



The health impacts of women's low control in their living environment: A theory-based systematic review of observational studies in societies with profound gender discrimination



Andy Pennington^{a,*}, Lois Orton^a, Shilpa Nayak^a, Adele Ring^a, Mark Petticrew^b,
Amanda Sowden^c, Martin White^d, Margaret Whitehead^a

^a Department of Public Health and Policy, Institute of Psychology, Health and Society, University of Liverpool, Whelan Building, Liverpool L69 3GB, United Kingdom

^b Department of Social & Environmental Health Research, Faculty of Public Health & Policy, London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London WC1H 9SH, United Kingdom

^c Centre for Reviews and Dissemination, University of York, Heslington, York YO10 5DD, United Kingdom

^d MRC Epidemiology Unit, University of Cambridge School of Clinical Medicine, Box 285 Institute of Metabolic Science, Cambridge Biomedical Campus, Cambridge CB2 0QQ, United Kingdom

ARTICLE INFO

Keywords:

Living environment
Autonomy
Health outcomes
Gender discrimination
Systematic review

ABSTRACT

We conducted a systematic review of observational evidence on the health impacts of women's low control/autonomy in the living environment in societies with profound gender discrimination and gender bias. Thirty observational studies of varying methodological quality were included. Overall, the evidence suggests that women's lower control or autonomy (for example lack of freedom of movement outside the home, lack of authority to access healthcare for sick children) was associated with poorer mental and physical health for women and higher morbidity and mortality for their children, after adjusting for their socioeconomic circumstances. Further studies are needed to disentangle and understand the pathways between low control and health outcomes in contexts of profound gender discrimination. This systematic review has highlighted the general low quality of the evidence base on this research question. It identifies the pressing need for high quality, longitudinal studies in the future.

1. Introduction

The proposition that the control that people have over their own lives is important for the health of individuals and societies is becoming more widespread in the public health and development literature (Whitehead et al., 2016). The Nobel Laureate, Amartya Sen, concludes:

“the success of an economy and of a society cannot be separated from the lives that members of the society are able to lead. Since we not only value living well and satisfactorily, but also appreciate having control over our own lives.” (Sen, 2003).

Both Sen and Marmot argue that control over your own life is a crucial determinant of health, well-being, and longevity (Sen, 1999a; Marmot, 2004). Furthermore, the global Commission on Social Determinants of Health (CSDH) concluded that inequalities in level of control and participation play a big part in generating social inequalities in health (CSDH, 2008).

There is a reasoned set of theories about how low control could lead to poorer health and contribute to inequalities in health (Whitehead et al., 2016), but what about the empirical evidence? There is a relatively strong body of observational evidence relating to the work environment, where robust measures of ‘job demand’ (the pressures of the workload) and ‘job control’ (degree of autonomy/latitude in managing that workload) have been developed in high income country contexts (Karasek and Theorell, 1990; Demerouti et al., 2001). These measures try to quantify ‘actual’ level of control that the employees experience in their jobs, rather than merely their perceptions or beliefs about how much control they feel they have. These studies generally show that high job demands coupled with low job control constitute health-damaging stressors that may lead to mental or physical ailments such as CVD (Van der Doef and Maes, 1999; Kuper and Marmot, 2003; Kuper et al., 2005; Bosma et al., 2005; Theorell et al., 2015). There is evidence that this combination of high demand but low control is more

* Corresponding author.

E-mail addresses: ajpenn@liverpool.ac.uk (A. Pennington), lorton@liverpool.ac.uk (L. Orton), shilpan@liverpool.ac.uk (S. Nayak), adeler@liverpool.ac.uk (A. Ring), Mark.Petticrew@lshtm.ac.uk (M. Petticrew), amanda.sowden@york.ac.uk (A. Sowden), Martin.White@mrc-epid.cam.ac.uk (M. White), mmw@liverpool.ac.uk (M. Whitehead).

<https://doi.org/10.1016/j.healthplace.2018.02.001>

Received 29 July 2016; Received in revised form 30 January 2018; Accepted 6 February 2018

1353-8292/ Crown Copyright © 2018 Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

common in lower skilled jobs, thereby providing a mechanism for generating inequalities in health between different occupational groups (Marmot et al., 1997).

The literature on the health effect of control in the living environment is less well developed and disparate, compared with the formal work environment. By 'living environment' we mean the households, communities and societies in which people live and go about their daily lives outside paid work. It is much more difficult to devise the equivalent measures of 'actual' control relating to the relatively unstructured setting of the living environment and to disentangle impact of control on health from all the other influences.

One approach has been to study the most severe forms of restricted control in the living environment: the limitations placed on women in societies with profound gender discrimination and gender bias (i.e. preference for sons). For millions of women in some low and middle-income countries with this profound gender discrimination, women's lives are highly restricted. They need a male relative's permission for all kinds of everyday caring activities, such as seeking healthcare for themselves and their children and going outside the family compound for any reason, even visiting other family members. They need to be accompanied by a male relative on such excursions outside their home. Women's access to schooling, to paid employment in the formal labour market, to food and nutrition may be severely limited.

Population health theories suggest that such lack of control and narrowly circumscribed autonomy in the living environment may have adverse effects on women's health and the survival of their children (Sen, 1999a, 1999b). One pathway between women's low control/limited autonomy and health is through reduced access to key determinants of health – including limited control over access to preventive and curative health services, education and paid employment opportunities, food and nutrition, fertility and reproductive rights. In turn, this reduced access to determinants of health may lead to poorer health including higher levels of anxiety and depression, malnutrition, health risks from greater numbers of pregnancies and childbirth, and domestic violence against women. Survival of the women's children may be adversely effected by not being allowed to take a sick child to hospital or for immunisations and other preventive procedures. In addition, in societies with marked son preference, lower female survival rates may also occur through mechanisms such as neglect or infanticide of girl babies and, in recent decades, as sex determination and selection technologies have become widely available, the practice of sex-selective abortion (Banister, 2004). Although women's autonomy in the living environment is generally constrained in cultures with profound gender discrimination, there is still variation across households and communities in the degree to which a woman is free to make decisions concerning key determinants of health. This variation provides opportunities for research to make comparisons between women with relatively low and high levels of control.

We set out to conduct a systematic review of empirical evidence of the impact of women's low control in the living environment on health outcomes, based on the hypothesised pathways between control and health in societies exhibiting profound gender discrimination.

2. Methods

2.1. Logic model and search strategy

The search strategy and interrogation of the evidence was guided by the logic model in Fig. 1. This shows the hypothesised pathways between the low status and constrained autonomy of women in their living environment in societies exhibiting profound gender discrimination/bias (column 1) and poorer health outcomes (column 4). Lower control/reduced power to use available resources that influence health (column 2) is hypothesised to act as a mediating factor, leading to adverse health-related effects (column 3), which result in poorer health outcomes for women and for their children (column 4). Son preference

is shown in a separate pathway as having both direct and indirect effects on child survival.

We searched the electronic databases MEDLINE and MEDLINE In-Process, PsycINFO, Social Science Citation Index, and Conference Proceedings Citation Index - Social Sciences and Humanities for articles published between January 1980 and December 2016 on the association between women's levels of control in their living environment and health-related outcomes. We also drew on relevant results of an earlier search from a broader review of associations between control/empowerment and inequalities in health. Reference lists of included studies were scanned for relevant articles. We also requested data from researchers who had published previously on control and health-related outcomes. The Medline search strategy is available in [Web Supplement/Appendix 1](#).

2.2. Inclusion and exclusion criteria

A study was only included if it reported empirical data from quantitative observational studies in low and middle-income countries (LMIC) with strong gender discrimination, that included all three of the following components:

- a) **Measured women's level of control in their living environment.** The measures had to indicate the degree of 'actual' control that the woman could exercise in her day-to-day life in the society in which she lived. For example, how much freedom of movement she had outside her home; whether she had autonomy to take a sick child for medical treatment. Many studies developed autonomy indices, combining several measures of what women reported they were able to do or not do in daily decision-making. Studies were excluded if they only measured perceived control or control beliefs, e.g. a general (non-specific) question about how much control a woman perceives that she has in her household. This exclusion also covered studies from the psychological literature that examined perceived 'locus of control' of individuals as a personality trait, without reference to the living environment or women's status in society. Studies which measured degree of control in the work environment were also excluded because they did not relate to the living environment. A substantial body of literature was located relating to the effects of son preference on survival, but these studies were excluded because they did not measure level of control.
- b) **Measured a health outcome.** Studies that measured women's physical or mental health or that of their children were included. Studies were excluded that only went as far as measuring intermediate health-related outcomes depicted in column 3 of Fig. 1 (e.g. access to health care), but did not go on to measure the health outcome. Application of this criterion led to exclusion of a large body of studies that examined level of control and health-seeking behaviour, but failed to measure health outcomes.
- c) **Made some adjustment for socioeconomic factors/circumstances (SES) that may operate in the pathways to influence women's health.** SES is a powerful determinant of population health in its own right, with the poverty and material disadvantaged suffered by poor rural women in low and middle-income countries causing higher morbidity and mortality directly. In addition, SES may act as a moderator in the pathway between control and health, or control may act as a mediator in the pathway between SES and health, as depicted in the logic model in Fig. 1. To be included, studies had to make some attempt to take SES circumstances and pathways into account.

2.3. Screening and review

Titles and abstracts of all records were independently screened by two reviewers to identify potentially eligible studies based on the initial

Download English Version:

<https://daneshyari.com/en/article/7456909>

Download Persian Version:

<https://daneshyari.com/article/7456909>

[Daneshyari.com](https://daneshyari.com)