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GENDER AND SOCIAL DETERMINANTS OF HEALTH

Abstract. The existing paradoxical differences in the mortality and morbidity rates (death rates and illness rates) between men and women, which are difficult to explain by biological factors, have called researchers' attention to social and cultural factors as a possible explanation. The worldwide statistics indicate that women outlive men in almost all countries, while at the same time they suffer from higher morbidity rates than men, due to chronic physical and affective disorders. In addition, the data shows that women, as compared to men, are underprivileged in several material resources that are important to preserve good health. This puzzling situation has invited a search for socio-cultural factors that could shed some light on the nature of different health patterns of men and women. This article uses a sociological perspective in an attempt to show that the observed differences may be attributable to differing socio-cultural and structural arrangements of both genders.

Key words: gender, health, health differences, health determinants.

1. Gender and health

The intention of this article was to discuss problems, questions, and issues related to women's health. However, it is difficult to dwell on this subject without also making reference to men's health. Thus our further consideration will be dedicated to gender differences and inequalities in health, and health-related behaviour. It is a well known fact, supported by medical statistics, that the life spans, as well as patterns of health and disease, of man and women are different.¹ They appear in the prenatal period and continue to the final years of life. Also, the health experiences of women differ from those of men; women generally perceive their health status worse than men do. Thus once again we will try to look for a possible sociological interpretation of these differences, and especially how they reflect the differing gender roles and the places occupied by men and women in society.

For many years the "gender variable" did not attract particular attention from researchers into the state of human health. Women's lower mortality and average

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¹ In Poland the difference in life span between men and women is just over 8 years (in 2010 men lived for 72,4 years on average and women for 80,9 years).

longer life was often explained by their more advantageous biological equipment and constitutionally better resistance to disease. However, there is a discrepancy between such an interpretation and the research results from several countries, which establish that the phenomenon of women's longer life coexists with a worse state of health – and that there is no inconsistency in this apparent paradox (Verbrugge 1985: 282–304). Statistics concentrating on the average length of life do not take into consideration loss of health as a result of chronic diseases and disability. Taking this variable into account indicates that women's state of health is worse than that of men in practically all countries, in different but comparable age groups and cycles of life, with a particular intensity of diseases and complaints in the most advanced age (Verbrugge 1990: 45–47, Lahelma et al. 1999: 7–19). Older women are more likely than older men to suffer from conditions which result in chronic and disabling illnesses which hinder them in their daily living activities. This is particularly visible at ages above 85, when about twice as many women as men suffer from severe impairment and need long-term home health services (Arber, Thomas 2001: 104–105, GUS 2007). Women also report significantly more sleep problems, anxiety, and sadness than men (Arber 2012: 55). Why then, despite living longer, do women suffer more than men from physical and emotional problems, are more depressed, and evaluate their health status as worse?

Throughout their whole life women are exposed to more severe and chronic diseases which may lead to disability and physical limitations, but which are not linked directly to a risk of death. The short-hand phrase says that “women get sicker but men die quicker”. This tendency is also reflected in the Polish data. According to the “State of Health of Poland's Population” (GUS, 2009) 51% of women and 41% of men suffer from chronic illnesses. Complaints such as diseases of the joints, of the thyroid gland, of the liver, gallstones, allergies and neuroses are twice as common in women as in men. Yet men die earlier than women. In particular they are more prone to cardiovascular diseases, cancer, and accidents.

In looking for the reasons behind the different mortality and morbidity patterns, the biomedical model was referred to in the first instance. This explains the differences in men's and women's health by anatomical and physiological (especially hormonal) dissimilarities, and by inherited genetic predispositions. Nevertheless, the impossibility of explaining all the differences in the state of health of the two sexes with reference to that model has induced researchers to turn towards the psycho-social model, in which one tries to explain the differences in men's and women's state of health by referring to a gender-diversified division of social roles. Presently, it is no longer questioned that the biological differences (i.e. between the sexes) which lie at the source of the morbidity or mortality rates in men and women are compounded by factors which are a function of the place and the social status allotted to those two categories (gender differences). Taking into account the latter perspective, social inequalities between the two genders may offer a more adequate framework to explain the existing variances. We should be

aware however that gender differences in morbidity rates might also be due to real disease processes, the behaviour of an individual in response to real or perceived illness, and diagnostic and treatment practices of health care providers (Sayer, Britt 1996: 257).

While undoubtedly interesting, the studies on biological versus social health determinants are not caused by researchers' curiosity alone; they are relevant, first of all, to health policy, or social policy in general. While biological differences are unavoidable, socially-induced differences, which often are connected with inequalities, are considered unjust and their reduction should be the goal and object of social and political interventions. Unfortunately, there is little systematic research on the factors differentiating health by sex/gender – and the existing findings are often inconsistent. In Poland there is almost no research into this issue, hence our ability to separate the effects of nature and the effects of culture is limited. Nevertheless, one can search for dissimilarities in the risk factors which women and men are exposed to throughout their lives. This article deliberates on them.²

It also needs to be kept in mind while considering social determinants of health that gender is not the most important factor differentiating a population's health. Age is, of course, of great importance (which is understandable), but a considerable role has to be ascribed to the social status enjoyed. The higher the status (and especially education), the better in principle are all the parameters linked to health. Education is a kind of capital which represents better health awareness – knowledge of health risk factors, ways of preventing them, and models of health care and fitness. Affluence also facilitates greater opportunities to put knowledge into practice. However, here also hierarchies of access to the realisation of particular elements of life style may appear, involving sex differences. This is not sufficiently understood, as the literature related to gender and health is rather insensitive to the social/structural dimensions of gender relations. Also, health differences *among women* related to structural factors - social class, material condition, employment, number of children, and marital and parental responsibilities - are not sufficiently recognised.

2. Social determinants of gender differences in health

Before proceeding to considerations devoted to social differences and inequalities in health from the gender perspective. the social factors that can be

² In the present text I do not deal with psychological factors (e.g. differences in personality, self-efficacy, locus of control), which may be responsible for the differences in health and health behaviour in men and women. This concerns such variables, as, for example, the hypothetically greater proclivity of women than men to express stress in somatic categories, or a different sensitivity to symptoms.

responsible for inequalities in health in general should be identified. Irrespective of whether we compare particular social classes, ethnic groups, or people of different sexes – the main sociological (apart from the biological or psychological) hypotheses will oscillate around following factors:

- Socio-cultural factors
- Socio-economic status
- Stress levels experienced and social support network
- Lifestyles and health behaviour
- Quality of medical care

All these determinants of health influence people's condition at all the different levels of the organisation of society. They are anchored in a comprehensive model of society - its economics, class structure, and scope of social diversity - in cultural elements (dominating values and social norms), in the level of social cohesion, and in social solidarity. They are also the basis of a specific "contract of the sexes", establishing the structure of mutual dependencies and duties between males and females. Since all these factors influence the quality of life, it may be assumed that the differences existing in these aspects between the sexes shape men's and women's health differently (Ostrowska 2012: 63–65).

2.1. Impact of culture

Cultural explanations take into account differences in social models, norms, and social roles regulating men's and women's behaviour in various social situations. The process of socialisation is of key importance here. Boys and girls are prepared for socially different tasks from early childhood. The substantive content absorbed in that process contains several elements, which are not without significance for the future health of men and women. From the earliest age girls are prepared for the role of a mother, a minder, a part of whose role is to play the part of "home doctor". This is visible even in playing with dolls or participating in the housework relating to nutrition and maintaining cleanliness. As early as in the first grades of primary school girls' display more knowledge of medicine and health awareness than boys' (Wojnarowska 1998: 17–20).

Girls are expected to be more aware of their bodies and to care more about their looks. Also, girls are trained more consistently than boys in habits of personal hygiene and the requirements of cleanliness. In the future this will bear fruit in the shape of women's greater sensitivity to the first symptoms of illness, and also with better prophylactic behaviours – e.g. undergoing medical checks on their own initiative and more frequent contacts with doctors in general. In the event of surgeries women will be more inquisitive, will ask more questions, and make sure that they have understood the doctor correctly, and even suggest a diagnosis (Ostrowska 1997: 9).

In our culture a man is taught not to show weakness or suffering; he should rather be “tough”, forego complaints, and not sentimentalise over himself. Children’s games show early on that speed, bravado, courage and physical fitness rewards boys. These types of behaviour will in the future contribute to the fact that men will more often put their life and health at risk by participating in brawls or pranks leading to accidents, and will more often get involved in activities which put their health at risk. The cultural model also indicates what is proper or improper for men and women in domains such as cigarette smoking (although lately the differences in this area have become increasingly blurred), and drinking alcohol. A drunken woman evokes considerably more resentment and social criticism than a drunken man.³ There are also different expectations concerning the food men and women eat – e.g. their favourite dishes. It becomes a man more to eat pig’s knuckles or other high-fat meat dishes, just as it becomes a woman more to have cakes and ice cream. Meeting these expectations accordingly shapes the tastes and choices of the two sexes. Studies confirm the existence of such differences, which are vital from the viewpoint of health (e.g. consumption of red meat and animal fats) (Ostrowska 1999: 58–61). Another example of cultural conditioning – incessantly fuelled by the media – is that women should have very slim bodies, which is linked to maintaining a ‘proper’, in fact often starvation-level, diet. For many women food is associated with a sense of guilt, because they are used to the fact that their looks to a large degree decide about their life. It is not by accident that anorexia is about ten times more prevalent in women than in men (Bożek, Rychłowska 2001).

Cultural norms also treat the sphere of sexual behaviour differently between women and men. Higher permissiveness towards male sexuality favours them having a greater, and frequently different, number of partners, which in turn emphasizes the casual character of sexual contact. Venereal diseases or incidence rates of AIDS in men exceed by several times that in women (Granicki 1998: 556).

This problem brings us closer to the question of mutual relations between men and women in their sex lives. Various forms of violence, including among married couples, are not infrequent in this context (Izdebski 2000: 230, Garcia Moreno et al. 2006), and obviously have a harmful impact on women’s health. The psychological and physical impact of rape on women can be severe and continue for many years after the incident. And sex within marriage may also include elements of force. The physical and emotional fallout in cases of rape by an intimate may be even greater because of the betrayal that marital rape implies (Heise et al. 1994: 1169). Even in non-violent marriages, many women feel unable to control the timing and nature of their sexual encounters. More often the man imposes the models and frequency of intercourse rather than it being the result of

³ This situation is also changing and a growing number of women are engaged in both smoking and drinking. It is often perceived as an effect of “female emancipation”.

the partners' agreement. It has to be pointed out, however, that this often happens with the women's silent consent. In many existing models of mutual sex life, the female partner's readiness to perform sexual services and obtain either authentic or faked satisfaction is treated as a condition of a stable, "successful" relationship (Długołęcka 2002).

Obviously it's not possible in a short article to analyse the comprehensive impact of the contents and requirements brought about by culture, addressed to men and women respectively. It is equally difficult to analyse all the factors that come into play in the second type of explanation, proposed below, which refers to the places men and women occupy in the social structure. In this instance however the fact that women occupy a less privileged position is well documented, so this article will be limited to mentioning briefly those factors which have a direct impact on their health.

2.2. Influence of socio-economic status

It is well known that better housing conditions, better nutrition, proper rest and, last but not least, access to good medical care, are conducive to maintaining good health. The availability of these resources in general is different for the two sexes. All over the world considerably more women than men live in poverty. Present analyses of the poverty phenomenon, both in developed and in developing countries, reveal the feminisation of poverty. It is a well-documented fact that men hold higher posts in the professional hierarchy, and that women who do the same work earn less. Compared to men, fewer women receive pensions from their places of work places, and if they do receive such pensions, they are lower than those of men. Women are also more frequently eliminated from the labour market when there is high unemployment (Sztanderska, Grotkowska, 2007: 211–215).

Women's relative deprivation in the field of employment and income is obviously less conducive to fulfilment of those health needs which are related to one's material situation. It is characteristic that women more often than men indicate a lack of money as a reason of not consulting a doctor in the case of health problem, while for men the main reason is lack of time (GUS 2007). In families with limited budgets, men's needs have priority over those of women. Moreover, the health and wellbeing of men are often enhanced by women's work at home and for the family. There is substantial research evidence that married men have better health and health habits than single men (Arber, Thomas 2001: 99). This 'support and service' role of women (also called women's "unpaid" work), combining professional work with home and family duties, is often mentioned as a reason for women's exhaustion and fatigue, where lack of rest is their daily reality (Duch-Krzyszczek 2007: 136, 147). Even older women continue to perform

the care-giving role, even though they themselves are often ill and lack necessary physical, psychological and economic resources (Carmel 2012: 50).

There is a little equality and partnership in relations linked to the health and illness of the partners. It is well-known that in the case of illness of a family member – not only the children but also the husband - it is usually the woman that will look after them, although it is not often that she can rely on reciprocity. Moreover, research reveals that men's knowledge about their partners' health problems is surprisingly low. In a study concerning menstrual pains (Bayer Shering Pharma 2010), nearly 80% of women stated that their periods are often, if not always, accompanied by pain, and in over 50% of cases they are very painful. Yet only 28% of men participating in the same research were aware of this. It is also worth mentioning that, when asked if their partner sometimes experiences pain during intercourse, over 20% of men answered that they did not know.

2.3. Stress levels experienced – social support

Since chronic and severe stress can cause physiological damage and affect health, gender differences in stress levels and reaction to it should be taken into consideration here. It is not easy to say whether men or women are more affected by stress, in part because there are several intervening variables (e.g. personality, socialisation, social class) which modify this relation, but also because it is usually triggered by different stress factors (Garmanikov 1983). Stress in men is more often attributed to “management factors” – the necessity to shoulder responsibility, multiplicity and rapidity of decisions, and finding solutions to conflicts. Of course women may also experience such stress, but it happens less often. Recently in Poland attention has been drawn to stress linked to unemployment and poverty. This kind of stress affects both sexes, even though the direct source and nature of the perceived threats may be slightly different. Stress linked to unemployment more strongly disturbs the functioning of the man, since activity in the ‘outside sphere’, i.e. away from home, is an element of the role and identity assigned to males (Rosenfield 1989: 231–235). If the male is the ‘only breadwinner’, the stress is exacerbated, since the whole family's material conditions depend on the husband's financial success. On the other hand, in families with tight budgets it is the women who have to make difficult daily decisions concerning the management of limited resources and making the proverbial ‘ends’ meet. In situations of poverty, the stresses which women are subjected to may be defined as arising from ‘managing the familial poverty’ (Tarkowska 2007). In the case of women engaged in professional work, the stress factor may be the inadequacy of salary (women's lower salaries in comparison with those of men in similar jobs) and the unappreciated, and thus devoid of gratification, housework. There are studies (Thoits 1995: 53–79) which consider this situation to be the cause of more

frequent cases of affective disorders, and especially depression, in women than in men. In this model, women's higher rates of depression are causally linked to their experiences of domestic labour, marriage, lower paid employment etc. In support of this argument, where groups of men carefully matched along social and economic dimensions have been compared, the female excess has disappeared. (Popay, Barley, Owen 1993: 21).

The visible differences between the two sexes, substantiated by research, are also linked to the ways in which men and women relieve stress (Budrys 2003: 146–151). Women more often than men use social support as a source of backup in difficult situations; they are more open in revealing their problems and ready to share them with their social environment. Men's social support mechanisms are weaker; their emotional relations with those closest to them are as a rule looser, and they are more oriented towards external goals than ones associated with home and the family. Presently it is believed that having social support and the ability to reach out for it is one of the most efficient ways of dealing with stress (Lazarus 1997:10–11, Ell 1996]. Thus women's stronger rooting in a social group becomes a buffer which diminishes problems and even failures in life. Also, the "chemical" strategies which men and women apply to reduce tension are different. In the case of men it will more often be alcohol, while women are more likely to reach for sedatives (Ostrowska 2000). It is difficult to say which of these two methods is more efficient and at the same time less harmful in the longer perspective. Undoubtedly however these different models of reaction to stress have significant meaning for the health and illnesses of men and women.

2.4. Factors associated with lifestyle

When returning to the aforementioned possibilities of shaping men's and women's health through different configurations of social and cultural factors, it is worth pointing out that a good illustration is provided by people's lifestyles. Their lifestyles are to an overwhelming degree shaped by the cultural models that dominate their milieus and by the places they occupy in the social structure.

Interest in the role of lifestyles as a factor potentially promoting health appeared at the end of the 1970s, when longitudinal epidemiological studies indicated that the average length of human life depends to a high degree on environmental factors, and particularly on the life style - more than on biomedical factors. The research in medical and social sciences enabled the identification of factors associated with lifestyle that were of vital importance for maintaining health, vigour, and longevity. They were: 7–8 hours of sleep per night; having breakfast daily; avoiding snacks between meals; maintaining the right weight; physical activity; non-smoking; moderate consumption of alcohol; undergoing medical check-ups and doing self-checks (e.g. of breasts by women); moderate exposure

to the sun; safe sex, and fastening seat belts in cars. Later studies, lasting for many years, have established that abidance by these rules does indeed correlate with an average longer life span (Berkman, Breslow 1983).

The next question that thus arises is: what are the differences in everyday lifestyles between men and women? The research conducted in Poland (Ostrowska 2000, GUS 2007) indicates that positive health-related practices are generally more frequent among women than men, and conversely risky health practices appear more often in men. Women eat healthier (more fruits and vegetables, less red meat and animal fat), more frequently do preventive check-ups, keep adequate body weight, and care more about daily hygiene. Men are more physically active, but also smoke cigarettes and drink alcohol more.

2.5. Health care and medicine

Many studies indicate differences in the use of health care by women and men. According to the “Study of the State of Health of Poland’s Population” (GUS 2009), women visit doctors (general practitioners and specialists) more often than men, take more medication, are a little more often hospitalised. They also more often contact a dentist, both for treatment and prevention.

However, studies devoted to the use of health care tell us but little about the quality of the care received, apart from the general level of satisfaction from the users of the services. In general there is no distinct difference in their evaluation by the two sexes. Does this mean that women and men are treated equally by medicine? Does medical science take sufficient account of the differences between men and women? This problem has not been a subject of more detailed study in Poland, even though it increasingly attracts the attention of foreign researchers studying the problems of health factors (i.e. conditionings) seen from the gender perspective. Since there is no reason to believe that the Polish medical scene is very different from that in other countries, it is worth considering some of the research results from other countries.

For many years in medicine, problems of women’s health were identified solely with problems of reproductive health. Thus, a woman – as a separate object of medical interest – appeared in the context of menstruation, prenatal care, childbirth, or illnesses of the reproductive organs. Even so, the majority of research on women’s reproductive health and control over their fertility tended to ignore the differences in women related to their social class, living conditions, and education. Although the situation is changing, still the specificity of women’s health is not sufficiently taken into account, neither in research nor in medical practice. Problems of women’s health are not satisfactorily factored into epidemiological research and clinical trials. For example, research carried out several times on populations of many thousands, which led to the discovery of

the pattern of type A behaviour, which was instrumental to understanding the aetiology of cardiovascular diseases, (Friedman, Rosenman 1974) was carried out exclusively on men. However, the results of that research were generalised for both sexes. Pharmacological research, requiring the use of laboratory animals, is carried out almost exclusively on males (the exception being tests of medicines linked to reproduction and so-called women's diseases), even though, as in the previously mentioned case, the results are then generalised for both sexes (McBride, McBride 1985). Several health problems relating only to women (e.g. resulting from the long term effects of taking oral contraceptives or the abortion pill – used only by women) do not meet with sufficient interest from doctors and are ignored in worldwide medical research (Abbot, Wallace 1993, Arber, Thomas 2001: 96–97). Nor is there any unambiguous interpretation of some women's health problems, which make the diagnosis and treatment more difficult. The syndrome of pre-menstrual disorders, causing considerable discomfort to many women, can be used as an example. In Poland, doctors often consider it a “natural phenomenon” that does not require treatment, recommending pregnancy as a solution to the problem. There is also lack of conclusive research on the treatment of menopausal ailments (Ostrowska 2010: 421–423). Hormonal replacement therapies (HRT) were able to bring relief to numerous women, considerably reducing the acuteness of the symptoms. Also, the prevention of osteoporosis and circulatory system diseases have been mentioned among the positive results of such therapy. Nevertheless, research into further health consequences of the prolonged application of such a therapy has not definitively and finally resolved their influence on the occurrence of negative health conditions – above all breast cancer. The broadly disseminated results of the *Women's Health Initiative* research, indicating the health risks associated with HRT (Chlebowski et al. 2003 after Astbury 2009: 83), although subsequently criticised for negligence in methodology, influenced many women to stop using it and thus lose the possibility to control the symptoms they experienced.

Women and men are not treated equally by health care systems either. The existing data indicates that the same complaints can be diagnosed and treated differently in men and in women. In two American NERI research projects (Stacey, Olesen 1993: 2) it was stated that doctors, facing identical symptoms, diagnosed them in men more often as circulatory disorders, referring their patients to a cardiologist and recommending hospitalisation or more invasive methods of treatment, while women's symptoms more often received psychiatric diagnoses. These results are, to a large extent, a function of epidemiological test results, but also of some stereotypes persisting in the medical world concerning illnesses and the way their symptoms are presented among men and women. Current findings suggest sex-role stereotyping by medical doctors; the sex of the patient biases them into reaching a psychiatric diagnosis due to preconceived beliefs about the likelihood of such a diagnosis in females (Sayer, Britt 1996: 262).

A conviction about the role of women's "nerves", "hysteria" and "hypochondria" in the aetiology of the presented condition quite often appears in medical diagnosis (Holtzman et al. 2002: 461–470). It should also be noted that some, albeit limited, subsequent studies concerning other conditions have shown that the differences in presentation of the same symptoms by men and women may lead to a different diagnosis and therapy (Enriquez et al 2008), with women more often than men underreporting symptoms (Macintyre 1993: 18). The limited research on whether men and women with the same medical conditions present their symptoms differently means that less is known about the effects of drugs or surgical treatment for women.

3. Discussion

Our deliberations on the social factors contributing to differences between men's and women's health show that we are dealing with a matter which does not easily subject itself to any unequivocal interpretation. Although on the average women live longer, this does not mean that they encounter fewer illnesses and conditions in their lives. Generally they evaluate their health as being less well than men's, especially with respect to their mental state. Also, the conditions surrounding women's life and work are less favourable than men's. However, even if their objective conditions are worse, it seems they cope better with life's difficulties and adversities, which results in them having larger bio-psycho-social resources allowing them to "survive". This is particularly visible in older age groups. Also, women carry out more activities aimed at maintaining health, have better health awareness, and recognise the first symptoms of illnesses better, even if medical institutions tend to treat men's health problems more seriously. Thus, individual predispositions predestine women to relatively better health. If it is not better, then it is usually worth looking for the reasons in the external, structural conditions of their life (Ostrowska 2012).

Differences in somatic and mental states of health, as well as differences in the average life span between men and women, are a phenomenon common to all industrialised countries. However, in Eastern Europe these differences are more pronounced than in other countries.⁴ What specific factors could influence the relatively larger difference in Poland, and also in other countries of Eastern Europe? In general anti-health behaviour is emphasised, in particular in the male population, the overwhelming influence of which is the simultaneous high consumption

⁴ In Poland the differences in the average life span between men and women in recent years equalled 7 years, while in Western Europe in general they do not exceed 4 years. The biggest difference is observed in Russia, where women on average outlive men by 12 years.

of alcohol and cigarettes, whose detrimental influence on health acts in a synergistic way.

Certain additional explanations, particularly relevant to the sphere of mental functioning, can be obtained from an analysis of the dominating values and ideologies linked to “being a woman” in Poland in recent decades. The post-war professional mobilisation of women, motivated mainly by economic factors, led to a broadening of women’s social role, albeit without the possibility of relinquishing a single element of their traditional role, and without providing at the same time any specific possibilities for self-fulfilment or particular gratification. For a considerable number of women, especially those from the lower social strata, such a situation, without any significant modifications, continues until this very day. Nevertheless, it does not seem that the assumption of many new tasks, along with additional duties and shortages, has been unequivocally stressful for most women. The tradition of a woman sacrificing herself for the children, husband and family, represented by the model of the ‘heroic Polish Mother’ who is capable of taking on all challenges, has been for many years incorporated into the personal model of a woman (Titkow 2007: 52). It is perhaps this very ability to meet difficult demands for the sake of the nearest and dearest that has for years constituted a reward for women’s daily efforts and has improved their self-esteem, while at the same time constituting a buffer which mitigates the impact of the negative factors disturbing health and well-being. Thus, if women have been and still are excessively exploited, it is generally not in a way which endangers their own sense of worth and dignity. Until the 1990s the notion of discrimination had not appeared in the discourse concerning the situation of women in Poland, nor had a popular feminist movement found a reason for being in Poland.

This thesis is confirmed by research which shows that still today, despite the objectively lower social status, heavier workload coming from the necessity to carry out work and family duties, and smaller chances to exist in the sphere of public life – many Polish women accept this state of affairs as natural and it does not seem to cause them much emotional distress. By the same token, this situation, albeit objectively unfavourable, does not present, to many women, any hazard either when it comes to the stability of the setup in which they find themselves or to their psycho-social condition (Titkow 2007: 54–56). Their ability to accept their situation, to work out ways in which to cope with the demands of life, and finding sense and reward in their efforts and sacrifices may have led – according to Aaron Antonovsky’s salutogenic model (1995) – to an increase in the level of their “generalised resistance resources”, preventing the negative effects of over-exertion, stress and failures, and in consequence leading to a lengthening of their lives. It may be supposed that this situation concerns, to a large extent, women from other countries of Eastern Europe as well.

References

- Abbot P., Wallace C. (1993), *Women, health and caring*, [in:] *An introduction to sociology: Feminist perspectives*, London: Routledge.
- Arber S., Thomas H. (2001), *From women's health to gender analysis of health*, [in:]: W.C. Cockerham (ed), *The Blackwell companion to medical sociology*, Malden: Blackwell Publishers.
- Arber S. (2012), *Gender, marital status and sleep problems in Britain*, "Przegląd Lekarski", nr 2.
- Astbury J. (2009), *Menopause*, [in:] WHO, *Mental health aspects of women's reproductive health*, WHO, Geneva.
- Antonovsky A. (1995), *Rozwikłanie tajemnicy zdrowia*, Warszawa: Fundacja IPiN.
- Bayer Shering Pharma, (2010). *Bóle miesięczkowe i endometrioza*, Research Report BSP, Warszawa
- Berkman L., Breslow L. (1983), *Health and ways of living. The Alameda County study*, Fairlawn, NJ: Oxford University Press.
- Budrys G. (2003), *Unequal health*, New York: Rowman and Littlefield Publishers.
- Bożek r., Rychłowska I. (2001), *Szczupła, chuda, chudsza... Kulturowe uwarunkowania anoreksji i bulimii*, "Kultura i Społeczeństwo", nr 2.
- Carmel, S. (2012), *Gender differences and the will-to-live in old age*, "Przegląd Lekarski", nr 2.
- Długolecka A. (2002), *Raport o seksualności Polaków*, Warszawa: Pfizer.
- Duch- Krzysztoszek D. (2007), *Kto rządzi w rodzinie*, Warszawa: Wydawnictwo IFiS PAN.
- Ell K. (1996), *Social networks, social support and coping with serious illness: the family connection*, "Social Science and Medicine", no. 2.
- Enriquez J.R. at all, (2008), *Women tolerate drug therapy for coronary artery disease as well as men do, but are treated less frequently with aspirin, beta-blockers or statins*, "Gender Medicine", no. 5.
- Friedman M., Rosenman R.H., (1974), *Type A behavior and your heart*, New York: Fawcett.
- Garmanikow E. (1983), *Gender, class and work*, New York: Heinemann.
- Granicki O. (1998), *Epidemiologia AIDS*, [in:] J. Rzepka [red.] *Zagadnienia prorodzinnej edukacji seksuologicznej o profilaktyki HIV/AIDS*, Katowice: Studio Wydawnicze Agat.
- Heise L., at al. (1994). *Violence against women: A neglected public health issue in less developed countries*, "Social Science and Medicine", no. 9.
- Holtzman J., Khal S., Kane R. (2002), *Gender differences in functional status and pain in the Medicare population undergoing elective surgery*. "Medical Care", no. 40.
- Izdebski Z. (2000), *Wiedza, przekonania o HIV/AIDS w społeczeństwie polskim*, Warszawa: PWN.
- Lahelma E.P., at al. (1999), *Gender differences in ill health in Finland: Patterns, Magnitude and Change*, "Social Science and Medicine", no. 48.
- McBride A., McBride M. (1985), *Theoretical underpinnings for women's health. Diagnosis and treatment*, APA.
- Ostrowska A. (1997), *Prozdrowotne style życia*, "Promocja Zdrowia. Nauki Społeczne i Medycyna", nr 10–11.
- Ostrowska A. (1999), *Styl życia a zdrowie*, Warszawa: Wydawnictwo IFiS PAN.
- Ostrowska A. (2012), *Health inequalities – gender perspective*, "Przegląd Lekarski", nr 2.
- Popay J., Bartley M., Owen Ch. (1993) *Gender inequalities in health: social position, affective disorders and minor physical morbidity*, "Social Science and Medicine", no. 1.
- Rosenfield S. (1989), *The effects of women's employment: personal control and sex differences on mental health*, "Journal of Health and Social Behavior". Extra issue, no. 33.
- Sayer G.P., Britt H. (1996), *Sex differences in morbidity: A case of discrimination in general practice*, "Social Science and Medicine", no. 2.
- Stacey M., Olesen V. (1993). *Introduction*, Special issue: *Women, Men and Health*, "Social Science and Medicine", no. 1.

- Sztanderska U. Grotkowska G. (2007) *Zatrudnienie i bezrobocie mężczyzn i kobiet*, [in:] Kowska I., Sztanderska U., Woycicka I., *Aktywność zawodowa i edukacyjna a obowiązki rodzinne w Polsce*, Warszawa: Scholar.
- Tarkowska E., (2000), *Zrozumieć biednego*, Warszawa: Wydawnictwo IFiS PAN.
- Thoits P. (1995), *Stress, coping and social support processes: Where are we? What next?* "Journal of Health and Social Behavior". Extra issue.
- Titkow A. (2007), *Tożsamość polskich kobiet*, Warszawa: Wydawnictwo IFiS PAN.
- Verbrugge L. (1985), *Gender and health. An update of hypothesis and evidence*, "Journal of Health and Social Behavior", no. 26.
- Verbrugge L. (1990), *Pathways of health and death*, [in:] R. Apple (ed.) *Women's health and Medicine in America*, New York: Garland Publishing.
- Wojnarowska B. (1998), *Zdrowie młodzieży szkolnej w Polsce*, Warszawa: Wydział Pedagogiczny Uniwersytetu Warszawskiego.

Statistical information and elaborations

- GUS. (2007) *Ochrona zdrowia w gospodarstwach domowych w 2006 roku*.
- GUS. (2009) *Stan zdrowia ludności Polski w 2007 roku*.

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PLEĆ SPOŁECZNO-KULTUROWA I SPOŁECZNE DETERMINANTY ZDROWIA

Streszczenie. Autorka koncentruje się na istniejących różnicach między kobietami i mężczyznami w wielkości odnotowywanych wskaźników śmiertelności i zachorowalności. Zróżnicowanie to trudno wytłumaczyć czynnikami biologicznymi. Dlatego uwaga badaczy skierowana została na czynniki społeczne i kulturowe jako możliwe wyjaśnienie owych dysproporcji. Kobiety prawie na całym świecie żyją dłużej niż mężczyźni, ale jednocześnie dotyczy ich wyższy poziom zachorowalności, związany z przewlekłymi fizycznymi i emocjonalnymi zaburzeniami. W artykule wykorzystano perspektywę socjologiczną, by pokazać, że obserwowane różnice mogą być związane ze zróżnicowaniem społeczno-kulturowym i umiejscowieniem obu płci w obszarze struktury społecznej.

Słowa kluczowe: płeć, zdrowie, opieka zdrowotna, determinanty zdrowia.