "Multi-level analysis in epidemiological research on health behaviors and outcomes", *American Journal of Epidemiology*, vol. 135, p. 1077-1082.
- WADSWORTH, M. E. J., and KUH, D. J. L. (1997), "Childhood influences on adult health: A review of recent work from the British 1946 National Birth Cohort Study, the MRC National Survey of Health and Development", *Pediatric and Perinatal Epidemiology*, vol. 11, p. 2-20.
- WATKINS, S. C., GOLDSTEIN, A., and SPECTOR, A. R. (1992), "Family planning patterns among Jewish and Italian women in the United States, 1900-1940", Unpublished paper.
- WEISMAN, C. S. (1998), *Women's Health Care: Activist Traditions and Institutional Change*, Baltimore, Johns Hopkins University Press, Ch. 3.
- WILKINSON, R. G. (1992), "Income distribution and life expectancy", *British Medical Journal*, vol. 304, p. 165-168.
- WILKINSON, R. G. (1996), *Unhealthy Societies: The Afflictions of Inequality*, Routledge, London.
- WILLIAMS, D. R. (1997), "Race and health: Basic questions, emerging directions", *Annals of Epidemiology*, vol. 7, p. 322-333.
- WILLIAMS, D. R., and COLLINS, C. (1995), "US socioeconomic and racial differences in health: Patterns and explanations", *Annual Review of Sociology*, vol. 21, p. 349-386.
- WILLIAMS, K., and UMBERSON, D. (2000), "Women stress, and health", in: M. B. Goldman and M. C. Hatch, eds., *Women and Health*, San Diego, Academic Press, p. 553-562.
- WOLF, W. C., and FLIGSTEIN, N. (1979), "Sex and authority in the workplace: The causes of sexual inequality", *American Sociological Review*, vol. 44, p. 235-252.

- WOLFF, E. (1995), *Top Heavy: A Study of the Increasing Inequality of Wealth in America*, The Twentieth Century Fund Press, New York.
- WONG, G. Y., and MASON, W. M. (1991), "Contextually specific effects and other generalizations of the hierarchical linear model for comparative analysis", *Journal of the American Statistical Association*, vol. 86, p. 487-503.
- WORLD BANK (1994), *Population and Development: Implications for the World Bank*, Washington, DC (p. 75).
- WORLD BANK (1998), *Engendering Development: Enhancing Development through Attention to Gender*, Draft report and commentary.
- WORLD BANK (2000), *World Development Report 2000/1, Consultation Draft*, January.
- ZAVELLA, P. (1987), *Women's Work and Chicano Families: Cannery Workers of the Santa Clara Valley*, Ithaca, Cornell University Press.