Gender equity: promoting healthy outcomes

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Abstract

Increased gender parity has provided women in many industrialized nations with greater disposable income and health benefits that improve access to quality health care. It would be assumed that this progress would lead to better health outcomes across the board. However, many health conditions attributed to preventable causes such as poor eating habits, smoking, and alcohol use are on the rise among women in these countries. In some instances, the aforementioned unhealthy habits have been increasing at rates greater in women than in men. Psychological causes of these unhealthy habits may include greater accessibility, increased disposable income, observational learning (of peers and media), and stress due to acculturation into male-dominated cultures and to continuing inequities at work and home. Researchers have reported similar patterns among immigrant cultures when pressured to conform to majority culture norms and values. Balancing participation in traditional culture with participation in the majority culture has been found to contribute to better health outcomes in the minority communities. This paper concludes with an examination on how the research of minority communities may provide clues for promoting positive health outcomes while minimizing the unhealthy habits as women achieve parity with men.

Introduction

It has been assumed that progress on issues of gender parity, such as better educational and vocational opportunities and increased income would translate into better health outcomes for women. Certainly women's health has generally improved in nations where movements toward parity have occurred. The United Nations has used a gender-related development index, using life expectancy from birth, adult literacy rates, a gross enrollment ration of women to men in primary, secondary, and tertiary educational institutions, and estimated earned income, to determine the relative ranking of societies with regard to gender parity. The results have indicated that the greatest progress in gender parity has occurred among so-called developed nations, with the top 20 ranked societies for gender equality including nations from Europe, Australia, Canada, the United States, and New Zealand (United Nations Development Programme 2006). Generally speaking, improvements in women's health have been attributed to greater educational opportunities leading to increased disposable income (e.g., Hill and Needham 2006). The life expectancy of women in nations in which progress in gender parity has been noted has increased over the last century and often exceeds that of men.

However, disturbing trends for women have been noted in developed nations for some health outcomes. In the United States for example, the prevalence for bronchial asthma among women was estimated to be at 8.38% in 1998 and that estimate rose to 14.9% by 2004. The prevalence for diabetes for women in the United States was estimated at 2.7% in 1980 and that estimate had doubled to 5.4% by 2005. In 1998, 18.3% of women in the United States were

estimated to be obese, and that estimate had risen to 24.5% by 2006 (Centers for Disease Control [CDC] 2007). For many years, these increased health problems seemed to be associated specifically with American society. However, many of these health trends are occurring in other developed nations. For example, increases in obesity and smoking among women have been noted in many European nations as well (World Health Organization 2007).

When asked in the *Behavioral Risk Factor Surveillance System* questionnaire by the CDC to rate general health, 23.5% of women respondents in the US reported their general health to be excellent in 1995 but that number had decreased to 20.1% in 2006 (CDC 2007). The CDC also found that in 1998, 9.8% of women reported 14 or more days that were "mentally unhealthy," and that percentage had increased to 11.9% by 2005. Among women 18-25 years of age, approximately 17% reported significant psychological distress, primarily depression, compared to near 11% for men of the same age range. The percentages reporting significant psychological distress among women aged 26-49 decreased to around 12% and to around 9% for women age 50 and older. Although women reported greater prevalence than men of significant psychological distress at all age cohorts, the disparities decreased as a function of age (Substance Abuse and Mental Health Services Administration [SAMHSA] 2004). Poor mental health has been associated with a wide variety of negative health outcomes that adversely affect length and quality of life (Blehar and Norquist 2002). Although the increases in prevalence of these aforementioned diseases and conditions are mirrored somewhat by men in the United States, the increased reports of mentally unhealthy days by women were not. In some cases the increases of disease prevalence may reflect improved diagnostic services for women by physicians or greater accessibility to health care services for women, but the trends are still disturbing and appear to defy the logic that women's health may be improving as a function of greater parity in American society.

Unfortunately, the gender gap seems to have been bridged in the United States in the prevalence of certain health problems that have been traditionally associated with men. For example, unhealthy habits appear to be on the increase among women in the United States. For the first time since epidemiological surveys had been conducted in the US, adolescent women were as likely to have smoked in the last month, used illicit drugs, and binged on alcohol as male adolescents (SAMHSA 2005). The increased prevalence of substance misuse by adolescent women suggests that subsequent health consequences from these unhealthy behaviors may

increase among adult women into the future. Some of these health problems have begun to manifest themselves. For example, more American women than men have been diagnosed with cardiovascular disease (American Heart Association 2007) and lung cancer rates continue to increase for American women even though the rates for American men have decreased (CDC 2007).

Does seeking gender parity mean assuming unhealthy habits?

The unhealthy trends among women in developed nations where progress toward equality has been noted begs the question, is it inevitable for women in these nations to assume the unhealthy habits of the male dominated culture as they assume a more equal role in that society? The epidemiological data clearly have documented changes in the aforementioned health behaviors that would parallel economic and educational progress for women in those societies.

The research findings also have shown a positive relationship between income and educational levels within developed societies and specific health outcomes. For example, in the United States, women with greater education and income are generally less likely to experience obesity (Baltrus, et al. 2005) or engage in binge eating events (Reagan and Hersch 2005) than women of lower socioeconomic status or with lesser educational attainment. Interestingly, the association between obesity and socioeconomic status in the U.S. has become less pronounced over the last thirty years as more people have become obese across all income groups (Zhang and Wang 2004), suggesting that obesity is becoming a health problem for women across all income groups. Another interesting study compared obesity in 30 different developed nations and found that countries with greater gender income disparities also had greater problems with obesity in women than countries with lower income disparities (Pickett, et al. 2005), suggesting that greater gender income disparities within societies may also harm women's health. Research findings in Sweden found that women classified as unskilled laborers were four times more likely to have been diagnosed with heart disease than other women in the workplace (Wamala, et al. 2000). These findings would tend to support the belief that as women progress toward equality in societies as measured by increased education and income, health outcomes improve. Ostensibly, high achieving women, women likely to assume leadership roles, are experiencing more positive health outcomes than women in the same society that are not as well-educated or have not attained higher levels of income. An interesting area of inquiry would be to examine how to improve health outcomes for all women within a society as it moves toward gender equality.

However, other research illustrates that factors besides income and education may be influencing health outcomes for women within societies moving toward gender parity. In the United States, for example, Dixon and colleagues (1991) found that women who perceive making significant sacrifices in career and relationships were more likely to experience heart disease of a serious nature. Researchers in Finland found that women who were more dissatisfied with balancing family and work responsibilities were more likely to experience significant weight gain (Lallukka, et al. 2005) or problem drinking (Roos, Lahelma, and Rahkonen 2006) that those who were satisfied. Swedish researchers found that being overweight was associated with poor health habits and an external locus of control; the belief that outside factors tend to control outcomes (like fate) rather than personally influenced outcomes (Ali and Lindstrom, 2005).

On the positive side, other researchers have identified factors associated with improved health outcomes among women in developed or developing societies. For example, in India, researchers found that positive and adaptive coping reduced stress, psychological problems, and physical health problems among working women (Pandey and Srivastava 2003). In the United Kingdom, researchers found that women who felt more competent at engaging in multiple life roles were more likely to have good health at age 54 than those who did not feel as competent in engaging in multiple roles (McMunn, et al. 2006). The evidence suggests that an ability to successfully cope with the competing demands placed upon women by the male oriented societies in a positive way seems to lead to better health.

Although generally speaking higher income and greater educational attainment have predicted better health, differential health outcomes among professional women and women in leadership roles have been noted and studied. Interesting research has been conducted in Australia to look at health outcomes among professional women. One study investigated the fit of leadership style of women professionals with type of profession in which they worked (female dominated versus male dominated). The results found that a mismatch of leadership style with type of profession led to increased mental health problems, namely that women who used an interpersonal leadership style in a male dominated profession were more likely to report greater mental health symptoms than women who did not use an interpersonal style of leadership (Gardiner and Tiggemann, 1999). These results are similar to a study in the United States in which researchers found that women working in male dominated professions are more likely to

drink alcohol (Cho 2004). Another Australian study investigated how children may influence health outcomes among professional women. In this study, the investigators found that women with three or more children reported greater numbers of headaches, more exhaustion, and greater levels of smoking, overeating, and drinking that those with fewer or no children, and women who were single reported greater mental health problems (Langan-Fox and Poole, 1995).

Taken together, the research findings suggest that professional working women who adapt and cope successfully with male dominated culture, as well as successfully balance multiple responsibilities and personal and professional life satisfaction without the sense of sacrificing personal or professional values or goals, are likely to have the best health outcomes among women in societies moving toward gender parity. The logical next step is to identify the factors that allow professional women to be competent in different cultures in a way that is professionally and personally rewarding so that a model for improving health outcomes for other women can be proposed and tested.

Acculturation, cultural competence, and health outcomes

Comparisons can be made between the changes in health outcomes among women as they attempt to achieve parity in various societies and the health outcomes of various ethnic-minority groups as they attempt to achieve parity in a majority culture often completely different than their traditional culture, or what is referred to as the process of acculturation. Acculturation can be generally defined as the process of adjusting to and successfully coping with the majority culture. Ethnic minority groups tend to be disempowered in societies and often are pressured to conform to the established beliefs and practices or face aversive consequences such as poorer quality of life, material disadvantage, and social stressors including prejudice and oppression.

Oppression can distort the process of acculturation, placing increased physical and psychological stress upon ethnic minority group members. Many groups are pressured to assimilate (i.e., melt into the melting pot), and in some cases actively forced to abandon their culture and language (e.g., Hawkins and Blume 2002). Other barriers hinder progress toward acculturation, including glass ceilings and other structural or organizational obstructions that limit access and advancement, as well as microaggressions (Sue, et al. 2007), brief verbal and non-verbal slights, intentional or unintentional, which have the effect of offending or denigrating ethnic minority members. Women, arguably the most disempowered demographic group in history, perhaps share many of the struggles that ethnic minorities have experienced as they

adjust to the prevailing male culture. Both women and ethnic minority groups have experienced pressures to acculturate (conform) to the majority cultural beliefs and practices. In addition, women experience many of the same barriers, including glass ceilings, lack of access and exclusion, and microaggressions.

Research concerning how ethnic-minority group members successfully negotiate two cultures, their own and the larger majority culture, has yielded useful information about how to improve health outcomes that may be applicable to women. For example, similar to some of the health outcomes previously discussed for women, ethnic minority members have been found to engage in less healthy behaviors as they acculturate, such as smoking, binge alcohol use, and overeating leading to obesity (Abraído-Lanza, Chao, and Flórez 2005; Caetano and Clark 2003; Hubert, Snider, and Winkleby 2005), even as income and educational attainment increase; acculturation into majority society can involve assuming the bad habits of the prevailing culture as well as reaping benefits of greater movement toward parity in majority society. Stress related to acculturation has been associated with poorer health (e.g., Finch and Vega 2003).

There is an inherent unfairness in the expectation that disempowered groups have to learn how to function effectively in two worlds, in a sense doubling the size of the task required to succeed. However, there is evidence that if ethnic minority group members are able to function competently in both worlds, maintaining a strong self-identity that includes integrating traditional ethnic practices while successfully engaging in majority culture activities, they have better outcomes than members who only identify with either the majority culture or the traditional culture. Bicultural competence in ethnic minority research refers to the ability to live and work successfully in both the traditional culture and the larger majority culture. Bicultural competence means a person is acculturated in both majority and the ethnic minority home culture (sometimes referred to as enculturation). Biculturalism is radically different than assimilation, which pressures people to give up their ethnic identities and melt into the majority culture pot. In biculturalism, personal identity is rooted in and comfortable with being a person of color living in White society, and one does not sacrifice ethnic identity to be successful in the majority culture, but instead uses the strengths of the traditional culture to sustain and nurture as s/he function in a White world. On the other hand, the person understands the majority culture, including its norms and expectations, and can act effectively within majority culture. Bicultural competence has a great deal to do with self-efficacy, or the "…beliefs in one's capabilities to

organize and execute the courses of action required to produced given attainments" (Bandura 1997, 3) in that a person develops mastery in living as a person of color in a White society. Research findings have suggested that bicultural competence, or the ability to skillfully and successfully negotiate both the culture of home and the culture of mainstream society, leads to better health outcomes (LaFromboise, Coleman, and Gerton 1993). In response to this body of research, many prevention and wellness programs serving ethnic minority communities address participation in and successful coping among traditional cultural institutions and institutions in majority society. In practice, a biculturally competent person is able to integrate the strengths of both cultures to competently and confidently cope with any situation they encounter in either world.

As discussed previously, many health conditions attributed to preventable causes such as poor eating habits, smoking, and alcohol use are on the rise among women in developed or developing nations, sometimes at rates exceeding those experienced by men in the same culture. These unhealthy habits may be the result of increased disposable income, observational learning (of peers and media--including targeted campaigns conceived from biases against women) of the bad health habits, or the result of societal gender bias that contributes to acculturation stress into male-dominated cultures and to continuing disparities at work and home. Given the historical similarities of women's experiences to certain ethnic minority groups, a model of bicultural competence may be helpful to consider for improving health outcomes of all women in societies where progress has been made on gender equality of rights. This line of reasoning would be consistent with previously cited research that suggested ability to successfully balance multiple roles within different cultures (McMunn, et al. 2006) without sacrificing personal and professional satisfaction (Lallukka, et al. 2005; Langan-Fox and Poole 1995; Roos, et al. 2006) leads to better health; in other words, competence in multiple cultures.

Women succeeding in male dominated culture: a model from academia

A paper published by Alfred (2001) may be helpful to initiate the discussion about the applicability of a bicultural model for women. In this study, Adler used qualitative analyses to examine how women of color successfully negotiated the White culture of academia. Although the principle focus of her study was on issues of race, academia also is representative of male dominated cultures. Analyses of the themes of the interviews with these African American academicians identified a particular pattern of coping strategies that enabled the women to

succeed. The first theme to emerge was what Alfred termed the "power of self-definition," which referred to the respondents' ability to use strong ties with traditional roots and culture to enhance positive self-worth and provide strength and balance that would carry them when confronted by the competing demands of the academic culture. The second theme was described as "finding a safe place," related to having a sanctuary or refuge available during times of oppression and duress to renew and re-energize. The third theme was the value of the "power of knowledge," or the skills of knowing the culture of academia, knowing the role expectations associated with that culture, and knowing how to behave in particular situations within that culture. The fourth theme, was described as the "power of visibility," indicating the importance of being active participants within the university and other academic institutions outside the university in order to succeed in the culture of academia. Finally, the final theme is referred to as "life structure and bicultural competence," which Alfred describes as skills and flexibility to adapt and adjust to changing expectations across the multiple cultures the professional women encountered in their academic experiences. She adds that the women in the study reported being able to adapt and adjust seamlessly to changing role expectations and demands, in a way that seemed second nature and without creating personal stress.

One critical point to make about the Adler study (2001) is that the women did not choose to assimilate, or to discard traditional cultural identity in favor of assuming the majority culture identity of academia. The women in the study succeeded not by assuming the identity of the majority culture but rather by developing an integrated identity ("power of self-definition") that allowed women to utilize skills and knowledge from traditional and majority culture to develop mastery as academicians ("the power of knowledge" and "life structure and bicultural competence"). Safe spaces were needed because there are those who will knowingly or unknowingly sabotage efforts to succeed, so social networks of likeminded people was helpful to provide balance and support. Visibility in the larger culture not only aided the women to succeed in majority culture role expectations, but also provided opportunities to transform the culture of the academy. Research has shown that women who act in ways that are perceived to be male, or that violate biased gender stereotypes, are often punished or ostracized for such behavior (Eagly and Karau 2002; Heilman, Block, and Martell 1995; Heilman and Okimoto 2007; Heilman, et al. 2004), suggesting that it may not be in the best interest of women to assimilate to male practices.

A bicultural approach would offer strategies to counter the prevailing biases against women while circumventing the negative outcomes of assimilation.

Bicultural competence for women operating in a male dominated world may be enhanced by being firmly rooted and oriented to the strengths and refuge of feminist culture and tradition, by developing personal sanctuaries free from the stressors of the majority male culture to rejuvenate and find balance and renewed strength, by understanding the male culture with its role expectations and how to effectively act as a woman within that culture (without assimilating), by actively participating and being visible in the male dominated culture and perhaps transforming the culture in the process. Women in leadership roles, with high visibility, have the opportunity to model success, challenging stereotypes and promoting a women's cultural perspective that challenges the prevailing models and biases inherent in the male dominated culture. Finally, bicultural women become skilled at cultural flexibility and competence as a successful woman in a male dominated culture. Bicultural competence offers the promise of improving health outcomes as women seek parity, since the best health outcomes can be found among highly skilled women able to successfully adjust to and cope with multiple worlds including those that are male dominated, and who are able to balance multiple responsibilities without compromising personal or professional values or goals.

Conclusion and future directions

The concept of bicultural competence, used to understand acculturation challenges of racial/ethnic minorities, also appears applicable to women simultaneously negotiating their feminist world and the male dominated majority culture. Research conducted among ethnic minority groups suggests that bicultural competence may serve as a protective factor that improves healthy outcomes and potentially helps people avoid the unhealthy behavior that seems to accompany acculturation into mainstream culture. A model of bicultural competence may help women avoid the unhealthy behaviors of the majority culture while benefiting from increased gender parity in the workplace and in other cultural institutions. Professional women in leadership roles, who have demonstrated the ability to successfully cope with multiple cultures and transform the cultures by their presence, should provide clues for how this model could be developed and applied. Such a model also would provide a template for enhancing organizational and governmental policies to improve health outcomes for all women in developed nations. Researchers will aid in the development of this model by identifying the functional qualities

utilized by successful women leaders that help them achieve excellent health even as they push against the limits of gender parity in male dominated cultures.

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Published by the Forum on Public Policy