Social Science & Medicine 67 (2008) 808–816

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The weaker sex? Exploring lay understandings of gender differences in life expectancy: A qualitative study☆

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ARTICLE INFO

Article history:
Available online 14 June 2008

Keywords:
UK
Gender
Lay knowledge
Men's health
Women's health

ABSTRACT

Despite increasing interest in gender and health, 'lay' perceptions of gender differences in mortality have been neglected. Drawing on semi-structured interview data from 45 men and women in two age cohorts (born in the early 1950s and 1970s) in the UK, we investigated lay explanations for women's longer life expectancy. Our data suggest that respondents were aware of women's increased longevity, but found this difficult to explain. While many accounts were multifactorial, socio-cultural explanations were more common, more detailed and less tentative than biological explanations. Different socio-cultural explanations (i.e. gendered social roles, 'macho' constraints on men and gender differences in health-related behaviours) were linked by the perception that life expectancy would converge as men and women's lives became more similar. Health behaviours such as going to the doctor or drinking alcohol were often located within wider structural contexts. Female respondents were more likely to focus on women's reproductive and caring roles, while male respondents were more likely to focus on how men were disadvantaged by their 'provider' role. We locate these narratives within academic debates about conceptualising gender: e.g. 'gender as structure' versus 'gender as performance', 'gender as difference' versus 'gender as diversity'.

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Introduction

Studies of 'lay' perceptions of health and illness can advance understandings of individual health choices and inform health education and social policy (Blaxter, 1997). Most commentators agree that 'lay' people have sophisticated understandings of health and illness, based on intimate knowledge of family members over the lifecourse, social networks and media accounts (Davison, Frankel, & Davey Smith, 1992; Hunt & Emslie, 2001; also see Bury, 1997; Prior, 2003 for useful overviews of the changing status of 'lay' perceptions in medical sociology).

Gender plays a key role in lay perceptions of health and health practices. Following West and Zimmerman (1987), we conceptualise gender as a dynamic set of socially constructed relationships embedded in everyday interaction, rather than as a simple attribute of individuals. 'Doing' gender means consciously or unconsciously *creating* differences which are then often viewed as 'natural' distinctions between men and women. This emphasis on 'difference' between men and women creates binary ways of thinking and being. As Annandale and Clark (1996) suggest:

> "we artificially, and inappropriately, divide people into two camps…we build a series of other characteristics on top of gender i.e. women are unhealthy, men are healthy; women are irrational, men are rational and so

☆ We would like to thank the respondents who participated in this study and Sally Macintyre for her helpful comments on the paper. We would also like to thank Rosey Davidson for conducting 12 interviews; CE conducted all of the other interviews. The authors are funded by the UK Medical Research Council (WBS U.1300.00.004). The first draft of this paper was written while CE was on study leave at the Department of Geography, Canterbury University, New Zealand; thanks to Wendy Lawson for hosting this visit.

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doi:10.1016/j.socscimed.2008.05.009

on…real life experience is not like this; attributes and experiences like acting rationally or being healthy cross-cut gender and are not the province of men or women as a group'' (p. 22).

Given that ''the doing of health is a form of doing gender'' (Saltonstall, 1993, p. 12), one way in which men can demonstrate culturally valued (or hegemonic) forms of 'masculinity' is by denying vulnerability, taking risks which may injure their health and rejecting health beliefs and behaviours which they associate with women (Connell, 1995; Courtenay, 2000). Whilst there is plenty of evidence to show that many men adopt such strategies, qualitative research supports Annandale and Clark's vision of 'real life experience' as being more complex; not all women are eager to consult and not all men are disinterested in their health. For example, a number of studies suggest that women place the health of their families above their own needs, and that a central feature of being a mother is to 'keep going' which may involve hiding symptoms and ignoring one's own health (Blaxter, 1983; Pill & Stott, 1982; Popay & Groves, 2000; Walters & Charles, 1997). Studies which explore health in the context of everyday life have often focused on women, but recent work suggests that some men, under certain conditions, resist hegemonic constructions of gender in the way that they talk about health or engage with health care (Emslie, Ridge, Ziebland, & Hunt, 2006; O'Brien, Hunt, & Hart, 2005; Robertson, 2007). In addition, the resources people have for constructing gender vary by socio-economic status, sexuality, ethnicity and other markers of social position.

These strong links between the acting out, and (re)creation, of gender differences and health suggest that there is much to be learnt from examining lay understandings of gender differences in health. In this paper, we are interested in exploring lay understandings of gender differences in mortality as we are not aware of any qualitative studies which focus on this topic. This neglect is interesting, given that in virtually every society in the world, women now have a longer life expectancy than men (Barford, Dorling, Smith, & Shaw, 2006). A few quantitative studies of perceptions of gender and life expectancy have been conducted, but the results are contradictory. In two studies, participants correctly perceived that women in the UK had longer life expectancy than men. Macintyre, McKay, and Ellaway (2005) found that 88% of women and 87% of men in a general population sample in Scotland indicated that women lived longer than men, while Popham and Mitchell (2007) found that a significantly higher proportion of men than women in the British Household Panel Survey believed that they were 'not likely' to live to 75 years. By contrast, a study of students in the United States (Wallace, 1996) did not find gender differences in young men's and women's estimates of their personal life expectancy. However, in response to an open-ended question about reasons for women's greater longevity, a higher proportion of female than male respondents attributed this to women taking better care of their health, while more male than female respondents attributed this to the physical demands of men's jobs. Only a small proportion of men and women (16% and 14% respectively) attributed the gender gap in life expectancy to biological factors. In-depth qualitative research can illuminate the reasoning and complex meanings attached to such perceptions. Below, we briefly review current hypotheses on gender and mortality before outlining our qualitative study.

Gender differences in mortality are influenced by both socio-cultural and biological factors, although the extent to which each makes a contribution varies for different health conditions (Krieger, 2003; Wizeman & Pardue, 2001). Bio-medical research has investigated biological differences between men and women in anatomy and physiology (particularly related to the reproductive system) and in a wide range of metabolic and hormonal factors and, whilst these biological differences are clearly important in shaping patterns of morbidity and mortality, they are usually considered quite separately from the social environment. Conversely, sociological research on patterns of illness ''treats biology as socially neutral and builds on the assumption that inherent biological differences between men and women are either minimal or largely irrelevant'' (Bird & Rieker, 1999, p. 107). In other words, ''the biological'' is explicitly played down (Birke, 2000). Furthermore, it has been suggested that interconnections between sex and gender, or the biological and cultural, might be typified as the *gendered expression of biology* when biological difference, such as reproductive capacity, influence gender divisions (making women responsible for looking after children because they have given birth, for example) or as the *biologic expression of gender* when gender divisions themselves are expressed in the biological body. In sum, despite an obvious need to understand when and how, or indeed whether, biology (sex) matters for a particular health outcome, very little research on gender and health has attempted to integrate biological and sociological models of pathogenesis or salutogenesis.

Variations in gender differences in life expectancy simply illustrate the complexities of the link between the biological and the social. The World Health Organisation notes that women's ''innate constitution appears to give women an advantage over men, at least in relation to life expectancy. When this female potential for greater longevity is not realised it is an indication of serious health hazards in their immediate environment'' (World Health Organisation, 1998). Before birth, sex manifests itself in higher male foetal loss and vulnerability to external maternal stresses (Kraemer, 2000). The complex ways in which this apparent greater biological vulnerability of males is then mediated by gender (the different social realities of being male or female in different contexts) is illustrated by the huge variation in sex differences in average life expectancy (LE). World-wide LE is 65 years for men and 69 for women (World Health Organisation, 1998), but sex differences in LE are smallest in countries where LE is lowest and currently highest in countries of the former Eastern block. These countries illustrate how social and political changes can have a profound impact on sex differences in health even within a short time frame: for example, between 1987 and 1995 the sex difference in LE in Russia increased from 9 to 14 years (Chenet, 2000).

Socio-cultural explanations for women's increased longevity generally draw on traditional gender roles and social constructions of 'masculinity'. There is some debate

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