INTRODUCTION*

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On January 20-22, 2000, the Committee for International Cooperation in National Research in Demography (CICRED) convened a seminar in Tunis on the "Social and Economic Patterning of Health among Women". Inequalities in women's health has been a neglected research topic both in developed and developing countries, and the seminar addressed both current substantive research and on theoretical and policy issues.

This volume assembles most of the contributions to this meeting, which was organized in collaboration with the National Office of Family and Population (ONFP) in Tunisia and with financial support from the United Nations Population Fund (UNFPA). Of the eighteen pa-

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pers, twelve have already been published together as a special issue of the periodical *Social Science and Medicine* (Volume 54, Number 5, March 2002), and each of the papers is included in this volume in its original language (3 in French, 15 in English). The contributions are international in scope, drawn from a range of countries, and multi-disciplinary in origin, including papers from geographers, sociologists, social psychologists, demographers and epidemiologists.

Until the late 1980s, most research focused on inequalities in men's mortality and morbidity according to occupational class, with less attention paid to inequalities in health among women (Townsend and Davidson, 1982; Drever and Whitehead, 1997). Since then research has examined whether structural factors, such as social class and material disadvantage, are associated in a similar way with women's and men's health (Arber 1991, 1997; Arber and Cooper, 2000; Bartley *et al.*, 1992; Macran *et al.*, 1994, 1996; Lahelma and Rahkonen, 1997). These researchers have stressed the importance of examining women's health, both in terms of their structural position within society and their family roles.

Within the broad tradition of research on inequalities in health, occupation-based social position has been the prominent factor related to the health of men, whereas for women, a role framework, relating to women's marital and parental role, as well as to their participation in paid employment, has been dominant. The papers in this volume integrate these two approaches, and consider the impact of multiple roles on women's health, and how this varies according to women's class position and their financial and material resources. A particular concern is how poverty, disdvantaged paid work and roles in unpaid work influence women's health. For example, women who live alone or as a lone parent may be vulnerable to living in poverty and have particularly poor health. It is also important to understand how women's earlier biography, in terms of their role in reproduction and production, impacts on their health later in the life course, and to what extent patterns of women's health vary across the life course, since different generations of women may have grown up in very different social and economic circumstances.

During this century there have been radical changes in actual and expected gender roles, especially for women. We may therefore expect the nature of inequalities in health for men and women to vary over time within any one society, as well as to vary among societies. Women

have entered the paid labour force in increasing numbers and most women in developed societies remain in the role of full-time housewife for only a few years when their children are young (McRae, 1999; Rake, 2000; Ginn *et al.*, 2001). However, women's attachment to the labour market tends to be weaker than men's often with high levels of part-time working during the childrearing phase. In many countries, there has been a growth of equal opportunities for women and women have gained greater financial independence, although women and men still usually occupy different structural locations within society; with persistent patterns of occupational sex segregation, and women have lower earnings (Rake, 2000). Women on average have less power, status and financial resources than men, as well as less autonomy and independence (Doyal, 1995).

Occupational class may be a less discriminating indicator of health inequalities for women than men because of women's more fragmented employment career, while educational qualifications may capture comparable or greater inequalities for women than men (Arber, 1997; Arber and Cooper, 2000). In the early years of the twenty-first century, fewer people remain in the same occupation for life, and an individual's occupational class is more likely to change over time. There may therefore be advantages in using socio-economic measures other than occupational class which can be applied to all adults and are more stable throughout the life course, such as educational qualifications. However, there are cohort differences in the level and meaning of educational qualifications, with younger age cohorts much more likely to have higher qualifications, such as a degree, than older cohorts (particularly amongst women). Financial and material resources of the household are closely tied to success in the labour market, although appropriate indicators of financial and material resources will vary between countries. Such resources are influenced by state policies, for example eligibility for and level of welfare benefits. The nature of welfare policies are particularly important for women with children, for example, the availability of subsidised day care, after-school care and the extent of maternity benefits, and especially for women not in the labour market, including lone mothers, who in Britain often rely on state benefits and live close to the poverty level.

Women are more likely to be unpaid carers for family members, providing both domestic labour and health care for partners, children and parents when required. Women also provide the majority of care

for chronically sick children and for older, frail or disabled relatives. Many women perform the 'double shift' of household work and paid labour, so it is important to assess how combining paid and unpaid work affects their health, and how this varies with socio-economic circumstances (Doyal, 1995). Societies vary in the extent to which conventional gender roles circumscribe women's ability to participate in paid work. Papers in this issue are drawn from a number of countries to improve understanding of how women's diverse roles impact on their health in a range of cultural contexts.

Research on women's health until the early 1980s focused primarily on women's roles, examining to what extent additional roles, such as the marital role, parental role and paid employment, had beneficial or adverse consequences for women's health (e.g. Nathanson, 1980; Verbrugge, 1983; Arber *et al.*, 1985). Research on marital status and health (e.g. Verbrugge, 1979; Morgan, 1980; Anson, 1989; Wyke and Ford, 1992) consistently showed that the divorced and separated had poorer health than the married, and that single men but not single women reported poorer health than those who were married. The previous orthodoxy that married women have poorer health than single women may no longer hold in some societies, possibly reflecting changes in the nature of marriage and career opportunities for married women which thirty years ago only existed for single women. Despite the growth in cohabitation over recent years, we know less about the health of cohabitees. In many countries, a major change has been the growth in divorce and the proportion of women bringing up children as lone parents. Thus, there is urgency to research how changes in family structure are associated with health, especially lone parenthood.

These profound structural changes in gender roles in the last quarter of a century across societies lead to the expectation that the pattern of inequalities in health among women and men will also have changed (Annandale and Hunt, 2000). The opening paper by Moss provides a theoretical framework for analysing women's health by examining the twin issues of gender equity and socio-economic inequalities and how these are manifest at the *macro* level and the *micro* level of the family and household. She addresses the ways in which the geo-political environment and country-specific factors associated with history, policies, legal rights and institutions interweave to impact on women's health, as well as the impact of community level factors related to social capital, social networks and social support. These considerations lead to an expecta-

tion that the nature of social and economic variations in women's health will vary between societies. Hunt then describes the marked changes in gender roles and relations between women born in Scotland in the early 1930s and twenty years later. The significant changes in the experiences, opportunities and attitudes of different cohorts of women would be expected to influence their health and their health-related behaviour, emphasing the importance of researchers taking into account the social, historical and political context in order to understand the changing nature of the social and economic patterning of women's health. Policy issues delineated in a government report on women's health in Norway are developed by Sundby, who stresses that efforts to reduce gender inequities should be part of future policy making regarding health, and that the very definition of women's health should be widened to include the needs of women in different ages and social layers of society.

Most of the papers are based on large, nationally representative samples, including the 1994 British General Household Survey, coupled with the 1994 Survey on Living Conditions in Finland (Lahelma *et al.*), the 1996 Survey on the Health Status of the Population of Poland (Wroblewska), the 1998-99 Survey on Divorce in the Netherlands (Fokkema), the 1995 Perinatal Survey in France (Saurel-Cubizolles, Blondel and Kaminski), and the 2000 Survey on Acts of Violence against Women in France (Jaspard, Saurel-Cubizolles and the Enveff team). A number use longitudinal data: the Whitehall II study of London-based British civil servants (Griffin *et al.*; Fuhrer and Stansfeld), the 1958 British birth cohort study (Matthews and Power), the 1994 Longitudinal Canadian National Population Health Survey (Walters, McDonough and Strohschein; McDonough, Walters and Strohschein), and the Longitudinal Study in England and Wales (Wiggins *et al.*). Other papers are based on more regional surveys, such as the West of Scotland Twenty-07 Study (Hunt), the Survey on Gender Relations and Health in two Communities in Jamaica (Henry-Lee, Bailey and Branche), the Mumbai Survey on the Health of Older Women (Raju), and the Socio-Demographic Survey in Rural Tunisia (Gastineau).

Several studies examine the link between women's health and the various dimensions of women's roles: domestic responsibilities, childcare responsibilities, age of youngest child, psychosocial job strain, job insecurity, length of the working week, unsocial working hours, and physical exertion. Further concepts which are operationalized and re-

lated to health, include social support (Walters, McDonough and Strohschein; Fuhrer and Stansfeld), control or decision latitude, extended from the work environment to the home setting (Griffin *et al.*), gender role orientation (Hunt), gender equity (Sundby; Dikbayir and Karaduman Tas) and gender relations (Henry-Lee, Bailey and Branche), and lastly chronic stress (McDonough, Walters and Strohschein).

Salient findings from papers that address the *social and economic patterning of women's health* include that in the Netherlands having children and a job is the most favorable combination, which holds regardless of the length of the working week once the children are above 5 years, except for divorced mothers who report better health if they have a part-time job (Fokkema). In Poland, higher morbidity is correlated with poor financial condition and poor education (Wroblewska), and the same is found in Mumbai, India (Raju). In Jamaica, acts of violence against women are not on the decrease, as opposed to most types of crime, and this is interpreted in relation to gender identities and male feelings of ill-being (Henry-Lee, Bailey and Branche). Very few data on the health impact of violence against women are available in France, and a national survey on acts of violence against women is presented, which was carried out in 2000 (Jaspard, Saurel-Cubizolles and the Enveff team). Concerning the intermediate factors involved in the patterning of women's health, the combined effects of work and home factors were not found to account for the class gradient in distress in Britain (Matthews and Power), and neither was chronic stress in Canada relevant to the pathways linking social roles to health, with employed women and parents living with children enjoying better health despite greater stress (McDonough, Walters and Strohschein). In France, the social inequalities in terms of prematurity of births and intra-uterine growth retardation remained even after adjusting for the classical risk factors for those conditions, and this is considered as an argument in favor of the role of group-level variables such as social cohesion and networks (Saurel-Cubizolles, Blondel and Kaminski). The importance of the historical frame of women's lives was illustrated with data from Scotland showing substantial changes in gender-related experiences and health between two generations of women 20 years apart in age (Hunt). Similarly, the relevance of the geographical frame was clearly demonstrated with the prevalence of limiting long term illness varying between localities in England and Wales among women with

similar material circumstances (Wiggins *et al.*). International variations in health patterning among women associated with differing social policies and cultural contexts were also pinpointed, for example, based on Britain and Finland, two countries which differ in the nature of the welfare policies to support child care for working mothers and in the level of paid employment for women (Lahelma *et al.*). Within Tunisia, health care utilization by women may be hindered by social and cultural barriers, and for this reason health services infrastructure is under-utilized in some regions (Gastineau).

Papers focused on explaining *gender differences in health*, include Walters, McDonough and Strohschein who present little evidence in Canada to support the role of gender disparities in exposure and vulnerability to paid work conditions, household structures and material and personal resources. The position of women in Turkey with regard to the health insurance system is pinpointed, and the ensuing inequalities in terms of access to health services are discussed (Dikbayir and Karaduman Tas).

With regard to *gender differences in health patterning*, the traditional framework ties men's identity more to their role at work, and women's more to their roles at home. However, Griffin *et al.*'s study of civil servants in London found that low control at home and low control on the job affected the psychological morbidity of both men and women, but in different ways according to their social position. Fuhrer and Stansfeld using the same dataset find that women have a wider range of sources of emotional support than men, but that gender differences in the effects of support on physical and psychological health were attenuated when a support index based on up to four close persons was used as a predictor.

Some of the studies address measurement issues and the appropriateness of indicators. Matthews and Power suggest that it may be that the quality of home factors, and the nature of the experience within a role is more important in explaining the socioeconomic gradient in distress than the number of roles. Lack of detailed knowledge in large-scale surveys of conditions in the home and of domestic responsibilities of women and household division of labour is pinpointed (Walters, McDonough and Strohschein). McDonough, Walters and Strohschein suggest that the inability to explain the education and income gradient in women's health by exposure to chronic stress may result from the inability of the stress indicators to capture the essence of the experi-

ences arising from these social locations. The question of whether defining and measuring social support should be gender-specific is investigated, since different experience and sources of emotional support are found for men and women (Fuhrer and Stansfeld).

In the final paper, Strobino et al. examine social policy issues surrounding women's health in the United States. A key policy recommendation for health programs directed at women is to shift away from a narrow focus on pregnancy and the childbearing years to one which emphasises the provision of economic security for women and integrated women's health services throughout the life course. It is therefore important to assess the likely consequences of changes in social policies for women's health in different societies. Policies may be specifically oriented towards women, such as childcare and maternity benefits, which have beneficial effects on women's health, although the magnitude of these effects may vary between women in different socio-economic circumstances. Other policies may not specifically be focused on women, but nonetheless have gendered effects. Some may disproportionately advantage women, such as minimum wage legislation since the majority of low earners are women, while others may disproportionately disadvantage women, such as the 'rolling back' of the welfare state over recent years, which has for example reduced the provision of public transport and state-supported care services for older people.

A number of recommendations and research perspectives can be delineated from the papers in this Special Issue. First, it is recommended that future models should incorporate work, home and social position variables for men and women. The concept of control or decision latitude in the home setting needs to be clarified in terms of balance between demands or resources and/or power balance within relationships, and questions should be added in survey questionnaires for a better assessment of home control (Griffin *et al.*). Studies should be contextualized in historical (Hunt) and geographical (Wiggins *et al.*) frameworks, and multidisciplinary research is indispensable to integrate social, economic and epidemiological approaches to women's health (Moss). Moreover, qualitative field work using ethnographic techniques would potentially be a very fruitful complement to survey research and analysis.

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